Regulated competition and citizen participation: lessons from Israel

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Abstract

Objective To investigate the relationship between health system structure and citizen participation, in particular whether increased reliance on competition encourages or depresses citizen involvement.

Setting The case of Israel's ongoing health reform, based on regulated competition among sick funds, is examined.

Design Interviews with government officials and representatives of consumer groups; analysis of policy documents, judicial rulings, public surveys and journalistic accounts.

Results The Israeli reform is based in large measure on a regulated competition model, in which citizens have free choice among highly regulated competing sick funds. At the same time, the reform process has been accompanied by legal, institutional and political frameworks, as well as significant interest group activity, all aimed at increasing public input into processes of health policy making and implementation. The Israeli case, it is argued, lends support to the proposition that citizen participation (voice) and individual choice (exit) are complementary, rather than alternative, modes of ensuring citizen influence over health services. The question is whether the development of multiple avenues for citizen involvement represents disarray or a healthy social learning process regarding the running of the health system.

Conclusion This paper expresses cautious optimism that citizen participation is a projection of a healthy social learning process, and suggests directions for public policy to encourage this outcome.

Introduction

It is by now generally accepted that health systems everywhere are confronting the difficult task of increasing efficiency while maintaining equity.^{1,2} As pointed out by the organizers of a recent conference, many countries are addressing this dilemma through structural reforms aimed at developing a 'third way' between 'classic welfare state ideas' and reliance on

'competitive mechanisms'.³ Given the value-laden nature of the substance of health policy and the ideological aspect of the procedural alternatives, it is not surprising that citizen participation has become a prominent issue.

The salience of citizen participation is further heightened by the shifting role of the medical profession. The pre-eminent role of physicians, both in large-scale health policy matters and in the interface with the individual patient, is being

increasingly questioned. The physician's agency relationship with the patient is coming under question, as is the trust between physician and patient.⁴ Charles & Demaio see lay participation as a reflection of the loss of faith in professional autonomy and the desire to make health care providers more accountable.⁵ These developments have led to an emphasis on patients' rights and a greater role for citizens and patients in medical decision making.

This paper examines the role of citizen participation in health systems relying to a significant degree on competitive mechanisms. This issue is important, because it might be assumed that the introduction of competition, especially if highly regulated by government, will lead to a reduction in various forms of citizen participation in the health policy process, since individual citizens will be increasingly empowered to make choices in the market. An alternative scenario is that the introduction of market mechanisms may be associated with increased citizen participation.

For example, Saltman & Von Otter used Hirschman's concepts of 'exit' and 'voice' in developing one model of a 'third way' between governmental command and control on the one hand and the market on the other.^{6,7} Voice alone, for example through some form of organized citizen involvement, they argue, is insufficient to induce more responsive and equitable behaviour from public health bureaucracies. Exit, though, in their view, need not necessarily be from the public to the private sector, but rather could involve 'lateral re-entry' into the public sector. In effect, they argue for competition among alternative service providers within the public system, 'linking individual choice to short-term operating budgets of service delivery units'.

Saltman & Von Otter,^{6,7} in a manner somewhat similar to other commentators on Hirschman's model,^{8,9} argue that the threat of exit will enhance the influence of consumers seeking to exercise voice. Command and control systems, since they are very hierarchical are, in their view, problematic in this respect. Such systems seek to involve citizens in a top-down fashion, making

citizen participation a part of the formal structure. Regarding such frameworks, Saltman & Von Otter⁶ raise doubts as to the extent to which citizens gain empowerment *vis-à-vis* the health system. The possibility of lateral re-entry, on the other hand, strengthens the hand of both individuals and resident or client associations concerned about quality-of-service questions.

Current developments in the Israeli health system are interesting to view through the lens of Saltman & Von Otter's⁶ analysis. The 1995 Israeli National Health Insurance (NHI) Law created, in effect, a situation of regulated competition among four non-profit sick funds. The NHI Law mandates that all four sick funds provide a standard basket of health services. Citizens can exit from one fund and enter one of the competitors once each year. Short-term operating budgets are linked to patient choice, since the funds receive risk-adjusted (based on age) capitation payments based on the number of people enrolled. Unlike the public competition model alluded to by Saltman & Von Otter,⁶ the Israeli set-up is more market-like, involving private non-profit firms. Thus exit and re-entry are lateral, but in the private non-profit sector, not the government sector.

The functioning of this regulated market has been accompanied by a variety of forms of citizen involvement. This is perhaps not surprising. Bracht¹⁰ has defined citizen participation as the process by which individuals voluntarily take part in either formal or informal activities, programmes or discussions to bring about a planned change or improvement in community life, services or resources. This implies that we might expect to find multiple forms of citizen participation.

None the less, finding increased citizen participation precisely in a market system that emphasizes exit raises interesting issues. Does exit, as argued by Saltman & Von Otter,⁶ promote voice, on the part of both individuals and organized interest groups? Alternatively, would we expect to find stepped-up interest group activity in any case resulting from a major health system reform? These questions will be taken up later, after presentation of the Israeli case.

The descriptions and analyses presented here are based on interviews with government officials and representatives of consumer groups, and analysis of policy documents, judicial rulings, public surveys and journalistic accounts. These sources provide information on the symbiotic relationship between Israeli health reform and citizen participation. The conclusions to be reached are tentative and suggestive, given the semi-structured nature of the investigation, and the fact that in many respects the reform is relatively new and many of its key elements are still evolving. Still, it is hoped that the case will provide insights that are relevant to other health systems as well.

Citizen involvement in Israeli health care

In the spirit of Bracht,¹⁰ citizen involvement in relationship to the Israeli health care system has been characterized by a variety of formal and informal activities, programmes and discussions. To an extent the activities discussed below are interdependent. Formal, government-initiated structures induce responses which take the form of organized citizen action, which in turn feeds back to and influences the formal structures. In some case it is the weakness of formal structures that calls citizen participation into being, forcing the former to take a more forceful role.

The Patient's Rights Law

In the wake of the passage of the NHI Law, a Patient's Rights Law, which had been evolving for a number of years, was passed. This legislation established the following basic rights: the right to unconditional emergency treatment; the right to information about the care giver; the right to a second opinion; the right to continuity of care; the right to human dignity and privacy; the right to informed consent for medical treatment; the right to access to medical information; and the right to medical confidentiality.¹¹ The law was met initially with some opposition. The medical profession questioned the viability, for example, of gaining fully informed consent. Subsequently, however, the Patient's Rights

Law has no doubt had some influence on the behaviour of care givers, and has raised awareness regarding patients' rights. It has also become a focus of the activities of various consumer and patient advocacy groups seeking to ensure that health care institutions operate according to its provisions. On the other hand, it is clear that much remains to be done to ensure that the majority of patients are aware of the law and to see to its enforcement.

The National Health Council

The NHI Law mandated creation of a 46-member National Health Council to advise the government on issues related to the law, such as updating the standard basket of health services. The council includes public and consumer representatives. These are a minority, however, among a group composed mainly of government and sick fund officials, and representatives of provider groups. Initially, the council met infrequently and had little impact.¹² Recently, it has begun to meet more regularly, but its discussions are, apparently, still dominated by the agenda set by the Ministry of Health. One of the roles allocated to the council, and barely carried out, is to provide information to the public on the functioning of the NHI Law.

Sick fund governing bodies

The NHI Law called for sick funds to have councils, which would serve as the supreme governing bodies. The councils were to include elected members of the sick funds. Opinions differ as to the nature of these elections and the degree of consumer representation afforded. According to the chairman of the largest sick fund, elections are likely to be dominated by special interests, and the question of sick fund governance has not been settled.¹³

The National Health Ombudsman

The NHI Law called for the appointment of an ombudsman to handle complaints by citizens

regarding the law. In 1997 the ombudsman, while not required to do so, issued a wide-ranging public report on the quantity and nature of complaints received. During 1997, the ombudsman handled over 20 000 complaints. For 858 of these the process of dealing with the complaint had been completed. The main areas of complaints included: problems related to transferring between sick funds (registration problems, lack of continuity of benefits, etc.); lack of freedom to choose medical care providers; failure to update the standard basket of health services; and failure to receive drugs and medical treatments. The ombudsman commented that few of the problems in the system had been seriously dealt with during the first 3 years of the implementation of the NHI Law.¹⁴

Health-related interest groups

Beginning with the legislative process leading up to the passage of the NHI Law, organizations of health consumers and associations linked to specific diseases, such as the Israeli Cancer Association, have become quite active.¹⁵ They appear at public hearings on the law and engage in lobbying, especially against government policies that they deem unacceptable. There is an umbrella group, Zvi, the Israeli Health Consumers' Organization. The various health-related interest groups and associations function both individually and, at times, in concert under the leadership of Zvi.

A remarkable example took place during the process surrounding the 1998 State Budget legislative process. The Ministry of Finance sought to introduce fundamental changes in the NHI framework. Key proposed changes involved eliminating the standard basket of health services mandated by the law and allowing the sick funds to determine their own baskets, as well as introducing increased copayments. The budget process galvanized Zvi and its constituents, as well as citizen and public interest groups. The Association for Citizens' Rights in Israel sponsored a coalition called Finger on the Pulse. This coalition brought

together representatives of groups such as consumer organizations, think tanks, Physicians for Human Rights, the Israeli AIDS Task Force, and other public interest groups in an effort to spread information about the status of the NHI Law and to lobby against the proposed changes.¹⁶ This coalition joined forces with the Israeli Medical Association in a mass protest demonstration held in front of the parliament building during the debates on the budget. The demonstration, involving a 1-day strike of the entire health system, was unique in that it dealt not with issues of health sector working conditions, but rather with more general health policy issues. In part as a result of these activities, the proposals to eliminate the standard basket of health services were defeated. Some copayments were increased for visits to specialists and outpatient clinics, and for drugs. Notably, during the debate a group of patients from a prominent children's hospital visited the State President as part of a visit to Jerusalem. One of the visitors pressed the President on the issue of the availability of drugs for cancer treatment. In the wake of the media coverage accorded this event, the government decided to add 15 new drugs (implying an increment of 150 million shekels, or 1% to the health budget) to the standard basket of health services. Until that point, the basket, with one exception, had not been updated since the inception of the NHI Law.¹⁷ Also, during 1998, partly in response to legal and public pressure on the part of couples seeking access to *in vitro* fertilization, the Minister of Health lifted limits being imposed by sick funds on the number of cycles available to couples under the law. Access to treatment will be based on approval of a panel of experts.

The committee to update the standard basket of health services

The decision to add 150 million shekels to update the basket was adopted by the government for the planned 1999 budget as well. A public committee, made up primarily of government and health sector representatives, joined by a few prominent public figures and

academics, was created to allocate these funds to new technologies. The committee has recently completed its first round of deliberations.¹⁹ Input has come from technology assessment activities of the Ministry of Health, as well as briefs and communications submitted by interest groups. Needless to say, the committee is faced with more requests than it can fund. It remains to be seen what public reaction, especially on the part of those whose requests have not been approved, will be to this process. Some have argued that it lacked sufficient public consultation. An alternative view, expressed by the Minister of Health, is that the annual prioritization of new technologies, while difficult, is a blessing.¹⁸

Legal appeals by injured citizens

The NHI Law allows for citizens who feel that their rights under the law have been violated to seek redress in the Labour Court. Several cases regarding sick fund refusal to cover the costs of treatment have been argued in both the regional and national Labour Courts. In some recent cases the court has ruled that sick funds are not required to provide services not explicitly included in the standard basket of health services mandated by the NHI Law. Moreover, even services included in the basket are only considered to be entitlements if prescribed as indicated listed in the national drug registry.¹⁹ However, denial of services based on clinical guidelines approved by the Ministry of Health, and even included explicitly in the language of the standard basket of health services, has not yet been tested.²⁰ If sick funds, supported by the Ministry of Health, seek to base medical decisions on clinical guidelines, it is unclear whether this will result in further appeals to the court, and how such appeals should be disposed.

Public appeals by patients and physicians regarding freedom of choice

The NHI Law calls for patients to have free choice of provider, except in cases where sick funds clearly publish their limits on freedom of

choice. Freedom of choice became a public issue in several cases in which patient complaints, echoed in the media, were levelled at sick fund attempts to channel patients to preferred providers. As a result, the sick funds published their regulations regarding freedom of choice, although it is unclear how aware the public is of these regulations.

Recently, physicians, purportedly on behalf of patients, have argued against sick fund directives requiring switching to cheaper drug regimens. Sick funds argue in response that they are fulfilling their obligation to keep within their budgets by utilizing drugs that are also effective. These debates have made their way into the media.²¹ It is unclear what public reaction will be and how it will influence decision making; however, the Ministry of Health has announced that it will look into the matter. As in the case of freedom of choice, the degree of clarity with which information on the right of sick funds to limit treatment will be conveyed to the public remains to be seen.

Summary: regulated competition and citizen participation

Introduction of regulated competition among sick funds in Israel has been accompanied by significant consumer involvement and the exercise of voice as much as it has encouraged exit. This would seem to indicate that reliance on competitive mechanisms is not necessarily a recipe for a reduction in organized citizen participation. Exit and voice support each other. In the following paragraphs we conclude by further examining this relationship and its implications for policy makers.

There could be a number of possible explanations for the finding that the introduction of regulated competition was accompanied by increased citizen participation. One is based on the thesis proposed by Saltman & Von Otter⁶ alluded to above, namely that the threat of exit enhances the role of voice. Alternatively, it might be argued that any major policy reform of the type introduced in Israel would be expected to mobilize enhanced interest group activity.

It is not possible to establish the superiority of either of these explanations without resort to comparison with other major reforms, which is beyond the scope of this paper. However, the Israeli case suggests several reasons to support the Saltman & Von Otter⁶ position. First, the case demonstrates, as stressed elsewhere, that introduction of competition in health systems implies the need for significant government regulation.^{2,22} Regulatory frameworks, by nature part of the political system, are ripe targets for organized citizen input. Indeed, the very prospect of embarking on a competition-based reform may lead policy makers to build in various forms of citizen participation in advance. Secondly, competitive reforms are often based on contracting, which requires explicit definition of entitlements and service requirements. It is no coincidence that the Israeli reform involved explicit definition of a standard basket of health services, and was accompanied by introduction of the Patient's Rights Law. Such clear definition of entitlements is also a magnet for citizen participation and interest group activity. Finally, while actual consumer choice of sick fund (the exit option) has become relatively infrequent, the issue of the market behaviour and differentiation among the sick funds has been highlighted, becoming an issue for public debate. The competitive model that was set up led to more open public discussion and patient advocacy regarding the competitive behaviour of the sick funds. So, while we cannot exclude the possibility that any major health system reform would spark increased citizen participation, the Israeli case appears to lend support to the notion that regulated competition encourages citizen participation in a special way, akin to the model suggested by Saltman & Von Otter.⁶

Whatever the source of the impetus for increased citizen participation, an important practical question for policy makers is whether the array of modes of citizen participation, the activities of organized interest groups and the voluntary activities of citizens' coalitions contribute to improved functioning of the regulated market in health care. It would seem

that one message for government policy makers is that they should seek to find ways in which regulated competition and citizen participation can best complement each other. It would be unfortunate, for example, if decision processes regarding the contents of the standard basket of health services were to degenerate into an uncontrolled contest among interest groups. This has not happened yet in the Israeli case, but one wonders what will happen as it becomes clear that the process set in motion regarding the standard basket implies not only adding but also excluding, at least temporarily, some services. Perhaps one option is for government to encourage and structure public discussion of these issues, using some of the formal frameworks that have not yet been adequately tried. For example, the National Health Council and the proposed sick fund councils could serve as forums for transmission of information to consumers as called for by the NHI Law.

The question also arises whether voice, in the form of citizen participation, actually cancels out exit. Movement among sick funds has been limited to around 4% of the population annually,²³ and the claim is often heard that the sick funds constitute a cartel. On the other hand, it may be the fact that the market is contestable, rather than the actual level of movement, that serves to induce (hopefully positive) competitive behaviour.²⁴ Healthy competition can be aided by clarifying the competitive role of the sick funds (e.g. to what extent *are* sick funds allowed to limit patient and provider choice?). By engaging the various citizen groups discussed above in an active dialogue, including development of citizen-friendly reports on the performance of the sick funds and other providers, government could utilize citizen participation to improve competition.

It is important to stress that government can build on the evolution of various forms of citizen involvement to improve the system, or, in the words of Saltman & Von Otter,⁶ maintain the centripetal force for solidarity and avoid the centrifugal tendency to dissolve the public system. However, conscious efforts may be required on the part of health system leaders to

ensure that citizen activity evolves into the kind of voice that best complements the exercise of exit within a publicly oriented health system.

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