

POLICY BRIEF

Your Place in Line

Waiting Times in Israel's Public Hospitals

Liora Bowers and Dov Chernichovsky*

Background

The National Health Insurance Law provides that every resident is entitled to receive healthcare within a reasonable period of time and at a reasonable distance. However, these have never been defined. As such, a key challenge for policymakers is defining what constitutes reasonable distance and waiting times given that different circumstances lead to differing perceptions regarding appropriate waiting times. Additional challenges include developing methods for the acceptable, transparent measurement of waiting times for public care, designing a delivery system that meets waiting time benchmarks and developing incentives or penalties to reach such targets.

In general, waiting times are an important health policy issue in countries around the world. In the OECD, 23 countries, including Israel, self-identified waiting times as a major policy issue. Nonetheless, Israel is behind in taking active measures to address it. Fifteen OECD countries with waiting times challenges have national strategies to shorten long waiting times.¹ Israel does not have this even though long waiting times are considered problematic across the system, including in elective (i.e., non-emergency) surgery, emergency, specialty and cancer care (Siciliani, Borowitz and Moran, 2013).

This study will show that there are disparities in waiting times in Israel for medical care based on the location of the hospital (periphery versus center), hospital ownership (whether by government, Clalit Health Services, or non-profit

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Patients in Israel face disparities in waiting times for medical care based on the location of the hospital (periphery versus center), hospital ownership (government, Clalit Health Services, or non-profit institutions) and payment type (public versus private). These gaps demonstrate to a great extent the challenges facing the Israeli health system. This study will discuss several possible options for improving the waiting times situation in the country.

* Prof. Dov Chernichovsky, Chair, Taub Center Health Policy Program; Department of Health Systems Management, Ben-Gurion University of the Negev. Liora Bowers, Director of Policy, Taub Center. I wish to thank Nofar Gueta, Taub Center Research Assistant, for her research help and Laura Schreiber, Taub Center Operations and Publications Associate for her assistance in data aggregation. I thank Dr. Eitan Hai-Am, former Director General of the Ministry of Health; Prof. Meir Oren, former CEO and Medical Director of the Hillel-Yaffe Medical Center; and Prof. David Chinitz, Hebrew University, for their input and perspectives on the research and Ruth Waitzberg, Meyers-JDC-Brookdale Institute, and Nir Kaidar, Ministry of Health, for providing input on relevant data and studies.

¹ These countries include: Australia, Austria, Canada, Denmark, England, Finland, Ireland, New Zealand, Portugal, Scotland, Slovakia, Slovenia, Spain, Sweden, Turkey.

15 Ha'ari Street
Jerusalem 9103401, Israel
Tel: +972-2-567-1818
info@taubcenter.org.il
taubcenter.org.il

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institutions) and payment type (private versus public). These gaps demonstrate to a great extent the challenges facing the Israeli health system. The final part of the study will discuss several possible options for improving the waiting times situation.

1. *Waiting Times in the Public System*

It is important to understand waiting times as a mechanism for rationing care in a system where patients do not pay the full cost of care. In such a system, there is concern that consumers may overuse services because they do not feel the financial burden of doing so (i.e., moral hazard).

Nonetheless, there is evidence that long waiting times for emergency and urgent procedures, such as coronary bypass surgery, lead to deterioration in the patient condition and symptoms and worsen clinical outcomes. For less urgent procedures, such as hip and knee replacement, studies are mixed with regard to the impact of long waits on patient pain and functioning. The Institute of Medicine considers long waiting times as a burden on society, increasing the likelihood of more complex hospitalizations and poorer outcomes – thus potentially increasing healthcare costs (Brammli-Greenberg, Waitzberg and Guberman, 2014). Furthermore, long waiting times may negatively impact the patient’s ability to work and quality of leisure time, as well as increase their personal anxiety and dissatisfaction with the health system as a whole (Brammli-Greenberg et al., 2014; Siciliani et al., 2013).

2. *Waiting Times in Israel*

As mentioned above, waiting times for medical care in the public system in Israel is considered a national problem and a priority of the Ministry of Health (MOH).

To gain a fuller understanding of the situation regarding waiting times, it helps to delineate the process that a patient in need of medical care or a consultation undergoes. Obtaining such an appointment may be a difficult experience. The path begins with a referral by a family doctor and obtaining Form 17 – an obligation by the health fund to pay for the treatment. Form 17 is a necessary condition for treatment, but it does not ensure that a patient will receive treatment – and certainly does not ensure a reasonable time or location. First, the treatment occasionally has to be approved by a special committee in order for the Form to be issued. Secondly, the health fund dictates the location of treatment, often without regard to the availability of the next appointment, even if it may take a number of months. As such, an individual who suspects he may have a malignant tumor may have to wait months to know his actual condition and begin the appropriate treatment. These delays – particularly in urgent cases – lead patients and their families to undertake intensive inquiries in an attempt to find an earlier appointment at another hospital. If such an appointment is found, the patient will have to obtain an updated Form 17 for that hospital. A new negotiation with the health fund thus begins, which may culminate with the health fund not agreeing to the change.

The State Comptroller’s 2009 report showed waiting times across Israeli hospitals of six to seven months – sometimes over a year – for ear-nose-throat surgeries. A 2007 Knesset study showed significant variation across hospitals, which was most recently confirmed by the release of the Ministry of Health’s official waiting times

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data in various hospitals. For a hip replacement, a patient waits an average three weeks at Bnai Zion Hospital in Haifa, while a patient near Be'er Sheva waits over a year at Soroka Hospital. For thyroid removal, the Assaf HaRofeh patient near Tel Aviv and Hillel Yaffe patient in Hadera wait a week on average, as compared with almost six months in Poriya near Tiberias. The same hospital can perform poorly in one area and well in another (MOH, 2014e).

A recent survey including nearly half of family physicians in Jerusalem finds that the majority of physicians are concerned with waiting times for hospital care.² As Table 1 shows, only 9% and 20% of the physicians surveyed believe that a majority of their patients see a specialist or receive a medical procedure, respectively, in a reasonable amount of time at Hadassah Hospital, with the comparable figures being 15% and 24% at Shaare Zedek Hospital. Over 60% of the physicians reported referring patients to the private track and a similar share report using personal connections to shorten waiting times for patients in the public track.

Table 1

Survey question responses from physicians regarding their patients' waiting times*

Treatment facility	Distribution of physicians' responses					
	How many of your patients are able to see a specialist within a reasonable length of time?			How many of your patients are able to receive medical treatment** within a reasonable length of time?		
	Minority	Half	Majority	Minority	Half	Majority
Hadassah Medical Center	60%	31%	9%	37%	44%	20%
Shaare Zedek Medical Center	35%	50%	15%	22%	54%	24%
Health fund hospitals	8%	31%	61%	7%	28%	65%

* The survey included about 150 physicians in Jerusalem (about half of the family physicians in the city).

** Diagnosis or treatment procedure (biopsy, injection, imaging, or endoscopy).

Source: Liora Bowers and Dov Chernichovsky, Taub Center.

Data: Lahad et al., 2013.

It is important to highlight, however, that the perceptions regarding community care are vastly different than for hospitals – with almost two-thirds of family physicians reporting that the majority of their patients received an appointment for a specialist or procedure via their health fund within a reasonable amount of time (Table 1). While the survey consisted of Jerusalem physicians and health facilities only, its results may indicate a national phenomenon (Lahad et al. 2013).³

² The results of this study must be qualified, as they were not published in a peer-reviewed publication and the physicians surveyed are not necessarily a representative sample. Nonetheless, this study at the very least provides strong anecdotal indications of the issue regarding waiting times in the system.

³ Central Bureau of Statistics data for 2009 show that, after controlling for age and gender, Jerusalem patients were likely to have shorter waiting times than patients in other places in the country (Lahad et al., 2013).

The physicians' positive perceptions regarding access to care in the community setting aligns with the results of a 2012 survey, which showed that about 90% of Israelis express high levels of satisfaction with their health fund (Myers-JDC-Brookdale Institute, 2013). A 2014 Myers-JDC-Brookdale Institute study assessed waiting times in community care for non-urgent medicine. The results showed that the average waiting time for medical consultation is 3.2 weeks, meaning that 72% of those surveyed who needed a specialist consultation waited less than one month for their appointment (which was defined as a reasonable waiting time).⁴ The majority of patients surveyed felt that their waiting times were reasonable.⁵ On average, those respondents who felt their wait time was unreasonable indicated that an acceptable wait time for either a specialist consultation or diagnostic/imaging tests is 1.5 weeks (Brammli-Greenberg et al., 2014).

Waiting times for elective procedures

The Ministry of Health took an important step toward improved transparency on waiting times in 2013, requiring that public hospitals begin reporting on waiting times for elective procedures and publicly releasing their findings (MOH, 2014e). Figure 1 shows the average waiting times for 18 elective procedures for the first half of 2014 across 27 public hospitals in Israel. Waiting times are measured as the time elapsed between the point at which a hospital places a patient on the list for care until the procedure takes place. Average waiting times range from a low of 12 days for coronary bypass surgery (which can be an urgent procedure) to a high of 147 days for a deviated septum surgery. There are two procedures for which the average waiting time is one month or less, eight procedures for which the average waiting time is less than three months, and eight other procedures for which the average waiting time is more than three months. It should be noted, however, that some of the waiting time is due to patients choosing to wait for a preferred surgeon rather than taking the first available appointment.

Within the 27 public hospitals, there is a large range in waiting times. For example, there is more than a year difference in waiting times for knee replacement, tonsillectomy and deviated septum surgery between the hospitals with the shortest and longest waiting times in these areas. Soroka Hospital in Be'er Sheva and Poriyah Hospitals near Tiberias tended to have the longest waiting times for a number of procedures, while Bnai Zion Medical Center in Haifa had the shortest waiting times for a number of procedures.

Average waiting times range from a low of 12 days for coronary bypass surgery (which can be an urgent procedure) to a high of 147 days for a deviated septum surgery.

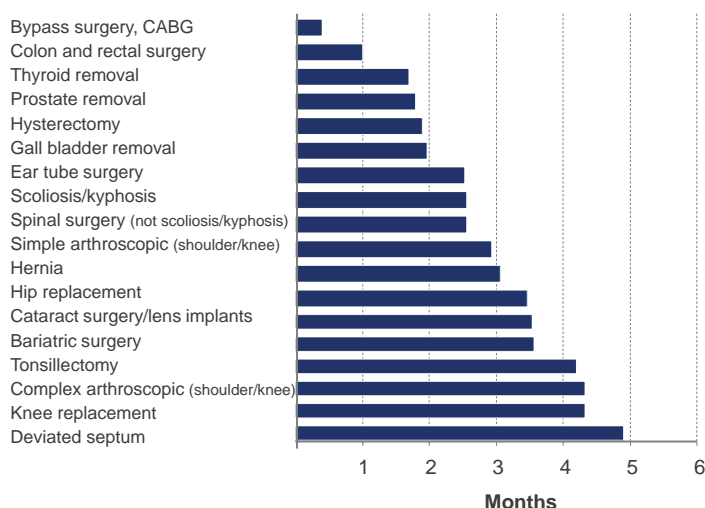
⁴ It is important to note that it is possible these waiting times also represent cases where patients used supplementary insurance in order to receive an expedited appointment.

⁵ Among respondents, 53% who waited for a specialist consultation felt the wait time was reasonable (their average wait time was 2 weeks as opposed to 4.9 weeks for those responding that their wait time was unreasonable). Similarly, 70% of those waiting for diagnostic or imaging tests felt that their wait time was reasonable (their average wait was 2 weeks as opposed to 4.7 weeks for those responding that their wait time was unreasonable). Patients in the Center had significantly shorter wait times to visit rarer specialists, but longer wait times to visit common specialists than patients in peripheral areas. The study suggests that, particularly in places with a higher supply of specialists in more common specialties (e.g., Haifa and Tel Aviv), the health funds utilize waiting times as a tool to address moral hazard (i.e., the overconsumption of health services).

Figure 1

Average waiting times in months for elective surgery

Data from 27 hospitals, * 2014



* Depending on their facilities and capabilities, some hospitals do not perform all of the procedures listed.

Source: Liora Bowers and Dov Chernichovsky, Taub Center.

Data: Ministry of Health, 2014e.

There is a strong sense among leaders in the healthcare system – physicians, hospital and health fund administrators, and others – that the average waiting times represent a blend of two very distinct groups:

- 1) more privileged Israelis, with personal connections, financial resources, persistence, and transportation flexibility, who can access care quickly and**
- 2) more vulnerable populations that do not have these resources and capabilities and often face very long waits with few alternatives.**

While data regarding averages are provided by the Ministry of Health, there are no data on the distribution of waiting times among different populations. The distribution is of great importance, as the averages in this case might obscure the story of individual patients. There is a strong sense among leaders in the healthcare system – physicians, hospital and health fund administrators, and others – that the average waiting times represent a blend of two very distinct groups: 1) more privileged Israelis, with personal connections, financial resources, persistence, and transportation flexibility, who can access care quickly; and, 2) more vulnerable populations that do not have these resources and capabilities and often face very long waits with few alternatives.

The following sections will demonstrate the disparities in waiting times due to three issues: hospital location, hospital ownership, and system of care (public or private). The large disparities evidenced between the center and the periphery, between hospitals under different ownership, and between those who are privately insured and those who rely on the public system represent the key problems of the health system as a whole.

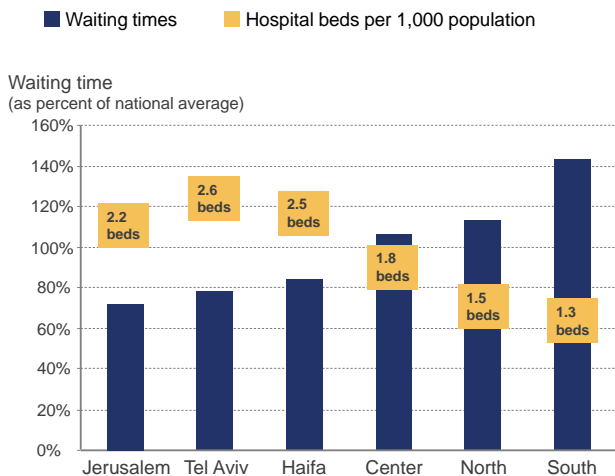
Waiting times by region

Figure 2 shows the median waiting times by region for 18 elective procedures, as compared to the national average.⁶ The median wait for an elective surgery in Jerusalem is only 72% that of the national average, as compared to the wait of 144% of the national average in the South. In other words, the median wait for an elective procedure is 28% shorter in Jerusalem than that of the country as a whole, while in the South, the wait is 44% longer. The large metropolitan areas of Jerusalem, Tel Aviv and Haifa have the shortest waiting times in general, while the peripheral areas – the Northern and Southern districts – have the longest waits.

The large metropolitan areas of Jerusalem, Tel Aviv and Haifa have the shortest waiting times while the peripheral areas – the Northern and Southern districts – have the longest waits. The median wait for an elective procedure is 28% shorter in Jerusalem than that of the country as a whole, while in the South, the wait is 44% longer.

Figure 2
Waiting times and hospital beds by district

For 18 elective procedures,* 2014



* Includes 27 public hospitals. Depending on their facilities and capabilities, some hospitals do not perform certain procedures.

Source: Liora Bowers and Dov Chernichovsky, Taub Center.

Data: Ministry of Health, 2014e, 2014f; Clalit Health Services, 2015; CBS, 2015.

The longer wait in the periphery aligns with the disparities in healthcare resources in these regions, long discussed in public discourse. As Figure 2 shows, there is a negative correlation between the supply of hospital beds and the waiting times for elective procedures. Jerusalem, Tel Aviv and Haifa have the largest supply of beds (ranging from 2.2 to 2.5 beds per 1,000 people), followed by the Center, the North and finally the South, which has only 1.3 beds per 1,000 people. In 2013, the supply of physicians in the North was about one-third fewer than in other parts of the

⁶ For each procedure, the weighted average waiting time compared to the national average is calculated for all hospitals in the region that perform the procedure, weighted by the number of hospital beds in each hospital. When the results are assessed using the average rather than median, the results are similar for both the regional and hospital ownership analysis that follows. However, the median is used instead of the average because there are one or more outlier procedures in each district that tend to skew the average figures upward.

country (2.2 versus 3.2 or more, respectively), while the supply of other healthcare professionals (such as pharmacists, physiotherapists, occupational therapists, etc.) in the North and South was half that of other regions (2.1 and 2.2 versus 4.0 or more, respectively).

There are efforts to reduce this disparity in recent years – for example, a new medical school was opened in the North (Safed) in 2011 and as part of the agreement following the 2011 physician strike, doctors working in the periphery received a substantial wage increase and those moving to the periphery receive a one-time grant of NIS 300,000. Nonetheless, it is accepted as fact among healthcare leaders that patients in the periphery face much greater access challenges than those in urban centers – and that much more would need to be done to change this reality. It is also worth noting that Jerusalem hospitals may have shorter waiting times as these hospitals allow private payment through *Sharap* (private medical care provided through the hospitals); data on this would improve the overall information on waiting times available.

Waiting times by hospital ownership type

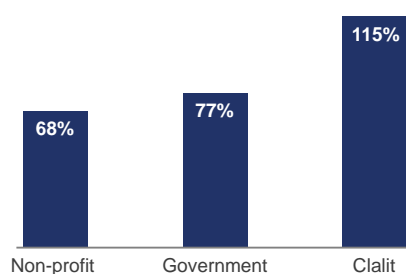
Figure 3 assesses waiting times by hospital ownership for hospitals in the metropolitan areas of the country (not including the North and South districts, so as to avoid the issue of peripheral location skewing the results). It includes data for 17 public hospitals, 7 of which are owned by the government, 6 by Clalit Health Services, and 4 are non-profits.

Clalit Health Services hospitals have the longest median waiting times, 15% higher than the national average. This may be due to limited options offered to Clalit members, who generally must seek care in hospitals owned by Clalit. The longer lines may also be due, as some suggest, to Clalit hospitals being more effective at minimizing the impact of private funding on the care received at public hospitals.

Figure 3

Waiting time as a percent of the national average, by hospital ownership*

For 18 elective procedures, 2014



* Includes 17 public hospitals in the Center, Tel Aviv, Jerusalem, and Haifa. Depending on their facilities and capabilities, some hospitals do not perform certain procedures.

Source: Liora Bowers and Dov Chernichovsky, Taub Center.

Data: Ministry of Health, 2014e, 2014f; Clalit Health Services, 2015.

When assessing waiting times by the ownership structure of the hospital, it appears that Clalit hospitals have the longest median waiting times, 15% higher than the national average.⁷ Non-profit hospitals have the shortest waiting times, at

⁷ Calculation methodology is similar to that of the regional comparison, as described in Footnote 6.

slightly under 68% of the national average wait. This result is likely greatly influenced by the fact that three of the four non-profit hospitals are in Jerusalem. Government hospitals fall in the middle, at about 77% of the national average.

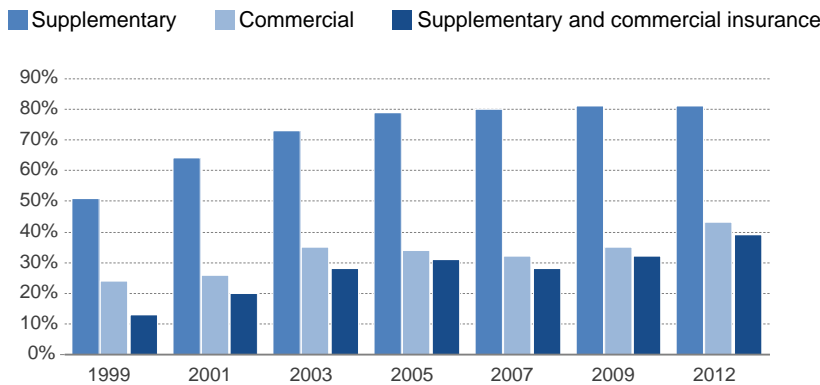
There are various potential explanations for this finding. First, because Clalit also operates its own hospitals (in contrast to the other health funds), it often steers its health fund members towards seeking care at Clalit hospitals. This may limit mobility for Clalit health fund patients, who may be less likely to choose among various hospitals based on waiting times. Secondly, it has been suggested that Clalit hospitals are more effective at minimizing the impact of private funding on the care received at public hospitals. As described above, Jerusalem non-profit hospitals are allowed to accept private funding (*Sharap*). Government hospitals also have mechanisms to allow some privately-funded services (or doctors have unofficial ways to prioritize their private-pay patients). If Clalit is more successful at minimizing the impact of private funding, this may be an explanation for the longer waiting times seen in Clalit Health Service hospitals.

Waiting times by type of insurance

Private payment for care (via supplementary or commercial insurance, or direct payment) is interwoven with public care in Israel. Since 1997/1998, coverage by supplementary health insurance in Israel has grown by almost 60%, to the point that nearly four in five Israelis in 2012 opted to purchase such coverage (Figure 4).⁸

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Figure 4
Share of population with supplementary and/or commercial health insurance



Source: Liora Bowers and Dov Chernichovsky, Taub Center.
Data: The National Institute for Health Policy and Health Services Research.

⁸ The share of individuals purchasing supplementary insurance from their health fund in 2014 ranges from 63% for Leumit Health Services to 84% for Maccabi Healthcare Services (Ministry of Health, 2014d).

It is important to note, however, that supplementary insurance is considered semi-public for several reasons: 1) this product is sold by the four health funds directly to their members; 2) it must be offered to all who wish to purchase it without consideration to or pricing based on health status; and 3) premiums are based only on age and number of household members insured.

Commercial insurance coverage, purchased by unions, employers and individuals from traditional insurance companies, grew 80% between 1999 and 2012, as shown in Figure 4 (Israel National Institute for Health Policy Research, 2013). Out of 20 OECD countries with available data, Israel has the third highest rate of private health insurance coverage.

The phenomenon of growing private insurance coverage may be partly due to the fact that, as a 2013 survey by Myers-JDC-Brookdale shows, 50% of Israelis do not believe they get the best and most effective treatment from the healthcare system and 40% are not confident that they can afford care in case of a serious illness. It is likely that such fears are enhanced by the fact that patients cannot officially select their surgeon within the public hospital system⁹ and by uncertain and non-transparent waiting times for particular treatments. On the other hand, the opposite has also been argued – that the longer lines in the public system are actually a result of the extent of private insurance coverage in Israel, as resources and health professionals are incentivized out of the public system and into private care settings (Chernichovsky, 2013).

The issue of private insurance is closely related to the issue of waiting times, as is illustrated by the Jerusalem hospitals. As mentioned above, these hospitals, which operate as non-profits, are the only public hospitals allowed to provide both public and private medical services (*Sharap*). In Jerusalem hospitals, a patient may be informed that a specific treatment is available via the public system in three months, but within a few days if he chooses to pay for it from his own pocket. A 2013 Hebrew University study showed that the average waiting times for a range of specialist appointments were 14 times as long for those patients seeking a public rather than private consultation at Hadassah Hospital. At Shaare Zedek Hospital, the waiting time was five times as long under public care (Lahad et al., 2013).¹⁰

⁹ Patients treated in the public system cannot officially select their treating doctor; although in practice they are sometimes able to after some negotiation or use of personal connections. Within this context, the issue of private payment arises. Surgeries and choice of surgeon accounted for 38% of medical spending by the supplementary insurance funds in 2010. This is the highest category of spending, followed by 14% on second opinions and 12% on dental care (The Israel National Institute for Health Policy Research, 2013).

¹⁰ As in the case of the study on the perceptions of family physicians in Jerusalem (see Footnote 2), these findings should be qualified, both because the results were not published in a peer-reviewed publication and because the study was conducted by Hebrew University medical school students and there may be questions regarding the consistency of the data collection methodology across interviewers.

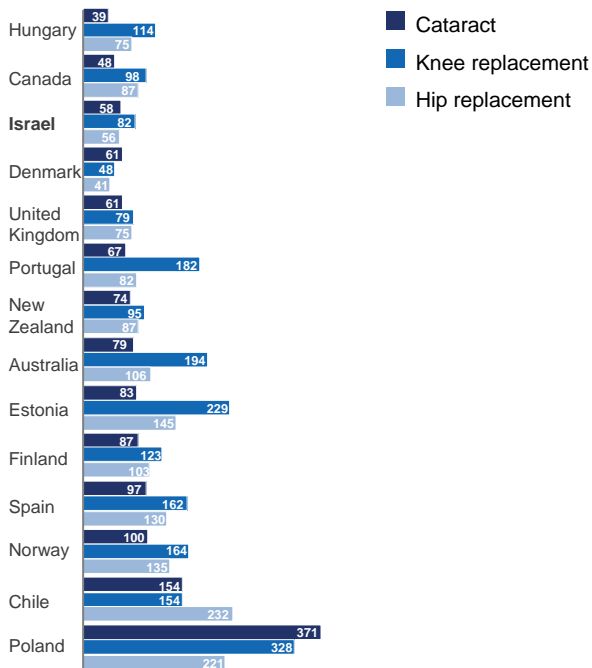
3. Elective Procedures: An International Comparison

The data available for international comparisons of waiting times is limited, and thus broad generalizations on the topic must be qualified. Nonetheless, waiting times for select elective procedures in Israel seem short relative to other OECD countries. Figure 5 shows the median waiting times for cataract surgery and knee and hip replacement for 14 countries. Israel has the third shortest median waiting time for cataract surgery and knee replacement and the second shortest median waiting time for hip replacement. Israel also performs quite well when looking at data on average waiting times (not shown).

There are several important caveats to this comparison. One caveat is that the countries with available data may reflect a problem of self-selection: all of these countries also self-identify as ones in which waiting times are a significant policy issue. It may be that countries with short waiting times are not reporting this information because it is not a policy concern in these places. In addition, the small number of countries and procedures with available data limits the ability to make broad generalizations.

Out of 14 OECD countries, Israel has the third shortest median waiting time for cataract surgery and knee replacement and the second shortest median waiting time for hip replacement. There are several important caveats to this comparison, however, including the fact that Israel's data are measured from the time a surgery is scheduled, rather than from when the referral for surgery is used as is done in other countries.

Figure 5
Median waiting times for elective surgery*
Days, 2013/2014



* From the time of referral until treatment.
Source: Liora Bowers and Dov Chernichovsky, Taub Center.
Data: OECD, 2015.

Second, Israel just recently began systematically collecting waiting times data, so its data are considered preliminary. Accuracy, detail and methodology are likely to improve in future data collection. In contrast, many of the other countries shown have been consistently collecting waiting time data for a number of years. As such, at this time, these data might not be entirely comparable. A methodological difference regarding the definition of waiting times is a particularly important issue. In other OECD countries, the clock begins ticking when a referral for treatment is made, and so the waiting time represents the period of time between referral for care and when the surgery takes place. In Israel, the clock only begins ticking when a patient is actually scheduled for surgery. There can often be a delay between when a patient is referred for surgery and when the surgery actually gets scheduled, and this time is not captured in the Israeli data. It is important to note also that Israel has among the lowest supply of hospital beds in the OECD, and the highest average occupancy rates, at 96%. OECD analyses show a strong correlation between low hospital bed supply and long waiting times. Thus, the Israeli data likely underestimate the actual waiting times.

Thirdly, while these data show waiting times for elective procedures, there are various other needs patients face through the entire care journey. For example, after a hip replacement, patients need rehabilitation and extensive physical therapy to recover. Access to these services may at times be limited in Israel. As such, even if a patient does receive his surgery in a timely fashion, his recovery process may be frustrated by long lines and lack of capacity needed to meet the patient's post-surgery medical needs.

A fourth point, and perhaps the most important, however, is that the median figures conceal disparities in access to medical care as noted above. One of the biggest concerns among the Israeli population and healthcare leaders is that many socioeconomically disadvantaged individuals struggle in Israel's complex, bureaucratic system and often face much longer waiting times than the median figures might suggest.

4. Policy Consideration in Addressing Waiting Times in Israel

Health system resources

Israel has a relatively large supply of physicians with 3.0 physicians per 1,000 standardized persons (i.e., after adjusting for the weight of different age groups in the population) compared to 2.8 in the OECD. However, it is clear that shortages in specific specialties and in nursing can create bottlenecks across the system. For example, the State Comptroller's 2009 report identified the lack of a sufficient supply of operating room nurses and of anesthesiologists (30% fewer than the recommended standard) as factors in the long waiting times for elective procedures. Israel also faces the risk of future shortages in general surgery, internal medicine and pediatrics, among others (Israel Medical Association, 2011). The 2011 physician collective agreement was designed to support and incentivize physicians to enter specialties with shortages, such as anesthesiology and nursing, and practice in underserved geographic areas.

The Ministry of Finance has long maintained budgetary pressure that limits the growth in hospital facilities and technologies, with the goal of keeping public and overall healthcare spending low. In 27 European countries as well, there has been

an average 2% annual decrease in hospital bed supply between 2000 and 2010 (OECD, 2012). This reduction has been partly fueled by improved technologies that reduce the need for hospitalization, and has been accompanied both by fewer hospital admissions and shorter lengths of stay (OECD, 2013). Nonetheless, as noted previously, Israel stands out in terms of its low investment in hospital infrastructure.

Community care

Community care – which is considered to be quite good in Israel – and good integration between care provided in the community and hospital can help reduce demand for hospital care. While information sharing within individual health plans is advanced, there is room to improve electronic cross-sharing of data between community and hospital physicians (Frankel, Chinitz, Salzberg and Reichman, 2013). Use of case managers for high-risk patients, remote monitoring devices that allow patients to be cared for at home, enhanced technologies for medication management to prevent adverse drug interactions can be used to help prevent unnecessary admissions and readmissions, and to free up capacity among hospitals. Israel performs poorly in two areas of avoidable admissions examined by the OECD – adult asthma and chronic obstructive pulmonary disease – but does outperform the OECD in terms of very low admissions rates for uncontrolled diabetes (OECD, 2011). The Ministry of Health has recently undertaken efforts to reduce readmissions by focusing on better measurement and incentives at the health plan level (Balicer, Shadmi and Israeli, 2013). Nonetheless, because medical information sharing in the community setting is quite advanced in Israel, there may be less return on investment in this regard than in other countries.

5. Options for New Policy Initiatives

Guarantees to meet targets

The discussion above points to the importance of more complete data collection with regard to both actual waiting times and expectations of the Israeli public. The Ministry of Health stated in 2014 that waiting times would be part of the National Program on Quality Measurement of Hospitals starting in 2015. Its December 2015 report also stated a vision for gradual transition from retrospective reporting of waiting times to real-time data availability on current waiting times, and for alignment with the OECD's measurement method. It appears, however, that no such data has been released yet. An ongoing commitment to accurate, timely reporting on waiting times is important in order to assess the health system's performance in terms of access to care. Increased transparency regarding waiting times could also alleviate the uncertainty among patients, and an online up-to-date system reporting on current waiting times could also improve health system efficiency, as patients could select hospitals based on waiting times and help balance demand. While it is a notable step to measure waiting times for specific procedures, it is important to recognize that the emerging best practice is to attempt to measure the waiting time for the full journey of care – starting from the initial appointment for a medical condition and through the full course of treatment (OECD, 2013).

Israel's Ministry of Health could consider establishing medically appropriate waiting time guarantees, or benchmark timelines under which patients should receive treatment. A study on waiting time policies of 13 developed countries showed that all had official waiting time guarantees.

Another step that the Ministry could consider is establishing medically appropriate waiting time guarantees, or benchmark timelines under which patients should receive treatment. A study on waiting time policies of 13 developed countries showed that all had official waiting time guarantees, as shown in Table 2. It's important to note that even this system does not completely prevent unequal treatment of patients; where the waiting times depends on an assessment of urgency, patients with stronger social or economic standing may obtain a higher urgency assessment from their physician and thus benefit from a shorter waiting time. Formulating clinical guidelines regarding urgency may lead to more objective assessments and reduce the potential for inequalities in such a system.

One of the biggest issues with regard to guarantees is how they are enforced – often times, such guarantees do not have the force of law or it may be challenging for patients to exercise their rights to such guarantees. Thus, guarantees are most effective at reducing waiting times when they can be enforced. One option for such is to impose penalties on non-performing providers. In England, there is monthly monitoring of the referral-to-treatment times. If the waiting time target set ahead of time is not met for 90% of the patients, then the relevant specialty may lose up to 5% of its funding for that month. In such a system, however, one should be careful not to create disincentives for physicians to issue referrals, who may be concerned that they will be unable to meet the waiting time guarantees.

Another example is from Sweden, which was one of the first OECD countries to implement waiting time guarantees. Sweden has experimented with such policies for almost 25 years. It appears that its latest reform on the issue, which provided substantial government funds to local county councils that provided treatment/surgery within 90 days of referral (OECD, 2013), has been the most effective in reducing wait times.

An example of a third approach comes from Norway, Portugal and Denmark, which allow patients to seek care outside their geographic region or in private hospitals if local public hospitals cannot meet the waiting time guarantees. Portugal has a national system with information on waiting times for all providers, and patients can access any public or private provider – funded by the government – once 75% of the deadline for care is reached (e.g., 45 days of a 60 day guarantee). Since 2011, the European Union as a whole is moving towards allowing individuals to seek care in other member countries based on their own country's entitlements, particularly in cases where there is an “undue delay” in receiving care. Thus, an EU country's own waiting times guidelines can be used by patients as the legal basis to seek reimbursement for care in other member countries.

It is important to note that one unintended consequence of waiting time guarantees is that they may lead to erroneous prioritization – that is, a delay in the treatment of urgent cases in order to care for less urgent cases that are approaching the maximum waiting time.

One of the biggest challenges with regard to guarantees is finding incentives or mechanisms for their enforcement. One example of this is in Portugal, which has a national system with information on waiting times for all providers. Patients can access any public or private provider, funded by the government – once 75% of the deadline for care is reached.

Table 2
Guaranteed waiting time by country

Country	Clinical area	Guaranteed maximum wait time
Australia	General	30 days: Patient's health has the potential to deteriorate quickly
		90 days: Patient's health not likely to deteriorate quickly
		365 days: Patient's health is unlikely to deteriorate quickly
Canada	Elective surgery	26 weeks: Hip and knee replacements
		16 weeks: Cataracts for high-risk patients
		2-6 weeks: Cardiac bypass surgery, based on urgency
Denmark	Cancer	2 weeks: From diagnosis to surgery
	General	4 weeks: Regardless of disease type or severity
Finland	General	3 months: Necessary treatment provided (some extension possible)
Ireland	Elective surgery	9 months
Italy	Elective surgery	80 days: Cataract surgery and hip replacement
	Cancer	3 days: Urgent diagnostic priorities
Netherlands	General	7 weeks
New Zealand	General	6 months
Norway	General	3 days: Urgent
		2 weeks: High priority
		2 months: Priority
		12 months: Normal
Portugal	Cancer	3 days: urgent
		15 days: High priority
		45 days: Priority
		60 days: Normal
	General	3 days: Urgent
		15 days: High priority
Spain	Elective surgery	180 days: Cataracts, cardiovascular, and hip and knee replacement
		90 days
Sweden	Elective surgery	31 days: From decision to first treatment
		62 days: From referral of suspected cancer to first treatment
United Kingdom	Cancer	18 weeks: From physician referral to treatment
	General	

Source: Liora Bowers and Dov Chernichovsky, Taub Center.
Data: OECD, 2013.

One of the problems in shortening wait times in Israel today is that health funds wield great control over where patients can access care. Health funds direct patients to hospitals with which the fund has favorable contract terms (and in the case of Clalit health fund, to its own hospitals), and patients can find themselves in a battle with the health plan to be able to seek care at their hospital of choice or one with shorter waiting times. The 2014 recommendations by the Committee to Strengthen the Public Health System¹¹ (the German Committee) included a requirement that health plans allow individuals to choose from among three different hospitals for their treatments. There were debates within the Committee about allowing even greater choice.

Allowing patients to choose among any public hospital – regardless of where they live or their health fund membership – could help address the variation in waiting times by region and hospital type. Nonetheless, it is important to remember that even if patients in the periphery would be allowed by their health fund to obtain care in Tel Aviv or Jerusalem, for some patients doing so in practice is not feasible, for example, elderly patients, those in poor health and those without personal transport or assistance. Yet, this approach could alleviate the problem to some extent, since those patients who could seek care elsewhere may do so, thereby reducing the local demand.

Among healthcare leaders, there also seems to be some distrust and concern regarding the care and the timeframe for that care to which patients are entitled. It could be that the high share of private health insurance coverage in Israel is a matter of heightened risk aversion among the public – some of which may be alleviated by more clarity and transparency regarding access to care. It could also be that waiting time expectations of the public in certain cases are unrealistic given the constraints of the Israeli public system and the need to ration and prioritize resources. Reporting on actual waiting times alongside government enforcement of wait time guarantees would help the general public set their expectations regarding waiting times and reduce patients’ uncertainty.

Hospital care incentives

Another area that affects waiting times is the incentives given to hospitals. Israeli public hospitals currently receive about two-thirds of their inpatient revenue based on “per diem” rates determined by the Ministry of Health according to number of patients hospitalized (MOH, 2014b). Per diem payment provides hospitals with the incentive to keep patients in the hospital longer, but not necessarily to provide them with better care.

Another payment option that already exists today is a fixed fee that is based on the complexity of the procedure (known as Diagnostic Related Groups (DRGs) or “prospective payments”) (Rosen, 2011). DRGs rely on a standardized, detailed categorization system that groups together patients based on the patients’ personal and medical characteristics and resources required to care for them (Busse et al., 2011). Hospitals are then paid a predetermined fixed-fee to care for a patient based on that patient’s DRG classification. Such a mechanism incentivizes

¹¹ In June 2013, then Minister of Health Yael German established a committee to review and provide recommendations on issues related to private funding in the healthcare system, *Sharap*, medical tourism and the Ministry of Health’s dual role as regulator and service provider. For details on the topic, see Bowers (2014).

Allowing patients to choose among any public hospital – regardless of where they live or their health fund membership – could help address the variation in waiting times by region and hospital type.

hospitals to reduce provision of unnecessary services, increase efficiency (to reduce costs), and increase productivity (to increase revenue from more patient cases).

Use of DRG is the main payment mechanism for hospitals in Austria, England, Germany, France, the Netherlands, and the United States, among others. In Israel, such payments account for only slightly more than one-third of Israel's inpatient revenues (Ministry of Health, 2014b). Israel's DRG payment system is also more limited in terms of payment categories and classification of patients. So that hospitals do not bear the full financial risk for patients, most DRGs payment systems also account for unusually long patient stays, complications or provision of particularly expensive care.¹²

Due to its impact on supporting productivity and encouraging hospitals to treat more patients, activity-based financing could help reduce waiting times (Siciliani et al., 2013). The State Comptroller's 2009 report highlighted that where activity-based payments were implemented in Israel, waiting times dropped significantly. For procedures where per diem rates were used – many ear, nose and throat, orthopedic and urological surgeries – the waiting times were particularly long. Similarly, a 2004 Ministry of Health initiative provided for using a DRG payment to reimburse hospitals for hip fracture surgeries conducted within the medically recommended 48 hours of a patient's hospitalization. This incentive is likely linked to the 86% increase in the number of hip fracture surgeries that were conducted within this recommended timeframe in 2005-2006 relative to 1999-2004 (Ministry of Health, 2015).

In February 2016, the government took a significant step on this issue, when the Ministries of Health and Finance announced that they had reached an agreement to invest NIS 900 million (about 2.5% of total annual public health spending) in a national program to reduce waiting times. Funds are intended to go toward keeping operating rooms running in the afternoons and incentivizing those physicians who today devote their afternoons to private practice to work the full day in the public hospitals (Linder-Ganz, 2016). A similar step was suggested some time back (e.g., Chernichovsky, 2013), where funding would be redirected from the supplementary insurance program towards use in the public system instead.

6. Conclusion

Both in the eyes of physicians and patients, Israel seems to perform well when it comes to waiting times for procedures and specialist appointments in the community. Similarly, a limited international comparison suggests that waiting times for select elective hospital procedures are relatively short. Nonetheless, Israel's data are considered preliminary, and more reliable, consistent data are needed to reach a stronger conclusion. Furthermore, the methodology of measuring waiting times in Israel (from the time a surgery is scheduled until it takes

¹² It is important to ensure that hospitals do not skimp on care provided or discharge patients too early, which can be a concern with such a system. Different countries have attempted to incorporate some quality measures within a DRG payment system: in the US, for example, hospitals whose patients have high readmissions rates are penalized, and in England "best practice tariffs" are used, whereby payment is adjusted upwards if high-quality medical guidelines are followed. As in any system, it is important that regulatory authorities have proper oversight and ability to monitor quality and outcomes.

In Israel, activity-based payments to hospitals account for only slightly more than one-third of Israel's inpatient revenues, with per diem rates making up the rest. Greater use of activity-based financing, because of its impact on supporting productivity and encouraging hospitals to treat more patients, could help reduce waiting times.

place) is less comprehensive than the international method, which instead measure the time between referral and treatment. In addition, access to the required after-surgery care, such as physical therapy should also be considered. The international comparison also demonstrates the need to address the issue of waiting times at a faster pace. A large share of the 23 OECD countries that self-identify as having long waiting times as a policy issue have a national strategy to deal with this challenge. Israel is one of the eight countries, however, that do not have such a strategy.

There is no doubt that in public hospitals, waiting times are longer than desired, whether in the eyes of physicians or patients. Patients' lack of confidence in the system is manifested in the large growth in commercial and supplementary insurance over the last fifteen years, largely as patients seek private coverage for surgeries. Indeed, there are documented, substantial differences in waiting times for procedures and specialists between the public and private system. Additional gaps are seen according to location of hospitals within the country, with waiting times for elective procedures in hospitals located in the periphery being substantially longer than those in the large metropolitan areas. In addition, it was found that hospital ownership is correlated with waiting times; hospitals owned by Clalit Health Services have the longest waits, while hospitals operated as non-profits have the shortest waits. All of these factors contribute to the widespread feeling that in Israel there are disparities in waiting times between stronger patient populations – those living in the center of the country, holding private insurance and with personal connections – and weaker patient populations – residents of the periphery who do not have private insurance.

In order to improve public healthcare services and increase the public's satisfaction with and confidence in the system – while reducing incentives to transfer patients into the private system with its shorter waiting times – Israel could take several steps. First, it is desirable to increase transparency with regard to waiting times and take actions to ensure they are reasonable. The Ministry of Health's initiative to collect and regularly release waiting time data is an important first step. Furthermore, establishing and communicating waiting time guarantees is a policy step that could help reduce uncertainty and more closely align patients' expectations with reality. Financial and logistical support from the government would be needed to meet waiting time guarantees. In Israel, in contrast to other countries, there still exist incentives and payment structures that remain barriers to increased efficiency, including hospital contracts that discourage afternoon surgeries, the use of per diem payments for hospital care, and insufficient supply in "bottleneck" specialties such as anesthesiology and operating room nurses. Furthermore, hospital infrastructure lags behind other OECD countries, which is somewhat mitigated by Israel's high-quality community care. In addition, there is room for improvement when it comes to integration between community and hospital care in the country, which can help keep patients out of the hospital. The issue of waiting times should be granted the importance it deserves in the health policy arena, which will bring Israel closer to the stated purpose of the National Health Insurance Law – adequate medical care to all residents within a reasonable time and at a reasonable distance.

In order to improve public healthcare services and increase the public's satisfaction with and confidence in the system – while reducing incentives to transfer patients into the private system with its shorter waiting times – Israel could take several steps. These include: greater transparency regarding waiting times data establishment of guaranteed wait times and incentives or penalties to enforce them, and hospital payment contracts that encourage increased efficiency.

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15 Ha'ari Street, Jerusalem 9103401, Israel
Tel: +972-2-567-1818
info@taubcenter.org.il
taubcenter.org.il



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