International Perspectives

Medical Care Under the Administration of a National Health Insurance: Israel's Kupat Holim

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Nearly two decades after the enactment of the 1935 United States Social Security Act, the Israeli Knesset approved the National Insurance Law. This legislation sanctioned workmen's compensation, unemployment insurance, and retirement security, acknowledging the government's responsibility in times of loss and financial hardship. As in the United States, insurance for medical care was conspicuously absent. This deficiency was not, however, disturbing. After all, the overwhelming majority of Israelis had arranged for the financing of their health care by participating voluntarily in one of several national health insurance funds. Conceived in 1911 by 150 Jewish settlers who sought protection from the expense of infirmity, these programs have expanded dramatically. By 1982, 3.7 million Israelis, or 96 percent of the population, had subscribed to the five national insurance funds.[1]

Kupat Holim, also called the Sick Fund of the General Federation of Labour (Histadrut), is the largest of the plans. It provides comprehensive medical care (primary physicians, specialists, and hospitals) to nearly 90 percent of all insured Israelis. This population includes members of the General Federation of Labour and other organized labor groups and their dependents as well as self-

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employed workers and their families. Furthermore, retired parents whose children participate in the program and some 100,000 welfare recipients (whose premiums are paid by the Ministry of Labour and Social Affairs) receive their medical care from the Sick Fund.[2]

Kupat Holim derives its revenues from several sources. Each participating laborer contributes almost 4 percent of his salary to the General Federation of Labor. Employers pay a "parallel tax" that approximates 5 percent of each worker's salary. The self-employed are assessed both an individual and a parallel tax. The General Federation of Labor allocates 63 percent of the sum collected directly to the Sick Fund.

Services rendered to members of other funds, dental care, and sales of nonprescription drugs generate additional income; nevertheless, the fund is not self-sufficient. Subsidies from the Israeli treasury account for 13 percent of the operating budget of Kupat Holim. (The size of the subsidy has diminished as the fund has grown. When membership was only 71 percent of the population, government resources were nearly triple their present level in the budget.[1,2])

Much of the revenue is used to maintain Kupat Holim's eight hospitals and 3,800 beds, almost one third of all general hospital beds in Israel. Ailing subscribers in areas beyond reach of these facilities may receive services from either government or private institutions. The fee for this care, predetermined by the government, is forwarded to Kupat Holim. More far-reaching, however, is the influence exerted by the Sick Fund at the level of primary care medicine. Kupat Holim owns and manages nearly 800 clinics located in agricultural settlements and villages throughout the country. In addition, there are approximately 400 larger urban clinics. Patient population approximates 10,000 at the urban clinics and 1,600 patients per clinic overall.[3]

Though there is no charge for hospitalization or clinic visits, patients do not abuse their right to receive medical care. In 1979 hospital utilization averaged 0.9 days per person for acute care, with a usual length of stay of 8 days. In addition, there were 7.2 annual visits to the clinics and 2.2 consultations with specialists per subscriber. Comparatively, in the United States acute care hospital visits totaled 1.5 days per patient with an average length of stay of 7.5 days. The number of overall physician visits per patient in 1980 was a mere 4.8.[3,4]

Prescription drugs are another matter. A more cavalier attitude about drugs exists in Israel than in the United States or in other countries where "socialized" medicine is practiced. In 1975 Kupat Holim dispensed, free of charge, an average of 24 prescriptions to each of its members. In contrast, the typical American received just seven prescriptions that year. (The English and Dutch filled an average of 9 and 10 prescriptions, respectively.) Determined to reduce the consumption of medications, the fund imposed, beginning in 1977, a renewal fee (about 5 cents) on each prescription. Patients exempted from this charge included welfare recipients, the chronically ill, and children less than four years of age. This symbolic payment has been supplemented by an aggressive educational campaign detailing the appropriate indications for prescription medicines. These programs have been most beneficial. By 1979 each patient filled an average of 16 prescriptions.[5,6]

Despite its reliance on government aid, Kupat Holim and medical care in general are apparently less expensive in Israel than in the United States. In 1979 the Israeli treasury allocated only 4 percent of its total expenditure to the Ministry of Health. Moreover, only 7 percent of the gross national product was spent on health care. These figures compare favorably with statistics compiled in the United States, where the government targeted 12.7 percent of the total budget for health care. Furthermore, 8.7 percent of the 1979 gross national product was spent on medical care, increasing to 9.4 percent in 1982.[3,4]

These figures are, however, somewhat misleading. Kupat Holim contains costs with methods that are not universally acceptable in the United States. The Sick Fund assigns to physicians not only a clinic location and staff, for example, but also a salary. Seniority is the primary determinant of a physician's income, but there are other considerations. Practitioners can increase their salary by locating in less desirable sites, accepting a greater patient population, or making house visits. Physicians do not provide fee-for-service care unless patients seek private consultations or wish to

avoid a prolonged period of waiting for a specialist. This system's drawback is obvious. Physicians have less incentive to improve the quality of care or their relationship with the patient.

Certainly, frustrations other than limited financial remuneration confront general practitioners in the Kupat Holim system. The scope of their practice is limited as well. Outpatients whose evaluations are still inconclusive after routine laboratory tests must be referred to a specialist for further diagnostic workup. More disturbing is the incapacity of the generalist to admit patients directly to the hospital. Specialists act as intermediaries between the primary care clinics and the hospitals, and they determine whether a patient requires hospitalization. When a specialist declines to admit a patient, the generalist's only option is to send the patient to the emergency room and hope he will be admitted by the emergency room physician. However the patient is hospitalized, the generalist has no authority to write orders in his hospital chart. Not surprisingly, feedback is poor. Physicians often do not learn the ultimate disposition of their patients until they contact the family.

Another source of contention for the primary care physician is the centralization of preventive medical care by the Ministry of Health. Family planning clinics, maternity clinics, and well-baby checks are organized by the government. In addition, clinic physicians do not administer immunizations or perform Pap smears. Although these screening programs have been successful, Kupat Holim administrators and physicians object to them because they interrupt the continuity of a patient's care.

Despite these problems, however, Kupat Holim delivers health care at a relatively low cost and with quite satisfactory results. Medical care is less expensive but no less effective in Israel than it is in the United States. Certainly, the Sick Fund is not perfect, and measures to redress these imperfections are being examined. Patients are content with the system, and physicians are committed to its continued growth and refinement.

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