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THE NETANYAHU COMMISSION REPORT: BACKGROUND, CONTENTS AND INITIAL REACTIONS

Prepared by the Health Policy Research Unit of
The JDC-Brookdale Institute

Edited by Bruce Rosen

This paper was prepared within the framework of the Joint Program in Health Policy Research of the Government of Israel, the JDC-Brookdale Institute, and JDC-Israel.

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WHAT IS THE JDC-BROOKDALE INSTITUTE?

A national center for research on aging, health policy and human development in Israel.

An independent non-profit organization that operates under the auspices of the American Jewish Joint Distribution Committee (AJJDC) and the Government of Israel.

A team of professionals devoted to identifying relevant issues and using an interdisciplinary approach to solving problems in the health and human service systems.

A meeting ground for researchers, policymakers, and professionals, facilitating the linkage of research findings to the implementation of changes in the field.

A center for collaboration between Israel and the international community.

THE HEALTH POLICY RESEARCH PROGAM

In response to the growing national crisis in health care and a request from the Government of Israel, the JDC-Brookdale Institute, in cooperation with JDC-Israel, has developed a program devoted to health policy research in Israel. The objective of the JDC-Brookdale Health Policy Research Program is to contribute to efforts to improve the financing and delivery of health services in Israel through the analysis of selected policy issues. The program has three major thrusts:

- To assist the Government of Israel in the process of planning, implementing and evaluating the government's efforts to reform and better manage the health system.
- To assist health care providers and insurers in Israel in their efforts to improve efficiency and effectiveness.
- To undertake applied research projects which are designed to make a long-term contribution to the Israeli health care system.

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ABSTRACT

In June, 1988 the Cabinet of the State of Israel decided to establish a State Commission of Inquiry into the Functioning and Efficiency of the Health Care System. In August, 1990 the Commission issued a majority report and a minority report, both of which call for sweeping reforms.

The Commission found that the Israeli health care system is currently characterized by overcentralization, barriers to the effective functioning of the Ministry of Health, vague financing and budgeting procedures, and a shortage of trained managerial personnel. Problems in the way the system is structured and financed have led to inadequacies in the level of service provided to citizens, a range of organizational barriers to effective care, low levels of employee satisfaction and motivation, and deficiencies in certain aspects of health status.

Key recommendations of the majority report include: the passage of a national health insurance law; reorganization of the Ministry of Health so that it can effectively develop overall health policy; promotion of decentralization along regional lines; the introduction of private medical services into public hospitals; the institution of financial incentives for increased productivity; and investment in information systems and research.

Although the minority report endorses many of the directions for change proposed by the majority, it argues that the majority report is unrealistic in calling for too many changes, all at the same time. A primary focus of the dispute between the two reports concerns the future role of the sick funds and the extent to which they would be regulated by the government.

Overall, the Commission envisions a system in which the financing system is centralized while the delivery system is decentralized. The new system would entail a synthesis of enhanced competition among providers and a key role for government in structuring and regulating that competition. The objective of this paper is to serve as an English-language overview of how the Commission defined the problems of the Israeli health care system, the Commission's recommendations, and the initial public reaction to the report. The paper also includes a brief overview of the Israeli health care system and background on the Commission's formation, composition, and functioning.

ACKNOWLEDGMENTS

Shortly after the Commission of Inquiry report was released, the members of the JDC-Brookdale Health Policy Research Unit undertook a three day retreat at Kibbutz Ramat Rachel in order to study the report and analyze its implications for the Israeli health care system. This summary is one of the products of that retreat.

The JDC-Brookdale researchers who participated in the retreat and the preparation of this summary were: Aliza Bar, Tamara Barnea, Netta Bentur, David Chinitz, Marc Cohen, Miriam Cohen, Haim Factor, Revital Gross, Denise Naon, Nurit Nirel, Bruce Rosen, and Dani Yuval.

Previous drafts were reviewed by John Beck (University of California at Los Angeles and the Rand Corporation), Gabi Bin-Nun (Ministry of Health), Jo Ivey Boufford (Kings Fund College), Jack Habib (JDC-Israel), and former Commission of Inquiry members Dov Chernikovsky, Mordecai Shani, and Aryeh Shirom. Their input is greatly appreciated.

Marsha Weinstein, Terry Beninga and Bilha Allon provided editorial support and prepared the report for publication.

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AN OVERVIEW OF THE ISRAELI HEALTH CARE SYSTEM

In 1989, Israel had a population of approximately 4.6 million, of whom 82% were Jewish, 14% were Moslems and the remaining 4% were of other religions, primarily Christians and Druse. The country is heavily urbanized, and is considered one of the middle-income countries by the OECD. Approximately 7.6% of GNP is allocated to health. In 1987 average life expectancy was 77.0 for females and 73.6 for males. The infant mortality rate was 10.7 per 1,000 live births.

Israel's health care system is dominated by two entities: the Ministry of Health, and the Kupat Holim Klalit (KHK) sick fund, which is part of Israel's labor federation (the Histadrut). The Ministry of Health has responsibility for the development of health policy and operates the nation's public health services. It also owns and operates about one-half of the nation's acute care beds, one-fifth of the beds in chronic disease hospitals, and one-half of the psychiatric beds. The Ministry plays a major role in regulating the other actors in the health-care system, and in subsidizing some of them.

Kupat Holim Klalit is Israel's dominant provider of primary care services, operating approximately 1,300 clinics and employing over 2,300 primary care physicians. Approximately 75% of Israel's population is insured by the KHK and another 20% are insured in three smaller funds (Maccabi, Meuhedet and Leumit), while 5% of the population are uninsured. In many ways, Israel's sick funds function like health maintenance organizations (HMOs) in the United States.

In addition to providing primary care and operating as an insurer, the KHK also owns approximately one-third of the nation's acute care hospital beds. The KHK's special role in Israel's health care system is a product of both its size and its strong mutual aid orientation. The KHK and its parent organization, the Histadrut, are ideologically committed to the preservation of a system in which health services are distributed on the basis of need and not on the basis of ability to pay.

Government's share in health care financing has declined over the past decade. In recent years, Israel has witnessed substantial growth in private health-care and in the smaller sick funds.

BACKGROUND ON THE COMMISSION

The 1980s was a decade of substantial labor unrest for the Israeli health care system, accompanied by increasing consumer dissatisfaction with lengthening queues for elective surgery, the growth of black-market medicine, and lack of responsiveness on the part of the public system to rising consumer expectations. Against this background, in June, 1988 the Cabinet of the State of Israel decided to establish a State Commission of Inquiry into the Functioning and Efficiency of the Health Care System.

Since the establishment of the State of Israel in 1948, numerous public committees have been set up to examine the problems of the nation's health care system. However, none of the previous committees had the stature and authority of a cabinet-appointed Commission of Inquiry. The fact that the Cabinet saw fit to establish such a high-level Commission reflected the public's sense that the health system was in a state of crisis and that drastic action was needed.

The members of the Commission, selected by the Chief Justice of the Supreme Court were:

The Honorable Shoshana Netanyahu (Supreme Court Justice), Chair

Professor Mordecai Shani (Director-General of Sheba Medical Center)

Professor Samuel Penchas (Director General of Hadassah Medical Center)

Professor Arye Shirom (Tel Aviv University; Labor Relations)

Dr. Dov Chernichovsky (Ben-Gurion University; Health Economics)

The Commission heard public testimony from 148 witnesses and gathered additional information from supplementary interviews, the professional literature, and documents submitted by witnesses and others.

In August, 1990 the Commission issued both a 464 page majority report and a 249 page minority report. Generally speaking, the minority (Professor Shirom) calls for less sweeping and less dramatic changes.

The recommendations of the majority have been adopted by the Minister of Health, Ehud Olmert, and a process of implementation is already underway.

The objective of this paper is to serve as an English-language overview of how the Commission defined the problems of the Israeli health care system, the Commission's recommendations, and the initial public reaction to the report. Unless otherwise noted, the analysis relates to the majority report.

THE DEFINITION OF THE PROBLEM

The Commission emphasized the following problems of the Israeli health care system:

a. Inadequacies in the services provided to the public:

* The public system has not responded to rising expectations and standards of living.
* The insurers are free to turn away potential enrollees and to limit coverage for high-risk individuals.
* There is a lack of sensitivity to the patient: his privacy, time, and right to freedom of choice.
* Substantial queues exist while expensive equipment lies idle.
* Strikes frequently disrupt the provision of services.
* Some physicians engage in "black-market medicine" — care provided illegally on a private basis within public health care facilities.
* Most patients lack freedom of choice in selecting a physician, unless they go outside the public health care system.

b. Constraints on the Ministry of Health:

* The health system is fragmented, with the Ministry of Health (MOH) sharing a great deal of decision-making power with the Ministry of Finance (which determines the MOH budget) and Kupat Holim Klalit (which is the nation's largest provider of services). This fragmentation has hindered the MOH's ability to establish and implement a clear and consistent national health policy.
* The Ministry is heavily involved in the operation of services. For example, it owns 40% of the hospital beds. Engagement in day-to-day operations detracts its time and energy from policymaking and monitoring. Serving as both a provider and a regulator also entails real and perceived conflicts of interest.
* Key MOH decisions have been influenced by political and other inappropriate considerations.
* Due to the lack of overall policy, important topics have not been given the priority they deserve. Prevention and health education have not received adequate resources. Medical manpower planning, regulation of technology

diffusion, and quality assurance activities have all been deficient. Information systems have suffered from many years of neglect.

* In this policy vacuum, providers and insurers engage in competition of an unhealthy variety – that which produces wasteful duplication. In addition, far too much attention is given to enhancing prestige, rather than meeting real societal needs.

c. Vague financing and budgeting procedures:

* The Ministry of Health's budget is determined by the Ministry of Finance without a professional analysis of the expanding need for funds in light of population growth, population aging, and technological advances.
* The division of responsibility in the provision of services between the government and the sick funds has not been spelled out in legislation.
* Government spending on health care services is channeled through a variety of ministries, without sufficient coordination.
* The system lacks incentives for increasing efficiency.
* Insurance premiums are set in a way which does not take costs into account.

d. Sub-optimal organization of the system and the lack of managerial tools:

* The system is overly centralized. This is especially true of the Ministry of Health and Kupat Holim Klalit.
* Wage policy is controlled centrally by the Finance Ministry which limits responsiveness to local conditions and institution-specific rewards for increased efficiency.
* There are no uniform financial or other reporting requirements.
* The internal organization of the hospitals is deficient, since each hospital director has scores of persons reporting directly to him.
* There is a critical shortage of trained managerial personnel.
* There is a lack of continuity between hospitals and community providers.

e. Low levels of employee satisfaction and motivation:

* Physicians and other professional groups feel that they are underpaid.
* Kupat Holim hospitals pay their physicians and other employees substantially more than government hospitals for equivalent work.

The Commission also noted a variety of problems with health status, including:

* Female life expectancy has increased less than in Europe.
* Israel lags behind in combatting infant mortality.
* There are high rates of mortality from ischemic heart disease.
* There are major problems in oral health.
* The incidence of certain infectious diseases is still high.

THE RECOMMENDATIONS

The report contains a large number of recommendations; even the summary of key recommendations which appears at the beginning of the report spans 12 pages. This section will focus on selected, central recommendations.

1. Passage of a National Health Insurance Law

The report calls for the passage of a national health insurance law which would ensure universal health insurance coverage, ensure freedom of choice among competing sick funds, define a minimum benefits package, set maximum waiting times for service provision, define how the health system would be financed, and provide a legal basis for government regulation of the insurers. The proposed benefits package goes beyond the packages currently guaranteed by most sick funds in that it would include institutional long-term care, psychiatric care, additional preventive services, treatments abroad which could not have been carried out in Israel and dental services for children and, to some extent, for the elderly.

2. Reorganization of the Ministry of Health

The Ministry of Health would relinquish day-to-day operation of government hospitals. Instead, the Ministry would focus on planning, policy-making and monitoring with highly professional units engaged in developing policy on technology diffusion, quality assurance, information system development, and health system financing. A separate National Health Authority would be set up which would be responsible for regulating the delivery system and which would operate through regional health offices (see below).

3. Regionalization, Decentralization, and Enhanced Competition

Service provision and regulatory functions would be decentralized, primarily on a regional basis. All hospitals (including those of the government and Kupat Holim Klalit) would be run as self-financed non-profit entities; within hospitals, budgetary authority would be delegated to department heads. The country would be divided into five – six regions, each with a regional branch office of the National Health Authority. This regional office would be responsible for certifying and monitoring the regional (decentralized) sick funds, hospitals, and other providers, in accordance with policy established by the Ministry of Health. The regional sick funds could be decentralized sub-units of national sick funds, but they would have to be financially independent of their parent organizations. Encouragement would be given to the formation of new regional sick funds, and consumers would have complete freedom of choice among sick

funds. Sick funds would be not-for-profit entities. Sick funds would decide where to hospitalize patients, and hospitals would compete to sign contracts with sick funds within their region. Patients would be channeled to hospitals outside their region only in exceptional circumstances (e.g., for highly specialized services available only at national centers).

4. Centralized Financing System and Capitation Payments

The public health care system would be funded primarily by payroll taxes on employers and employees (to be collected by the National Insurance Institute), with supplementary funding from government general revenues and other sources. The sick funds would cease to set premium rates and would no longer collect premiums directly from their members. (This would make it impossible for the Histadrut to continue to collect Histadrut dues and Kupat Holim Klalit premiums as part of a "joint tax"; the crucial financial link between the Histadrut and Kupat Holim Klalit would be broken. Similarly, Kupat Holim Leumit would no longer be able to pass on a portion of the health insurance premium to its parent organization, the Histadrut Leumit.) Funds from all sources would be channeled into a single pool. A portion of the general pool of funds would be set aside as a government-controlled reserve which would be used to finance major capital expenditures.

The remaining resources (in the general pool) would then be distributed among regions according to a capitation formula which would take into account various indicators of need (including demographic factors) and the extent to which the region lacks basic services and infrastructure. Within each region, the monies would be distributed among regional insurers (sick funds) in accordance with a capitation formula which would reflect demographic and other characteristics of each fund's membership. Membership in a regional sick fund would be limited to residents of that region, and monies received by such a fund could be spent only on providing health care to members in that region.

5. Introduction of Private Medical Practice into Public Hospitals

Private medical services would be allowed in public hospitals subject to a series of limitations which would seek to minimize inequity. In return for out-of-pocket payments, the private service could allow the patient to choose his physician or offer deluxe accommodations, but would not be allowed to give the patient preference in the surgical queue. Private health care providers would be allowed to continue to operate, but efforts would be made to ensure that they not flourish at the expense of the public system. Commercial and supplemental health insurance would be encouraged.

6. Financial Incentives for Increased Productivity, along with Enforcement of the Principle of Equal Pay for Equal Work in the Public Health Care System

A uniform national wage agreement would prevent the current situation in which Kupat Holim Klalit hospital physicians earn substantially more than their counterparts doing equivalent work in government hospitals. Wage scales would be rationalized and most of the distortionary wage supplements would be included in the base salaries. The national agreements would be supplemented by worksite-specific agreements which would enable efficient hospitals to share savings from increased productivity with employees. Senior managers and professionals would be employed on a personal-contract basis.

7. Information Systems and Research

Government, insurers and providers would all invest heavily in information systems and planning. Among the priority areas mentioned are manpower planning, departmental budgeting systems, capitation formulae for distributing monies among regions and sick funds, and quality assurance. One-half of one percent of the parallel tax monies collected from employers by the National Insurance Institute would be set aside for general health research. The Office of the Chief Scientist of the Ministry of Health would set the policy for the distribution of these research funds.

The majority report also contains chapters on the following topics: public health; ambulatory (community-based) care; mental health services; geriatric services; oral health; and purchase of equipment and pharmaceuticals.

In its summary, the majority report noted that implementation of its recommendations would entail significant legislative and organizational changes. A four-year timetable for implementation was proposed.

The Minister of Health has adopted the recommendations of the majority report. Implementation task forces have been established to deal with the following: the reconstitution of government hospitals as free-standing non-profit entities; the reorganization of the Ministry of Health; preparation of the National Health Insurance law; and health system economics (including the design of capitation arrangements).

INITIAL PUBLIC REACTION

The report was greeted with broad public appreciation of the Commission's professional and thorough approach to dealing with the problems of the health care system. The Minister of Health has announced that, in broad terms, he is adopting the majority report. In addition, the Minister has set up several committees to advise him on the implementation of the Commission's recommendations.

While many observers have expressed support for the Commission's recommendations, and while concrete steps have been taken toward implementing them, others involved in the health care system have criticized some of the key recommendations. Some of their claims include:

* The forced separation of the Histadrut and Kupat Holim Klalit interferes with citizens' right of free association and the right of voluntary organizations to organize internally as they see fit.

* Proposed changes would take the insurance function away from the sick funds and make them the "errand boys" of the government.

* Separation of insurance and provision will lead to an increase in national health expenditures.

* Introduction of private services to public hospitals would increase inequity and widen the social gap.

* Regional organization would eliminate economies of scale, further bureaucratize the system, and result in too much competition and duplication of services.

* In a system of regional sick funds, no one will want to give services in peripheral regions.

* The establishment of a National Health Authority distinct from the Ministry of Health will add more layers of bureaucracy and will result in bureaucratic conflicts between the two organizations.

* Labor relations issues (particularly the issue of wage levels) were not addressed adequately by the Commission's report.

* The real problem is that the government has reduced its financial contribution to the health care system, and this problem was not addressed. The recommendations would have most new funds for the health system come out of private payments by individuals.

* The recommendations would place too many restrictions on competition among sick funds. Sick funds would be allowed to establish their own premium rates and collect premiums directly from consumers.

* The recommendations increase government involvement at a time when government cannot cope with its existing responsibilities. Administrative costs would increase substantially.

* If all financing is via the government, then there is a risk that the Treasury will gradually starve the health care system. Centralized financing will also further politicize the system.

* The report does not consider possible changes in the health care system's order of priorities (e.g., the balance among preventive, primary, secondary, and tertiary care).

* The majority report is overly hospital-focused and does not give sufficient attention to issues related to primary care and prevention.

These claims, along with the responses of those supporting the Commission's recommendations, have been taken up in a number of public forums. In addition, they are being considered by the committees and policymakers charged with implementing the reforms.

THE MINORITY REPORT

In the view of its author, the minority report differs from the majority report in the values upon which it is based, its diagnosis of the system's ills, and in the reform strategy proposed to decisionmakers.

According to the minority report, the major problems of the health system have to do with labor relations issues. The roots of the problems are severe imbalances in the supply of professional manpower relative to the system's needs, faulty collective bargaining structures and processes, poor functioning of the Ministry of Health and continuous cutbacks in the government's share in health system financing.

Accordingly, the minority report calls for a major increase in the public share of health system financing (to at least 80% of total financing), and focuses attention on the need for substantial reforms in the collective bargaining and job enrichment areas. In particular, the wage scale for the health system would be disconnected from the economy-wide wage scale and within the health sector, national wage agreements would be supplemented by worksite-specific agreements.

The author of the minority report argues that system change can best be brought about in phases, and by focusing on a small number of critical change levers. It is argued that these levers will bring about vital change in the short-term and will create conditions that will enable the system to continue improving itself in the future.

The minority believes that the majority report is unrealistic in calling for too many changes, all at the same time. It argues that many of the majority's proposals are not feasible for organizational and political reasons.

The minority rejects the call for a national health insurance law as unnecessary (as many of the objectives can be accomplished via regulations and through changes to existing laws). It rejects the call for regionalization as inappropriate for a small country like Israel. The health system would be decentralized, but not by force. Instead, the government would persuade providers and insurers to decentralize.

Like the majority, the minority sees a need for reorganization of the Ministry of Health. The Ministry would disengage from the direct provision of services and would be reconstituted as a policymaking and regulatory body. The minority opposes the establishment of a separate National Health Authority that would be organizationally distinct from the Ministry.

The minority report calls for allowing the sick funds to continue to collect premiums directly from members, thereby enabling them to compete on price as well as quality.

The minority report calls for a change in the values and priorities which govern how health care monies are spent. For example, the basic benefits package would not include expensive treatments abroad, so that more resources could be directed toward developing preventive and primary care services in Israel. In addition, the system would do more to address the health needs of under-served and poorly served groups such as Arabs and women.

Overall, the major focus of the dispute between the minority and majority reports appears to be over the future role of sick funds and the extent to which they would be regulated by the government.

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דו"ח ועדת נתניהו: רקע, תוכן ותגובות ראשוניות

הוכן על־ידי היחידה לחקר מדיניות בריאות
ג'וינט־מכון ברוקדייל

עורך: ברוך רוזן

מאמר זה הוכן במסגרת התכנית המשותפת לחקר מדיניות הבריאות של ממשלת ישראל, ג'וינט־מכון ברוקדייל, וג'וינט־ישראל.

ג'וינט — מכון ברוקדייל לגרונטולוגיה
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דמ-24-91

מהו ג'וינט-מכון ברוקדייל?

מרכז ארצי לחקר הזקנה, מדיניות בריאות והתפתחות אדם וחברה בישראל.

מוסד עצמאי ללא כוונת רווח, הפועל בחסות ממשלת ישראל והג'וינט העולמי.

צוות מומחים המתמקד בזיהוי סוגיות נבחרות ונוקט גישה רב־תחומית לפתרון בעיות במערכות שירותי רווחה ובריאות.

נקודת מפגש לחוקרים, מעצבי מדיניות ואנשי מקצוע, המסייעים לקשור את ממצאי המחקר לביצועם של שינויים בשטח.

מרכז לשיתוף פעולה בין ישראל לקהילה הבינלאומית.

התכנית לחקר מדיניות בריאות בישראל

בתגובה למשבר המעמיק בשירותי הבריאות ולבקשת ממשלת ישראל, פיתח ג'וינט־מכון ברוקדייל בשיתוף ג'וינט ישראל תכנית לחקר מדיניות בריאות בישראל. מטרת התכנית היא לתרום למאמצים לשיפור מימון שירותי הבריאות והספקתם דרך ניתוח של סוגיות מדיניות נבחרות. לתכנית שלושה יעדים עיקריים:

- לסייע לממשלת ישראל בתהליך התכנון, הביצוע וההערכה של רפורמות מרכזיות לשיפור ניהול מערכות בריאות.
- לסייע לספקי שירותי בריאות ולמבטחים בישראל במאמציהם לשפר את יעילותם ואת מועילותם.
- לפתח פרוייקטים מחקריים אשר נועדו לתרום תרומה לטווח ארוך למערכת שירותי הבריאות בישראל.

רשימת פרסומים נבחרים
של התכנית לחקר מדיניות בריאות

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דו"ח ועדת נתניהו: רקע, תוכן ותגובות ראשוניות

הוכן על־ידי היחידה לחקר מדיניות בריאות
ג'וינט־מכון ברוקדייל

עורך: ברוך רוזן

סיון תשנ"א ירושלים מאי 1991

ג'וינט – מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה בישראל
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תקציר

ביוני 1988 החליטה ממשלת ישראל להקים ועדת חקירה ממלכתית לבדיקת תפקודה ויעילותה של מערכת הבריאות בישראל. באוגוסט 1990 פרסמה הוועדה שני דו"חות: דו"ח של רוב חברי הוועדה ודו"ח מיעוט. שני הדו"חות המליצו על רפורמות מרחיקות לכת.

הוועדה מצאה שמערכת הבריאות בישראל מאופיינת כיום בריכוזיות יתר, קשיים בתפקוד יעיל של משרד הבריאות, בנוהלי מימון ותקצוב בלתי ברורים, ובמחסור בכוח־אדם ניהולי מיומן. ליקויים במבנה המערכת ובמימונה הביאו לרמת שירות לאזרחים שהיתה בלתי מספקת, הערימו מכשולים ארגוניים למתן טיפול יעיל, הורידו את רמת שביעות־הרצון והמוטיבציה של העובדים וגרמו לליקויים בהיבטים מסוימים של שירותי הבריאות.

ההמלצות העיקריות של דו"ח רוב חברי הוועדה כללו: חקיקת חוק ביטוח בריאות ממלכתי; ארגון מחדש של משרד הבריאות כך שיוכל לפתח וליישם ביעילות מדיניות בריאות כוללת; הנהגת ביזור על־פי אזורים; הכנסת שירותי רפואה פרטיים בבתי־החולים הציבוריים; שימוש בתמריצים כספיים להגדלת התפוקה; והשקעה במחקר ובמערכות מידע.

למרות שדו"ח המיעוט תומך במרבית כיווני השינוי שהוצעו על־ידי הרוב, הוא מותח ביקורת על דו"ח הרוב שחינו בלתי מציאותי בכך שהוא קורא להכנסת שינויים רבים מדי בו־זמנית. מוקד מרכזי של הוויכוח בין שני הדו"חות קשור בתפקיד העתידי של קופות־החולים ובמידת הפיקוח שהממשלה תפעיל עליהן.

כללית, הוועדה חוזה מערכת שבה המימון יהיה ריכוזי בעוד שמערכת הספקת השירותים תהיה מבוזרת. המערכת החדשה תשלב בין תחרות מוגברת בקרב ספקי השירות לבין תפקידה המרכזי של הממשלה בהבניית התחרות ובפיקוח עליה.

העבודה הנוכחית נועדה לסקור עבור דוברי האנגלית את הדרך בה הגדירה הוועדה את הבעיות של מערכת הבריאות בישראל ולהציג את המלצות הוועדה ואת התגובה הראשונית לדו"ח. נכללת גם סקירה קצרה של מערכת הבריאות בישראל ושל הרקע להקמת הוועדה, הרכבה ותפקודה.

תודות

זמן קצר לאחר פרסום הדו"ח של ועדת החקירה הממלכתית - דו"ח ועדת נתניהו, התכנסו חברי היחידה לחקר מדיניות בריאות של ג'וינט-מכון ברוקדייל במשך שלושה ימים בקיבוץ רמת רחל כדי ללמוד את הדו"ח ולנתח את השלכותיו על מערכת הבריאות בישראל. סיכום זה הינו אחת התוצאות של התכנסות זו.

החוקרים מג'וינט-מכון ברוקדייל שנטלו חלק באותה התכנסות והשתתפו בהכנת תקציר זה היו: נטע בנטור, עליזה בר, תמרה ברנע, רויטל גרוס, דוד חיניץ, דני יובל, מרק כהן, מרים כהן, דניז נאון, נורית ניראל, חיים פקטור וברוך רוזן.

טיוטות קודמות של הדו"ח נקראו על-ידי ג'ו אייבי בופורד (Kings Fund College); גבי בן-נון (משרד הבריאות); ג'והן בק (אוניברסיטת קליפורניה בלוס אנג'לס ו-Rand Corporation); ג'ק חביב (ג'וינט-ישראל); ודב צ'רניחובסקי, אריה שירום ומרדכי שני (לשעבר חברים בוועדת החקירה הממלכתית). אנו חבים להם תודה מיוחדת על תרומתם.

מרשה ויינשטיין, טרי בניגה ובלהה אלון סייעו בעריכה ובהכנה לדפוס.

תוכן העניינים