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Healthcare reform implementation: stakeholders and their roles—the Israeli experience

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Abstract

In early 1995, Israel implemented a healthcare reform. The course of any such reform depends largely on the strengths and interests of different stakeholders in the health system and their roles during the implementation phase. This paper discusses the roles of stakeholders in the recent Israeli healthcare reform, analyzes their motives, and describes their impact on the course of the reform. In retrospect, the Israeli healthcare reform had a profound effect on the country's overall healthcare environment and involved significant social, cultural, and financial changes and advancements. However, imbalances among stakeholders in the health system caused several aspects of the reform to stray from the original plan. Thus, in the first few years after the reform only first steps were taken toward the fulfillment of the vision of the reform, an equitable healthcare system that meets the health needs and welfare of the population from cradle to grave. A study of the stakeholders may further our understanding of the process of health-reform implementation.

Keywords: Healthcare reform; National health programs; Health planning

1. Introduction

Health reforms are considered "process-oriented." They aim to apply a political process in order to restructure relations between public and private sectors, managers and policymakers, and providers and consumers [1,2]. The success of the restructuring depends on the way the reform is implemented, who is likely to win or lose and by how much, and the identity, strengths, and interests of the participating stakeholders.

In early 1995, Israel implemented a healthcare reform. A new National Health Insurance (NHI) Law went into effect, creating compulsory health insurance for all Israel residents by means of one of four existing health funds[1] of their choice, with portability of membership among funds. The main goals of the law were to provide universal health coverage; spell out residents' rights to a basic package of health services; promote increased equity; assure the solvency of the

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[1] A health fund is an organization similar to an American HMO. The law also made provisions for the establishment of new funds.

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healthcare system; give residents greater freedom of choice among health funds; and absolve the Ministry of Health (MOH) of operational responsibility for the provision of health services, thereby allowing MOH to devote more effort to monitoring and regulating the system [3].

The health system was to be financed mainly by progressive and earmarked taxes. In the first stages of the reform, financing was based on a progressive health tax that each adult resident had to pay, an earmarked tax collected from employers, minimal user charges (mainly for medications), and direct injections of state revenue.

The NHI Law stipulated a standard package of services that all health funds had to provide their members. Under the law, services provided until then by the government, such as preventive, psychiatric, and geriatric care, were eventually to be transferred to the health funds. The law allowed funds to offer complementary health plans[2] for services beyond those in the basic package. Private insurers could cover basic and supplemental services by offering policies that were not subjected to the law.

The reform culminated a process that began in the early 20th century [3–7]. After generations of unsuccessful attempts to effect a health reform, the 1995 measure was the direct result of several major events: the economic collapse of the Histadrut (the General Federation of Labor), which owned the country's largest health provider (KHC, today CHS); the 1992 return to power of the Labor Party, which was willing to respond to the Histadrut's appeals for help; and labor disruptions in 1993–1994 by health professionals and, particularly, physicians, which motivated the government to attempt to place healthcare services under tougher control. The reform was implicitly influenced by Enthoven's managed-competition model [3,8,9]. Its original model was negotiated continuously by multiparty coalitions and various stakeholders in the public and private sectors, leading to evolutionary changes as it was implemented [5,7,10,11].

[2] The health-insurance plans offered by the funds in Israel contain components of both supplementary and complementary health insurance. For readers' convenience, here we term all these plans "complementary."

Since the implementation of any reform depends largely on the stakeholders and their actions, a study of the stakeholders' behavior in this case may be an important guide to future healthcare reforms. This paper, then, describes the stakeholders' activities and analyzes their impact on the implementation of the 1995 health reform in Israel.

2. Methodology

Two policymaking models were considered in the preparation of this paper: (1) a "political will" model, in which a rational, dominant, and strong leader uses rational analysis to make "right" choices that will benefit the public and whose will affects, if not determines, the course of the reform; and (2) a "pluralistic" model, in which the policymaking process is the result of give-and-take among the stakeholders involved [1]. Many scholars have used one version of the latter model, the "stakeholders approach," to analyze processes of healthcare and health-system reforms [12–14]. Since uncoordinated, contradictory, inefficient, and therefore seemingly "irrational" legislative outcomes are sometimes the sum of many rational but diverging considerations of the stakeholders involved [15], this paper employs the stakeholder approach, which is better suited to the Israeli political environment than the alternative. We define a stakeholder as any group or individual that can affect or is affected by the policymaking process [12]. Of concern to us are the stakeholders' identities, their relative power, and their actions, roles, and impact on the development of the healthcare system during the implementation of Israel's recent health reform. The study was conducted from June 2002 to January 2003, and it was based on journal articles, research reports, committees' reports, and official publications that relate to the stakeholders' attitudes and actions between 1995 and 2003. The expression "implementation period" refers to the period from January 1, 1995, when the NHI Law went into effect, to January 2003.

Each stakeholder's role is presented according to its interests in, and its explicit attitudes toward, the stated goals of the reform, as listed above. Finally, in view of the current balance of forces in the Israeli system, we discuss impediments to some of the stated goals and suggest some lessons for future reforms.