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State Comptroller report on the Health Ministry

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Nearly 1/3 of the Comptroller's semi-annual report is devoted to Health Ministry, signalling many shortcomings.

The seriousness of the Health Ministry's shortcomings in half-a-dozen fields examined by the state comptroller is made clear by the fact that 280 Hebrew-language pages of the whole 800- page semi-annual report have been devoted to it. The section is thus no compliment to Deputy Health Minister Ya'acov Litzman (United Torah Judaism), who has been at its head for the last three years, and indirectly to Prime Minister and formally Health Minister Binyamin Netanyahu, not to mention some of its senior administrators.

Litzman has had three different directors-general in the same number of years that he has run the ministry.

Never within memory has a third of a state comptroller's report been devoted to a single ministry's administrative failures. Lives have been endangered or shortened; quality of life has declined among the bureaucratic victims; huge amounts of money have been wasted and administrative rules broken, the comptroller clearly declares or implies.

Running as a thread through much of the criticism is the fact that for decades, the ministry has failed to persuade itself and the Treasury that it cannot ethically or practically own and run state hospitals that it is also responsible for supervising as a regulator.

Medical negligence by professionals in the public and private hospitals and health fund clinics was the first subject the comptroller handled.

He recommended that the whole system of risk management, reporting to the authorities and to patients and their families, insurance coverage in public and private institutions and supervising needs to be completely reconsidered and reorganized. Failure to do so could risk the stability of the health system as we know it, he stated.

The cost of pending medical negligence cases against general, psychiatric and geriatric hospitals, district health offices and ministry headquarters totals NIS 3.2 billion.

This estimate does not include the health funds and their hospitals, other hospitals owned by voluntary organizations and private hospitals.

The public's growing awareness of the possibility of suing for what patients and their families believe are medical errors and outright negligence, as well as eager handling of cases by lawyers, have led to a seven percent increase in state payments for insurance in the last five years alone. In the last six years, the comptroller wrote, average payments to patients and their families due to lawsuits have risen by 260% in the last six years, and insurance premiums paid by the employers skyrocketed by 30% between 2008 and 2010.

The number of lawsuits rose between 2005 to 2011 by 13%.

The Health and Finance Ministries don't even have up-to-date statistics on the general cost of medical negligence insurance or estimates of future costs, the comptroller wrote, adding that massive sums of money are spent on legal expenses, with less going to patients and their families who were genuinely harmed. The cost to the health system and the government of "defensive medicine" in which doctors try to protect themselves from lawsuits by ordering unnecessary tests, is also astronomical.

The fact that the insurance market in this field is controlled by Harel Insurance and its agent (the Madanes company) and that few subcontracting insurance companies abroad have been found to share the risk has also hiked premiums tremendously, the comptroller said.

Obstetricians in hospitals, clinics and Tipat Halav family health centers are among the most-sued medical professionals, and "defective children" whose congenital problems were not detected in the uterus can sue as much as 25 years after their births; this liability period should be shortened, he said. Other high-risk specialties are orthopedic surgery and neurosurgery and those who privately perform esthetic plastic surgery.

Having malpractice insurance, the comptroller continued, may encourage doctors to be less careful, as their hospitals, clinics and other employers pay the premiums.

In addition, the comptroller wrote time after time that because doctors at public institutions who do private work have their malpractice insurance paid for by the public purse -- which is a heavy burden on public hospitals and heath funds that employ them for their "day jobs."

Numerous committees have discussed these subjects and made recommendations, but the government has never managed to cope with the complicated issue.

Young physicians and those living in the periphery of the country who work for public medical institutions and do not "freelance" (or have the opportunity to do so) in private hospitals "subsidize part of the cost of insurance policies who do private work," said the comptroller. "This is problematic and creates distortions in the health economy."

As some of the riskiest professions are not required to have insurance to cover malpractice and premiums through the "monopolistic" insurers, hospitals and health funds have set up independent "self-insurance" funds to cover lawsuits, but the Health Ministry did not set up guidelines or require supervision of these to ensure that patients and families are legitimately compensated for damage to health.

As medical staffers do not want to be labelled as chronically prone to accidents and outright malpractice, they are reluctant to report cases in which patients were hurt, and many families are not provided with swift and accurate medical records to prove their cases, the comptroller wrote.

The medical institutions have not been required to run effective risk-management and error-prevention departments.

The ministry fails to provide "knowledge management" to share information about medical errors among the various institutions despite a large amount of know-how in the field, the comptroller wrote.

He recommended that the government adopt a no-fault system that would encourage medical professionals to report errors and to consider the possibility of requiring all medical institutions to have insurance as a condition for being licensed.

As a large amount of time generally passes between the medical incident and investigations, the ministry must set time limits and appoint objective experts to make recommendations as soon as possible. All institutions must quickly report all details to patients/families that a medical error took place, the comptroller recommended.

In addition, he said, legislation or directives are needed to set down the authority of the Health Ministry's

ombudsman, who deals with complaints. More must be done to prevent medical errors, he concluded.

REHABILITATION OF GERIATRIC PATIENTS

An elderly patient who suffers a stroke or fractures his hip can usually improve his functioning and raise his quality of life if he undergoes physiotherapy and other medical rehabilitation as soon as possible. If there is a delay, or the patient is sent to an unsuitable facility or does not get any such treatment at all, he or she is likely to further decline, require geriatric nursing care in an institution, suffer a serious decline in quality of life and even have a shorter life expectancy. But there is also a serious shortage in the number of physiotherapists and others who perform rehabilitation.

All of this means not only human suffering but – as the population continues to age – major losses to the economy as well. Ironically, the lack of suitable facilities is due to the government desire to “save” money.

Yet the comptroller found that the Health Ministry is sorely lacking in supplying such services at a high level or at all, even though residents are entitled to them as part of the basket of health services.

The number of general and geriatric rehabilitation beds and of hospitalization days in such institutions has declined seriously in the last decade, with average occupancy at over 105%. Some parts of the country have an adequate number of beds, while others – especially the north (one geriatric rehab bed per 3,200 elderly) and the Jerusalem area (one bed per 1,268) – have too few. The national average is one per 486, the comptroller wrote.

As a result, many patients needing rehabilitation remain too long in general hospitals, internal medicine departments, making them even more crowded. He also found that they are also hospitalized in departments and institutions that are not licensed for geriatric rehabilitation.

As the Health Ministry owns geriatric hospitals, it has a conflict of interest in that there are private institutions that compete with them; the comptroller found that despite serious crowding in state-owned institutions, the ministry allowed the the number of licensed beds in private facilities to decline, he continued.

As the disabled elderly needing rehabilitation usually need transportation to get outpatient care, they should be reimbursed for this, but the ministry does require the health funds to do so; only Maccabi Health Services does it voluntarily. In addition, the ministry did not set standards and measurements to determine whether the patient’s condition was improved by therapy he did receive. Many rehab departments were not required to function in the afternoon, when family members are free from work to help get them there; there is no care on Fridays or eves of holidays.

The comptroller noted that the possibility of using telemedicine to encourage patients in the periphery to do exercises themselves under professional supervision and assessment from afar has been totally ignored by the ministry.

As the share of the elderly in the population is expected to double by 2030, the comptroller urged the establishment of a professional team to examine ways to expand the number of rehabilitation beds significantly. The ministry’s conflict of interest between owning state institutions and regulating and supervising them –and of giving preference to their own facilities at the expense of private ones – must be resolved, he continued. The comptroller recommended that in view of the “serious shortcomings” in the ministry’s handling of this key field, the establishment of a separate and independent new unit or branch that would deal exclusively with rehabilitation policy and implementation around the country.

KIDNEY DIALYSIS AND ORGAN TRANSPLANTS

Among 21 Western countries, Israel has the highest mortality rate for kidney-failure patients who are undergoing dialysis. Between 1990 and 2011, the number of patients requiring the mechanical filtering of their blood by dialysis has risen from 1,590 to 5,500. But the comptroller found that the ministry has failed to promote prevention of the condition (partially by heading off diabetes), early diagnosis of kidney problems and the proper supply of the treatment.

There is a severe shortage of nephrologists (kidney specialists) – of the 171 in the specialty, 30 are retired, 44 are 60 years old or more and only 18 younger than 40. Who will treat the patients of the future without incentives for doctors to go into the specialty? A number of public hospital nephrologists were also allowed to work at up to three nephrology clinics in the community – some located at some distance from one another – without receiving ministry approval for this.

This means a nephrology specialist is absent from the hospital facility while patients undergo dialysis even though regulations require one to be present.

In addition, although a significant number of kidney patients could undergo peritoneal dialysis (through the abdomen) at home – reducing the burden on public and private clinics and minimizing costs – the number of such patients has dropped significantly, reducing their quality of life. The ministry did not even investigate why this has happened, he wrote.

The ministry also has not required the health funds to assess the quality of their work according to patient outcomes.

As for organ transplantation, even though the ministry's Israel Transplant coordinating center has increased the number of potential organ donors by various innovative ideas and programs, the comptroller said that not enough is being done to save lives. In January 2011, some 1,150 Israelis were waiting for organs, and by the end of the year, 105 of them died without getting one.

There were dozens of cases in which nephrology units and dialysis clinics failed to send blood samples, as required, from their patients to determine whether they are suitable for a transplant if a donor kidney was received.

Instead, dialysis patients themselves had to arrange for the blood test. As a result, at least some of the patients did not undergo a transplant even though an organ was available. Abroad, there are advanced tests to suit donor kidneys to patients who have high levels of antibodies so their bodies do not reject the organs, but these sophisticated tests are not available here, the comptroller wrote.

While there still are countries willing to accept foreigners for organ transplants that do not deal with the illegal removal of organs, the ministry has not looked into the possibility of taking advantage of such supplies and services, even though more Israeli lives could be saved by legal transplants abroad paid for by Israeli health funds.

The comptroller also protested against the fact that the ministry has not issued regulations that would as an incentive exempt live kidney donors from paying health taxes, even though it was decided back in January 2010.

The Israel Transplant's ADI database contains a list of 400,000 Israelis willing to become organ donors after they die. That should be enough for a hospital to remove the organ when needed to save a life. But the comptroller noted that Israel Transplant usually allows close relatives to veto the taking of an organ even in the case of a ADI member. He suggests that this policy be reassessed so that any card-holder's commitment actually be carried out.

The comptroller disapproved of the initiative by a number of modern Orthodox rabbis (the majority of haredi rabbis are opposed to recognize lower-brain death for taking organs) who set up an "alternative" organization (called Bilvavi) of Jewish clergymen.

They were assembled to ensure for member families that the potential donor indeed suffered lower-brain death. The comptroller opined the this organization was unnecessary, as families can already – by checking a square on the ADI card – stipulate that the clergyman of their choice can do this.

MISMANAGEMENT AND LACK OF SUPERVISION AT MAGEN DAVID ADOM

The nationwide ambulance, first-aid and blood supply organization Magen David Adom was established here in 1930. More recently, it lost much of its independence: It is supervised by the Health Ministry and required to observe regulations, some of which prevent it from giving services without collecting fees from those it serves. A whole list of positions and official bodies was set down, from the president appointed by the president of Israel for three years to the national convention to the council and the actions committee and its various subcommittees.

The government is supposed to have representatives on these bodies to help supervise them.

The last two were charged with supervising the daily activities of MDA, whose director-general since 2005 is Eli Bin and whose chairman of the actions committee, Dr.

Noam Yifrah, was appointed in 2004. A control committee met only once in 2008/2009; at other times, only a small number of members were present. Too often, MDA institutions supervised themselves, the comptroller reported.

The comptroller stated that actual supervision of these MDA officials and institutions is highly inadequate due to the lack of professional appointments and followup.

He noted that the tenure of senior officials has not been limited.

“This is liable to bring about the accumulation of too much power in their hands and prevention of monitoring and renewal in the organization,” he wrote. MDA president Yehuda Skornik “could be faulted for not succeeding in getting the council to discuss changes in the rules that the committee recommended.”

There are a number of first-aid and rescue organizations that are purely voluntary and do not charge for the services, the comptroller said. But while ongoing disputes among them over “territory” have caused disruptions, the ministry has not managed to resolve the the disagreement and set down who does what.

MOONLIGHTING BY HOSPITAL DIRECTORS

Although directors-general of state-owned medical centers make excellent salaries, some of them “moonlight” as advisers, members of boards of directors and even board chairmen in private companies to earn more. The comptroller focuses on two veteran administrators – Sheba Medical Center at Tel Hashomer’s Prof. Zev Rotstein and Tel Aviv Sourasky Medical Center’s Prof. Gabi Barbash.

As a follow-up to a previous report, the comptroller wrote that Rotstein worked in five other positions at “eight hours a week for a total additional salary of NIS 20,000 a month. Rotstein had written in a ministry form that he was giving “medical advice” to four companies without detailed, as required, exactly what was the nature of his work, the amount of hours and what he earned at each of them.

In 2009, the ministry and the Civil Service Commission approved his request for a five-year arrangement.

Since he put all four companies on a single form, there was not enough detail to know exactly what Rotstein was doing and whether his moonlighting work constituted a conflict of interest between this and his “day job” at Sheba -- the largest public hospital in the country, according to the comptroller.

Sourasky is a large and prestigious state-municipal hospital in Tel Aviv. Barbash, who was at one time director-general of the Health Ministry, performed work at six other jobs, four of them as a board member in three private companies that develop medical equipment and drugs and a fifth doing academic teaching (but he resigned from this last November). Besides that, he was an adviser to a private company that produces soft drinks. The comptroller said Barbash did not receive authorization to work at one of the biotech companies.

In one form, Barbash wrote that the three biotech companies that paid him had business and research connections with Sourasky but stated he did not make decisions there on the hospital’s purchase of goods from the three companies. But Barbash noted that in the future, there could be a connection between his work

as a company director and his position at Sourasky. The ministry/Civil Service Commission committee should not have been depending only on Barbash's written statement but instead should have studied in detail his outside work and whether they conflicted with his hospital work, said the comptroller.

In 2007, the Tel Aviv Municipality allowed Barbash to be chairman of the board – a much more influential position – of a subsidiary of one of the biotech companies, even though he was permitted to be only a board member and had promised to update the authorities if his work description changed.

The comptroller said the ministry had not set down uniform criteria for senior government health officials to do private work. The comptroller said that public hospital directors should be allowed to teach part-time in medical and nursing schools, but the authorities should consider barring them from moonlighting for private companies so that they could devote most of their time to the hospital, their main job.

Personal contracts could be signed to raise their salaries so they could give up external and perhaps conflicting employment, he added.

Asked to comment to *The Jerusalem Post,* Barbash said: "The problem is not with the salary, which is OK, but with the pension. We did negotiate with the Treasury wage chief to change our employment agreement to increase the retirement salary and give up all external work. but he did not want to change it."

Barbash maintained that even though other state hospital directors moonlight, the report focused on him and Rotstein. "We are more interesting."

As for his advice to the soft drink company, Barbash explained that he was "advising them on employees, health issues, not on manufacturing, and by the way, they do a lot to change toward healthier drinks.

There is a need to set reasonable suitable salaries to hospital CEOs with [fair] retirement payments so that they can be asked to devote all their time to running their medical centers."

HEALTH MINISTRY COMMENTS

To defend itself from criticism, the ministry sent health reporters a 1,420-word Hebrew document giving a list of dry, technical responses, such as "We have set up a committee," to only some of the shortcomings raised in the report, and numerous important issues were ignored. Numerous important issues were glossed over; for example, the MDA section of 54 pages rated only three sentences from the ministry.

On other issues, the ministry passed the buck to other authorities.

The ministry refused to orally provide the *Post* with a detailed overview on why it had earned such a huge chunk of criticism in the report and hinted that it is run better than had been described.

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