



Report of the State Comptroller of Israel | November 2024

Special Reports

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# **Waiting Times for Specialist Medical Services – Special Report**





## Waiting Times for Specialist Medical Services – Special Report

### Background

The National Health Insurance Law, 1994, establishes that the national health insurance system is based on principles of justice, equality, and mutual assistance. The law guarantees every resident's right to receive a health services package that is periodically updated and includes a comprehensive, universal, equitable, and equal set of medical services funded by the state. These services are provided through one of four health funds of the resident's choice: Clalit Health Services (Clalit), Maccabi Healthcare Services (Maccabi), Meuhedet Health Fund (Meuhedet), and Leumit Health Services (Leumit).

Different levels of medical care are available to insured individuals within Israel's healthcare system. The main levels are primary care, secondary care (consultative or specialist care), and tertiary care (provided in hospitals by specialists with additional dedicated training). Secondary care is delivered by health funds in both community settings and in hospitals, by specialist physicians such as otolaryngologists, dermatologists, or orthopedic doctors. Its role is to address complex and specific medical issues. The success of consultative care provided by the health funds to their insured members in the community is essential for maintaining a high-quality healthcare system that promotes public health and efficiently utilizes available resources.

The waiting time for an appointment with a physician or for medical services in the community reflects the availability of healthcare services for members of the health funds. In order to ensure the optimal availability of consultative care in the community for all population groups, it is necessary to guarantee, among other things, a sufficient number of physicians to meet the population's needs while considering projected demographic trends. Additionally, it is crucial to efficiently utilize medical human resources, especially in areas where availability is suboptimal, and to manage the demand for consultative medical services effectively.



## Key Figures

### **55–62 days**

The average waiting time in endocrinology for individuals aged 70 and above compared to those aged 20–30, who wait an average of 32 to 40 days

### **53–71 days**

Waiting time in rheumatology health fund the specialty with the longest waiting times among the 13 specialties examined across all four health funds

### **53%**

of scheduled consultative care appointments in the four health funds in 2022 were not realized, either due to cancellations or no-shows. Approximately 24% of appointments that were not canceled resulted in the insured not showing up ("no-shows"), amounting to around 3.5 million secondary care appointments in the community annually

### **58%**

of Israeli medical graduates in 2020 studied abroad, more than in any other OECD country

### **Only 18–35**


Number of medical specialties available in the peripheral communities examined is significantly lower compared to the 69 specialties offered in Tel Aviv

### **34%**

of newly licensed physicians in Israel in 2022 graduated from foreign universities that the Ministry of Health has ceased to recognize. In peripheral regions, most of the new physicians are these graduates: 51% in the Southern District and 63% in the Northern District




## Audit Actions

 From January to December 2023, the State Comptroller's Office examined waiting times for specialist medical services, including public service quality and appointment management. The review included mapping and analysis of waiting times – from the scheduling of an appointment until its realization (in days), examining the geographic distribution of specialist physicians in the community, utilization of appointments, and instances of no-shows. The audit was conducted at the Ministry of Health and the health funds, with supplemental examinations performed at the Ministry of Finance. The audit employed both quantitative and qualitative tools to provide a comprehensive perspective on the audited subject. The audit team collected big data on all specialist medical appointments in the public healthcare system from all four health funds for the years 2019 and 2022 (a total of approximately 57.3 million appointment records, including follow-up appointments) and analyzed them using quantitative tools such as linear regressions. Some of the data were cross-referenced with data from the National Insurance Institute, which includes socioeconomic information about recipients of consultative medical services. Linear regressions were used to identify relationships between explanatory variables and dependent variables, and the actions of the Ministry of Health and the health funds were evaluated in light of these relationships. Additionally, two roundtable discussions were held with the participation of 21 specialist physicians from two health funds (Clalit and Maccabi) in order to ascertain the challenges faced by specialist physicians in peripheral areas. In June 2023, an online survey was conducted among a panel of respondents who had required or been referred to specialist care over the past year. A total of 708 insured individuals aged 21 and older responded. The survey was aimed at gathering firsthand public opinions regarding the availability of specialist appointments and satisfaction with the care provided.

## Key Findings




 **Partial Information at the Ministry of Health on the Physician Workforce in Israel** – The Ministry of Health lacks accurate data on the physician workforce in Israel, leading to discrepancies in its various publications, which rely on different datasets and present varying figures for the number of physicians. For instance, according to the Healthcare Professions Workforce 2021 report, published by the Information Division, there were 3.9 physicians per 1,000 population. In contrast, data from the Strategic and Economic Planning Division of the Ministry, used to project the number of employed physicians per 1,000 population for the years 2020–2035, indicated 3.21 physicians per




1,000 population, a difference of 0.69 physicians per 1,000 population. When calculated for the entire population of Israel, this discrepancy amounts to more than 6,000 physicians.

#### **Ministry of Health Projections for the Number of Physicians in Israel –**

According to projections for 2020–2035, the number of physicians in Israel per 1,000 population is lower than the OECD average, ranging from 3.16 in 2019 to 3.02 in 2035, compared to 3.5 in the OECD over the same period. In 2020, 48% of physicians in Israel were aged 55 and older, the highest percentage among OECD countries (where the average was 33%), second only to Italy (56%). The Ministry of Health's policy proposals to increase the number of physicians, along with plans to establish three new medical schools, aim to ensure the required quantity of physicians and maintain their high professional standards in the long term. However, in the short and medium term, it was found that while the Ministry of Health has commenced internal planning work, it has not yet been completed or developed into a comprehensive operational program with defined goals and metrics by medical specialties and geographic regions. In the absence of such a program, it is not possible to adequately address the shortage of specialist physicians across different geographic areas.

 **Standard for the Availability of Medical Services –** According to the National Health Insurance Law, healthcare services included in the health services basket must, among other things, be provided within a reasonable time. The Ministry of Health's Director-General Circular from February 2013 outlines the components of standards for providing quality service and improving the patient experience in the healthcare system. Regarding the availability of medical services, the circular states that the waiting time for an appointment for an examination or treatment, whether in the community or via hospitalization, should align with the patient's clinical condition and be reasonable from a service perspective. The audit revealed that while the Ministry of Health has established a standard addressing the availability of medical services in the community, it has not defined measurable indicators for it – such as the desired and reasonable availability range. It should be noted that the health funds have set their own internal standards for the availability of consultative medical services; however, they are not disclosed to the public.


 **Measuring Waiting Times for Medical Services –** As part of the national program to strengthen public healthcare, the Ministry of Health launched, at the end of 2019, a national system for measuring waiting times for consultative medical services in the community and reporting them to the public. The calculation method used in the Ministry of Health's measurement system is prospective. This method allows for estimating the future distribution of waiting times for appointments during a specified period, based on the availability of open appointments in physicians' schedules as offered by the health funds to their insured members. It was found that this method does not examine the




correlation between demographic factors – such as gender, age, or population group of the insured – and waiting times.

### **Consultative Medical Specialties with Particularly long Waiting Times –**


According to data from the health funds for 2022, the majority of appointments (approximately 70%) are concentrated in the common specialties: gynecology, orthopedics, dermatology, ophthalmology, and otolaryngology (ear, nose, and throat). However, it was found that in three health funds – Clalit, Maccabi, and Leumit – these specialties do not necessarily have the highest rates of long waiting times. In Clalit, the specialties with the highest number of appointments with waiting times of more than 90 days are breast surgery, endocrinology, and neurology. In Maccabi, gastroenterology and endocrinology account for a significant proportion of the specialties with waiting times exceeding 90 days. In Leumit, the specialties with the highest number of appointments with waiting times over 90 days are endocrinology, rheumatology, and psychiatry. Analysis of the data also revealed that in 2022, there was an increase compared to 2019 in the total number of appointments (across the top 50 specialties) with waiting times longer than 90 days. Clalit experienced a significant increase of approximately 31% (from 221,573 to 290,105). Maccabi saw an increase of approximately 43% (from 360,010 to 513,517). Leumit reported an increase of approximately 8% (from 109,665 to 118,308). Additionally, across all four health funds, the specialty with the longest average waiting time was rheumatology (ranging from 53 to 71 days), followed by endocrinology (ranging from 47 to 53 days). The shortest average waiting time was for orthopedics (ranging from 13 to 20 days), followed by otolaryngology (ear, nose, and throat) (ranging from 15 to 21 days).

 **Average Waiting Times for Consultative care by Districts –** In most specialties examined across the districts of Clalit, Maccabi, and Leumit, waiting times were shorter and statistically significant in the districts of Jerusalem, Northern Israel, and Judea and Samaria compared to the Tel Aviv District. For example, Jerusalem District – Clalit, shorter waiting times were found across all specialties except for ophthalmology and cardiology; in Maccabi, shorter waiting times were found except for ophthalmology, psychiatry, and geriatrics; in Northern Israel – in Maccabi, all specialties except for ophthalmology and psychiatry and in Leumit except for pulmonology; in Judea and Samaria – Clalit, all specialties except cardiology, and in Leumit except for otolaryngology (ear, nose, and throat). Additionally, it was noted that in certain specialties, such as endocrinology, waiting times in the Tel Aviv District were significantly longer compared to other districts across all three health funds.

 **Correlation Between Patient Age and Waiting Time –** According to the survey conducted by the State Comptroller's Office, individuals aged 70 and above schedule more appointments via the telephone call center (approximately 7 percentage points higher than the overall respondents) and fewer appointments online (approximately 10 percentage points lower than the overall respondents) compared to younger insured individuals (aged 21–59). This reliance on the telephone hotline may limit their options



for scheduling appointments, for instance, due to difficulties in reaching the hotline or a reduced ability to consider traveling slightly farther from their place of residence to secure an earlier appointment. The majority of appointments for individuals aged 70 and above are follow-up visits with the same physician (21.5–28.1 percentage points higher than other age groups). Respondents aged 70 and above reported longer waiting times compared to younger insured individuals, with an average of 14 days more than the overall respondents. An analysis of health fund data revealed a positive correlation between patient age and waiting time: the older the patient, the longer the wait for an appointment. For example, in endocrinology, each additional year of age increases the average waiting time by: 0.3 days in Clalit, 0.36 days in Maccabi, and 0.29 days in Leumit. Across all three of these health funds, unique patterns were identified in the services provided to individuals aged 70 and above. On average, the waiting time for appointments in all consultative care specialties is 8–12 days longer for individuals aged 70 and above compared to those aged 20–30 (26–34 days vs. 17–23 days, respectively, across the three health funds). This raises concerns about a potential decline in the quality of service for older adults, which could negatively impact their well-being. The data also showed that as the age of insured individuals increases (including those aged 70 and above) they are less likely to schedule appointments for consultative care outside their town of residence, which may also contribute to longer waiting times. For example, 25% of appointments booked by women at Leumit Health Fund in Kiryat Shmona were scheduled within the town by women aged 55 and older, whereas 75% of appointments outside the town were scheduled by women aged 30 and younger.

 **Analysis of Waiting Times Based on Demographic Variables** – In nearly all the medical specialties examined, waiting times for appointments in Arab towns or areas were shorter than in Jewish or mixed towns and areas. The survey revealed that in Arab society, there is a growing tendency to visit a specialist based on a recommendation from a family doctor. This can help shorten waiting times, as the family doctor often provides appropriate medical care, eliminating the need for additional referrals to specialists. Additionally, Arab respondents showed a greater willingness to schedule appointments outside their residential area compared to other groups (Haredi and non-Haredi Jewish respondents). It was also found that in most specialties across Clalit, Leumit, and Maccabi, waiting times for consultative care were shorter in towns with a higher percentage of Haredi residents. Among the survey respondents, 24.7% of those who identified as Haredi reported that when attempting to bring their appointment forward, they scheduled an additional appointment with another specialist in the same field (compared to 7.3% among non-Haredi Jewish respondents and 5.4% among Arab respondents). These findings may partially explain the correlation observed in the data analysis between the proportion of Haredi or Arab residents in a town and shorter waiting times for appointments. Furthermore, it was found that in 32 out of the 37 specialties examined in Clalit, Maccabi, and Leumit, men had shorter waiting times than women, with differences ranging from one day to 22 days.





**Utilization of Consultative Medical Appointments in the Community** – More than half (52.5%) of the appointments scheduled for consultative care at the four health funds were not utilized (i.e., they did not result in the insured visiting the specialist). In Leumit Health Services, the utilization rate of appointments booked shortly before the consultation date was higher compared to the other health funds. For example, only about 15% of same-day appointments in Leumit were not utilized, whereas in Meuhedet, Clalit, and Maccabi, the rates were approximately 22%, 41%, and 56%, respectively. If the utilization rates of appointments booked up to 10 days before the consultation date in Maccabi and Clalit were similar to those in Leumit, an additional 2.2 million appointments with community-based specialists could have been fulfilled.

**No-Show for Appointments** – The phenomenon of no-shows (patients not showing up for scheduled appointments without canceling them) significantly impacts the availability of appointments, wastes physicians' time, and extends waiting times for insured individuals who require medical treatment. Certain specialties have significantly higher no-show rates than others. In Leumit Health Services, the average no-show rate across all specialties is approximately 20%. This includes specialties with high no-show rates, such as pediatric rheumatology (43%), proctology (32%), and immunology-allergology (31%), as well as specialties with low no-show rates, such as medical genetics (6%), liver diseases (11%), and pediatric otolaryngology (13%). In Maccabi Health Fund, the overall no-show rate is approximately 21%. High no-show rates were observed in oral medicine (41%), pediatric urology (35%), and proctology (34%), while low no-show rates were found in geriatrics and pediatric rheumatology (14%), liver diseases (12%), and diabetes (9%). Despite the importance of taking steps to reduce no-shows for scheduled (and non-cancelled) appointments, as of the conclusion of the audit, the government had not submitted a legislative proposal to the Knesset to address this issue. Such a proposal could include mechanisms like imposing co-payments for missed appointments.

**The Impact of the Yatziv Reform on the Number of Physicians in Peripheral Areas** – In 2022, 34% of those receiving medical licenses in Israel were graduates of foreign universities that the Ministry of Health no longer recognizes. In peripheral regions, most new physicians are graduates from such programs: 51% in the Southern District and 63% in the Northern District. As a result of the Yatziv Reform, and in the absence of a full and adequate alternative source of new physicians, a significant decline in the influx of new doctors is expected starting in 2026. From that year onward, Israeli graduates of unrecognized foreign medical schools will no longer be eligible for medical licenses in Israel. This group constitutes a substantial portion of new graduates – one-third – and the change is likely to disproportionately affect peripheral regions, where there is a high concentration of physicians from unrecognized institutions. Specialist physicians who are graduates of Israeli medical schools are primarily concentrated in Jerusalem, the Tel Aviv metropolitan area, and Haifa. By comparison, the concentration of unrecognized foreign medical school graduates in Tel Aviv and Haifa is lower. Conversely, in peripheral towns and regions (the North and South), the concentration of



graduates from now-unrecognized foreign medical school is higher than that of Israeli graduates.

**Availability of Consultative Care in Peripheral Areas** – According to Ministry of Health data from June 2023 on physician schedules across the four health funds, it was found that in the seven peripheral towns examined (Katzrin, Kiryat Shmona, Safed, Eilat, Sderot, Netivot, and Ofakim), the health funds do not provide face-to-face (frontal) services in all specialties. For example: in Kiryat Shmona, 12 out of 35 specialties are not offered to Maccabi members (approximately 3,500 insured individuals). In Safed, 11 out of 32 specialties are not available to Clalit members (approximately 17,100 insured individuals). In Eilat, a city with over 57,000 residents, the health funds offer 25 medical specialties. Of these, only four (obstetrics and gynecology, pediatrics, family medicine, and ophthalmology) are provided by all health funds. The remaining specialties are offered only by some of the health funds. It was also found that in many specialties examined in the seven peripheral towns, the health funds offer only one specialist per specialty. Consequently, insured individuals in these towns are unable to choose their preferred physician. Moreover, since members of one health fund cannot receive services from a physician affiliated with another health fund in the same town, not only is competition among physicians eliminated, but the level of service to which the insured are entitled is compromised. For instance, in Safed, Clalit and Leumit offer nine specialties with only one physician each, while Maccabi and Meuhedet provide 12 such specialties out of the 32 specialties available across all health funds in the city.

#### **Economic Aspects of Consultative care in the Community**

- **The Correlation Between Physicians' Salaries and Treatment Hours** – A negative correlation was found between the salaries of physicians in the top income deciles and the number of treatment hours offered to health funds. This may stem from the tendency of individuals to allocate more time to leisure as their income increases, thereby reducing their working hours (income effect). In other words, at these salary levels, as income rises, fewer treatment hours are offered to the community. For example, physicians in the community with an annual income of NIS 600,000–700,000 offer an average of 26.7 treatment hours per week to the health funds. In contrast, physicians earning NIS 1.5 million–2 million annually offer 4.38 fewer hours per week on average, amounting to approximately 22.32 hours.
- **The Impact of the Model of Competition Between Health Funds on Competition Among Physicians in Peripheral Areas** – The structure of competition between health funds is suitable for regions with a large pool of specialist physicians in the community within each fund, such as in central areas. However, it is less suited to peripheral areas, where the pool of such physicians is already limited. The low population density in peripheral regions, which prevents health funds from providing all specialist medical services locally and forces insured





individuals to travel to other towns to receive necessary care, requires the Ministry of Health and the health funds to evaluate a model that addresses the gap in service levels available to residents of peripheral areas. In this regard, it is worth noting that the Israel Medical Association (IMA) recommended in 2017 adopting a "unified clinic" model in towns with a shortage of community clinics. It should be noted that during the early weeks of the Swords of Iron War, insured individuals evacuated from their homes were able to receive services from any health fund, regardless of their registered fund. The shortage of physicians in peripheral areas is expected to worsen, based on Ministry of Health projections and the implementation of the Yatziv Reform, which is anticipated to reduce the number of new physicians entering peripheral regions due to the non-recognition of certain foreign medical schools.



#### **Actions by the Ministry of Health to Increase the Number of Physicians in Peripheral Areas**

– The Ministry of Health has taken measures to mitigate the decline in the number of specialist physicians in peripheral areas. Examples include the Ilanot Program – enrolling 60 medical students with strong ties to the Negev and Galilee, who are expected to work in these regions after completing their studies and specialization; the Star Physicians Program – concentrating outstanding medical residents from across the country, placing them in peripheral areas, and training them to become future leaders in Israeli healthcare, particularly in the periphery; the Ofakim Program – offering conditional loans to fund medical studies abroad. Students who choose to specialize in high-demand fields and work in peripheral areas may have their loans partially or fully forgiven. However, as of the conclusion of the audit, these initiatives have yet to yield significant results, with their impact anticipated in the future. This is alongside the projected effects of the Yatziv Reform, set to come into play starting in 2026.

## Key Recommendations

-  It is recommended that the Ministry of Health, in collaboration with all relevant entities, including the Tax Authority and the Population and Immigration Authority, develop an appropriate model for transferring information regarding the physician workforce in Israel. Based on this information, the Ministry of Health should map out the number of active physicians by specialty.
-  Additionally, it is recommended that the Ministry of Health, together with the health funds, formulate an operational plan to develop a data infrastructure and a standardized measurement system to enable the retrospective measurement of waiting times for appointments (actual waiting times). This would allow for the assessment of correlations between the demographic characteristics of insured individuals and waiting times. For example, it would allow examination of whether waiting times differ by gender, age groups,



or population segments based on their characteristics. Such measurements would facilitate tailored responses suited to various population groups. Furthermore, it is recommended that the Ministry of Health and the health funds analyze the specialties with a large number of appointments that are not follow-up visits and have particularly long waiting times (over 90 days). They should identify the reasons for the increase in such appointments and develop solutions to reduce this trend.



It is recommended that the Ministry of Health establish metrics for the standard of availability of medical services in the community and, in collaboration with the health funds, examine the results of the data analysis conducted in the audit and the reasons for the disparities identified in waiting times for appointments. In particular, it is recommended that they assess waiting times for appointments among the senior population and consider the following: establishing a dedicated call center or at least setting unique rules within existing call centers for the senior population; allocating appointments specifically for this group, including prioritizing the utilization of canceled appointments; assigning dedicated service coordinators to assist this population. Regarding the gender-related disparity observed – where women's waiting times for appointments are almost always longer than men's – it is recommended that the Ministry of Health and the health funds further investigate this finding, identify the underlying causes, and analyze the effectiveness of appointment scheduling from a gender perspective. For example, this could include examining changes made to scheduled appointments, such as preferences for specific specialists that may result in longer waiting times.



It is recommended that the Ministry of Health, after consulting with the health funds, examine the consultative care specialties that genuinely require referrals. This is to ensure the availability of consultative care in the community, particularly in light of various trends, such as physician retirements, population aging, and the implementation of the Yatziv Reform, which may negatively impact the availability of medical services, including consultative care. It is further recommended that the Ministry of Health, together with Meuhedet and Leumit, identify the reasons for the low realization rates of appointments scheduled well in advance (over 40 days prior) and take measures to reduce this rate. Additionally, it is recommended that the Ministry of Health, along with all four health funds, identify the reasons for the discrepancies in realization rates of appointments scheduled up to 10 days prior to the visit and work with the health funds in order to reduce this discrepancy.

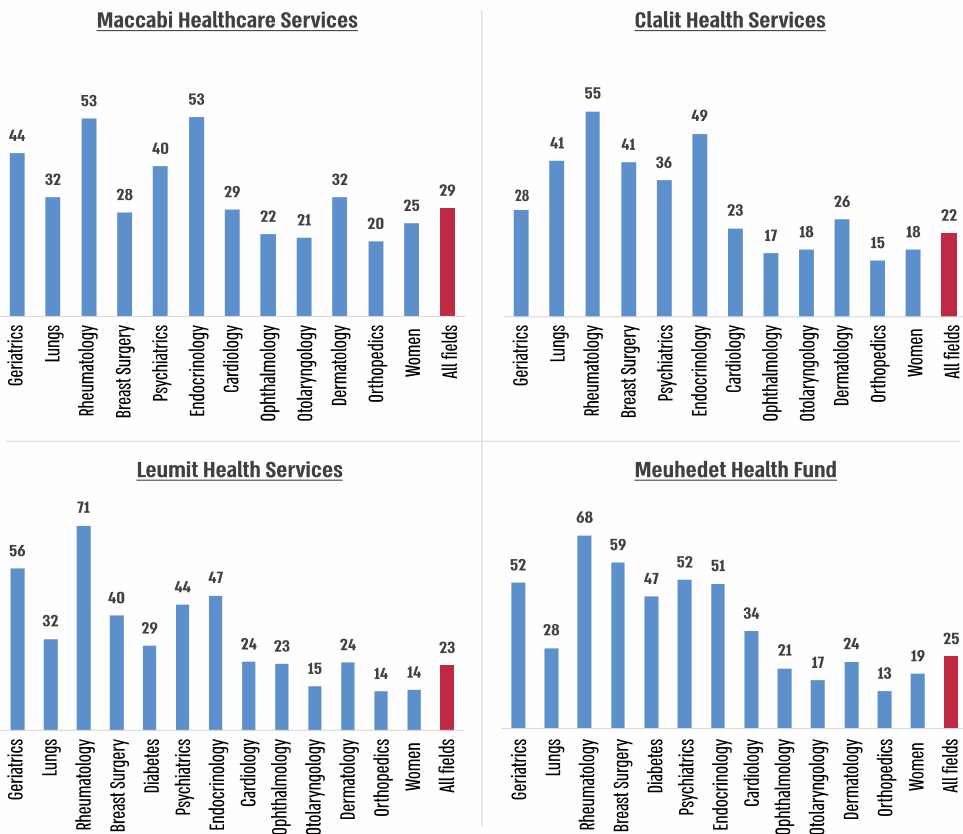


Recommendations regarding peripheral areas: it is recommended that the Ministry of Health periodically assess the effectiveness of actions taken to increase the number of physicians in peripheral areas, particularly in addressing the anticipated shortage of doctors. It is further recommended that the Ministry examine alternatives to the competition structure in peripheral areas, such as regional tenders among health funds, creating a "unified clinic" that would provide a pool of all physicians and community-based medical services to insured individuals of all health funds, or other alternatives that would enhance competition among service providers. Changes to the competition structure in



peripheral areas could lead to direct competition among physicians, broaden the range of medical services available to residents – particularly in specialties with a low supply of doctors, such as neurology – and create economic viability for maintaining expensive medical equipment in clinics. Furthermore, strengthening peripheral hospitals could enable them to provide appropriate tertiary care (in the hospitals) for residents of the region. It is recommended that before adopting any alternative, a pilot program be implemented.

Average Waiting Times for Selected Specialties Across the Four Health Funds, 2022 (in Days)<sup>1</sup>



<sup>1</sup> Due to differences in the way data is managed by the health funds, there may be variations in the definitions of appointments and specialties, which can affect waiting times. Therefore, comparisons can be made between specialties within each health fund, but not between the health funds.



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## Summary

The National Health Insurance Law stipulates, inter alia, that healthcare services must be provided based on medical discretion, at a reasonable quality, within a reasonable time, and within a reasonable distance from the insured's place of residence. These principles also apply to consultative medical services in the community, which are provided by specialist physicians, through the health funds. According to projections by the Ministry of Health, the availability of healthcare services provided to the population, including consultative medical services, is expected to be impacted in the coming years. Among the reasons for this are the retirement of physicians; the implications of implementing the Yatziv Reform, which defines the recognition criteria for medical studies abroad; the lengthy time required for training specialist physicians; and the increasing demand for consultative care, partly due to an aging population.

Ensuring the continued availability of consultative medical services is essential for maintaining a high-quality healthcare system in line with the principles of the National Health Insurance Law. It is recommended that the Minister of Health and the Ministry of Health, in collaboration with the health funds, formulate solutions to guarantee the availability of services to the insured population, particularly in peripheral areas. The focus should be on ensuring equitable services for all insured individuals, with an emphasis on senior citizens, and on optimizing the utilization of available resources.