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جامعة بن غوريون في النقب
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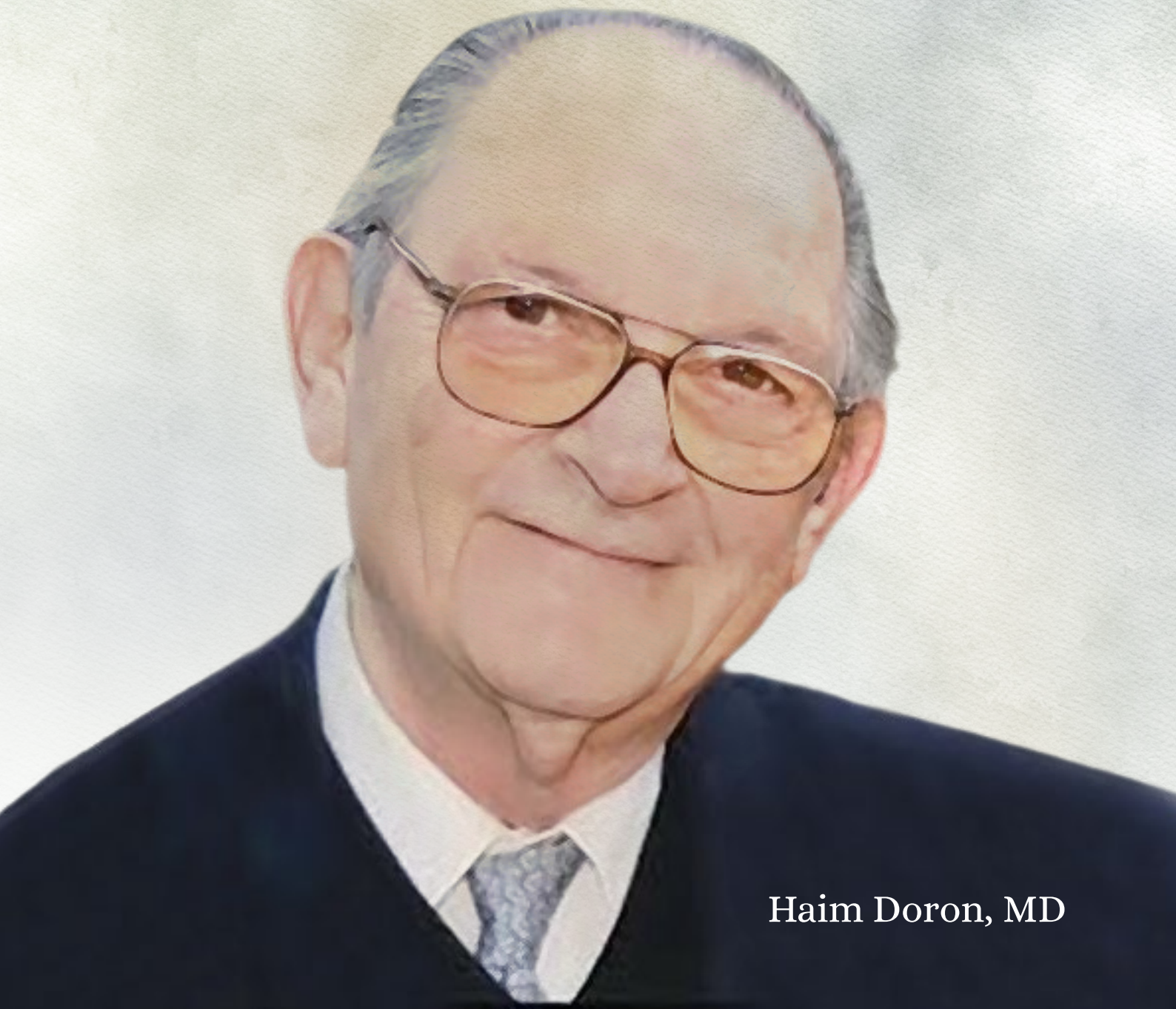
MY PATH

In the Israeli Health System

A collection of
conversations and reminiscences



Haim Doron, MD

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Edited by Profs. Shifra Shvarts & Gabi Bin Nun,
and by Stephen C. Schoenbaum, MD (English Edition)

This book is dedicated
with all my love
to my wife Neomi
and our children and grandchildren

ACKNOWLEDGEMENTS

My heartfelt gratitude to my wife Neomi, my son Yeshayahu, and my daughter Hana for their encouragement throughout the course of preparing and writing this work.
My thanks to my colleague, the outstanding medical historian Shifra Shvarts, a fellow at the National institute for Health Policy Research. Prof. Shvarts was the one who initiated recording oral histories by a number of figures in the health system that led to audio-taping my story and triggered her suggestion that I write this book. I want to also thank Prof. Gabi Bin Nun who agreed to Prof. Shvarts' request that he join her in editing the book. Also, to Prof. Shvartz' research assistant, Aya Bar Oz, for her assistance.

In addition, I want to thank the scientific director of the National Institute for Health Policy Research Prof. Alexander ('Alik') Aviram; and the Institute's administrative director Ziva Litvak. I am also grateful to Sigal Sheffer and Bianka Dekel from the National Institute staff and all staff members who played an assistive role in the publishing process.
Finally, my deepest gratitude to my dear granddaughter, Rivka Doron, for the extraordinary assistance she rendered me in the task of preparing the manuscript in a published form, particularly during the period when my health declined.

Haim Doron, Jerusalem, 2017

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EDITORS' NOTE

In the foreword to his earlier work Medicine in the Community (2004), the late Haim Doron wrote that in all his years of action, he was guided by a "deep belief in a self-realizing Zionism and a process for 'the ingathering Jews from the Diaspora' that would envelop the vision of an egalitarian public medical framework founded on the principles of mutual assistance, while assuring the best level of medicine as one of the cornerstones of Israeli society." This wasn't merely a slogan; indeed, these principles were a "Pillar of Fire," a lantern at his feet, for Professor Haim Doron throughout the fifty years he served as one of the leaders and architects of the public health system in Israel.

This autobiographical work by Prof. Doron was born in the course of a project carried out by the National Institute for Health Policy Research to document the work of the leaders and founders, path-makers and architects of the health system in Israel, an initiative designed to mark the first two decades since inauguration of Israel's National Health Insurance Law (1994). In this framework and even prior to it, Prof. Haim Doron had been interviewed at length - tens of hours of videotapes -- on "his path in the health system" as he labeled it. The initiative to publish a book dedicated to his life and life endeavors within the health system in Israel was fueled by the tapes and the rich material they contained. I didn't know at the time that Prof. Doron was living on borrowed time, and we were exceedingly fortunate that we could complete the interviews before he died in November 2017.

The work at hand constitutes a primary source about the legacy Prof. Doron's left behind, and his tremendous impact on the shape of the health system on Israel. The taped and videotaped interviews that served as the basis for this work will be archived at the National Institute for Health Services and Health Policy, where they will be available in full for scholars who wish to learn firsthand about the history of the public health system in Israel in more detail.

As an autobiography based on interviews conducted with Prof. Doron, we invested a great effort to preserve the author's 'voice,' distinctive speech patterns, and narrative flow, placing details about the individuals he mentions in recapping events in footnotes, alongside other explanatory passages with subtext for the readers of this English edition. Prof. Doron placed in our hands the task of editing the work a short time prior to his passing, and we did our best in the editing process to preserve the spirit of his narrative.

Veterans of the health system who read this work in Hebrew will be familiar with many of the topics discussed, including events that will hit home for those readers who may have also played a personal role in this or that juncture. Younger readers will encounter in this book documentation on a unique figure -- one of the 'lion kings' of the public health system in Israel whose entire life was bound up in realization of the foundational principles of a health system for Israel based on "justice, equality, and mutual assistance" he so believed in.

Prof. Doron more than once that his motto to be effective and get results was "think before you act; getting action begins with forethought." Even when those surrounding him were skeptical, in the end they were forced to admit he had been right all along. Thus, core concepts such as family medicine and regional health centers that he conceived of, were born and put into action. In the same manner, finding the right path to realize a vision succeeded time and again -- including the establishment of the school of medicine at Ben-Gurion University of the Negev and the Israel National Institute for Health Policy Research. Prof. Doron said that those who are convinced of the worthiness of an idea should never give up; they only need to wait for the right opportunity to arise, to realize their goal, and put their ideas into action. This wasn't just a

proverb - to “think before you act”: It was a ‘take the long view and wait for the right moment’ strategy that Doron followed throughout his life.

The chair of the directorate of the National Institute, Prof. Orly Manor, said of Prof. Doron that he was “a man who knew how to transform a vision into a concrete act.” Dr. Dorit Weiss, the chief nurse of Clalit, Israel’s largest HMO, where at one time Haim Doron was first the chief medical officer and later the CEO, crowned Prof. Doron “the Ben-Gurion of the public health system in Israel.”

Thus, this work presents the life story of a physician, a committed Zionist, and a visionary thinker, who dedicated his life to realizing in practice foundational concepts that today are the underpinnings of the public health system in Israel.

Prof. Shifra Shvarts, Prof. Gabi Bin Nun, editors
October 2018

TRANSLATOR'S NOTE

In this work, translated from the original Hebrew, in most cases the proper name of Clalit Sick Fund has been shortened, referred to as "Clalit" and at times – the sick fund (singular, regular noun). The term kupot holim or sick funds was employed for more than a century, until modified relatively recently in keeping with the spirit of the times that now labels these constructs as sherutei bri'ut or health services [providers] as in Clalit Health Services.

When referring exclusively to 'the [Clalit] Sick Fund,' the translation has stopped short of capitalizing this term to avoid confusion – although Kupat Holim is often used as a synonym for Clalit. For example, Prof. Doron has sometimes referred to "Kupat Holim vs. Maccabi" or "Kupat Holim and Meuhedet," both Maccabi and Meuhedet being rival health service providers to Clalit. Doron at times uses certain Biblical phraseologies that are common in modern Hebrew in certain situations. These carry a negative connotation that does not easily translate into English. The most marked example is "blending (sha'atnes) of public and private medicine." In Hebrew, the verb sha'aznez strongly suggests this blending is a form of pollution. Or when Prof. Doron employs the Biblical concept of "a Sodom's bed," he does not simply mean the value-neutral "fitting a square peg in a round hole." Rather, he uses the Biblical allusion to signal an act that he views as fundamentally immoral. Such cases are elucidated in footnotes to faithfully convey Prof. Doron's feelings and attitude that are clear in the original Hebrew volume.

In Israel, health and politics intrinsically have been intertwined; and this theme runs like a thread through this volume. Nobel Prize laureate José Saramago once commented that the problem with reading a work in translation is "the foreign reader doesn't always know what norms are being broken." There is a parallel to this insight in the work at hand, that have led to insertion of some explanatory footnotes to provide subtext at certain junctures in Doron's narrative about the dynamics – human and political – that are clear to the reader in the Hebrew original.

Daniella Ashkenazy

ENGLISH EDITION EDITOR'S NOTE

I first met Haim Doron, briefly, in January 1987. I had spent a couple of weeks as a guest at the Faculty of Health Sciences at Ben-Gurion University of the Negev (BGU) where a series of interviews and visits allowed me to learn about the Israeli health system, particularly about Clalit. My last interview before returning to the United States was with Prof. Doron in his office in Clalit headquarters in Tel Aviv. Then, after he stepped down as the director-general of Clalit and was on sabbatical, he visited me in my office at Harvard Community Health Plan, then a small HMO in Boston. Though we then knew each other casually, we became friends about a decade later when Haim joined the International Academic Review Committee of BGU, where we served together for about 20 years.

Haim was an extraordinary person. He had very strong, excellent values. One might say that he had "True North" principles which include "integrity, moderation, self-discipline, loyalty, responsibility, honesty, and patience." In this book, he illustrates his dedication to Zionism, socialism, and doing things for the benefit of all people. His career-long interest was in seeing better health and health care in Israel through a strong health care delivery system, an excellent healthcare workforce, and scholarship that would guide developing greater effectiveness and efficiency in every aspect of healthcare. He firmly believed in the integration of the various components of health care. He championed the need to integrate the continuum of care between hospital and community, the need to integrate physical and mental health services, and the need to have interprofessional team care.

As much as Haim achieved in his lifetime, his vision can still serve as a map for the future in health care delivery, health professions education, and health services research.
It has been an honor to be able to edit the English translation of this book. I have taken some liberties in the wording and also added a number of footnotes in an effort to make the narrative as readable as possible by persons who, like me, are not likely to know the details that Israelis reading the original Hebrew edition would know.

Stephen C. Schoenbaum, MD, MPH
March 2022

FOREWORD

Prof. Haim Doron - Architect of Public Medicine and Health Services in Israel.

I met Prof. Haim Doron at meetings of Ministry of Health's health council, in the last years of his life. There, at these meetings of the council, I encountered his vigorous and clear voice championing the importance of public medicine and the centrality of family medicine.

As a longtime administrator in the framework of Clalit, I was well acquainted with Prof. Doron's work, and his longstanding contributions to the public health system in Israel, and emphasis on the Negev. I always viewed him as one of the founding fathers of medicine in Israel, beginning with his impressive project bringing immigrant doctors to serve in the Negev, through his core role in the establishment of the Faculty of Health Sciences at Ben Gurion University of the Negev, and then, in my opinion, his crowning achievement: Establishment of the specialization program in family medicine in the community during his tenure as general-director of Clalit. In this way, Prof. Doron changed forever the quality of family medicine in Israel, and transformed it into an attractive, prestigious and desirable specialty,

At one of the meetings of the health council, Prof. Doron requested to meet with me in private. At the time, I was director of Clalit's southern division and director of the Soroka Medical Center - the former, a role that Prof. Doron had held himself for many years. I was curious to know what he wanted to talk about. It turned out that Doron was worried about the future of family medicine in the Negev. He felt Clalit's leadership in the region need to initiate a move to upgrade family medicine and carry things forwards to improve its quality in the region to a level he believed the inhabitants of the Negev deserved. I was deeply moved to see him return to his first love, and I put together a program designed to take this issue forward.

Decades had passed since Prof. Doron had served as chair of Clalit's directorate (today the director-general) but here again, I find myself expected to fill his big shoes, this time as director- general of Clalit. In this role I carry with me his legacy regarding the importance of public medicine and the duty to strengthen it, and family medicine as the leading force in this objective.

I congratulate my colleagues, Prof. Shifra Shvarts and Prof. Gabi Ben Nun, on the scientific editing of the late Prof. Haim Doron's manuscript to bring it to fruition. I am sure that the work will construe a significant milestone in the understanding the history of medicine in Israel.

Prof. Ehud Davidson,
Director-general,
Clalit Health Services (2018-2021)

PROLOGUE

The work at hand is autobiographical. It covers my endeavors in sixty-five years of involvement with the health system in Israel, between the years 1952-2017, including thirty-five years in the operations in Clalit Sick Fund (today Clalit Health Services Organization).

I have no intentions here to glorify my actions, but rather to share my own path in the health system, while giving voice to my opinion on issues and problems relevant for discussion in coming generations. However, I don't mainly seek to talk about them, but rather to describe the processes involved in the establishment of some of the core endeavors I had the privilege to play a part in their founding -- at times even as a decisive participant. These are, for example, locating a medical school in the Negev, anchoring family medicine as a recognized specialization in Israel, founding the National Institute for Health Services and Policy Research in Israel, and more. Other endeavors I had the privilege to participate in, and I don't make light of their importance, are establishing the School of Health Professions at Tel Aviv University and finding Irving Schneider and convincing him to establish the first pediatric hospital in Israel, an institution that already has splendidly served the health needs of several generations of Israeli children.

The book faithfully expresses my outlook on the absolute imperative of egalitarian public medicine and ruling out any mixing or blending of public medicine with private medicine. Dr. Yosef Meir stated this position1 in his book Medicine and the Public, and I also believe that money has no place in mediation of the physician-patient relationship.

If somewhere down the road, a researcher will consider it worthwhile to investigate this formative period and delve into the facts as they were, I hope the material within – to be added to the National Institute's archives – will be of utility.

1Dr. Yosef Meir (1890-1953) was born in Galicia (Poland), studied medicine in Vienna, and immigrated to Israel in 1911. A physician and tuberculosis specialist. He was director of Clalit from 1928 up to establishment of the state in 1948, and director-general of the Ministry of Health from May 1949 to September 1950. He initiated and organized the airlift and immigration of Yemenite Jewry in 1950. Sachlav Stoller Liss, Shifra Shvarts, Mordechai Shani, L'hiyot Am Ba'ree b-Artzeinu (To Be a Healthy People in Our Land), Ben-Gurion University Press, 2016, 29-52; Yosef Meir, Ha-refu'a vha-Tzebor: Leket Ma'amarim (Medicine and the Public: A Compendium of Articles; collected and edited K. Tamari, Tel Aviv: Clalit Directorate, 1955. On the history of the Clalit see also:
https://boydellandbrewer.com/9781580462792/health-and-zionism/
https://boydellandbrewer.com/9781580461221/the-workers-health-fund-in-eretz-israel/

CHAPTER 1

From Argentina to Israel: Personal Background:

I was born in the capital of Argentina, Buenos Aires, in 1928 -- the grandson of Jewish immigrants who in 1900 immigrated to Argentina from Slonim, in Eastern Europe (then in Poland; today in Belarus). Their immigration was fueled by the initiative of the German Jewish banker and philanthropist, the Baron de Hirsch, who sought to solve the distress of Eastern European Jews by establishing agricultural settlements in South America, Argentina in particular. My grandfather settled in the agricultural sector of Moises Ville, one of three main townships in the history of Eastern European Jewish settlement in Argentina.
It is interesting to note that while he immigrated to Argentina, grandfather prayed three times a day: "May our eyes behold your return to Zion." Not only that; in the earliest stages of settlement in South America, its youth also organized in their villages into Zionist movement frameworks.

My late father immigrated to Argentina with his father when he was still young, and from his youth he was an ardent Zionist, very dedicated to the Zionist movement, and he maintained a traditional religiously observant lifestyle. Seeing to it that his children would receive a Jewish education was deep set in his soul, particularly in regard to my education. As soon as I began to attend an Argentine elementary school in the mornings, my father also enrolled me in an afternoon studies program -- the first and only school at the time where they taught modern-spoken 'Hebrew in Hebrew' with envoy teachers from the Land of Israel. Thus, I learned fluent Hebrew, as well as studying Talmud with a private tutor.

All of my youth I was very active in the Zionist movement. For years, I served as general secretary of all the youth movements and Zionist hubs of Jewish youth in Argentina, and I viewed immigration to Israel ('making *aliyah*') as the essence of Zionist endeavor. My view was that that true Zionism was expressed in *aliyah*, and I believed there was no justification for a person who viewed themselves as a Zionist to remain in the Diaspora -- particularly after the establishment of the Jewish state in 1948. I dared to express my position at the Latin American Zionist Congress. The Israeli envoys who came to the Congress from Mandate Palestine weren't thrilled with such sentiments, perhaps because they thought the country was not yet ready to absorb *aliyah*. For my part, I planned on making *aliyah* and took steps to prepare myself.

After I finished high school, at first, I thought to study law, thumbing through international law texts for several weeks. But I knew that the Jewish state-in-the-making didn't need jurists, it needed doctors -- leading me to the decision to study medicine. This was the first but not the last step in my life to express the linkage between my Zionist outlook and my work in the health system. This tie would run like a thread in everything I will recap in this book about my actions in the health system in Israel.

Permit me to share at this juncture an interesting anecdote: When I began my medical studies. I was celebrating my birthday at my house. My mother had prepared refreshments, and friends from the pioneering youth movement I belonged to were participating. I thought it was an apt opportunity to announce that I was not going to follow the movement's expectations from me, i.e., preparing myself for *aliyah* through hands-on experience in Argentina in farming in preparation for life on a kibbutz. Rather, I was studying medicine and planned to make *aliyah* afterwards and become a doctor in Israel. One of the female members of my group, who afterward made *aliyah* to Kibbutz Gazit in the Galilee and wrote a book about that, intervened. She said that I should be booted out of the movement. She considered Zionism as only preparation for life on a kibbutz, and my desire to be an academic and a doctor in Israel stood in contradiction to Zionism.

I stood my ground and continued to march to my own drum. I married Neomi, nee Gutman, who was also active in a pioneering Zionist movement and had chosen to study nursing to become a nurse in Israel. After my period of specialization at the Jewish Hospital in Buenos Aires and acquaintance with the 'commoditized' medicine practiced by Argentine Jews at the time, Neomi and I made *aliyah* to Israel in 1953. At the close of 1952, on the eve of our *aliyah*, I wrote a letter to the Clalit Sick Fund's directorate, which at the time insured the majority of Israeli citizens. I requested they find me employment in rural villages on the border and development towns in the Negev[2] The shortage of doctors was so dire that within ten days I already received a detailed reply signed by Clalit's head of medical manpower, Dr. Leon Goldman[3] In his reply, he detailed the settlements where I would serve as a doctor: The largest community where most of the medical work in the vicinity was concentrated at the time was Kibbutz Gvar'am, hugging the border with Gaza. Surrounding Gvar'am, two new immigrant settlements had been established. These were semi-collective agricultural villages of small family farms. Beit Shikma was founded by immigrants from Tripoli (Libya), and Moshav Geha was founded by Holocaust survivors. There were also two more kibbutzim in the area -- Kibbutz Erez and Kibbutz Talmei Yafe. After our *aliyah*, we went to live in Gvar'am so I could serve as an on-site district doctor.

2A development town is an urban locality (town or city) established in the periphery during the 1950s in order to disperse the population, which was composed mainly of new immigrants, throughout the State of Israel. Most of the development towns were built in the Galilee and the Negev, which were sparsely populated areas compared to the central area and Jerusalem.
The program proposed dispersing the immigrant population in a controlled manner in 24 defined districts throughout the country, so that the population in the major cities would continue to constitute about 45% of the urban population, while the remaining 55% would be directed to medium-sized cities and towns. This was the practice of an idea that later became known as the "Development Towns", which was a kind of Israeli version of the "New Town" concept that was introduced in Europe after World War II.

3 Dr. Leon Goldman (1914-2014) was born in Galicia (eastern Poland under the Austro-Hungary Empire), studied medicine in Italy, served as a military doctor in the Red Army, and, as a member of the retreating Anders' Army, immigrated to Israel in 1943. From 1947-1950, he served as a physician in the DP (Displaced Person) camps in Italy and France. From 1950, he was a Clalit doctor, among the pioneers in rehabilitation of chronically ill and elderly patient care in Clalit and was among the founders of Harzfeld Geriatric Rehab Hospital in Gadera, Beit Loewenstein Rehab Hospital in Ra'anana and Beit Rivka Geriatric Center in Petach Tikva. Levi Nissim, Levi Yael - *Rofeha shel Eretz-Israel 1799-1948* (The Land of Israel's Physicians 1799-1948), Bahor Publishers, 3rd edition 2017, p. 166. Henceforth, Levi, *The Land of Israel's Doctors.*

CHAPTER 2

First Steps in the Health System in Israel

First Years in the Negev- at Kibbutz Gvar'am

We arrived for a meeting at Clalit's Judea District offices on Benyamin Street 3 in the heart of the city of Rechovot. We were greeted by the district physician Dr. Tzvi Canani and the administrative director of the district, Moshe Edelbaum. At the time Clalit's management structure was split into two directorates. This structure is discussed further on.

When they met us, Dr. Canani and Mr. Edelbaum were astonished -- two very young people, a new immigrant doctor and a nurse, fluent in Hebrew, who wanted to go to the Negev! They said that on the first day of May, I would begin work in the Kibbutz Gvar'am area. But first I must undergo two weeks of in-service training under a veteran physician in another kibbutz within the Judea District, Kvutzat Yavne near Gedera. Furthermore, for Neomi to become a nurse with the *Tipat Halav* ('Drop of Milk') healthcare network for infants and their mothers, she needed to undergo several weeks of in-service training in preventive medicine, and work at one of the temporary housing transit camps (ma'abarot) and immigrant villages.

I believe that a set date and time have to be met to the letter. Thus, when the appointed date arrived, I managed somehow to get to Ashkelon city, only to discover that, since it was the 1st of May, International Worker's Day or Labor Day, public transportation was at a standstill. Consequently, I began to hoof it, along the Ashkelon-Gaza Road to Gvar'am. I had walked quite a distance when a small vehicle suddenly appeared, driven by the head of the regional council. He asked: "Are you the young doctor for us, arriving today?" Then he took me into his car and drove me to my destination.

A number of days later, Neomi joined me. I received a small room as living quarters that was way too small to contain all the baggage we had brought with us from Argentina. Neomi made us dinner on a kerosene burner found in a closet on the porch. We got settled in Gvar'am and I began working as a doctor. It was there that my outlook crystallized as to the work of the doctor in a kibbutz. The bottom line was: a kibbutz doctor does not need to be a kibbutz member. The doctor and nurse in

the kibbutz clinic make important decisions regarding the lives of the members in the kibbutz (sometimes the nurse even more than the doctor, since the nurse heads the kibbutz's Health Committee). The doctor and nurse decide the diet this or that member requires, the individual's work hours and work conditions, i.e., workload and schedule. In order to make such decisions, it is inadvisable that the doctor and nurse be members in the community. Rather, they should be professionals who come from outside the kibbutz, in order to deal objectively with the health issues of its members.[4]

At the time, I was working day and night as a doctor in the Gvar'am area while Neomi worked in the Ashkelon ma'abara 26 as a nurse. These were times of insecurity in the area -- marked by border incursions by armed guerrillas from Gaza against Israeli civilians in the Negev. For my work, I received a jeep from Clalit that would no doubt make you laugh today at the sight of it. I used it to travel to the various points of settlement.[5] One rainy night, I was driving my

4 Ideally, decisions would be made on medical grounds only, free of group pressure, conflicting priorities, vested interests, status gaps between individuals, or conflict between individual needs and the 'good of the group.' For example, in times of food scarcity or rationing, a medical decision on diet could determine whether a particular kibbutznik got half an egg or a full egg per day, or 'enjoyed' a piece of chicken at the main noontime meal vs. only half a watermelon to stave off his or her hunger.

5 No doubt an open canvas-top jeep. Due to the precarious security situation at the time, civilian travel throughout the Negev and parts of the southern coastal plain was by car convoys.

jeep in the direction of Kaplan Hospital in Rechovot and it turned over. I arrived at Kaplan's ER as a patient. In fact, the ER at the new hospital would only open to the public several weeks later, but they treated me for my injuries, which left me with a nice scar to this day. This road accident was a critical turning point, a catalyst of sorts for me.

I decided at this point to leave Gvar'am because we also wanted to be more than a doctor and nurse -- to be positioned to play a broader role in social activism shaping the country and society. As already noted, it was my belief that a doctor should not be a member of the kibbutz; moreover, I never thought I was personally suitable in makeup to be a kibbutz member. In the interim, prior to my transfer to Beer Sheva taking effect, I exploited the break to participate in six-weeks in-service training at Kaplan's Internal Medicine Department B, headed by Dr. Pinchas Efrati.[6] Efrati would provide remarkable learning experience opportunities at the patient's bedside for his staff during doctor's rounds. He was the best pedagogical physician I ever encountered in the course of my medical education and specialization.

In Beer Sheva

I arrived in Beer Sheva. In those days, Beer Sheva was a desert wasteland -- the Old City and two immigrant clusters - the Aleph and the Gimmel Neighborhoods -- the Keren Cinema at the hub. I would judge that the population of the city in those days was in the vicinity of 7,000 residents. In 1949, a year after Beer Sheva was taken by Israeli forces, the military hospital in Be'er Sheva, which was established on the foundations of the British military hospital that operated in the city during the mandate, was transferred to the management of the Hadassah Medical Association which operated municipal-public hospitals in Jerusalem, Tel Aviv and Haifa during the mandate. The hospital was named in memory of Dr. Haim Yaski.[7] Parallel to this, Clalit opened a clinic, under the management of Dr. Itzhak Shatal.[8] Within a short time the hospital doubled the number of its beds to 50. It was functioning in the old Turkish government buildings without running water and without electricity. The hardships demanded a solution.

I was assigned to work in the Alef neighborhood clinic. The neighborhood was horribly overcrowded, and the patients were new immigrants from across the globe -- from Iraq and Morocco, from Egypt and Yemen, from Hungary and Romania and more -- almost every ethnic origin one could imagine. Three doctors worked in tandem at the clinic -- and we, too, as staff reflected the 'ingathering of the exiles': Dr. Gabriel Danon from Bulgaria,[9] Dr. Corry Boasson from Holland[10] and myself from Argentina. This was my first serious encounter dealing with health issues of new immigrants. Many of them didn't understand Hebrew at all, and therefore I opened a course at the clinic to teach Hebrew to the patients after hours. For years I worked at this clinic, and afterwards moved to the Gimmel Neighborhood clinic. After our regular hours at the Beer Sheva clinic, in the evening we went out to work in Negev settlements due to the catastrophic shortage of doctors in the Negev.

6 Prof. Pinchas Efrati (1907-1988), born in Slovakia, studied medicine in Prague, and immigrated to Israel in 1933. He became a professor of internal medicine at the school of medicine in Jerusalem and director of Kaplan's Internal Medicine Department B, among the first specialists in blood morphology in Israel. Levi, *The Land of Israel's Doctors.* p. 119.

7 Dr. Haim Yassky (1896–1948) was born in Kishinev in Imperial Russia, studied medicine in Odessa and Geneva, and immigrated to Israel in 1919, serving as Hadassah's director in Mandate Palestine between 1928-1948. He was murdered on 13 April,1948 in the 'Doctors Convoy Massacre' along with 77 others, when Palestinian Arabs attacked the medical convoy bringing supplies to Hadassah Hospital in the Mount Scopus enclave of Jerusalem. Levi, *The Land of Israel's Doctors,* p. 265.

8 Dr. Itzhak Shatal, a physician of Dutch origin, was Clalit's district medical director in Beer Sheva and the Negev from 1949. Tal, Hilah, *Toldot Sherutei ha-Re'fua ba-Negev* (History of Medical Services in the Negev), Ben- Gurion University of the Negev. 1993. pp. 91-106. (Henceforth, Tal)

9 Dr. Gabriel Danon (1921-2007) studied medicine in Sofia, Bulgaria, immigrated to Israel in 1949, worked as a family physician in the Aleph neighborhood of Beer Sheva and then in the 1960s in Ramat Gan. He served as a Clalit neighborhood medical administrator in the Ramat Yitzhak Neighborhood of Ramat Gan and died following a road accident in 2007.

10 Dr. Corry Hava Boasson, nee Mac Gillavry (1912-2009), was born in Holland, studied medicine in the Netherlands and in England, immigrating to Israel in 1939. She practiced medicine for a short period, then, afterwards turned to a career in medical librarianship in Jerusalem. Levi, *The Land of Israel's Doctors.* p. 128; Tal

To demonstrate just how dire this shortage was, let me share with readers my first meeting with Dr. Itzhak Shatal, a religiously observant physician from Holland, who was Clalit's district medical administrator in the Negev when I arrived there. Shatal claimed with a wink that he was "the first physician and the first *mohel* (religious circumciser) in the Negev since our forefather Abraham of yore"; and indeed, Shatal performed our eldest son's *brit* (circumcision), too. As a district medical director, he had to combine clinical work with administrative functions even on the most basic level. But most of the workload placed on his shoulders was receiving and treating patients. Therefore, when I arrived for a work interview with him at the beginning of my years in the Negev, in lieu of interviewing me, he said: "They already informed me of your coming. Good you're here. Perhaps you can begin now to examine patients?" I came for an interview – to ask, to listen, to see what was involved and so forth; but the shortage of doctors was so acute that Shatal mobilized me immediately on-the-spot.

Another figure I remember well was Dr. Irwin Cohen.[11] Cohen was a cardiologist in Tel Aviv, but gave up his career and his private practice to come to the Negev to treat patients. He was older than we but would travel by jeep from rural settlement to rural settlement to treat patients, staying overnight in an isolated development town in the boondocks, Yerucham, in order to be within calling range to take care of Ben-Gurion at kibbutz Sde Boker - if need be. Once he also had an accident with the jeep that left him with a limp for years.

Together with all the difficulties, we were overjoyed to live in Beer Sheva and be part of the community developing in the city and the Negev as a whole. A short time after our arrival, I initiated the establishment of an open forum to delve into and discuss fundamental problems facing Israeli society. We invited various figures, such as Prof. Yishiyahu Lebowitz[12] and Prof. Aharon

Katzir.[13] Prof. Katzir was among the scientific leadership of the Weizmann Institute and also a lecturer of the first order. Unfortunately, years later he was murdered in the Lod (now Ben-Gurion) Airport Massacre that killed 26 persons and was perpetrated by a three-man Japanese Red Army terrorist squad operating on behalf of a Palestinian terrorist organization.

I remember one rainy winter night, the first mayor of Beer Sheva, David Tuviyahu invited me[14] to the Beit Yatziv community center together with educator Sara Bahat and Gershon Ostrovsky.[15] Ostrovsky had a vision to establish a unique cultural center in Beer Sheva. The sense that we were part and parcel of Beer Sheva's flowering filled us with joy and satisfaction. They labeled us veteran Beer Shevans, although we were new immigrants: Veteran statuses were set, not merely by chronological years. They were measured by knowledge of Hebrew, both as one's vernacular and professional vocabulary, one's mastery of reading and writing, and so forth.

11 Dr. Irwin Cohen was born in Germany, studied medicine in Germany and immigrated to Israel in 1938. In 1951, he volunteered to serve as a doctor in the Negev and was David Ben-Gurion's physician in kibbutz Sde Boker -- living part-time in Beer Sheva, part-time in the kibbutz. Levi, *The Land of Israel's Doctors*, p. 273

12 Prof. Yeshayahu Leibowitz (1903-1994) was born in Riga (Latvia). He was a scientist and thinker, who studied science and philosophy in Berlin and Basel and immigrated to Israel in 1935. He served as editor of the *Hebrew Encyclopedia* and was a professor of biochemistry, organic chemistry, and neurophysiology at the Hebrew University in Jerusalem. He published a host of books and articles in which he set forth his philosophical, religious, and political doctrine.

13 Prof. Aharon Katzir (1913-1972) was born in Lodz (Poland) and immigrated to Israel in 1925. He was a professor at the Weizmann Institute of Science, a Fellow of the Israeli National Academy of Science, and Israel Prize laureate. He was murdered in a massive terrorist attack in 1972, staged in the Arrivals terminal of Israel's international airport.

14 David Tuviyahu (1898-1975) was born in Galicia (Poland), studied law and political science at the University of Lvov in Poland (now the Ivan Franko National University of Lviv, Ukraine), and immigrated to Israel in 1920. He was the first mayor of Beer Sheva after establishment of the State of Israel. At Prime Minister David Ben-Gurion's request, at the end of 1948 he settled in Beer Sheva to stand at the head of the council that served as a custodial government for the city, parallel to serving as director for operations in the south for the Labor Federation's construction company Solel Boneh. In February 1950, he was appointed to head the Beer Sheva municipality. With his retirement from the mayorship of Beer Sheva in 1961, he promoted establishment of "the Institute for Higher Learning in the Negev" which, in time, became Ben-Gurion University of the Negev. He was awarded Beer Sheva's Key to the City in 1964 and in 1973 was honored as an Honorary Fellow by BGU.

15 Gershon Ostrovsky, born in Ukraine, immigrated to Israel in 1923. He was a member of the *Gdud HaAvodah* socialist Zionist labor brigade and from 1949 a member of kibbutz Ein Harod. He served as director of the public works department in Beer Sheva and was founder (1953) of Beer Sheva's Beit Yatziv hospitality, education and culture center. He was awarded Beer Sheva's Key to the City in 1978.

The Plan to Bring Doctors from Latin America to the Negev

The gravest problem occupying my thoughts during the period we lived in Beer Sheva was the problem of the shortage of doctors in the Negev and immigrant settlements -- particularly in development towns and in border areas. I fear this problem, with all the ramifications this carries as a nation was one of the biggest failures in the historic mass immigration of Jews to the fledgling State of Israel. Who hadn't tried to solve this problem? Prime Minister Ben-Gurion raised several proposals: There was an attempt to mobilize physicians for a period of compulsory service treating patients in these areas -- something the doctors' professional organization, the Israel Medical Association (IMA), never accepted; nor did Minister of Labor Golda Meir accept this idea. A year of service in underserved communities for medical students after graduation was tried, material incentives were offered, and other schemes -- but the problem remained acute.

When I arrived in Beer Sheva in 1954, I asked myself - why shouldn't my friends who studied medicine with me in Argentina not come to serve as doctors in these areas? After all, they were put off by the Argentinean medical system, and a portion of the Argentinean Jewish physicians was active already in Zionist circles. But, why weren't they making *aliyah*. My explanation to myself was: They aren't coming because they fear the unknown. They don't have a clue about Israeli life or how the health system operates in the country. They don't know the language. And they fear they won't be able to cut it, i.e., to make it, and so forth. I devised a plan to offer solutions to their fears: They were afraid to come alone? Have them come in groups. They are apprehensive of not knowing the language? We'll ensure they can first go about learning the language in specially-tailored intensive Hebrew courses (*ulpan*, in Hebrew). They worry about their lack of familiarity with the health system in the country? We'll provide them with an introductory orientation course to the Israeli health system.

I turned to two entities who together could execute this plan: the Jewish Agency, the body responsible for arranging the *aliyah* of Jews from the Diaspora, and Clalit, which, beyond major population centers, was almost exclusively responsible for providing medical services in the country. First of all, I approached Yitzhak Kanev, Clalit's chair at the time. Kanev was, historically speaking, the father, or architect, of social security in Israel. He was the chair of the committee that prepared Israel's National Insurance Law, and for years he headed various committees that proposed a national health insurance scheme for the country. Although he was the chair of Clalit's directorate -- loyal to the Labor Federation under which Clalit operated, and while he strived to preserve the Labor Federation's vested interests, he was in favor of state-mandated health insurance. It was a top priority in his mind.[16] His worldview as an economist had been greatly influenced by economists at the London School of Economics.

I went to present my plan to him, and he immediately responded enthusiastically, asking: "Perhaps you would like to travel to Argentina to bring the doctors?" I had no interest in such a trip. I told him there was no need for me to go and that if the plan was launched, there were suitable Israeli envoys in place who could organize the plan from there. So, I went with the plan to my friends from my days in Argentina -- lawyer Ephraim Avigur who was the head of the Latin American desk of the Jewish Agency's *Aliyah* Department. He also was immediately enthralled, and lent a hand to carry out the plan. At the time Avigur was at the Jewish Agency, there was also an organization called PATWA (Professional & Technical Workers *Aliyah*) that had emerged in England and a bit in South America via which we advertised the program.

16 Clalit was but one highly hegemonic body established and controlled by Labor Zionists, which was far more than a union. It embodied a Federation-run 'workers' economy' network ranging from construction companies like the above-mentioned Solel Boneh group along with major manufacturing entities and marketing channels, agricultural and transportation coops to banks and other financial institutions. While the overarching objective was to forge a civil society, scaffolding for an independent Jewish state, the Federation not only provided essential services, but also had enormous leverage in shaping Israeli society along Social Democrat lines. A Federation-controlled health system that required membership in the Federation to qualify for Clalit membership embodied inherent conflicts of interests. Not the least of these was the status of Clalit on an uneven playing field, far too often viewed by the parent body as a cash cow to underwrite other Federation needs and priorities that had nothing to do with healthcare. This led to conflicts of interest and thrust managers such as Kanev into an impossible position of trying to serve two masters at the time while preserving their integrity. (D Ashkenazi, translator.)

In the end, we absorbed 13 groups through this program -- some 250 young physicians from South America. The first group arrived in Israel in 1956, in the middle of the Sinai Campaign. Since a large 'Central Hospital of the Negev' in Beer Sheva still didn't exist, we absorbed the lot at Kaplan Hospital in Rechovot.[17] One pair of doctors grabbed their suitcases and headed for Lod to fly straight back to Argentina, but the rest stayed. In the end, out of these 250 doctors, over 90 percent remained in Israel for good, even though they were not required to under the terms of the program.

They came with their families and enjoyed comfortable lodgings during their Hebrew ulpan period. Hadassah Gershoni and Sara Betz[18] were outstanding teachers who taught the immigrant doctors and their families Hebrew in a three-month long ulpan in Beer Sheva. After their ulpan, they underwent a period of orientation studies held at the newly-established Central Hospital of the Negev (today, Soroka Medical Center) to introduce the doctors to health services in Israel. I conducted the courses in medical terminology in Hebrew and the introductory course to the health system for a number of the groups, perhaps all of them. I set about assisting these immigrant doctors adjust far beyond my institutional roles -- smoothing their path and extending a hand on a personal level -- from obtaining heating for their apartments in the winter to extending our friendship and sharing our "street smarts." Our house in Beer Sheva was always open to help absorb immigrants.

According to the plan, they committed to devoting one year of service in a development region or village. Afterwards, they could choose between assistance in finding a suitable place of employment elsewhere or continuing to work in these underserved areas. The majority of the doctors remained in the Negev beyond their one-year commitment. No small number were family physicians. A portion of the doctors came to occupy senior positions in the health system including becoming department heads. At Hadassah Hospital Ein Karem, in Jerusalem, and at the hospital in Beer Sheva there were ENT, gynecology, and geriatrics department heads who were graduates of the program.

There were two takeaways from the program: First of all, it created a model for absorbing immigrant doctors from other countries. I recall that Prof. Shimon Glick,[19] dean of the medical school in Beer Sheva, approached me and requested that I provide him with all the details of the program so he could use its tenets for bringing doctors from other countries on *aliyah*. Secondly, the program served as tremendous momentum for *aliyah* of Jews as a whole from Latin America, particularly the *aliyah* of Jews from South America to kibbutzim in the Negev district (and subsequently, the *aliyah* of the parents of the kibbutz members). Furthermore, the success of the program led to a rise in the number of doctors who made *aliyah* on an individual basis.

The program was an expression of my personal linking of the good of the health system and *aliyah*. But this tie was not limited to a one-time endeavor; it was also expressed in my dealings with *aliyah* issues in other capacities that I filled later, for instance, when I chaired the committee that handled absorption of doctors from the Soviet Union during waves of immigration to Israel from Russia. This topic remained central in my thoughts and a core personal passion throughout my life.

17 The idea that this small Hadassah hospital was inadequate was not discussed; nor was the idea discussed that there would be a large IDF-run hospital there next.

18 Sara Batz (1923-2010) was born in Yavniel in Mandate Palestine and arrived in Beer Sheva in 1952 to serve as the city's first Hebrew teacher. She held a Master's degree in education and was principal of the Achva Elementary School in Beer Sheva. She was one of the initiators behind establishment of the Alef Mekif High School, a comprehensive academic and technical high school. In 1957, she opened and managed for 20 years the first academic Hebrew *ulpan* in the country designed for professionals in need of a working knowledge of vocabulary relevant to their profession, not just the ability to navigate and communicate in one's daily affairs. She authored many textbooks, primarily for *ulpanim*, and for years engaged in assisting new immigrants in the Negev. She was also the first woman elected to the city council where she represented the ruling *Mapai party*.

19 Prof. Shimon Glick (1932-) was born in New York, studied medicine in the United States, including specialization in endocrinology, and he immigrated to Israel in 1974 following the opening of a faculty of medicine at Ben Gurion University (BGU). He served as head of internal medicine at Soroka Medical Center. Among the founders of BGU's faculty of medicine, he was the dean of that faculty between 1986 - 1990. Subsequently, he headed the Center for Medical Education in the Negev and the Center for Medical Ethics, two entities that occupy a central place in the professional education process of medical students at BGU.

There was a period of time when it was said with a chuckle that "if one didn't know Spanish, they couldn't function at the hospital in Beer Sheva." Of course, decades later – in the 1990s – it was said in the same vein that "if one didn't know Russian, they couldn't function at the hospital in Beer Sheva." To backtrack: During the years of accelerated *aliyah* from Latin America to Beer Sheva, a branch of the Latin American Immigrants Association was opened; and over the years, Beer Sheva became a magnet, one of the primary absorption sites for immigrants from Latin America.

On the Eve of My Next Roles

My Identification with Clalit HMO and Its Founding Principles

The problem of the shortage of doctors in the Negev and other development areas was not only expressed in terms of accessibility. A core problem was that many of the doctors who agreed to come to work in the Negev were elderly and were not specialists in primary medicine. Moreover, there was a rapid turnover among these doctors, every two months, preventing or disrupting their ability to provide suitable solutions to the health problems of the population.

In essence, during this period, the country had developed a two-tiered health system: Doctors who were young and trained at the highest-level from a medical standpoint worked in hospitals. Some were graduates of Hebrew University's medical school in Jerusalem, and some were immigrants who were already well integrated. By contrast, elderly physicians, temporary substitutes from various areas of specialization without proper professional foundations in community medicine, worked in community-based medical centers. In terms of their numbers, there was even a surplus of doctors *per capita* in Israel, but there was a critical shortage of doctors the right age and with the proper professional foundations. Doctors in their seventies and eighties were shipped off to work in regional clinics in rural areas and on the borders without taking into account how problematic this was. I clearly recall how once a doctor with a drinking problem was sent to the Sha'ar HaNegev area, took the jeep and took off for Gaza. Of course, the Egyptians returned him. But incidents like this, indeed, took place.

Thus, in the 1950s and 1960s, there was a shortage of young doctors, with suitable specialization, who were willing to work in isolated rural areas and border settlements.

I was a primary physician in the Negev for fifteen years. Part of the time I was in the Beer Sheva clinic, but due to the shortage of doctors I also served moshavim and immigrant communities in other areas of the Negev. During the first eight years of my work, well acquainted with the problems at the time, I learned to appreciate the work of Clalit.[20] I was witness to the arrival of the first unadorned wooden prefabs brought by Clalit to serve as a clinic in Sederot, the development town hugging the Gaza border. And, in just such a prefab clinic, I received the first residents arriving in Dimona, a development town east of Beer Sheva in 'the middle of nowhere.' I also worked in two prefabs established by Clalit in the development town of Netivot in the western Negev. Thus, in these eight years, I could appreciate the presence of Clalit serving the population- at-large.[21]

Clalit's first principle was that it was different from the German *Krankenkasse* system[22] that refunds patients for their out-of-pocket payments for medical expenses. While labeled a "sick fund" ("*kupat holim*") that was responsible for insuring its members from an economic

20 Here Prof. Doron is alluding to Clalit's ethics-driven and pioneering role filling voids that other health entities couldn't or wouldn't fill.
21 The other sick funds were much smaller than Clalit. Moreover, the others lacked infrastructure such as having their own medical staff; or operated primarily in urban concentrations; or had a different ethos, e.g., operating primarily among specific sectors of the population such as the non-socialist middle class
22 "Sick fund" in German

standpoint, Clalit's main role was to develop health services that would be sufficient to serve to an adequate degree the country's entire Jewish community (the *Yishuv*, in Hebrew) in kibbutzim, moshavim, development towns, and urban neighborhoods; And Clalit's hospitals were all on an academic level. Another principle was the principle of equality and mutual assistance, e.g., that membership dues from the center of the country would assist opening medical services on the periphery. The last principle was that money would have no role in the doctor-patient relationships.[23] A fundamental condition for good and proper medical standards is striving relentlessly for equality and refusing to allow money to stand between the doctor and the patient.

All this attracted me, because I was well familiar with the opposite, private medicine, having done my residency at the Jewish Hospital in Buenos Aires where I became all too familiar with the dominance of private medicine in some places abroad. I totally identified with the principles of Israeli public health as I understood them, and as I expressed them in the various capacities I filled in Clalit during my career. Such identification runs like a thread in all my life endeavors in the diverse roles I've played in Clalit; in my teaching positions at Tel Aviv and Ben-Gurion Universities; and in my volunteer work organizing health services.

From Beer Sheva to London

Seven years after I arrived in the Negev, I stood to replace Dr. Itzhak Shatal who was chief district physician and regional medical director of Clalit in the Negev. Dr. Tova Yeshurun Berman,[24] the medical director of Clalit proposed to send me for in-service training in public health at the University of London. To do so, she managed with great effort to secure a grant from WHO, among the handful of grants that the Ministry of Health allocated for study abroad. She was able to accomplish this even though the Ministry was not eager to allocate grants to Clalit and favored allocating them to services the Ministry was directly responsible for.
I went ahead on my own to London, to prepare the ground, and Neomi came afterwards with our two children.

My studies in London were an important juncture in my medical career. I delved into epidemiology. I can recall how I went to the professor of epidemiology and asked him whether the adaptation process of new immigrants to Israeli society (*mizug galuyot*)[25] could be a fruitful ground for epidemiological research. He said to me, "Yes, but you have to do this quickly, because the Diasporas are merging very fast." Sir Austin Bradford Hill, among the first statisticians to engage in health as a topic, was my statistics instructor. I learned a lot in his course, and I was very much drawn to organization of health services.

During this period, the first community health centers were being opened in England and Scotland. As part of my work, I studied the new health centers; and I surveyed most of the health centers that existed at the time. In Scotland I went to Edinburgh and Glasgow, where there were some very important centers; and I went to Stanraer. In Stranraer there was a very interesting health center because it combined a hospital and community services, a "cottage hospital." At a later stage, I would copy this model for the Yoseftal Hospital in Eilat.

23 Yosef Meir, *Ha-refu'a vha-Tzebor: Leket Ma'amarim* (Medicine and the Public: A Compendium of Articles), collected and edited K. Tamari; Introduction by Yitzhak Kanev, Tel Aviv: Clalit Directorate, 1955. Published posthumously.
24 Dr. Tova Yeshurun Berman (1898-1997) was born in Ukraine, studied medicine in Kyiv, and immigrated to Israel in 1923. In 1948, she was elected as a member of the *Clalit* directorate and a member of the Medical Department in place of Dr. Josef (Yosef) Meir, who had been appointted director-general of the Ministry of Health. She served in this capacity until 1952 when she was appointed chair of the Clalit directorate's Medical Committee and served as Clalit's medical director until 1968. Tzipora Shachar-Rubin, *Dr. Tova Yeshurun-Berman, ha-Giveret ha-Rishona b- Mamlechet Kupat Holim* (Dr. Tova Yeshurun-Berman: The First Lady of the [Clalit] Sick Fund Kingdom). Dekel Publishers, 2013.
25 The Hebrew term is literally 'merging Diaspora', which in practice meant pressing for accelerated acculturation to transform Diaspora Jews who came from oriental-mizrachi communities in North Africa and Asia, and Holocaust survivors from Europe, into Israelis who conformed to the dominant culture and norms of the veteran Zionist-driven society and ruling socialist party.

As part of our program, we also had a six-week seminar on health service management that took place in Oslo, conducted by the director-general of the Norwegian Ministry of Health himself, Dr. Karl Owing, who was also the head of WHO at the time. Owing was a first-rate pedagogue in the public health field. He had been invited to Israel in the 1950s, and upon his return had written a report that praised Israel's health services. After the Oslo seminar, we went far north to learn about health service issues for the indigenous Saami ("Lap") population of Finland.[26]

The public health program at the University of London included writing a thesis. The topic of my thesis paper was organization of health services in Israel.

Then, at the conclusion of the public health program, my study grant included a tour under the auspices of WHO for a group of five or six participants in all, including me. One was from Jordan, another from Ghana, a third from Poland, and others. We visited Sarajevo, today in Bosnia. As fate would have it, at the time, the Yugoslav dictator Tito had suddenly become bosom buddies with the Egyptian dictator Gamal Abdel Nasser and consequently there was an Egyptian delegation in Sarajevo during our sojourn. The head of the WHO mission presented me to the Egyptian delegation, and I introduced myself saying "It's a pleasure. I'm from Israel." Within a second, the head of our delegation was asking me, somewhat piqued, "Do you always have to mention the fact you're from Israel?!"

The next day, we – both delegations – were invited to a meeting at the Sarajevo Health Service. Six doctors in white coats greeted us in a lab. The lab was in charge of the war against malaria. In the course of discussion, the representative of the Jordanian Health Minister claimed he would have taken the struggle against malaria forward, but Israel refused to cooperate. I responded sharply to counter the canard. Ironically, very quickly I realized that all six of our host doctors were Jewish. In fact, one day back in Israel, I got a call from one of them seeking to consult with me whether to make *aliyah*. In the end he came to Beer Sheva.

District Physician for the Negev

I returned to Israel, Neomi and the children having preceded me. Immediately upon my return, my friend Dr. Uri Spearman, who would become my deputy, then inherit my position as Clalit's regional physician for the Negev, hinted to me[27] that rumors were circulating that Clalit's regional director was pressuring to put off the retirement of Dr. Shatal, in order to delay my appointment. At the time, the regional director who was not a physician was the one who held all the cards and pulled the strings, controlling without any restraint all aspects of Clalit's operation including professional decisions. Dr. Tova Yeshurun-Berman, the medical director of Clalit fiercely opposed this delaying move, and such pressures from "the powers that be" failed. Thus, I was appointed regional physician - a position today labeled "medical director" of the region.

I served in the position of director of the region in medical matters between 1961-1968. In the course of this work, I also worked once or twice a week as a Clalit primary physician in Tifrach, an agricultural moshav established by members of the religious Agudat Poalei Israel party and populated by ultra-Orthodox (*haredi*) Jews, and moshav Nevatim whose members hailed from Cochin in India. When I would ask the latter "whether their tummy hurt, they would say 'yes' even though they intended just the opposite..." so I was forced to request a translator for my medical work.

26According to the *Encyclopea Britanica*, such native Laplanders can be found in Norway and Sweden (40,000 and 20,000 respectively, at the end of the 20th century and in even smaller numbers in Finland (6,000) and Russia (2,000).
27 Dr. Leonid (Uri) Spearman, Tuviyahu Archives, Ben Gurion University of the Negev, "Interviews with medical pioneers in the Negev" portfolio

In August of 1968, after seven years as medical director of the Negev, I was appointed medical director of Clalit directorate. We were still living in Beer Sheva and didn't want to leave. For five years, until 1973, a few scant months before the outbreak of the Yom Kippur War, I would commute daily from Beer Sheva to *Clalit* headquarters in Tel Aviv.

My sense of mission in fulfilling the principles of public health I so believed in was in a sense all consuming, occupying even my leisure time. Thus, when Neomi and I would take road trips as a family around the country, I usually couldn't help myself from seeking out the clinic in this or that community to evaluate its quality and check out its working conditions.

During the period of time that I was commuting daily to Tel Aviv, my workday was significantly longer than the proverbial eight-hour day. I would return late at night and every morning at 7:20 my car was already parked at Clalit headquarters in Tel Aviv in a time when the highway between the two was a far cry from what it is today. While I had a regular driver, when he had trouble getting up in the morning, I would take the wheel and drive myself alone. He would be forced to catch up with me, taking several buses from Beer Sheva to Tel Aviv.

Finally, I said to my wife Neomi that we had to choose one of the two: Either I quit my job, or we leave Beer Sheva, because we couldn't go on like this. Our period in Beer Sheva spanned some 19 years, and counting our time in Gvar'am, we lived 20 years in the Negev. This was the most momentous and exciting period in the course of our lives in Israel.

CHAPTER 3

The History of Establishment of a School of Medicine in the Negev

First Strides towards Establishment of the Medical School

The endeavor to establish a medical school in the Negev was born as part and parcel of the vision of settling the Negev as a whole. To understand this initiative, one needs to grasp the state of settlement in the Negev and in the State of Israel in general in the 1950s and first half of the 1960s.

Ben-Gurion had gone to the Negev to set a personal example for Israeli youth after stepping down from office in 1963, and he retired from political life for good in 1970. Settling in Sde Boker, he called on Israeli youth -- particularly the offspring of established kibbutzim and moshavim -- to go down to the Negev to volunteer in immigrant communities in the Negev.

Terrorist attacks were not foreign to life in the Negev at the time. Nonetheless, there were calls from public figures, the most outstanding being Moshe Dayan, who championed settling the Galilee and the Negev by spreading out the population which was heavily concentrated in the coastal plain in the center of the country between Hadera and Gedera and in major cities. From the time I arrived in the Negev, I argued that spreading out the population would not happen without spreading out institutions of higher learning and research. From my first days in the Negev, my perception of the grave shortage of doctors and its solution was tied to my dream of a medical school in Beer Sheva. The first mayor of Beer Sheva, David Tuviyahu, also had a vision of establishing a university in Beer Sheva. It is much to his credit that Ben-Gurion University of the Negev became a reality. He was the person who in the first stage established the Institute for Higher Learning in the Negev, the seed from which Ben Gurion University (BGU) sprang forth and developed. To do so, he initiated convening a commission for establishing a university. It was comprised of professionals in the basic sciences, such as chemistry and physics, plus professionals in engineering, law, and medicine. I was a member of this commission, representing the medical discipline. From the start, the demand and the struggle to establish a medical school was intimately entwined in the struggle to establish the university.

In November 1967, as a result of the demand to establish the university, Prime Minister Levi Eshkol established the Gillis Committee. He called on Prof. Yosef Gillis, an important scientist at the Weizmann Institute of Science, to head the Committee, which was mandated to investigate if there was justification for a university in Beer Sheva. As he was preparing to sum up the Committee's deliberations, I went to Prof. Gillis' home in Rechovot with my wife Neomi for dinner and told him: "All I'm asking is that you write that the conditions for establishing a medical school will be examined in the future." I didn't dare ask for more. The member of the Committee who supported my position was Prof. Andre de Vries from Beilinson Hospital, who had been one of the initiators behind establishment of the medical school at Tel Aviv University. In the end, with the submission of the Gillis Committee's findings to the Prime Minister, we did succeed in sneaking in a sentence stating that the conditions for establishing a medical school in the future at the Central Hospital of the Negev and the Negev in general, would be examined.

At the same time, Prof. Yosef Stern, the director of the Central Hospital for the Negev,[28] Prof. Eliyahu Lehman, who had been head of the old Hadassah Hospital in Beer Sheva and was head

28 Prof. Yosef Stern (1913-1992) was born in Russia, studied medicine in Bologna, Italy, and immigrated to Israel in 1936. Beginning in 1950, he was an internist at Beilinson Hospital. Then, from 1959, with the establishment of the Central Hospital for the Negev in Beer Sheva, he was appointed the first director; and he continued in the role of director from 1972-1978 after the hospital had been renamed in memory of Moshe Soroka. At the same time, he headed the internal medicine department at Soroka Hospital and fathered the establishment of a school of nursing, physiotherapy and paramedical professions, which led Soroka Hospital to being the main teaching hospital for Ben- Gurion University.

of the internal medicine department at Soroka Hospital,[29] and Prof. Gabriel Terek,[30] head of orthopedics at the new hospital, offered me the position of chair of the committee to investigate conditions for establishing a medical school. They did this although I was not a department head at the hospital, just Clalit regional physician; but they were cognizant that my appointment ensured the struggle to establish a medical school would continue.

One of the first actions I took was to go to Kibbutz Sde Boker to request Ben-Gurion's support behind establishing the school of medicine. I knew Ben-Gurion. As a physician, I had treated him; and from time to time, I would go to his prefab domicile to discuss various matters. So, I went to him and said: "Ben-Gurion, we want to establish a school of medicine in Beer Sheva, and I'm asking for your help." He looked at me and asked: "Who's the Minister of Health today?" I responded, "Israel Barzilai." Ben-Gurion replied curtly: "With that Minister of Health...I don't talk (sic. I'm not on speaking terms)!" Indeed, Ben-Gurion was a political rival of Israel Barzilai, but there was another unstated motivation behind Ben-Gurion's lack of support. From the start, Ben-Gurion had been against establishing a university in Beer Sheva because he wanted to establish a university along the lines of Oxford or Cambridge near Kibbutz Sde Boker. Only at a much later stage, when the university in Beer Sheva became, for all intents and purposes an established fact, was Beer Sheva's mayor Tuviyahu able to convince Ben-Gurion that there was no turning back the clock. Thus, I left Ben-Gurion without any help on his part or support for a school of medicine in Beer Sheva. Whether Ben Gurion was right or wrong, let history be the judge.

I embarked on seeking a candidate for dean. At the time Dr. Charles Kleeman from Los Angeles had been appointed head of the internal medicine department at Hadassah Ein Karem for a period of one year. In the U.S., Kleeman had been head of the nephrology department at Cedars-Sinai hospital. In my efforts to bring doctors to Israel, I had visited L.A., and we'd become friendly. The bond was cemented by our shared outlook of the importance of community medicine. Kleeman had delved deep into this subject and was passionate about it. I viewed him as a possible candidate for the deanship of the medical school and approached him during his year-long sojourn in Israel. Unfortunately, his wife was not interested in staying in Israel and they returned to Los Angeles.

But during this period, the Institute for Higher Learning for the Negev was taking shape. And together with the Institute, we convinced a committee – that became known as the Kleeman Committee – to discuss establishment of a medical school. The objective was to "to formulate within a short time, an operative program for running such a school of medicine" with a curriculum that would meet the health system's needs in the community. Asked to join the Committee were Prof. Moshe Rachmilevich from Hadassah Hospital, one of the founding fathers of the medical school in Jerusalem, Prof. Moshe Prywes,[31] who was the head of medical-education at the medical school in Jerusalem, Prof. Shimon Gitter who was the second dean of the school of medicine in Tel Aviv, and another two or three professors from the United States. The Kleeman Committee convened in the city of Arad in the Negev. After two or three days of deliberations, a landmark report was hammered out that set forth the architecture for a medical school that would reflect our outlook -- one with a community orientation: "Initial studies would

29 Prof. Eliyahu Lehman (1914-2011), an internist, was born in Germany, studied medicine in Heidelberg and was among the first physicians in the Negev. He founded and directed the first hospital in Beer Sheva (Hadassah Hospital in Beer Sheva), and he was the first director of Internal Medicine Department A at Soroka Medical Center, a position he held for 20 years. He was awarded Beer Sheva's Key to the City in 1975.

30 Prof. Gabriel Terek (1917-1991) was born in Hungary and studied medicine in Czechoslovakia. He immigrated to Israel in 1949; and he was the founder and first director of the orthopedics department at Soroka Medical Center and among the founders of Ben-Gurion University's medical school.

31Prof. Moshe Prywes (1914-1998), who was born in Poland, studied medicine in Paris and Warsaw, served in the Polish army in the Second World War, became a prisoner of war (POW), and served as a doctor in a POW camp in a Siberian gulag. After the war, he served as a member of the medical directorship of the Jewish health organization OSE in Paris [OSE or OZE in French, Œuvre de secours aux enfants, which had been established in 1912.] He initiated the OSE's program to eradicate tuberculosis, trachoma, and ringworm in Jewish communities in North Africa in the years 1947-1951. He then immigrated to Israel in 1951 and was appointed deputy dean for medical education at the faculty of medicine in Jerusalem. He later became the first president of Ben-Gurion University of the Negev (1969- 1974) and first dean of the Faculty of Health Sciences (1974-1979).

be comprised of five years, followed by two-years when the fledgling doctor would be doing an internship in the community" The convening of the Committee and its recommendations set in motion the great struggle to establish a school of medicine in Beer Sheva.

The Question of an Additional Medical school in Israel

The first full-fledged medical school was established in Jerusalem in 1949 through collaboration between the Hebrew University and Hadassah. It occupies a special place in the history of medicine in Israel. The school pioneered the training of dozens of doctors who ultimately became department heads in all the hospitals in Israel. But these individuals had one weakness: every time an initiative was raised for an additional medical school in the country, in Tel Aviv, in Haifa or in Beer Sheva, their opposition was unbending and extreme. Their primary argument in opposition was the claim there was no need for an additional medical school in the country, a claim that reinforced the natural tendency of the Ministry of Finance to oppose establishment of another medical school.

In spite of the likelihood of opposition, two figures led the initiative to establish a medical school in Tel Aviv as part of Tel Aviv University: Prof. Andre De Vries from Clalit's Beilinson Hospital, who had gotten his medical training at Hadassah Ein Karem Hospital, and Prof. Chaim Sheba, director of the Tel-Hashomer Hospital, a 1948 military hospital that had turned into a civilian, government-run, hospital that was on the outskirts of Ramat Gan and not far from Tel Aviv.

Hebrew University faculty exhibited strident and unreasonable opposition to establishing a medical school in Tel Aviv. There certainly weren't any logical foundations for their opposition, particularly when one takes into account the abundance of hospital beds in the Tel Aviv area. The opposition, De Vries, Sheba, and their colleagues discovered, lay in the fact there was also an initiative afoot to establish a medical school in Haifa, where Prof. David Erlich from the Technion was the chief driving force.

Later, the same sort of oppositional behavior was encountered in regard to the initiative to establish a medical school in Beer Sheva. But the struggle against a medical school in Beer Sheva was far more pronounced and unbridled. How and why will be elucidated further on.

The Berenzon Commission - Haifa or Beer Sheva?

Minister of Health, Ysrael Barzilai, established a commission headed by a supreme court justice, Zvi Berenzon. The members of the Berenzon Commission were: Prof. Pinchas Efrati from Clalit's Kaplan Hospital, which was affiliated then, and to this day, with the Hebrew University's medical school; Prof. Moshe Prywes, who was head of medical education in Jerusalem; Prof. Chaim Sheba; Prof. Andre De Vries, who represented the school of medicine in Tel Aviv; and S. Rosen, who, as chair of the Knesset's Public Services Committee that addressed health matters, represented the Knesset on the panel.

Minister Barzilai requested the Commission address three questions.

A. Is there a need for a third medical school in the country?
B. If the conclusion is that there is a need, where should it be located, Haifa or Beer Sheva?
C. If the conclusion is that there is no need for an additional medical school, what are the solutions to the severe shortage of doctors in villages, on the frontier, and in immigrant communities?

As the medical director of Clalit, I submitted a detailed report to the Barzilai Commission on the shortage of doctors on the periphery, particularly the shortage of young doctors in primary

medicine and the issue of the medical level of primary care staff in outlying areas.
A delegation of students from the medical school in Jerusalem appeared before the Commission and without any attempt at cosmetics, declared:

> *"You should know, we won't go to serve in rural settlements and frontier settlements on the periphery because this is not the medicine for which we have been educated. We are taught hospital medicine, are being groomed for research, but not for work in the community, and certainly not under conditions of [mass] aliyah absorption. The training we receive is not suitable for this role."*

This confession gave me a lot of food for thought. It impacted on the path I took and the initiatives I would champion.

To the surprise of many, the Berenzon Commission decided there was no room for founding a third medical school in the country -- because establishing one would be counter to the interests of the universities in Jerusalem and Tel Aviv. When suitable conditions would present themselves, it would be possible to establish another medical school, but first in Haifa and only afterwards in Beer Sheva. On the positive side, they recommended bringing back to Israel students studying medicine abroad, primarily in Italy, to complete their studies at home and do their last years of study in Tel Aviv or in Jerusalem.

Before the Berenzon Commission reached its recommendations, I went to the Sheba Medical Center, previously the Tel Hashomer Government Hospital for a semi-secret meeting with Prof. Haim Sheba. The meeting was at 7:00 AM, i.e., before normal working hours.

At that time Moshe Soroka[32] was deputy director general of Clalit. As medical director, I was his subordinate. Relations between Sheba and Soroka at the time were exceedingly antagonistic.[33] Prof. Sheba was Ben-Gurion's personal physician, and he knew I had taken care of Ben-Gurion for a time. So, his attitude towards me was positive. I told him: "I know you will decide in favor of Haifa, which has a government-run hospital, and I admit that today conditions there are much better there than in Beer Sheva. I only have one request: That the Commission's decision include a passage that in the future there will be a place for establishing a school in Beer Sheva." He promised and kept his word. The Berenson Commission report said in the future a school of medicine would be established in Haifa, and afterwards in Beer Sheva.

The driving force behind establishing the school in Haifa was Prof. David Erlich, who was supported by Haifa mayor, Abba Hushi. Politically, Abba Hushi was perhaps the most powerful mayor in the history of the State of Israel. After the Berenson Commission submitted its findings, Abba Hushi put pressure on the Minister of Education, Yigal Allon, who succeeded in pushing a decision through the cabinet. Although the decision was not to establish a third medical school, the cabinet passed a clever resolution - that the students returning from abroad would complete their medical studies in Haifa: Thus, the school of medicine at the Technion was founded, de facto. The struggle to establish the medical school in Beer Sheva was left on its own, to continue the fight.

32Moshe Soroka (1903-1972), was born in Belarus and immigrated to Israel in 1920, where he engaged in healthcare administration as a promoter and central figure in the establishment of Clalit's hospital network beginning with the Emek Hospital in the Jezreel Valley (1930), then Kaplan in Rechovot (1953), Meir in Kfar Saba (1956), and Yoseftal in Eilat (1968). He served as director of Clalit between 1968-1972 and was a central figure behind establishment of the Central Hospital for the Negev, which since 1960 has been the Soroka Medical Center, named in recognition of his substantial role in the establishment of Clalit's network of clinics, labs, research institutes and rest and recuperation facilities. Idit Zartal, *Yaim oo-Ma'asim* (Days and Endeavors), Machbarot le-Safrut, 1975.

33 Following the independence of Israel, a lengthy power struggle ensued. There were tensions between elements of the formal government, such as its ministries, and elements of the dominant *Mapai* party (the Labor or worker's party) and its affiliates such as the Labor Federation (Histadrut). As just one example, there were ongoing underlying tensions between the fledgling Ministry of Health and Clalit, its parent organization being the Labor Federation. This struggle was an undercurrent whenever a new power hub was on the table. It enveloped not only key players, but also conflicting ideologies and vested interests. Thus, the antagonism between Sheba and Soroka went beyond a simple personal clash. There was much more at stake such as wrestling over powerbases, Clalit hospitals vs. government- hospitals, or which academic players would be involved in the training of doctors.

Soroka's Attitude and Approach to Medical Education and Collaboration between Us

As noted, during my tenure as medical director of Clalit, Moshe Soroka was the general director of the sick fund. His position on medical education was identical to mine in terms of conclusions, but different in terms of motivations: Soroka wasn't a physician. In light of the acute shortage of doctors in rural and border areas, Soroka viewed the way medical education was being handled in Israel as a betrayal of Zionism. He felt that medical educators and outstanding scholars were betraying the objective needs of the State of Israel at this crucial juncture.

I saw things differently. The people in the medical community were serving in the medical corps of the IDF, the Israel Defense Forces, or army, with great dedication and faith, and I did not think they slacked in their loyalty to the needs of the country and its citizenry. I recalled what the medical students had said in the Berenson Commission report - that there was a gap in the level and quality of the health system in the hospitals and the health system in the community. Hospitals were staffed by high-level young doctors, the community by a constant turnover of elderly physicians. I knew that as long as we didn't raise the level of medical personnel in the clinics and bring it up to par with the level of medical personnel in the hospitals, there was no way we would come to grips with the problem. As long as we failed to address medical education, first and foremost, professional specialization in community medicine on a high level, nothing would change. In other words, in my opinion, it was not a question of Zionism or lack of Zionism. Rather, it was a matter of good medicine or bad medicine. From my perspective, the issue began with medical education, then in-service training, and especially specialization in family medicine.

Despite this, the collaboration between Soroka and myself was spectacular – and not just on this issue. When I traveled to the States to look for a dean for the medical school in the Negev, Soroka took steps to ensure there would be an additional internal medicine department at the hospital in the Negev, so there would be room for more students, and more study opportunities at the Negev hospital. Every time a new medical school was founded, in Tel Aviv or Haifa, Soroka proposed collaboration with Clalit, and even provided budgets. Even though he was treasurer of the sick fund, it was far from simple for him to invest resources in medical education.

From Zichron-Yaakov to Establishment of the School of Medicine in Beer Sheva

Even prior to the founding of Ben-Gurion University of the Negev, Beer Sheva's founding mayor David Tuviyahu called, wishing to consult with me. The invitation was prompted by my position as a member of the steering committee on establishing a university in Beer Sheva, and, no doubt, by my keen interest in fighting for a medical school within it. He invited me and two or three other figures to a meeting, including Micha Talmon,[34] director of the southern region of the Ministry of Housing. The discussion took place at the municipal headquarters, housed at the time in the former mosque at the entrance to the Old City, where Tuviyahu spread out a map of three possible locations for the university: The first was beyond the tracks of the northern train station at the time – today, in the Ramot Neighborhood; the second was in place of the Na'ot Midbar Hotel that had been razed several years earlier and on the road to Ashkelon; and the third was facing the hospital. I recall that I fought the positions of others present at the meeting, arguing that the university must be built facing the hospital, so that the school of medicine would be in proximity to the hospital. My reasoning was adopted by David Tuviyahu. Later, along with Prof. Moshe Prywes, I took the position that the medical school shouldn't be located on the university campus, but rather within the hospital campus.

34Micha Telmon (1922-2013), arrived in Beer Sheva in 1949 where he served for a decade as the Ministry of Housing's director for the Negev District, overseeing public construction in Beer Sheva and the region, e.g., villages and development towns such as Sderot, Ofakim, and Netivot in the western Negev. Afterwards, he served for a decade as director-general of the Israel Lands Authority, working hand-in-hand with mayor Tuviyahu to found Ben-Gurion University of the Negev, and he then served as BGU's comptroller. Telmon was also a member of the Labor Federation's executive committee and was among the promoters behind establishing the Tuviyahu Archive of Negev History. He was awarded Beer Sheva's Key to the City in 1999.

Prof. Prywes was head of the medical education department at Hebrew University's medical school in Jerusalem. As a member of the Berenson Commission, he had voted against establishing a medical school in Beer Sheva. But later, Prywes began to think that my, and Clalit's, concept for a medical school in Beer Sheva wasn't just another idea. He wrote a letter to Soroka at Clalit headquarters that indicated he had changed his opinion on the matter. This move was designed to adopt the same guise used to establish a medical school in Haifa: to bring students to Israel from abroad to continue their studies in Beer Sheva and then train them for work in the community. Soroka answered in a letter saying, "I'm glad to receive your letter" - quoting the Sayings of the Sages: "In the place that true repenters stand, the most righteous cannot stand."[35]

Clalit at the time had a medical council that would convene two or three times a year. It was comprised of top figures in Clalit's medical staff. We invited Prywes to speak about medical education. I knew that several days before the get-together, he had lost the election of a new dean at the Jerusalem medical school to Prof. Aharon Beller who was head of neurosurgery at Hadassah Ein Karem. The contest had a personal edge, but also a clash of philosophies. Prof. Beller's approach was research-oriented, more clinical and scientific, the approach of the hospital physician, while Prof. Prywes' approach was broader and more community-oriented. Prywes had lost only by a few votes. At my invitation, we sat down to talk after his lecture. I told him "I'm recommending you to be the first dean of the school of medicine in Beer Sheva which we will establish, working together. He didn't answer immediately, but said: "I'm leaving tomorrow for three weeks in the United States. I'll think about the matter. When I return, we'll talk." He went abroad, and with his return brought me a plan, saying "If the sick fund accepts my plan, I'm in. If it doesn't accept it, I have no interest in establishing a school like all the existing schools."

In short, the principles of his plan were the following:
A) Medical education wasn't an entity in and of itself. Rather, it had an objective - medical service. Accordingly, medical education must serve needs for health services.
B). In doing so one much combine research and service in medical education. He had a slogan: "Those who serve, teach; those who teach, serve."
C). He proposed that the dean be the director of Clalit's Negev region. This proposal wasn't simple from my perspective. While I was a medical director, not an administrative director, it wasn't easy for me to simply hand over some of Clalit's regional director's authorities in the Negev to the university.[36]

Prof. Prywes also supported having entrance interviews with applicants for medical school. The objective of the interview was to evaluate whether the applicant's personality was suitable for their role as a physician. In those days, schools of medicine in Israel accepted applicants solely on their high school grade averages, and their matriculation and psychometric scores for higher education.[37] And indeed, to this day, an interview is part of the acceptance process in the medical school in Beer Sheva. It now has been adopted by other schools, as well.

Prof. Prywes also insisted on the idea that health services within the community be at the center of the medical school's program. He stressed the importance of a high professional level being maintained both in hospitals and in community-based services, a principle that Clalit had always stressed. He coined the concept of the "Beer Sheva Spirit," an ethos that accompanies BGU's school of medicine to this day.[38] I can't swear he is the one who coined the term, but

35 The meaning for persons who have repented is that "their level is greater than the level of those who never sinned before, since they have conquered their evil inclinations more than they." Chapter 7, Law 4 – Voices in Our Head – Torah.org https://torah.org /learning/mlife-lor7-4/
36 On the managerial structure of Clalit, see the upcoming chapter.
37 The matriculation and psychometric examinations are Israeli "College Board Exams."
38 The "Beer Sheva Spirit" or "Ruach Beer Sheva" inculcates both a person and community centered approach in students and graduates of Ben-Gurion University's medical school. Graduates of BGU's medical school who work elsewhere in Israel are generally considered to be more person-oriented and patient-centered than the graduates of Israel's other medical schools.

his ideology, outlined above, was what led to this ethos, a school with a holistic outlook and community- centered view.

From this point onward, we became partners in the struggle to establish a medical school. Prof. Prywes would be the candidate for the deanship. He knew that the objection in Jerusalem to establish a medical school in Beer Sheva was partly philosophic difference about the objective of medical education and partly personal.

To this day, the Minister of Education in Israel serves as chair of the Council for Higher Education, and the Council considers and votes upon whether new schools should be created. When the Council is tied, the Minister of Education, as its chair, has the deciding vote. At the time, the Minister of Education was Yigal Allon, a former general in the Israeli Army who later became prime minister. With respect to creating a medical school in Beer Sheva, Allon was between a rock and a hard place. He was unsure whether he could get the government's budget to underwrite establishment of a medical school in Beer Sheva, and he didn't know whether conditions were finally ripe for founding such a school. So, he appointed an investigatory committee headed by Prof. Michael Feldman, one of the Weizmann Institute's most outstanding scientists.

Members of the Feldman Committee were mandated to take the Prywes Plan that we had adopted and give their opinion of it. I submitted to the committee statistics on the shortage of doctors, the need for doctors in frontier areas, and so forth. At the head of the opposition stood Prof. Aharon Beller, the dean of the medical school in Jerusalem. At the time there was, and still is, an Israeli Association of Medical Deans, whose head is rotated among the deans of the various schools. In this period of time, Prof. Beller was the chair, and he sent the harshest of letters in the Association's name against establishment of a medical school in Beer Sheva. Prof. Gitter, who was dean of the medical school in Tel Aviv and head of the physiology institute at Beilinson Hospital, tried to soften Beller's strident opposition, but with little success.

In parallel to this, there were annual discussions between the Ministry of Finance and Clalit over possible governmental participation in Clalit's budget. The meeting took place at Clalit's Arza rest and recuperation facility in the Jerusalem foothills. The Ministry of Finance's director-general forewarned us: "You should be aware that if you establish a school of medicine in Beer Sheva de facto, without government approval, we will cancel all proposals for governmental participation in the sick fund's budget." Despite this threat, a short time afterward, I convened at my home in Beer Sheva a meeting with four participants in attendance: David Tuviyahu, Prof. Moshe Prywes, Moshe Soroka, and myself. It was there that we signed the first agreement between the Institute of Higher Education in the Negev and Clalit – that we were establishing a school of medicine in Beer Sheva. It was a document that was undeniably historic – a tipping point.

The Feldman Report took a positive position vis-à-vis the Prywes Plan. The report was submitted to the Council of Higher Education with Minister of Education Yigal Allon chairing. The central opposition was of the Hebrew University's delegation. The first to take the floor was archeologist Prof. Yigal Yadin, who spoke in harsh terms against establishing a medical school in Beer Sheva. Prof. Avraham Harman, president of the Hebrew University told Prywes in a private conversation: "It's not going to happen." The vote closed with half in favor and half against establishment of a medical school. Minister of Education Yigal Allon, as chair of the Council, had to cast the deciding vote. He decided to vote in favor of the medical school in Beer Sheva.[39]

[39]Doron H., Shvarts S., "Academia, politics and health: the struggle for the establishment of a school of medicine in Beer Sheva", in Sustaining Change in Medical education (Benor, D.E., editor) Ben Gurion University of the Negev Press, Beer Sheva, 2005, p.60 Doron H., Shvarts S., "The Process of the Establishment of a School of Medicine in Beer Sheva," in Ben Gurion University Book (Grados Y., editor), 2014.

We prepared a festive opening. In attendance were Prime Minister Golda Meir, U.S. Senator Edward Kennedy, Beer Sheva mayor David Tuviyahu, and others. Opening of the school was delayed by a year due to the October 1973 Yom Kippur War; but it did open in 1974. To the best of my recollection, it opened with 36 enrollees.

At that time, at the Central Hospital for the Negev, a school of nursing named for Paula Ben-Gurion was already in operation.[40] I had been the anatomy instructor at the school, and therefore was familiar with conditions there. The school of nursing, unlike other nursing schools in the country, was not an academic program. When I was no longer working in the Negev, but at Clalit's directorate, Yosef Tekoa, who had been elected president of BGU after completing his tenure as Israel's ambassador to the United Nations, asked to meet with me.

He told me that one of the Recanati brothers was prepared to donate to establish a school of nursing at the university, provided it would be on a high academic level. I told him there was already a school of nursing at the hospital in Beer Sheva named after Paula Ben-Gurion. It would be no easy task to grapple with Ben- Gurion's family on this issue, while at the same time it was out of the question there would be both a hospital-based school of nursing and a university-based academic school of nursing. I also told Recanati that in keeping with the spirit of the medical school in Beer Sheva, I would insist that a nursing school in the Negev would have to be community-oriented.

Various other individuals in Clalit, not myself, engaged quite a bit with the family of Paula Ben- Gurion, in the end receiving the family's agreement; and an academic-level school was established on the foundations of the existing school of nursing.

Prof. Moshe Prywes, who was already serving as dean of the Faculty of Health Sciences, appointed my friend Dr. Reuven Adler as the first director of the Recanati School of Community Health Professions.[41] Dr. Adler, who had previously been the IDF's Chief Medical Officer and was a neurologist by training, dedicated himself to his new position. After serving as director of the school, he took a management position at the government-owned Rambam Hospital in Haifa.

Later at my invitation, he became director of Clalit's Loewenstein Rehab Hospital, in recent years heading Loewenstein's research institute.

As for the concept of "a school with a community-orientation" - this phrase expressed my outlook on the health system in the country, a view that to no small measure had been forged by my experience in my first years in Israel, in the Negev. The most prominent shortcoming that I saw was the existence of two health systems. There were orderly high-quality hospitals, but there also was a patchwork of low-level community services, a shortage of doctors, and much more. I considered transformation of family medicine into a recognized specialty as a top priority. Even at this time, I understood that without a revolution in medical education, this objective in medical services couldn't be achieved. This was my point of departure, guiding all my actions regarding the character of the new medical school.

My Outlook on a Medical School in Beer Sheva- 43 Years after its Founding[42]

Moshe Soroka, while still director-general of Clalit, died a short time prior to the medical school opening. I was then elected director-general of Clalit. As the director-general, I signed the official agreement between Clalit and the university.

40 The Paula Ben-Gurion School of Nursing operates today as an academic nursing program within the framework of the Recanati School of Community Health Professions, which is part of BGU's Faculty of Health Sciences.
41 The Leon and Mathilde Recanati School of Community Health Professions includes studies in nursing, physiotherapy, and emergency medicine. Today, over 1,000 students are enrolled in its undergraduate and graduate programs.
42https://in.bgu.ac.il/en/fohs/Pages/Fohs_History.aspx

Years later, I was appointed a member of the Goldman Committee which was mandated to oversee the academic program of the medical school and make recommendations.[43] This committee, formally named the International Academic Review Committee (IARC), was initially comprised of three American and three Israeli Professors. The Goldman Committee's task would be to convene once a year or year-and-a-half, to monitor and comment on the academic operations of the school and make recommendations as to where to invest the fund's money. I joined the committee a short time after it was established and have served as a member for 17 years. Each time the committee convened, I have participated in its deliberations: I have viewed it my duty to preserve the medical school's original vision and ensure it will not be lost.

Thus, I've had the privilege of following the workings of the medical school in Beer Sheva as the medical director of Clalit; as a participant in its founding; as director-general of Clalit, and afterwards as a member of the Goldman Committee. Consequently, I think I am in a good position to sum up the outcomes of the struggle to establish the school with a candid look on this project, now in its fifth decade, and wish to do so for posterity.

Today, 43 years after its founding, I can say with candor that the medical school in Beer Sheva is excellent, among the best in the country, a pride and joy. The existence of a medical school in Beer Sheva has a far-reaching impact on the Ben-Gurion University and the Negev as a whole. This is reflected in the fact that in recent years, those who aspire to develop the Galilee understood that the best way to leverage such a process is to establish a medical school in Tzfat.[44]

BGU's medical school has played a major role in raising the level of Soroka Hospital and even has been central to its very existence. I can't image it would have been possible to develop Soroka Hospital, today a major hospital in Israel, without the ability to provide Soroka with department heads and staff physicians with high level academic credentials drawn from this sister institution under the same roof. The school also impacts on the quality of other hospitals associated with it, including the government-run mental health hospital in Beer Sheva, the Barzilai Hospital in Ashkelon, and more recently, much to my pleasure, affiliation with the new Assuta Hospital in Ashdod.

Prof. Prywes' concept that one person would serve as dean of the medical school and director of Clalit's Negev region didn't last. The first three deans -- Moshe Prywes, Prof. Lechaim Naggan,[45] and Prof. Shimon Glick -- indeed filled both posts. On paper, the fourth dean Prof. Shimon Moses also did so;[46] but in practice this combination was not so marked. The reason: Such a setup was not natural: Clalit is an institution that deals with health services, while the hospital deals with medical education. Although there is an interface between the two, they are not identical. But today there are physicians here and there who have realized this principle

43 The donation that established the "Goldman Committee," formally named the International Academic Review Committee, or IARC, was made after the deaths of both Irving Goldman and his wife, Joyce. It was part of a large donation to BGU made by the Joyce and Irving Goldman Foundation in New York whose board members were the three children of Joyce and Irving Goldman – Dorian, Katja, and Lloyd Goldman. The decision to direct the large gift to BGU's medical school was determined by discussions with the leadership of the university about where the greatest need was. That, in turn, led to the naming of the medical school as the Joyce and Irving Goldman Medical School at Ben-Gurion University of the Negev; and it led to the establishment of the IARC. See also Schoenbaum S.C., et al, "A view from the Outside." In, Sustaining Change in Medical Education, (Benor, D. E., ed.) Ben-Gurion University Press 2005, pp.588-604.

44 The Bar-Ilan University Azrieli Faculty of Medicine in Tzfat (Safed) established in 2011.

45 Prof. Lechaim Naggan (1936 -), born in Tel-Aviv, studied medicine first in Geneva, Switzerland, completing them at the Hebrew University in Jerusalem. He also holds MPH and DrPH degrees in epidemiology from the Harvard School of Public Health; and he served for many years in the IDF, where he was the deputy commander of the Medical Corps from 1972-1974. He became chair of the epidemiology and health services evaluation unit at BGU in 1976, was acting dean in 1979-80 and then the dean of the Faculty of Health Sciences (FOHS) from 1982-1986. Within the FOHS he developed the Basic Sciences Division and the Graduates Program; and he championed family medicine. From 1991-1998, he was BGU's vice president and dean for research and development. In addition to his activities at BGU, he has long taught epidemiology in summer programs at Johns Hopkins University (USA).

46 Prof. Shimon Moses (1926-2021) was born in Germany and immigrated to Israel in 1938. In the Second World War, he fought in the Jewish Brigade, and then studied medicine in Leiden (Holland) and at the Hebrew University in Jerusalem. He specialized in pediatrics. In 1961, he moved to Beer Sheva where he founded a pediatrics department at Soroka Hospital, at the time the Central Hospital for the Negev. Prof. Moses researched and published widely on pediatric metabolic diseases and was among those who pioneered research into familial dysautonomia. As dean of BGU's Faculty of Health Sciences (1990-1994), he led establishment of a new medical library at the hospital and took first steps towards developing plans and design of a new building for the school of medicine on the hospital campus. He also led the campaign to absorb fifty immigrant doctors from the former Soviet Union at the Soroka Medical Center that was accompanied by a special assistance package. He retired in 1994, and up until 2015 directed research of Dead Sea treatments.

of combining the two functions in their work – primarily various division heads who have integrated medical services with medical education and research at the same time.

The "Beer Sheva Spirit" is a concept that exists to this day. One of the elements that characterizes the school is that from the start of their studies, medical students have contact with the patient and the community, the patient's home, social background, and so forth. I can't forget the conversation I had with an internal medicine department head at the Meir Hospital in Kfar Saba, who later served as dean in Tel Aviv. When I asked him about Beer Sheva graduates, he told me: "When a candidate for specialization in my department comes to me from Beer Sheva, I grab him immediately because I know his capabilities in doctor-patient relations are much higher than the others." I heard appraisals of this sort from both Beer Sheva graduates and department heads. The Beer Sheva Spirit embodies a more humanistic outlook that takes the entire patient into account, and sees the person, not just the malady.

One thing I must mention: The Division for Community Health was established immediately with the founding of the medical school. In the first stage, it was based on the foundations of several different departments, including the clinical departments of family medicine and pediatrics, as well as departments such as public health, epidemiology, and medical sociology. All these departments worked together, developed research on a high par, and created the Sial Research Center of Family Medicine and Primary Medicine. But, at a certain point, content from the clinical and public health departments was separated.

On the whole, our original objective was to establish a school directed towards raising the level and improving medical services in the community in the Negev. This was in marked contrast with the objective that prevailed for years in other schools of medicine in Israel which were oriented more strictly towards hospital practice. At BGU, divisions for service, education, and research in the community existed and continue to exist to this day.

A downside is that BGU's school of medicine does not have a special community-based medicine major that is designed to attract students at the outset. If one measures success in terms of the number of graduates who choose to work in the community, I am sad to say, the number who turn to primary medicine in the community among graduates of other medical schools in Israel is greater than the number of graduates from Beer Sheva.

From the medical school's earliest days, we invested great efforts to improve working conditions in community clinics so they would be suitable for students' specialization, and we established a special unit for this purpose which was underwritten by the American Jewish Joint Distribution Committee. We added a secretariat and social workers to the clinics. Positive strides were made in Netivot, at the time an immigrant and refugee absorption camp *(ma'abara)* with terrible living conditions, and in other Negev development towns, such as Sderot and Ofakim.[47] Afterwards such endeavors ran out of steam. At the outset, Professors Prywes and Glick believed nurturing good primary medicine in the community had to be built on nurturing primary internal medicine and primary pediatric medicine. I took issue with this approach. I did not believe, and I still don't believe, that primary internal medicine can compete with the other specializations in internal medicine – cardiology, gastroenterology and hematology that are perceived to be on a higher level in the process of atomization of medicine in the current era. Today, the physician knows more and more about less and less. The physician knows more about the organ, and less about the entire patient; and such narrow perspectives are considered more prestigious and, let's be honest, more lucrative. Of course, I am not opposed to primary

47 *Ma'abarot* were transit camps that dotted the landscape, rows of prefab wooden cabins (and originally tents and tin huts) provided minimum shelter during the period of mass aliyah, the absorption of immigrants that doubled the population followed statehood. They remained a 'temporary' feature into the early 1960s and served in many cases as the nucleus for new development towns.

internal medicine. There is an excellent model in Yerucham[48] and a model for primary pediatric medicine in Ofakim; but these are the exceptions.

When I realized the Beer Sheva medical school was not coming on board to promote community medicine on a high level, I invited myself to a meeting of the faculty's governing council and told them: "Distinguished colleagues. Your way doesn't lead to the development of primary medicine in the community on a high level. Only specialization of family medicine can contribute to this." I succeeded in convincing them that it would be worthwhile to bring in a department head from the Emek hospital. Only then did they accept my argument and establish a department of family medicine that operates to this day as an independent department.

The greatest waning in the community medicine concept has come from the deans who came after the first. Those deans believed the more the school would deepen the scope of its research and distance itself from the community, the more prestigious it would become. Even though I am not in any way opposed to nurturing research, this view of the deans was a mistake. In the last analysis, academic democracy as practiced at the university, whereby every few years a new dean is chosen by a majority vote, is not the best way to conduct things. The most relevant consideration in choosing a dean should be the best person for furthering the objectives of the medical school. There were deans who were excellent 'as deans,' but not for realizing the vision of community medicine which was among the foremost objectives of the medical school at its inception.

At every meeting of the Goldman Committee, at my initiative and that of others such as Prof. Stephen C. Schoenbaum,[49] who for many years served as the Goldman Committee's chair, and Prof. Steven Schroeder,[50] his predecessor in that post and the founding chair of the committee, we made recommendations to strengthen primary medicine in the community. But unfortunately, our recommendations had little effect. The funds were channeled to the hospital and to research – not to medicine in the community.

All these processes led to a retreat from a community-oriented commitment. However, the most dramatic event having an adverse effect on channeling of resources to medicine in the community would come from elsewhere: Legislation of the National Health Insurance Law. The public still doesn't fully appreciate how much damage was inflicted on the health system and medical education in Israel with this law. The law abolished the Parallel Tax.[51] What ensued in the wake of this move, threw Clalit into a budgetary straitjacket. Clalit, even if it was convinced that channeling budgets to medical education was right and proper, couldn't do this under the conditions forged under the new law. This represented a pitiful philosophy of partition that dominates medicine to this day. The upshot is that the Ministry of Health deals only with medical services, and the Ministry of Education and the Council for Higher Education deal with medical education. This split delivered a death blow to the collaboration between the school of medicine and Clalit, and killed the agreement between them. Thus, cancellation of the Parallel Tax was the decisive factor striking down the original vision of BGU's school of medicine in Beer Sheva; and the integration of medical service, medical education, and research was dealt

48 A small development town 35 km. southeast of Beer Sheva in the heart of the Negev plateau.
49 Stephen C. Schoenbaum, M.D., is the former medical director and then president of Harvard Pilgrim Health Care of New England, Providence, Rhode Island. He was an associate professor of medicine and associate professor of ambulatory medicine and prevention at Harvard Medical School. He then became Executive Vice President for Programs at The Commonwealth Fund and Executive Director of its Commission on a High-Performance Health System. He is currently Special Advisor to the President of the Josiah Macy Jr. Foundation in New York City and an adjunct professor of healthcare leadership at Brown University.
50 Steven A. Schroeder, M.D., studied medicine at Harvard, and later became director of the Division of General Medicine at the University of California San Francisco (UCSF) where he also did health services research. From 1990-2002, he was the president and CEO of the Robert Wood Johnson Foundation in Princeton New Jersy. In 1996, he became the founding chairperson of the IARC. He currently is Distinguished Professor of Health and Health Care at UCSF, where he heads the Smoking Cessation Leadership Center.
51 Parallel Tax (*Mas Makbeel*, in Hebrew) - a special tax that underwrote the operations of the sick funds. A tax had been collected from employees by Israel's National Insurance Institute, allocated to the four health funds proportionally, *per capita*, according to a yearly census of their memberships (whose nature has been subject to controversy). The tax was abolished in 1997 in the framework of the annual Arrangement Law. See Chapter 9 for a detailed discussion of the National Health Insurance Law, Parallel Tax, and Arrangement Law.

a terrible blow. The BGU medical school is an excellent school, but it is no longer entirely identified with its original ethos to uplift medicine in the community. I continued to give voice to this painful fact of life at every opportunity in meetings of the Goldman Committee.

One day, I requested to meet with Prof. Rivka Carmi,[52] president of the university in Beer Sheva, whom I have known her since her days as a geneticist at Soroka Hospital. She came to our house in Jerusalem, and I spoke with her about the abandonment of the vision of specialization in community medicine. I asked: "Where is all this leading?" And she asked what I proposed be done.

I suggested, in order to take this forward, that she recruit an outstanding professor of family medicine from Israel or from abroad. There are good candidates for this, I said. And, it is possible to offer good conditions to strengthen-retain existing staff, and thus provide momentum for developing specialization in this field in the Negev. I asked her what position they could offer such a candidate. Prof. Carmi replied that the person could be appointed as an advisor to the president for development of family medicine.

Several weeks later, it came to my attention that Prof. Michael Weingarten, an excellent physician who was head of the Department of Family Medicine at Tel Aviv University might consider a change. I immediately sent his curriculum vitae to Prof. Carmi, but there was no further effort to find a suitable candidate. Today [1997] I am well into retirement and cannot do more. I imagine that a doctor of Prof. Weingarten's stature, among the best professors of family medicine in Israel, if not the best, would have gladly come to Beer Sheva had he been offered the opportunity. But there was no initiative on the part of the BGU medical school. In the end, he volunteered to go to the new medical school in Tzfat and became one of its founders.[53]

I still hold that a professor or two, specialists in family medicine with good directorial skills, should be brought on board with the objective of revitalizing family medicine in the Negev. There are neighborhood clinics that are suitable to serve as a clinical setting for family medicine specialization, and the physical plant already exists. This could be underwritten through funding from Ben-Gurion University's far from insignificant donor sources. But one needs to aspire to realize our original vision. I don't have the ability to externally infuse the powers-that-be with the desire to bring this change of heart about. We built a model that was copied from us at the beginning, one that today serves as a role model in many countries, while paradoxically, in Israel we have fled from realizing it ourselves.

52 Prof. Rivka Carmi (1948-), who was born in Zichron Yaakov in Israel, studied medicine at the Hebrew University- Hadassah medical school in Jerusalem. She specialized in pediatrics and neonatology at Soroka Hospital, with further specialization in medical genetics at Harvard Medical School. She directed Soroka Medical Center's genetics institute, and became dean of the Faculty of Health Sciences at BGU from 2002-2005 as well as the chair of the Israeli Association of Medical Deans. From 2006-2018, she served as president of Ben-Gurion University. She was the first women elected to the post of president of an Israeli university. In 2015, she was appointed by the Queen as Honorary Commander of the Order of the British Empire (CBE) for her outstanding scholarship that deepened scientific ties between the UK and Israel.
53 Prof. Michael Weingarten (1947-2018) was born in London and came to Israel in 1973. From 1978-2011, he directed the family medicine clinic in Rosh HaAyin, a Yemenite community near Tel Aviv. He taught at Tel Aviv University where he became the head of the Department of Family Medicine and also head of the Department of Behavioral Sciences. He subsequently became one of the founders of the Bar-Ilan medical school in Tzfat.

CHAPTER 4

Clalit's Directorate

Dual-Management in Clalit

As already noted, in August 1968, after seven years as director of Clalit's Negev District, I was appointed Clalit directorate's chief medical director. At the time, Clalit was the largest institution in the health system in Israel, and at various times it insured between 85-90 percent of the insured population.

Well before my appointment as a director at Clalit headquarters, I had become familiar with the organization's dual administrator structure. This double format operated at all levels in the organization: At the head of each district (North, Center, South) stood a physician and a director. Dr. Tovah Yeshurun-Bergman, who had been the medical director of Clalit, dubbed the administrative directors "the civilians." Clalit hospitals as well had two directors, although naturally in the hospitals the medical director was more powerful, due to the nature of the institution. Nevertheless, the administrative head in Clalit hospitals was far from weak in stature.

Even clinics, the basic unit, had a doctor and a clerk. The clerks, who generally had no medical education, considered themselves the directors of the clinics and did everything in their power to prove so. From the clerk's perspective, the role of the doctor was to sign prescriptions and sick leave slips, approve home visits, and so forth.

As a director of Clalit's Negev District, it was clear to me that there was a huge gap between the district physician and the administrative director in the way they perceived their roles. The administrative directors viewed themselves as district directors and the real decision-makers, and believed the district doctor was only their medical advisor. This outlook was encouraged and bolstered by Clalit's treasury because the authority and clout of the treasurer was channeled through these administrative directors, who were under him. The administrative directors were very powerful, expressed not only in the functions they fulfilled, but also by various perks such as the type of vehicle the administrators received, compared to the physicians. The administrators did everything in their power to prove their seniority in running things. This caused many quarrels between the district physician and the administrative director over issues of authority. Management became impossible.

I was all too familiar with this system, having suffered greatly from it personally in my days as district physician for the Negev. When I was appointed chief medical director at Clalit headquarters, I knew this was a badly flawed system that needed to be combated, and I considered it my duty to gradually change the situation. I understood that to succeed, I couldn't change things overnight, but could only do this slowly, and with a lot of cunning. This was a difficult mission to accomplish because Clalit's directorate was comprised overwhelmingly by administrative directors, and few physicians.

My policy objective was to gradually lead towards one director in authority. Such an individual did not have to be a physician. It hinged on the nature of the unit, but the person filling the position had to have proven credentials in terms of education or experience. Physician or not - the main thing was that there be one director whose professional administrative skills were suitable to the job. I endeavored that there should be a balance: If in one place I appointed a doctor, in another I appointed an administrative director as head. This was the only way to change the situation.

Introducing a Regional Model

During my tenure, the medical department of Clalit was a mixed affair, orchestrating both hospital operations and clinic operations. Only later were the two separated. This policy of one director for each unit enabled me to also insert my outlook on partnering hospital work and services in the community within Clalit. All in all, I was very much in favor of regionalism, a socioeconomic concept that in my mind is decisive in health matters.[54]

I introduced four regions (*merchavim*), each being an entity with one director that included the clinics and their respective regional hospital. In the Negev Region integrating the hospital and health services in the community was essential due to the shortage of doctors. In the Emek Region, the presence of pioneering figures from the early days of Clalit enabled me to entrust them with managing this sector. The Sharon and Petach Tikvah Region had the Sharon Hospital at the hub. And last, in the north, we had the Haifa and the Western Galilee Region.

The director of the Negev Region was a physician, as was the case in the Sharon Region. The latter was headed by Prof. Yaakov Hart,[55] a family physician by profession who previously had replaced me as regional physician for the Negev. In the Emek Division a physician and administrative director rotated as head of the division. In the Haifa and Western Galilee Division, the senior official was not a doctor but was an individual with the managerial credentials to successfully carry out the role.

The regional model rested on the principle that the patient at the clinic was the same person sent to the hospital when need arose. Thus, the idea of continuity of treatment from the community to the hospital and then back to the community was a critical advantage. Another advantage was the feasibility of the hospital physician meeting the patient in the person's family surroundings and community environment. When the hospital operates separately from the clinic, there are no opportunities for the attending physician to evaluate the patient's natural surroundings or to encounter the disease in a clinic setting. Other advantages are that this model economizes. It optimizes personnel; and in periods of doctor shortages, it is essential that hospital physicians combine their hospital practices with filling shortages at clinics.

Circumstances surrounding my appointments in Clalit's Directorate

I feel is is important to understand the circumstances surrounding my appointments to three key directorial positions in Clalit in the course of my medical career.

My first appointment was as regional physician for the Negev in 1961, an appointment made solely on professional grounds, not political. This was sparked by my studies in London in public health, and a series of previous roles in the Negev such as responsibility for the occupational health of employees in the first industries and manufacturing plants in the Negev. Despite my opposition to the dual-management model, I was totally dedicated and engaged in developing health care in Beer Sheva and the Negev, to absorbing immigrant doctors in the Negev, and to being very attuned to the needs of Negev settlements and their pioneering members. Thus, it was natural that I was picked to serve as regional physician for the Negev.

The circumstances surrounding my appointment in 1968 as head of the Medical Division of Clalit's directorate were very different. There was tremendous tension surrounding the dual management of Clalit, and adamant opposition among the doctors to the candidacy for director- general of Moshe Soroka, who, at the time, was treasurer of the sick fund. The doctors demanded that a physician stand at the head of the institution, and even threatened

54 Alas, today, in an era where the workings of the health system since 1995 are dictated by the terms of the National Health Insurance Law, this concept has almost been lost.

55 Prof. Yaakov Hart (1944-) was born in Israel, studied medicine at Hebrew University Jerusalem (1961-1967) and specialized in Community Health. He joined the Tel Aviv University School of Medicine in 1974. Since 2015, he has been Dean and President of Netanya College.

to strike over the issue. The backdrop was bitterness over salary issues and opposition to the "reign of functionaries."[56] The director-general of the Labor Federation at the time, Aharon Becker,[57] declared a compromise: Soroka would be appointed director-general of Clalit, and since Dr. Tova Yeshurun-Berman was retiring as head of the Medical Division, a young regional physician from the Negev, Haim Doron, would be appointed to succeed her. Clalit doctors agreed to the compromise.

In 1965, when Ben-Gurion left the ruling Mapai Party to found the RAFI Party (an acronym for Israeli Workers' List), I didn't hide my affinities for the new party and its championship of *mamlachtiyut*, or "statism."[58]

Although *RAFI* reunited with *Mapai* in 1968, I believe the *RAFI* representative in the Federation, Gad Yaacobi, influenced formulation of Becker's compromise. After the compromised jelled, I received a telephone call from Shimon Peres -- who wanted to propose me as a candidate for Clalit director-general. I wasn't thrilled with this scheme. I preferred the post of medical director, in part because I surmised that the proposal was influenced by Peres' rivalry with Gad Yaacobi.[59]

In all my years as a key directorial figure in Clalit, my top priorities were health system matters - considerations regarding the level of the sick fund's medicine, the purity of its ways, and its stability. The political structure disturbed me, and I did everything I could to reduce its impact. One day, after the resignation of Moshe Dayan from the Begin Government in early 1979, one of the Hebrew weeklies leaked the news that Moshe Dayan planned to run as an independent party candidate in upcoming parliamentary elections. It said "his number-two man on the List would be the chair of Clalit's directorate -- Haim Doron." I hadn't a clue where this tidbit came from, and what I was doing there. Several days later I received a call from Dayan with an invitation to meet with him at the Knesset. He opened our conversation asking, "Are you going to stay in Clalit forever?" I said, "Yes," and that's where our conversation ended. I had no intention to get involved in party politics.

The backdrop to my appointment as Clalit's director-general in 1976 was entirely different. After the death of Moshe Soroka in 1972, while he was still serving as director-general, the Minister of Finance, Pinchas Sapir and the secretary-general of the Labor Federation Yitzhak Ben-Aharon agreed to appoint Asher Yadlin, the head of the Federation's all-powerful *Hevrat HaOvdim* ("Society of Workers")[60] as the new chair of Clalit's directorate. This was a purely political appointment. Yadlin served for only a very short time. His political aspirations were purely in the economic direction. When his candidacy for Governor of the Bank of Israel was announced, accusations of corruption during his tenure at the helm of Clalit surfaced. A criminal investigation was opened that closed with Yadlin's conviction for bribe-taking. When he was taken into custody for interrogation, as second-in-command at Clalit, I automatically became the stand- in for the directorate's chair, the acting director-general.

This was a very difficult period for me. In my outlook on life, which I inherited from my parents, I identified ideologically and spiritually with the principles of Clalit, which were completely contrary to a sordid affair like this. I found it difficult to face Clalit workers who had been

56 Here, Doron was delicately hinting about the Soviet-style corporate culture within the Clalit, riddled with apparatchiks chosen more on party affiliation and party loyalty than actual credentials for the job.
57 Aharon Becker (December 21, 1905 - December 24, 1995) was a labor leader. He was secretary general of the Histadrut, the Federation of Labor, (1961–1969) and a member of the Knesset (Israeli parliament), In 1974 he was elected chairman of the Clalit HMO.
58 Ben-Gurion's trigger behind his leaving *Mapai* to form RAFI was personal rivalry between him and his *Mapai* successor, Levi Eshkol. *"Mamlachtiyut"* is literally "statism," which in broad terms, championed putting the state, its governing institutions and the country's needs, above the party and vested party interests and institutions. It favored rule by the government, which also involved subordinating or dismantling fragmented pre-state constructs.
59 Doron realized Peres' offer was part of internal struggles between rival *RAFI* members. Gad Yaakobi had previously been an advisor to Moshe Dayan. Doron did not want to be anyone's pawn or straw man.
60 *Hevrat HaOvdim*, or "Society of Workers," was the Labor Federation's economic arm through which it owned and operated many enterprises that constituted a full third of the entire economy at the height of its power. These included industrial conglomerates, Bank Hapoalim, and the ZIM shipping line. See: https://en.wikipedia.org/wiki/Histadrut

dedicated employees all their working lives and who identified with Clalit's lofty mission, to answer the question hanging in the air: "How could this happen within our halls!?" I can't forget how, during those days, before signing any document, I would hesitate and request the approval of Clalit's legal counsel, my friend, advocate Amiram Sagiv.

It was a forgone conclusion, inside and outside Clalit, that I would be appointed the permanent chair of the sick fund. This assessment reflected my standing in the institution, as well as my past achievements as the medical director in Clalit. But a physician had never stood at the helm of the institution. Days prior to my official appointment. the secretary-general of the Labor Federation Yerucham Meshel called and asked if I would agree to continue serving in an acting capacity. My reply was 'Absolutely not!' He backed off. Thus, for the first time in Clalit's history, a doctor was appointed to direct the sick fund. Not only that. Not only was I a physician, but I had independent ideas and was guided by a *mamlachti* ('for the public good') approach: As director-general of Clalit, I even penned a proposal for a national health insurance law that was contrary to the position of the Labor Federation.

My Path in the Halls of Clalit

Although the sick fund was a Federation, not a state, institution, my directorial approach was mamlachti: Only the good of the health system and public guided my actions. In the 1950s and 1960s there was opposition, harsh disagreements, and friction between the Ministry of Health and Clalit. During my tenure, as well, there was still opposition from within. Although I could never understand why such opposition existed, and I certainly had no allegiance to it and refused to accept it, I knew my approach was for the good of the health system of the country as a whole. For example, I didn't hesitate to sign a regional hospitalization agreement with the Ministry of Health in 1981, a reform championed by Minister of Health Eliezer Shostak, from the Likud party, and his director-general Prof. Baruch Modan. Modan came from the leading government-run hospital, the Sheba Medical Center. The agreement opened all hospitals, including Clalit hospitals, to members of all the sick funds. This entailed Clalit giving up to a certain extent the preference its members enjoyed over other patients at Clalit hospitals. The agreement also organized hospitalization nationwide on a regional basis. I declined to sign the agreement until it included a clause that gave every family physician special discretion to hospitalize a patient in any hospital when warranted, and I personally stood firm behind this clause. Nonetheless, signing this agreement was a surprise for the people at the Ministry of Health. This was hardly in keeping with the tradition of opposition relationships and friction between Clalit and the Ministry of Health.

When Moshe Soroka was still the general-director of Clalit and I was still the medical director, I made efforts to ignore this clash and to strive for genuine cooperation, matter-of-factly, case-by- case. Staff at the government-run hospitals sensed this. Here are several examples of how this was played out:

I have already mentioned that my meeting with Prof. Sheba on the eve of the decision to establish the medical school in Haifa took place during a fierce clash between Prof. Sheba and his people at the government hospitals and Soroka and Clalit's people. Despite this, he honored my request that he mention in the recommendations that a fourth medical school would be established in the Negev.[61]

Another example is that Prof. Sheba published an opinion piece in the daily newspaper, *Ha'aretz*, expressing his opinion against Soroka's decision to establish the Harzfeld geriatric rehabilitation Hospital in Gedera rather than on the Kaplan hospital campus in Rehovot. From an objective professional standpoint of what might have made a better location, he was correct. In reality,

61In the subtext, Doron's effectiveness rested on his demeanor that opened channels and his independence of thought and action, his integrity, which won him respect and credibility and a sympathetic ear in broad circles.

however, Sheba was in error since what Clalit had decided to do was to build the hospital, which would be named for Harzfeld on land in Gedera that Harzfeld had given for this specific purpose. But Sheba also wrote that he was prepared that a young doctor from the Negev who had just been appointed medical director of Clalit would decide who was correct. He clearly felt that my approach to things was objective and to the point.

There was a strong collaboration between the then director of Sheba Hospital, Prof. Mordechai Shani,[62] and me during the period of conflicts of interest between Clalit and the government hospitals: Together we established a rehabilitation institute for patients after heart attacks, Kfar HaMacabia, in Ramat Gan. It was a partnership between Clalit and Tel Hashomer. We also established the hospice at Tel Hashomer; and we were partners in founding the Center for Public Medicine, a forerunner to the Gertner Institute for Epidemiology and Public Health Research.

Another example: At the time of the Yom Kippur War [1973], the director-general of the Ministry of Health was Prof. Baruch Padeh.[63] I was quite friendly with him and collaborated with him.

When the war broke out, together we went to all the hospitals to see which patients could be released to free beds for the war casualties. I took it upon myself to open a home care system for chronically ill, long-term care patients, a setup that was established at the time with *Clalit* funding. Padeh did promise a government budget for this, but in the end, we never received it. There were other such instances of cooperation. I didn't see any justification to split such functions, and didn't see any logic to fight over control of them, I tried to ignore the clashes, and to collaborate as much as I could on concrete matters.

A different example of my approach was reflected in my position regarding establishment of a hospital in the Negev. Ben-Gurion held the hospital must be a government-run one. While, in general, I identified deeply with Ben-Gurion's *mamlachti* approach and his theory of the state taking on many independent pre-state functions, in the matter of the Negev hospital I didn't agree with his position because I knew this was not good for residents of the Negev. At this juncture in time, without doubt, the most effective institution to develop a modern hospital was Clalit. Considering that this hospital was for the good of the community, this was also my position. Thus, I believe that in my management of a non-governmental agency such as Clalit, my approach was also *mamlachti*. I expected a person such as Ben-Gurion would forego a general principle in favor of the matter at hand. He did not. Nevertheless, I remained a warm and dedicated admirer of Ben- Gurion for many years.

62 Prof. Mordechai Shani (1938 -) twice served as director-general of the Ministry of Health (1979, and 1993-1994). He was director of Sheba Medical Center for 33 years, and he partnered with Prof. Doron in establishing the National Institute for Epidemiology and Health Policy Research (the Gartner Institute). In 2005, he was the founder and subsequent director of the Tel Aviv University School of Public Health. He also was among the architects of the law for Rehabilitation of the Mentally Ill in the Community; and he chaired the Basket of Services Committee that sets the basket of services and pharmaceuticals covered under the National Health Insurance Law. He was awarded the Israel Prize in 2009 for lifetime achievements and contributions to the health system.

63 Prof. Baruch Padeh (1908-2001), studied medicine in Prague, and immigrated to Israel in 1939. He served as IDF Chief Medical Officer, was director of the Poriya Hospital in Tiberius, and also was director-general of the Ministry of Health. A professor of internal medicine, he was awarded the Israel Prize in 1985. The Poriya Hospital is now named in his memory.

CHAPTER 5

Vitalizing Family Medicine in Israel

My Outlook on Family Medicine

I've already mentioned the deep impression that the testimony of medical students from Jerusalem at the Berenson Commission left on me regarding the tremendous gap between the high level of hospital medicine taught at their medical school, and the low level of medicine in the community. This candid admission moved me to set in motion and promote various initiatives to vitalize family medicine in Israel.

What is good family medicine? In my view, family medicine is a holistic branch of medicine that sees the human being in his or her entirety. Family medicine must be integrative, medicine that sees the physical and mental sides of the patient as one. I also believe that in discourse of mental health reform today, the role of the family doctor has been overlooked in understanding certain situations in mental health.

Family medicine must focus on the entire person not just the specific organ where a problem or disease has been diagnosed. Today, in an era of atomization of specialties, it is essential that there be someone who can coordinate all the aspects of the patient's health and know how to bridge diverse approaches. Sometimes the specialists are at odds with one another over what is the most suitable treatment. For example, between cardiologists and specialists in hypertension there are different opinions on treatment. The treatments can be contradictory, and it is essential someone orchestrate the treatment for the patient. This is essential to prevent negative drug interactions, particularly in cases of extended illness. Synergizing treatment for the patient is precisely the role of the family doctor.

Family medicine must address all stages of health. Its role doesn't boil down solely to the acute diagnostic and treatment aspects of primary medicine. Rather, it ought to include all stages of medicine - beginning with preventive medicine, medical treatment in the community, and, if deemed necessary, referral to hospitalization and to medical rehabilitation. Sometimes the boundaries between these medical stages are blurry.

I, and my predecessor as medical director, Tova Yeshurun Berman, were greatly influenced by Prof. Sidney Kark's approach.[64] He and his wife, specialists in public health, brought the concept of community-oriented primary care from abroad to Israel. This concept of primary medicine views the situation in the family, in the neighborhood or place where a person lives, and in the community and understands these can all be factors in a person's health. This approach had a tremendous impact on me. Of course, hospitalization is an episode in the life of a patient that can be very important, but it is not the sum total of all a person's health components. I see it as our duty to address all health components in the life of the individual.

Vitalizing Family Medicine in Israel

The first buds promoting family medicine in keeping with this outlook were the initiative of Dr. Mendel Pollack,[65] a family doctor from South Africa and a particularly talented, thorough, and dedicated physician whom one can't praise enough. Arriving at the Tel Aviv medical school, Pollack set about examining whether it would be possible to establish a family medicine department. At the time there were quandaries in Beer-Sheva over the question of what

64 Prof. Sidney Kark (1911-1998) was born in South Africa, studied medicine in Johannesburg, and immigrated to Israel in 1959. He was renowned for pioneering Community Oriented Primary Care (COPC) in South Africa, Israel, and other places in the world. It revolutionized the face of family medicine.

65 Prof. Mendel Pollack (1929-2000) was born in Lithuania and immigrated to South Africa with his family at age three. He studied medicine in Capetown and then immigrated to Israel in 1962. Head of family medicine at Tel Aviv University's Faculty of Medicine (1973-1991), he became the first chair of the Israel Association of Family Physicians.

would best promote medicine in the community - investing in primary internal medicine and primary pediatric medicine, or investing in family medicine. I was adamant that a department of family medicine must be established, but we barely succeeded in convincing anyone to begin establishing such an entity. I recognized that several different efforts would be necessary to vitalize family medicine.

One initiative that I embarked on as medical director of Clalit was to convene an international conference on family medicine. The convention was held in September 1972 at the Sharon Hotel in Hertzlia Pituach, just north of Tel Aviv. The gathering had three organizers: Dr. Mendel Pollack, Dr. Jack Medalie,[66] and myself. Dr. Medalie was a very thorough family physician and epidemiologist who had done important work in Jerusalem and Tel Aviv in epidemiology. For the conference, we brought the best family medicine professors from 13 countries in western Europe and the United States. They participated in plenary sessions and in various panels that dealt with all aspects of the field of family medicine -- education, specialization, services, and research. Minister of Health Victor Shem-Tov, who had a very positive attitude towards our initiative, gave the opening speech with greetings on behalf of the State of Israel. Afterwards, Clalit published all the presentations and panel discussions in a special book entitled *"Discussions in Family Medicine".*

Physician-Nurse Team

I believed then, and to this day, that advancing quality family medicine is impossible as a solo performance by the practicing physician in the clinic. The doctor must work as part of a team, with the clinic nurse. The nurse does not have just a marginal role of giving shots and applying bandages. Rather, the nurse's role is to join forces with the doctor to promote all aspects of the patient's health. Accordingly, I developed a doctor-nurse teamwork model. In a teamwork relationship, the role of the nurse stands at the forefront and is very important to promote good health, educate patients in correct nutrition, physical exercise, and so forth. The nurse also engages in preventive medicine at the clinic by monitoring blood pressure, glucose levels, and other parameters. The nurse must understand the patient's background, find out what the individual's family and socioeconomic situation is like, where the person works, etc. Otherwise, there is a tendency to overlook factors such as a person's occupation and work environment, which may impact on their health.

Within the Clalit network we established some 700 doctor-nurse teams both in villages and in the cities. Health outcomes, for example, treatment of hypertension, were better under this model than at clinics that did not operate doctor-nurse team units. Since my first years at Clalit were under the dual-administration system of an administrator and a doctor, I had to convince the powers-that-be to allocate budgets for this. At the time there was a shortage of doctors and a heavy patient load at clinics. That led to dissatisfaction among the public. I convinced the powers-that-be that teamwork would reduce congestion at clinics and satisfaction would grow. This proved true, but from my perspective I did not view teamwork primarily as a vehicle for reducing congestion, but rather as a totally new concept of how best to practice medicine.

After I left my positions at Clalit, these team medicine units were abolished. There were a couple of reasons: From a budgetary standpoint, we calculated at the time that to implement the doctor- nurse model in a clinic with four doctors would require adding a half-time nursing position. This was a budgetary issue that needed to be weighed. But in my opinion, if the long-term impact was taken into account, it would lead to net savings. Much to my regret, however, the long view isn't taken into account. Rather, decisions are made by forecasting not more than

66 Prof. Jack Medalie (1922-2006) was born in the United States, grew up in South Africa, and studied medicine in Johannesburg. He served in the Second World War as a physician and then immigrated to Israel in 1948 as a member of the Israel Defense Forces (IDF) volunteers-from-abroad, and joined the IDF Medical Corps. In early 1960s, he established the 'Little Hadassah' family medicine clinic in Jerusalem's Kiryat Yovel Neighborhood. He was the first professor of family medicine in Israel; the chair of the first family medicine program in Israel, which was at Tel Aviv University's medical school; and a founder of the Israel Association of Family Physicians.

a year ahead. Another difficulty in operating doctor-nurse teams was that conflicts sometimes developed between team members. These usually were related to competition over status issues and allocation of authority, and they arose because of not focusing on best practices in teamwork. While I do not know just how much weight should be given to these issues, the fact is that today, more and more voices are being heard in favor of physician-nurse teamwork; and I believe with all my heart, that in the future strengthening family medicine will encompass a teamwork setup.

I did not stop at introducing a doctor-nurse team structure. I also guided introduction of broader teamwork encompassing a social worker and even the secretary of the clinic. I am most pleased that this clinic-wide teamwork concept is partially implemented to this day in the form of monthly staff meetings. Before I added medical social workers to the team, they were employed only at hospitals. I introduced social work into community medicine. I brought Baruch Ovadia, who was the chief social worker at the Ministry of Immigrant Absorption, to head Clalit's social services. Each social worker employed by us covered twelve clinics and participated in each clinic's monthly staff meetings together with the doctor-nurse team and the clinic administrator.

The In-Service Training for Clinic Physicians

It was clear to me that the in-service training that clinic doctors were receiving was insufficient. I introduced 24 days of in-service training for doctors per calendar year within Clalit, organized in close cooperation with the Clinic Doctors' Committee. We established a joint framework together with the school of medicine in Jerusalem. It was called the University Institute for Medical In- Service Training. We mandated the Institute to be responsible for executing the 24 days of in- service training every clinic physician was entitled to -- primary physicians, specialists, and so forth. The Institute developed various types of in-service training: a regular day off in the doctor's clinic work schedule for in-service training at a hospital internal medicine department; intensive courses focused on specific topics; and so forth. I feel duty-bound to cite the pioneering role played in this regard by my predecessor, Dr. Tova Yeshurun Berman, who first paved the way for medical in-service training at Clalit.

Integration between Hospital and Community

Already, in my days as regional doctor for the Negev, the integration of clinic and hospital was a key point in managing medical personnel and raising the level of medicine in the community. I believed that the role of the physician in the hospital out-patient clinic shouldn't simply be in examining the patient before and/or after hospitalization. I hoped that the doctor in the hospital clinic would serve in an advisory capacity in all the medical realms for the individual in the community.

The opening move for such integration was to declare that out-patient doctors would provide services in both the hospital and the community. Prior to this, as just one example, the Remez regional clinic in Rechovot operated totally disconnected from Kapan Hospital in Rechovot. Immediately after this change was introduced in the Negev, the first buds of change appeared in other regions, as well. When we opened Clalit's Carmel Hospital, we didn't open an on-site out- patient clinic; rather, we declared that the large Lin Community Clinic would be the designated out-patient clinic for the Carmel Hospital; and Lin would serve both as a community and hospital clinic. The same setup was introduced in the Emek, Petach Tikva, and other places around the country.

Another mechanism for integrating hospital and community operations was to send doctors specializing in various fields at the hospital to see patients in community clinics where there

was a shortage of doctors. In addition, senior hospital physicians at Soroka Medicla Center were sent to see patients in outlying development towns such as Dimona, Ofakim, Nitivot and Kiryat Gat.

Specialization in Family Medicine

Despite these steps, it was clear to me that this was not enough. I knew that the thing that would be decisive in the standing of family medicine was nothing short of having a specialization in the field. In Israel, the scientific council of the Israel Medical Association was the body regulating medical specializations. Just as the scientific council has four-and-a-half and five-year specialization programs for a host of medical specialties, and in certain fields, even longer ones, I hoped that there would be a four-year specialization in family medicine. Such a program would include a two-year rotation among the various departments in the hospital, followed by two years residency in a clinic operating with the doctor-nurse team model. The attending physician mentoring a resident's specialization would have to be a specialist in family medicine; and, like any other specialization, there would be two qualification exams (stage one and stage two). The scientific council of the Israel Medical Association did collaborate in this endeavor. It approved a specialization program in family medicine in 1969.

Prof. Yair Yodfat, who was among the pioneers of doctor-nurse teamwork in Clalit clinic in Beit Shemesh, a development town at the foot of the Jerusalem Hills wrote a booklet entitled, *"Family Medicine,"* in which he stated that the decisive factor in developing family medicine was creating 150 job positions for specialists in family medicine. Although I considered doing so a great privilege and knew this was essential, it wasn't easy to do so since I had to fund it out of Clalit's budget, for which I was responsible.

In 2012, the OECD (Organization for Economic Cooperation and Development) heaped high praise on the primary medicine system in Israel, citing it as perhaps one of the best in the western world.[67] Why? This was due to two major factors: One was the more than two thousand family medicine specialists and clinic directors that have transformed the face and the quality of family medicine in Israel, and the other was the initiation of Israel's National Program for Quality Indicators.

It would be apt at this juncture to say a word about the first department of family medicine in the Clalit network, which opened at the Central Hospital for the Emek in Afula, in the Jezreel Valley. The moving force behind establishment of the department was Prof. Hava Tabenkin, who had come from Ben-Gurion University of the Negev and for many years also served as department head in Afula.[68] The department dealt with specialization of family physicians in the North.

When the new Carmel Hospital opened in Haifa in 1976, I saw there were conditions suitable for establishing a department of community medicine, including family medicine, in the spirit of Prof. Sidney Kark's doctrine of community-oriented primary care. We brought in Prof. Leon Epstein,[69] a protégé of Prof. Kark, to serve as department head. He settled in Haifa and began to develop epidemiology and family medicine in this region of the country, visiting clinics in the Galilee and throughout the north. The dean of the Technion's Faculty of Medicine was Prof.

67 Organization for Economic Cooperation and Development (OECD): OECD Reviews of Health Care Quality: Israel 2012: Raising standards. OECD Publishing, 2012. 172 pp. Available for reading at: http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/oecd-reviews-of-health-care-quality-israel-2012_9789264029941-en#page1

68 Prof. Hava Tabenkin (1947-) was born in Jerusalem, and studied medicine in Tel Aviv, and then specialized in family medicine. She worked for years as a family doctor in the Jordan Valley settlements, the Beit Shaan development town, and kibbutzim in the Jezreel Valley. Between 1987-2014, she was director of the family medicine department at the Emek Medical Center and director of the *Clalit's* Northern Region. She served as chair of the Israel Association of Family Physicians. She also was the first female professor of family medicine in Israel - in the Ben-Gurion University Faculty of Health Sciences.

69 Prof. Leon Epstein (1935-) was born in South Africa, studied medicine there, and immigrated to Israel in 1958. He was an epidemiologist and specialist in Community-Oriented Primary Care (COPC) at the Department for Social Medicine at the Hebrew University medical school (1965-1975). Then he became director of Rambam Hospital in Haifa (1979-1981) and also was director of the department of family health and the community at the Technion medical school and at the *Clalit* in Haifa (1975-1990). After that, he became director of the department for social medicine at Hadassah and the School of Public Health and Social Medicine at the Hebrew University (1990-2003).

David Barzilai, with whom I had a friendly relationship. We agreed to work as partners on this department. When Prof. Epstein wanted to include family medicine in the curriculum of the Technion's medical school, Prof. Barzilai and I went to the heads of the Technion requesting they affiliate the Carmel Hospital's family medicine department with their medical school. We brought data and explained our request. They looked at us with astonishment, as if we came from Mars. To affiliate a department of family medicine with a medical school with a marked technological bent appeared highly irregular in their eyes. We left empty-handed. Years went by until the Technion agreed to recognize the family medicine department and add it to its medical school. At a later stage, not during my tenure, the department was separated from the Technion medical school and moved to one of Clalit's clinics in Haifa, where it is one of the best family medicine departments in Israel.

Hebrew University in Jerusalem also established a department of family medicine. Dr. Avraham Harman, president of the Hebrew University in Jerusalem, who had adamantly opposed establishment of a medical school in the Negev, ran into me at some sort of event. Harman turned to me and told me with open pleasure that he had secured a donation to establish a department of family medicine in Jerusalem. Indeed, this department, headed by Prof. Amnon Lahad,[70] is excellent.

The first family medicine specialists in Israel established the Israel Association of Family Physicians, similar to doctors' associations in other specialties. The Association has played an important role in anchoring family medicine's status and prestige, as reflected in its annual scientific conference. This gathering began as an initiative of the family medicine department in Afula but today is sponsored by the departments of family medicine at all the Israeli medical schools.

A Major in Community Medicine at Tel Aviv University

Another milestone in the advancement of family medicine was the opening of a study program in community medicine at Tel Aviv University. In those days Clalit's doctors' union was struggling against Clalit's Clinic Branch in an effort to change the dual management of the sick fund's clinics. This much-needed reform was achieved by setting a new policy – that the director of the clinic would be a physician. We set down certain credentials the doctor must possess. Today the position requires the clinic director be a specialist in family medicine, not just a doctor who could be a specialist in internal medicine or pediatrics. At the same time, gradually the universities were opening majors in health management that enabled administrative directors to professionalize. Slowly, the situation changed: Today the clerk in the clinic is not a political hack, but an educated person with at least an undergraduate degree in health management.

Even when I was bringing about these changes, I realized that without educating the physicians in good management of a clinic, community medicine would remain a theoretical matter. To solve this problem, I opened a program in community medicine at Tel Aviv University's School of Continuing Medical Education. Aviva Ron, who had directed Clalit's Department of Planning and Evaluation during my tenure as general-director, coordinated this course. Each year, many physicians enrolled and studied once a week in this program. Clalit underwrote a reasonable portion of the tuition. We taught epidemiology, medical statistics, medical sociology, health management, and organization of health services in other countries. This study program became the foundation for health management as a major, which is taught today at all the universities and no small number of colleges throughout Israel. Health management is a discipline where today one can earn a Masters or PhD.

70 Prof. Amnon Lahad (1958-) was born in Israel, studied medicine at the Hebrew University, specialized in family medicine, and earned a Master's degree in public health from the University of Washington in Seattle, USA. He directed the Shimshon Center in Bet Shemesh (1998-2016), where Prof. Doron and Prof. Yodfat established the doctor-nurse teamwork model, and beginning in 1997, he has been director of the department of family medicine at the Hebrew University. Since 2007, he has chaired the National Council for Health in the Community.

Thus, the vitalization of family medicine and its transformation into a recognized specialty in Israel was, at its genesis, an endeavor of Clalit. It is important to stress that this endeavor, pioneered by

Clalit, came to be the province of all the sick funds. Family medicine also became a full-fledged department in all four medical schools in Israel. I believe that the new school of medicine in Tzfat in the Galilee being established by Bar-Ilan University in collaboration with the nearby government hospital, the Ziv Medical Center will follow suit, contributing its share to the development and strengthening of primary medicine in the community. While the Ministry of Health, as the navigator of policy and operations at government-run hospitals was not involved in this important process, it cannot stay on the sidelines in regard to the future and the quality of community medicine. Today, one must view the future of family medicine as a national mission that to a large extent will determine the level of medicine in Israel to come. The future of specialization in family medicine hinges to a large extent on incentives that the state must grant on the periphery of the country for all specialties -- not just family medicine. The medical schools have a special role to play in strengthening their departments of family medicine.

CHAPTER 6

Building Clalit's Hospital Network

Addressing the Physical Plant and Professionalism of Hospitals Moshe Soroka - Architect of the Hospitalization System in Israel

From the outset, people at Clalit viewed hospitals as an integral part of the sick fund's service system. This was so even in various periods when Clalit's hospitalization system provided, on the average, half of the hospitalization days of the people it insured, and the other hospitalization days were acquired at government or public hospitals. This outlook stemmed from the fact that Clalit never perceived itself as a mere insurer that would merely reimburse the medical expenses of those it insured; but rather, it saw itself as a medical institution responsible for the medical level of its hospitals and clinics.

One of the primary issues that I addressed during my service in the sick fund, both as a medical director and as director-general, was the medical standard in Clalit's hospitals. This was not only for the general hospitals, but also for the psychiatric, geriatric, and rehabilitation hospitals. A historical argument was waged between Haim Sheba and his people at the government hospitals and Clalit's general-director, Moshe Soroka, over hospitalization. Sheba argued that good medicine could be achieved within a physical plant based on clusters of simple single-story barrack-style buildings, as in Poriya hospital and Tel-Hashomer hospital, and there was no need to invest resources beyond this minimum in the hospitals' physical infrastructure. By contrast, Moshe Soroka argued that good medicine could only be done by creating a solid physical medical infrastructure in the construction of hospitals. He took the long view – that one must think along lines of a proper medical response for generations of patients, not only on the needs and situation in the here and now. In my estimation, Moshe Soroka was correct; and, I was glad that over the years the government system also adopted this assessment.

One of the reasons for the disagreement between Haim Sheba and Moshe Soroka was the fact that in the decades the Mapai-party was in power, Soroka's access to sources of funding was much better than that of the government system. Moreover, personal feelings were not absent, deriving from the dispute between Clalit and Sheba and his people which went back to the 1940s.

In my view, Moshe Soroka was the architect of the State of Israel's hospitalization system for his championship and construction of Clalit's network of hospitals. It became, and still is, a crucial component in the Israeli health system's physical infrastructure.
When I was appointed medical director of Clalit, Soroka initially feared I was some sort of Trojan Horse of the sick fund's doctors, sent to work against him at Clalit headquarters. But the truth was the opposite: I immediately recognized Soroka's lofty qualities and worked in close cooperation with him. In construction of hospitals, he worked with one architectural firm: Sharon, Richter, Yasin. In contrast, Clalit clinics across the country were designed by a host of architects.

The Professional Level of Hospitals

Collaboration between Moshe Soroka and myself was splendid. Let me say with all modesty, he built the buildings, the essential physical infrastructure, while I, for my part, contributed their medical content. The two components were complementary, and both were essential in determining the level of Clalit's hospitals and clinics.

Some examples are in order: During the Yom Kippur War, Soroka was completing construction of the new Loewenstein Hospital. He was in charge of all the physical plant, and I gave the new hospital its content as a rehabilitation hospital. I provided the necessary personnel and equipment, according to standards at similar rehabilitation centers abroad. The same was the case in Eilat: Soroka built the hospital that was later named for Giora Yoseftal, and I provided the content for it to function both as a regional hospital and provider of medical services in the community.

From the outset of my work at Clalit headquarters, addressing the medical level of sick fund's hospitals was a top priority for me. I did this with a painstaking search in Israel and abroad for the best candidates for appointments as department heads and senior physicians in Clalit. Panels were involved in making the actual appointments. These decision-makers included representatives of the doctors' union who had little knowledge about the candidates and whose preferences were colored by vested interests of one or another kind. I drove such panels crazy in my demand that the appointments be objective and unbiased. With the exception of one case where I was outmaneuvered, I believe in all the other cases, I succeeded in assuring that the merits of the candidates determined the outcome over personal interests.

In 24- or 48-hour "quickie trips" abroad, I interviewed doctors who were suitable for senior hospital posts. I also thought it was possible to mobilize Israeli doctors who were interested in returning home or were vacillating about whether to do so, as well as tapping into Zionist reservoirs, i.e., Jewish doctors who were already interested in making aliyah, or could be coaxed to do so. Thus, for example, I brought Dr. Michael Blumental[71] back to Israel from New York. He became head of ophthalmology at Soroka Hospital in Beer Sheva. And I found physicians, not only in New York, but also in Buenos Aires, Chicago, London, Washington, Paris, and elsewhere, bringing doctors who strengthened Israel's health system and raised its level.

All Clalit hospitals achieved high academic standard during my tenure. I viewed the "trinity" of service, education, and research, as an inseparable whole. To the best of my ability, I encouraged not just medical education, but also research. Most of Clalit's hospital departments were already recognized for specialization; and for those that weren't, I did everything in my power to prepare them for such status.

The Emek Hospital in Afula in the Jezreel Valley

The Emek Hospital in Afula, built in 1930, was Clalit's first hospital, replacing the prefab 'hospital hut' at kibbutz Ein Harod that had been founded in 1923. From 1930 on, the Emek Hospital was headed by eminent physicians and Zionist pioneers. Over the years, excellent doctors joined the staff in waves of aliyah of physicians from various countries. Some from South America were brought in the program to place physicians in underserved rural and frontier settlements.

The primary problem of the Emek Hospital in my time was doctors' living conditions. We planned that the physicians would live within the hospital compound as was already the practice at Kaplan Hospital. The senior physicians revolted against such arrangements and embarked on a struggle for the right to live elsewhere. I realized there was a process afoot that would be hard to stop. I surmised that it would be enough if we had within the hospital compound only the standby physicians and physicians on alert, which would allow department heads to commute from their place of residence within close proximity to the hospital; and that is what we did.

71 Prof. Michael Blumenthal (1935 - 2007), who was born in Tiberias, studied medicine (1954) at the Hebrew University of Jerusalem and specialized in ophthalmology at Hadassah Ein Kerem Hospital (1965). He worked in African countries (1965-1966) and then went to study in New York. He returned to Israel, and from 1970-1976 served as director of the ophthalmology department at Soroka Hospital in Be'er Sheva. After 1976, until 1993, he managed the ophthalmology department at Sheba Medical Center. In 1984, he founded the Ein Tal Center for Ophthalmology in Tel Aviv; and in 1985, he was appointed a full professor at Tel Aviv University. In 1997, he developed a cataract surgery method that is named after him.

We made an effort to channel the best of our doctors to the Emek, but this was not easy. Today it is easier to bring specialists there, because the hospital is associated with the Technion's school of medicine.

I have mentioned that we established the first department of family medicine in the Clalit network at the Emek Hospital, headed by Prof. Hava Tabenkin. The department was designed to serve as a family medicine specialization site for family physicians throughout the north of the country. For many years, it, indeed, fulfilled this function.
Here are a few examples regarding efforts to develop the Emek Hospital and bring top physicians there:

- Dr. Victor Magal was a young doctor who had arrived as a member of the program to bring doctors from South America to the Negev. He had worked at Kibbutz Be'eri in the western Negev, and after completing his period of commitment, he chose to specialize in psychiatry. He went to do so at the Talbiya Mental Health Hospital in Jerusalem. After completing his specialization, I brought him to the Emek Hospital where he established a department of psychiatry. I was a devotee of psychiatric departments within general hospitals; and I was against separate facilities for psychiatric patients, with all the stigma such isolation carries. I made Dr. Magal responsible for establishing a regional psychiatric service network that would include a hospital ward, the Omer psychiatric clinic in Afula, and a psychiatric clinic that we opened in Beit She'an, a new development town in the northern Jordan River Valley for the new wave of immigrants to the area. He directed both psychiatric hospitalization and the community psychiatric system, services that, indeed, should not be separated; and he took steps that significantly advanced mental health in the Jezreel Valley and in Afula.
- Dr. Nachum Sadan, who initially went to Kibbutz Mishmar HaNegev, was among the first immigrant doctors from Argentina. He served as director of the pediatrics department at the Emek Hospital, later moving to the Meir Hospital in Kfar Saba.
- Dr. Peretz Raznitzsky was a senior physician in the internal medicine department at Kaplan Hospital under Prof. Pinchas Efrati, whose department trained a host of good doctors for Clalit's hospitals. Raznitzsky became a very successful director of the Emek Hospital's internal medicine department.
- We also brought Dr. Eran Golden, a gastroenterologist from Argentina, to the Emek Hospital. Afterwards he would become head of gastroenterology at Hadassah for many years, and today, he serves as head of the gastroenterology institute at Shaare Zedek in Jerusalem.
- Another acquisition for the northern periphery was Dr. Yaakov Zilber, a young doctor and new immigrant from the Soviet Union who arrived with the first wave of Russian immigrants in the 1970s. He settled in Beit She'an where he served as a family physician. It was there, after I discovered Dr. Zilber's talents, that I appointed him director of the Emek Hospital. Afterwards, Zilber went on to become Clalit's director of the community medicine department at Clalit headquarters. Subsequently, he served with distinction as director of the new Carmel Hospital in Haifa until his retirement.

I also initiated the establishment of a central mechanized laundry adjacent to the Emek hospital in the Jezreel Valley, and it serviced most of Clalit's hospital network.

In keeping with my dedication to Clalit adopting a regional district approach in structure, the Emek hospital was situated in the center of the district and, when he was the hospital director, Dr. Zilber was also director of Clalit's regional district. In keeping with this form of organization, the out- patient clinic of the hospital was supposed to serve two functions, as the pre- and post-op out- patient clinic and as the regional district's advisory (specialist) clinic.

This promoted tightening the linkage between hospital doctors and community medicine. The hospitals in the Jezreel Valley and in the Negev were the first to implement this important reform, and it exists to this day.

The New Carmel Hospital in Haifa

The first event I participated in as Clalit medical director was the opening of the new Carmel Hospital. One of my first decisions as director of the medical division was not to close or sell the old hospital building, which had been built in 1935, but to house two new departments there - the psychiatric and the geriatric departments – where they would be in proximity to the general hospital. This decision, as elsewhere, derived from my outlook that there should be no division between physical medicine (the body) and mental medicine (the mind), and this is my perspective to this day.

We tapped outstanding individuals to head the new Carmel Hospital's departments. I would cite, in particular, cardiology, where there was a cardinal problem that needed to be addressed: The main hospital in Haifa was, and remains, Rambam. Rambam's heart surgery department did not adequately fill the needs of the northern region. I could not reconcile with such a reality and aspired to solve the problem through the auspices of the new Carmel Hospital. But, the director-general of the Ministry of Health did not agree to establishing a heart surgery department at Carmel. His position on the matter was motivated by the vested interests of government hospitals that included Rambam hospital in Haifa. Consequently, I brought in one of the most senior physicians at Hadassah in Jerusalem, Prof. Gideon Marin, to open such a department at the new Carmel Hospital. To overcome the opposition of the Ministry of Health director-general, I agreed that Prof. Marin would conduct surgery once or twice a week at Rambam. That solved the problem, and thus the new Carmel Hospital acquired an outstanding heart surgery department. As director of cardiology, I appointed Prof. Basil Lewis, an outstanding Hadassah cardiologist, perhaps one of the most eminent in the country at the time. Collaboration between Prof. Lewis in cardiology and Prof. Marin in surgery gave inhabitants in the North an excellent solution to the problem of cardiology in that part of the country. Later Prof. Marin returned to Jerusalem, first to Shaare Zedek hospital, then to serve for many years as director of heart surgery at Hadassah.

During my tenure, I also united two adjoining geographical regions - Haifa and the western Galilee into one regional region, appointing the Western Galilee director to head the new entity. Such a move contributed to enhancing the level of medical services in the area as a whole.

The Meir Hospital in Kfar Saba

Originally, the Meir Hospital was a special facility for patients with pulmonary conditions. Mass immigration of Jews from the Diaspora in the late 1940s and early 1950s brought many persons with tuberculosis into the country. With funding from the "Invalid Fund,"[72] Clalit built a tuberculosis hospital in Kfar Saba, in the Sharon region. Over the years, a concerted effort by health services in Israel had successfully curtailed the incidence of TB in Israel by the late 1950s. The management at Clalit had come to the conclusion that there was no justification for maintaining a special tuberculosis facility; and needs could be incorporated within a general hospital with a major pulmonology department at what became the Meir Hospital.[73] Meir Hospital is responsible for hospital-level care in the area north and northeast of Tel Aviv proper, encompassing the cities of Herzlyia, Kfar Saba, Ra'anana and the concentration of Arab villages and towns eastward, in the vicinity of the Green Line.[74]

72 This fund was established by Clalit during the British Mandate period (1918-1949) to provide health services to the disabled. Labelled the "Invalid Fund" in English, in Hebrew it is *Keren Hanechut* – fund for "physically-challenged" or "special needs populations."
73 Meir hospital is named after Dr. Yosef Meir, the medical director of the Clalit between the years 1928-1948.
74 The Green Line, drawn as part of the armistice agreements in 1949, demarcates Israel from the West Bank.

Again, I made every effort to bring top-notch physicians to head Meir's hospital departments. A short time after I became Clalit's medical director in 1976, we grappled with the question who could best direct the sick fund's primary department for lung patients. There was a candidate at Hadassah Ein Karem in Jerusalem, but we weren't sure this individual was the right person for the job. I decided, together with a green light from Moshe Soroka, to go abroad to look for a suitable candidate. Soroka recalled that there had been an Argentine doctor at Beilinson Hospital in Petach Tikva who dealt with pulmonary diseases as an internist, not a surgeon. The physician had left the country and Moshe Soroka suggested I interview him. I immediately told the Jewish Agency to invite him for an interview. I arrived at the cubbyhole-like office at the Jewish Agency in New York, and he also arrived. We didn't know one another well, but we spoke in Spanish and hit it off. Before the interview, Moshe Soroka and I agreed that in this case it was an open market since this was a core department of the hospital and it justified a substantial investment. The interviewee told me that his specialty needed a team that I surely couldn't provide. I asked, "Like what?" And he enumerated the number of required doctors, nurses, specialized technicians, and so forth. I made a list and told him we would take care of bringing all these staff. He was taken aback, and then added he would also need equipment - this and that device. I made a list and told him we agreed to that also. The doctor was visibly flustered, and invited me to go with him and his wife to the theater that evening. I was so keen to convince him and bring him on board that I agreed to go. I was dead tired, and hoped I wouldn't nod off in the middle of the play. Afterwards he left his wife and accompanied me to my hotel, where he admitted with candor, "To tell you the truth, I'm not interested in going back to Israel." And that was the end of our negotiations. In the same trip I interviewed other doctors for other positions; but I returned to Israel empty-handed in the pulmonology department. In the end, the Hadassah Ein Karem candidate was appointed; and for many years, the department was very successful in treating lung patients.

We were able to bring to Meir hospital some excellent senior physicians mentored by Prof. Efrati at Kaplan Hospital, such as Prof. Kleeman, who was appointed a department head, and Prof. Arieh Rozenstein, an immigrant from Argentina who took up the position of director of Meir's labs while also heading the life science department at Bar-Ilan University. In light of the high standards Meir Hospital maintained, there was never a question about affiliating the hospital to the Tel Aviv University School of Medicine as a university teaching hospital.

Later, other eminent physicians joint the staff as department heads, such as Prof. Yossi Mekori, an internist who is a renowned scholar in the field of allergy and clinical immunology.[75] In my last year at Clalit, I found a donor to establish what became known as the Felsenstein Medical Research Institute which was originally at Meir hospital and now is under the wing of the Schneider Children's Hospital. I appointed Prof. Mekori to head the Institute. The Beilinson hospital's people were unhappy with this decision, feeling the post should have been filled by someone from inside Beilenson, not Meir hospital. I found it difficult to grasp their argument. After all the distance between the two cities - Kfar Saba and Petach Tikva - was a mere ten-minute ride; but I was unsuccessful in convincing them of the logic behind my choice.[76]

With the opening of the Meir Hospital in Kfar Saba, a special auditorium was established for conferences on clinical topics. I thought it was fitting to name this auditorium for Prof. Josef Kott, who at the time the decision was made to establish the Meir Hospital was the director of the Invalid Fund and the chairman of Israel's Magen David Adom.[77] I had first met Prof. Kott when he visited Argentina before I made *Aliyah*. In fact, his home in Tel Aviv was the first place my wife and I visited when we arrived in Israel in 1953.

75 Prof. Yossi Mekori (1948 -) went to Tel Aviv University's medical school, graduating in 1975, and served as dean of that school from 2006-2014. Since 2015, he has been the president of Tel-Hai College in the Galilee.
76 In the subtext to this statement, Doron was signaling to Israeli readers that he elected to use objective criteria, while Beilinson personnel were miffed by the challenge to the status quo in the power matrix of seniority and prestige: Beilinson was a larger and older organization; whereas Meir was newer and perceived as an upstart.
77 Similar to the Red Cross, and meaning "Red Star of David," Magen David Adom is Israel's national pre-hospital emergency rescue squad, ambulance fleet, and blood service.

While serving as medical director of Clalit, I reached an agreement with the director-general of the Ministry of Health, Prof. Baruch Padeh, that all the government-run and Clalit maternity hospitals that until then had operated as separate entities would be moved and incorporated within the country's general hospitals. The logic behind this decision was that at the general hospitals, one could provide a higher standard of medical treatment, which particularly in emergency situations, could lower mortality rates of mothers and infants. Among the maternity facilities that were closed was the facility in Kfar Saba, which was moved to the Meir Hospital premises. In the old building that had housed the maternity hospital, we would establish a geriatrics department. Today it houses an off-site geriatric hospitalization ward that operates under Meir's geriatric department and a regional clinic that serves the Sharon area.

As for acting on the decision, we couldn't relocate the old maternity hospital to be within the Meir campus without first constructing a new building to house it. But I didn't have a budget for this purpose. So, I turned to Yaakov Levinson, the head of the Bank Hapoalim, the Labor Federation- controlled bank. At the time, Levinson was in the USA on bank business; and I asked him to help me find a donor for this purpose. Levinson gave me the name of Louis Stulberg, head of the International Ladies' Garment Workers Union.[78] Stulberg agreed to donate three million dollars to build a maternity ward at the Meir Hospital. Levinson, however, had a *proviso*. He required that the hospital be renamed for Pinchas Sapir, who was a resident of Kfar Saba and a mentor of Yaakov Levinson. Levinson wanted to use this opportunity to honor his mentor on his home turf.

Meir Hospital, however, was already named for someone else. On the one hand, I couldn't deliver the goods without hurting the Meir family; on the other hand, I had to secure this donation to establish the maternity wing. I devised a solution: Meir Hospital would continue to bear the name Meir; but the geriatric hospital in the old maternity hospital in Kfar Saba, the Shalvata mental hospital in Hod Hasharon, the Loewenstein Rehabilitation Hospital in Ra'anana, all the community-based clinics in the Sharon area, and the Meir Hospital, as well, would be amalgamated under the name Sapir Medical Center. The Meir family wasn't thrilled, but they didn't protest vigorously. Thus, I secured the donation and built the maternity wards that were so essential to the area.

A word would be apt at this juncture about naming hospitals according to donors' wishes. I'm not a great believer in the sticking power of name changes following a substantial donation. For example: Tel Aviv Sourasky Medical Center, originally Ichilov Hospital, was renamed formally the Sourasky Medical Center. While this exists on paper, how is Ichilov hospital called today in the public mind? Ichilov! Beilinson hospital was renamed the Rabin Medical Center. How is it called today by the average Israeli? Beilinson! The Sharon area hospital was named after Golda Meir, because we collected funds in America to build it, leveraged by promising to call the hospital after Golda Meir. This was a source of pride to the donors, as Golda Meir was American Jewry's most eminent figure among the generation of the country's builders and founders. How is it called today? The Sharon Hospital! In short, renaming maneuvers don't seem to work. The weight of tradition usually prevails.

Beilinson Hospital in Petach Tikva

Beilinson Hospital, constructed in 1936, was the second hospital that Clalit built. Dr. Moshe Beilinson[79] was a physician, journalist, and philosophical mind within Labor Zionism. From its

78 Founded in 1900 by Jewish garment workers, many of the International Ladies Garment Workers Union (ILWGU) leaders were Jewish and had an especially close relationship with Israel's Federation of Labor. They occasionally helped mobilize donations for establishing health institutions in Israel, including not just this instance but also Soroka Hospital in Beer Sheva. https://boydellandbrewer.com/9781580462792/health-and-zionism/ pp. 240-261.

79 Dr. Moshe Beilinson (1889-1936) was born in Russia and studied medicine at universities in Moscow, Freiburg, and Basel. In 1924, he immigrated to Israel and settled in Petach Tikva. In 1925, with the founding of Davar newspaper, he joined the editorial staff at the invitation of editor Berl Katznelson. Beilinson became the Israeli labor movement's chief spokesperson, expressing in his writings the position of a principled individual, including fierce criticism of British Mandate policies. He was the initiator behind establishment of the "Hospital for the Moshavot in Judea and the Sharon," and after his death, it was named Beilinson Hospital. Today, it is the Beilinson campus of the Rabin Medical Center.

founding, Beilinson Hospital has been the flagship hospital of Clalit, and one of Israel's most important medical institutions. Today Beilinson and Soroka are the main anchors of Clalit's hospital network. The hospital includes all departments that a leading university hospital must have.[80] Like all Clalit hospitals, much time and effort was devoted to bringing physicians of repute to serve as department heads. But because of its centrality, efforts in this direction were double.

I was particularly keen to find a top-notch department head for oncology for two reasons: First of all, the centrality of the hospital to Clalit's network was not just geographical. No less important was the fact that cancer, not heart disease, was, and is, the greatest cause of death in Israel. I traveled far and wide in search for candidates, with meager success. Once I went to the United States to meet with Dr. Zvi Fuks, an Israeli who studied medicine in Jerusalem and worked for a short period as a senior physician and director of oncology at Hadassah Ein Karem. Afterwards he was appointed director of the oncological radiology department at Sloan-Kettering in New York. I conducted negotiations with him and was left with the impression that maybe I could bring him on board. He came to Israel, but it turned out that parallel to negotiating with me about the position at Beilinson, Dr. Fuks was also negotiating with Prof. Moshe Prywes for the same post at Soroka medial center, as well as other options. In the end, he decided to go to Hadassah Ein Karem; and then, after a year or two, he returned to Sloan-Kettering.

In another case, we lost the head of gynecology at Beilinson, who died very prematurely. We began to seek a replacement. I didn't find any suitable candidate, but I heard that in South Africa there was a well-known Jewish doctor named Yoel Cohen, who was not only a renowned gynecological surgeon, but also an ardent Zionist. When Dr. Mendel Pollack went to South Africa to encourage Jewish physicians to make *aliyah*, I asked him to locate Dr. Yoel Cohen and offer him an opportunity to make *aliyah* as director of gynecology at Beilinson. Dr. Pollack returned and reported that he had spoken to Dr. Cohen, who was taken by surprise but didn't faint at the offer and had some interest in it. In short, he didn't sound very enthusiastic, but said he would come to Israel to speak with me. Indeed, he came and we spoke at length. His demands were very high; and I agreed to all of them, since I was very keen to bring him on board. He made *aliyah* and headed the department at Beilinson until he retired.

During the period of Prof. Ciro Servadio's tenure as director of Beilinson, he came and told me about a renowned physician in organ transplants. He offered to establish such a department at Beilinson. To do so would require a very hefty budget. Nevertheless, I agreed. For years this department operated as one of the most advanced organ transplant facilities in Israel, if not the most advanced.

Without doubt, the hardest facet was dealing with issues surrounding management of Beilinson. Clearly anyone picked as director of Beilinson had to be both a great physician and an able administrator. But the individual would also have to be a person for whom the word of the director- general of Clalit was respected and carried weight. Otherwise Beilinson would become 'a state within a state'. I had appointed Ciro Servadio as head of urology and director of the hospital because of his good performance as chief administrator at the Emek Hospital. After his resignation, I appointed as director, Prof. Andre De Vries, one of the fathers of Israeli medicine. Prof. Andre De Vries, who immigrated from Holland, had been a senior internist at Hadassah Ein Karem. He distinguished himself as both an educator and as a researcher, including developing the anti-venom for the Israeli viper. Together with Chaim Sheba, De Vries had been one of the chief promoters behind establishment of Tel Aviv University, then its medical school. He served as one of Tel Aviv University's first rectors and was the first dean of the medical school.

80 Beilinson hospital doesn't have a geriatric department. There is a separate entity called Beit Rivka that has a new building and serves as a regional geriatric hospital.

Even prior to my appointment as director-general of Clalit, Moshe Soroka engaged De Vries in negotiations for a department director slot at Beilinson. De Vries established the Felsenstein Medical Research Center, located on the Beilinson campus, as part of the Sackler Faculty of Medicine in Tel Aviv University. After Prof. Servadio's resignation as Beilinson's director, I thought Prof. De Vries would be a suitable replacement to raise the academic standard and research operations at Beilinson. He was no longer rector or dean at Tel Aviv University. I embarked on negotiations with him even though there were people who warned me that I was inviting trouble for myself with such an appointment. They argued that De Vries wouldn't bend to any superior authority and wouldn't go in the direction that I, as director-general, envisioned for Clalit.

The fact is, I never feared strong-willed individuals with such a makeup. I felt that if the appointment itself was objectively a good fit, De Vries would be good for me as well. There were prior examples where this assumption on my part had worked: I had a special weakness for hiring pensioners of high merit. For example, after his retirement, I hired Prof. Moshe Rachmilevich to serve as a mentor for senior physicians at Beilinson. He had been the top figure at the school of medicine in Jerusalem, where he had directed the internal medicine department, Likewise, Prof. Baruch Padeh had been director at the Sheba Medical Center and director-general of the Ministry of Health while I had been a "Clalit man." Despite all the problems and conflicts between the two institutions, we worked in full cooperation with one another. We were each fully aware of the other's position, and had a working relationship that was also very warm and enabled us to work together to do much to advance the country's health needs. One previously cited example of this was our joint efforts to free up beds for war causalities during the Yom Kippur War. After Prof. Padeh retired and went to live in the town of Katrzrin on the Golan Heights, I employed him to run Clalit clinics in Kiryat Shmona and Hazor in the Upper Galilee. There, he contributed his expertise on diabetes, geriatrics, and internal medicine. Once a week, he also went to Sheba Medical Center outside Tel Aviv where the served as a hematologist at the hospital's laboratory.

To return to Prof. De Vries, despite the warnings that his appointment was a recipe for problems, I appointed him, and everything went well. De Vries had a private "hobby" parallel to his official duties at Beilinson -- to mentor Arab doctors in Nazareth. He viewed such efforts for professionalization and integration in society as a very important mission. After a period, De Vries resigned from the post of hospital director at Beilinson, but we remained friends for years.

Schneider Children's Medical Center

For many years the physical plant at Beilinson Hospital's pediatrics department was well below par. Moshe Soroka prepared a modest plan to establish a new department but he didn't live to see his plan implemented. Years later, due to drastic curtailments in development budgets, many hospitals in Israel began fundraising in the United States. I decided to embark on mobilizing funding independently in the United States and to carry out this mission, I established a special non-profit in New York, the MEREFDI.[81]

I had heard about Irving Schneider[82] who was the co-chairman of a large real estate firm in New York, and for whom the Schneider Children's Hospital in Long Island, New York was named. I found out that he had a legal advisor named Arnold Foster, an ardent Zionist who visited Israel twice a year; and I requested to meet him. It turned out, when I met Foster, that he was

81 More on this subject is in the chapter on the National Health Insurance Law (Chapter 9).

82 Irving Schneider (1919-2012), born in Brooklyn, New York, studied at City College of New York, and made his fortune in real estate in New York. He became a renowned American Jewish philanthropist. He supported institutions such as Brandeis and Long Island University, and countless Jewish objectives in New York. He was the founder and donor of Clalit's Schneider Center for Pediatrics in Petach Tikva, which is adjacent to the Beilinson Medical Center. His close ties with Israel were also reflected in other philanthropic investments. His two daughters continue his legacy and closely follow the operations of the Schneider Children's Hospital.

very tied to Israel and even had family in Kiryat Gat in the northern Negev. In our meeting, which was at his home in the U.S., conversation blossomed, and I told him that I was looking for a donor to establish a modest pediatrics department at Beilenson hospital. I asked him about Schneider. Mr. Foster told me: "Mr. Schneider loves Israel, and he's nuts about one thing – children's hospitals. Mr. Schneider established a hospital for children on Long Island. If you are promoting such an idea, perhaps you'll have some chance at it." I returned to Israel and devoted some time to this subject. Later, I learned from Teddy Kollek[83] who was friendly with Schneider, that Schneider was planning to visit Israel. Schneider was a member of the board of the Jewish Agency, and he was coming to advise Teddy Kollek about transforming the cavernous Binyanei HaUmah [The Nations' Halls] at the entrance to Jerusalem into a convention center.

I had collaborated with the mayor in the past in establishing a health clinic in the Sheikh Jarrah neighborhood. It was on the road to Mt. Scopus and had become a well-established health center for thousands of East Jerusalem residents. Therefore, I asked for Kollek's assistance in organizing a small dinner gathering in Schneider and his wife's honor. Kollek promised to assist; and, indeed, we succeeded in holding the dinner party. I called ex-general Mordechai ('Motta') Gur, who was Minister of Health, and invited him to dinner. As a matter of friendship, I asked Gur not to 'kidnap' Schneider for the government hospitals. He promised and kept his word.

I also invited Dr. Aviva Ron, the head of the planning and evaluation department of Clalit, and Yehuda Danon, who at the time was Beilinson's director. At this dinner, which lasted three hours, Schneider didn't stop peppering me with tough questions, such as – "Does the State of Israel need a children's hospital," "Why should it be within Clalit," and many more. Although initially I wasn't convinced of the idea of a children's hospital, I apparently succeeded in answering Schneider's questions and met the challenge honorably. As for why the hospital should be within Clalit and located near a large central hospital for other services, there was one reason: A tertiary children's hospital needs to have a network of primary pediatric clinics spread throughout the entire country. Only Clalit could provide such a network since it already had some 500 clinics of this type in place. I believe this point was the decisive one in favor of Beilinson. When we left the dinner, Teddy Kollek was sitting and waiting for us. As we stood there, Schneider, Kollek, and I, Kollek said to Schneider in English: "Petach Tikva isn't Jerusalem; but do it in Petach Tikva." After that dinner, Schneider sent a committee to Israel to investigate the matter. Three individuals sat on the committee: a health services planner; one of the architects of the Children's Hospital in Boston; and the director of the Schneider Children's Hospital in New York. They stayed in Israel three weeks, visited all the big hospitals and other places; and in the end, I convinced them to establish a children's hospital adjacent to Beilinson Hospital despite the fact that there were two more institutions that sought to sway things so the first children's hospital to be built in Israel would be theirs: Sheba and Hadassah Ein Karem.

Schneider loved pomp and ceremony. I went to my friend Shlomo Hillel who was the Speaker of the Knesset and told him about Schneider and his mobilization on behalf of establishing a children's hospital. Hillel immediately invited Schneider and his wife for lunch at the Knesset, where we conversed pleasantly in an atmosphere of friendship. At the lunch it was agreed that the signing of the agreement between Schneider and Clalit would be held in the Chagall Hall of the Knesset in royal fashion with a crowd of distinguished guests in attendance. And so it was. Attorney Jerry Silbart read the agreement out loud to the assembly, and Schneider and I signed the document. Thus, the planning stage of the hospital was ushered in and placed in the hands of the Americans, with Dr. Yehuda Danon, the director of Beilinson who was slated to be the director of the new children's hospital, participating.

83 Theodor "Teddy" Kollek (1911 – 2007) was an Israeli politician who served as the mayor of Jerusalem from 1965 to 1993 (six terms). After reluctantly running for a seventh term in 1993 at the age of 82, he lost to Likud candidate and future Prime Minister of Israel, Ehud Olmert. During his tenure, Jerusalem developed into a modern city, especially after its reunification in 1967. He was once called "the greatest builder of Jerusalem since Herod." In 1966, he established the Jerusalem Foundation, a charitable foundation that raises money to invest in projects in the city.

The Ministry of Health's projects committee had the role of approving all plans for any new department or new hospital in Israel. At the beginning the committee balked at approving the establishment of the Schneider Children's Hospital. Therefore, I requested Minister of Health Shoshana Arbeli-Almozlino to do so; and she gladly approved it. She was present at the cornerstone laying ceremony, along with Schneider and his wife, and the President of the State of Israel, Haim Herzog.

Concrete negotiations over all the details of the hospital's construction and hammering out the relationship between Beilinson and Schneider took three weeks. This was carried out in a little room next to the administrative offices of the Schneider Children's Hospital in New York. During the first stages of construction, I was still chair of Clalit. Schneider would come every fortnight to see how construction was progressing. We would meet for breakfast at the Dan Hotel in Tel Aviv and talk about the plans. I can testify that he knew every single floor in the 9-story building as it took shape.

During this period, I was being subjected to harsh media coverage. In one of the articles in the media the idea of building a children's hospital was branded "Doron's White Elephant".

In those days of media pressure and criticism, I pondered whether perhaps it would be wise to freeze the building of the upper floors of the hospital at this stage and build them later. I requested that Aviva Ron who knew one of Schneider daughters well, check this idea out with the donor. Schneider responded with wrath at the very notion, and we didn't dare to ever raise this idea again. Construction continued, and the hospital became an established fact. Thus, out of sticktoitiveness, the first children's hospital in Israel was born, opening in 1991. Today it operates at full throttle, ensuring high-level medical care for generations of Israel's children.

When we embarked on planning Schneider Children's Hospital, we reduced the number of pediatric beds at Kaplan Hospital in Rechovot and Meir Hospital in Kfar Saba; and we closed the entire pediatrics department at the Sharon Hospital in Petach Tikva. All of this was in order to concentrate beds.

Prof. Yitzhak Versano was a brilliant pediatrician at the Sharon Hospital. As part of the planning for Schneider Hospital, we transformed Prof. Versano's department into a day hospitalization department. He didn't object. The change was in keeping with his own view that day hospitalization for children was preferable to full hospitalization. Later he would establish an out- patient day unit in pediatrics at Beilinson, one of the first in the country.

The Sharon Hospital in Petach Tikva

The Sharon Hospital in Petach Tikva was established in a joint endeavor of the municipality and Clalit. The mayor of Petach Tikva, Pinchas Rashish, was for many years also the chair of Clalit's national supervisory board. He envisioned a municipal public hospital in his city, and thus we established the Sharon Hospital in partnership. Although Beilinson is also located in Petach Tikva and is just a short distance from the Sharon Hospital, I viewed the Sharon Hospital as logical. Beilinson, with its specialized departments, was Clalit's central hospital that served the entire country. By contrast, the Sharon Hospital was to be a regional hospital, solely with departments designated for a regional hospital. I considered this a good opportunity to implement my regional districts design for Clalit -- to forge one regional district out of Petach Tikva and adjoining Arab and Jewish communities. I appointed Prof. Yaakov Hart, who at the time was deputy regional director for the Negev, as director of the hospital and director of the regional district. He embraced the regional district concept completely, and Petach Tikva became one of the most successful regional districts in the reorganized Clalit system,

demonstrating this structure's many advantages. I'm not embarrassed to admit that the Sharon Hospital was my pet project, though not at the expense of any other institution, because I felt it embodied an apt juncture to implement my regional district model. I followed the hospital's progress closely.

Avigdor Kaplan,[84] who took over as director-general of Clalit after I left, had a different approach -- fiscal management. In his mind, on the grounds of economy, all the departments needed to be concentrated at Beilinson, leaving the Sharon Hospital with only a minimum of services. He closed the new regional clinic named for mayor Rashish and merged the Sharon Hospital into the campus of the Rabin Medical Center.

I believed that his approach to the Sharon Hospital was a failure because over the following years it became clear that the region needed a regional hospital. Half the departments in Beilinson are not regional hospital departments, but rather national general hospital departments. Therefore, decision-makers should have begun by investing in renovating the Sharon Hospital, rather than drying up its resources. To anyone who visits the Sharon Hospital today, its state of neglect is clearly evident: It is old and badly in need of renovation. I am convinced that over the years, replacements and ad hoc renovations have cost a lot more than the decision-makers figured they were saving in what was viewed as an economy move.

Another episode tied to the Sharon Hospital: There was a physician who served successfully as head of surgery for many years with dedication to medical care and no problems. When he was reaching retirement age, suddenly complaints began to surface concerning surgeries he had conducted. When I saw the charges, I didn't think twice about demanding his resignation as head of surgery department. Years later he wrote a book in which he said that I'd cut his life short. But in my opinion, there is no room to hesitate in circumstances like this. Heads of surgery departments hold the life of their patients in their hands, and when complaints begin to arrive on the quality of the surgery performed, there is no room for indecision.
The positions I had the honor of filling didn't always enable me to preserve friendships that would have come at the price of harm to the health of the public. For me, the public's health always came first, before personal friendships.

Kaplan Hospital in Rechovot
In the beginning of this book, I noted that Kaplan Hospital was opened south of Tel Aviv in the city of Rechovot, a few months prior to my making *aliyah*. It was an impressive complex based on a cluster of separate one-story units for each department; and there were on-site housing accommodations for department heads and senior physicians.
Some of the best doctors in the country took senior positions at Kaplan. I will cite a few examples:

I've already said that Dr. Pinchas Efrati was one of the best medical pedagogues[85] I've ever encountered. He was instrumental in affiliating Kaplan Hospital as a university teaching hospital for the Hebrew University's medical school. This association continues to this day, a relationship that has served as a way of attracting and retaining excellent personnel and a quality enhancer for the hospital. As I noted earlier, between my period as a doctor in Kibbutz Gvar'am and my period practicing medicine in Beer Sheva, I underwent in-service training under Prof. Efrati at Kaplan. In addition to his unique bedside instruction techniques, Efrati had a special sense of kinship with primary physicians in the community, particularly those working on the periphery – physicians for whom his knowledge and insights were particularly critical. I remain deeply indebted for the wisdom he shared; and after I completed my work in Beer Sheva and moved to Clalit headquarters, Prof. Efrati

84 Avigdor Kaplan, PhD (1939 -) has held many important administrative posts in his career. He was appointed director-general of Clalit in 1992 and served in this capacity for five years during the period the sick fund was disengaged from the Labor Federation and the Compulsory National Health Insurance Law was passed that fundamentally changed the health system in Israel. The economic recovery plan Kaplan introduced led to reduction in Clalit's heavy deficit. From 1997-2013, he was president and CEO at Clal Insurance Pensions & Finance Group, and he then became director-general of Hadassah Hospital (2013-2014).
85 See footnote 6.

and I remained in close personal contact. Whenever I encountered a complex problem in medical administration, without hesitation I would request that Prof. Efrati chair a committee established to examine the issue at hand.

Dr. Haim Gordon was a senior internist at Beilinson whom I brought to serve as director at Kaplan Hospital. As head of Kaplan for many years, he was not only an able administrator, but also an exceedingly fair and honest person. Dr. Gordon was a Holocaust survivor from Slovakia, and in the 1970s was very involved in illegal immigration from the Soviet bloc. In this capacity, he was appointed representative of an institution tied to Eastern European Jewry. I much admired his devotion.

After Dr. Gordon left Kaplan hospital, I appointed Prof. Yossi Proust as Kaplan's chief administrator. Later Prof. Proust served as director of Clalit's Jerusalem region.

Soroka Hospital in Beer Sheva

I have already described conditions at the Hadassah hospital in Beer Sheva when I arrived in the city. In fact, I was familiar with the hospital from both sides since our eldest son was born there. Although Hadassah had plans to establish a modest new hospital in Beer Sheva, the Beer Sheva plan was scrapped when Hadassah decided to focus solely on the its hospital in Jerusalem.

I have also described the fact that there was a disagreement between David Tuviahu, the mayor of Beer Sheva, and David Ben-Gurion, who was living in the Negev south of Beer Sheva. David Tuviyahu had a dream of both a university and also a large hospital in Beer Sheva. He also favored that Clalit would build the hospital; whereas Ben-Gurion favored the state.

Both Moshe Soroka, head of Clalit, and Israel Barzilai, the Minister of Health, suffered from severe heart disease. When Barzilai was hospitalized, Soroka visited him in Beilinson hospital where the two signed an agreement that the state would build a hospital in Ashkelon, today Barzilai Hospital, and Clalit would build a hospital in Beer Sheva. Suffice it to say, this arrangement didn't please Ben-Gurion, but it became a fact of life for him.

The American Union leader David Dubinsky, head of the ILGWU, the International Ladies Garment Workers' Union, stepped forward with a substantial contribution to the Labor Federation's donor campaign in America for building a large hospital in Beer Sheva. But when the Federation 'translated' the gift into net dollars and cents for the hospital, not much was left.[86] Nonetheless, in 1960, the Central Hospital for the Negev, now Soroka Hospital, opened. Clalit appointed Prof. Josef Stern as director of the new hospital parallel to his serving as director of one of the internal medicine departments. Prof. Stern, who had studied both medicine and life sciences in Italy, had been an internist at Beilinson, at one point directing Beilinson's department of emergency medicine.

In parallel to the building of the Beer Sheva hospital, a housing complex, facing the facility, was added for new department heads. Tongue-in-cheek, staff dubbed it "Blair House".[87] The apartment building did house the families of all the 'movers and shakers' at the hospital, including Prof. Josef Stern, director of the hospital; Prof. Noah Ben Aderet,[88] director of the women and new mothers department, who had previously been on staff at Kaplan hospital; Prof. Gabriel Terek, director of the orthopedics department, who had come from the government hospital in

86 The ILWGU, the International Ladies Garment Industry Union, of the United States and Canada (Op cit., Footnote 38) made a gift of $1,000,000 in 1956 earmarked specifically for building the hospital; but the Labor Federation siphoned-off $600,000, claiming this was for the Federation's donor campaign. Only $400,000 remained for building the hospital, See details in Shifra Shvarts, Health and Zionism, The University of Rochester Press 2008, pp. 247-261. https://boydellandbrewer.com/9781580462792/health-and-zionism/

87 Blair House is the U.S. President's Guest House. It is across the street from the White House, in Washington, DC.

88 Prof. Noah Ben Aderet (1925-1988), a gynecologist, was among those who pioneered Soroka Medical Center and Ben-Gurion University's medical school and was the founder of the Division of Gynecology and Obstetrics.

Bnei Barak; and Prof. Menachem Hersch,[89] a radiologist who had been at the original Hadassah hospital in Beer Sheva. Joining them on the hospital's senior staff were others who remained in their homes in Beer Sheva's Old City. They included Prof. Lehman, who had headed the old Hadassah hospital and came to direct one of the internal medicine departments; and Dr. Wilhelmina Cohen,[90] who had been on staff at the Hadassah facility and became director of the pediatrics department at the new hospital.

I believe the close collaboration we maintained, Prof. Stern as director of the hospital and myself as Clalit's regional medical director, served as a health enhancer for residents of the Negev as a whole.

As already noted, there was a catastrophic shortage of doctors in the Negev, and it also was difficult to draw doctors to relocate there for the hospital. Beer Sheva was hardly as attractive as it is today. What did Stern and I do in collaboration? First of all, the out-patient clinic of the hospital was initially designed to examine patients prior to and post-surgery. We transformed it into a regional specialist's clinic that could provide consultation for the entire Negev, thus solving one of the most serious problems of the doctor shortage. Secondly, we appointed senior specialists from the hospital to serve in an advisory capacity for doctors in the community. With free and attractive housing, we enticed hospital doctors to live in places where there had been no doctors in the vicinity.

When Prof. Josef Stern went on sabbatical, to keep our collaboration going, he appointed me, the regional medical director, to fill in as acting director for the hospital, even though it was customary to appoint one of the hospital department heads to step in temporarily. Thus, for a year I wore both hats. During that year I did everything I could to strengthen the standing and further the interests of the Beer Sheva hospital.

Later, when the struggle to establish a medical school began, three department heads -- Prof. Stern,[91] Prof. Terek and Prof. Lehman -- approached me, requesting that I serve as chair of the committee entrusted with taking this struggle forward.[92]

Another contribution to the health of inhabitants of the Negev was our collaboration establishing a program in Beer Sheva at the hospital for in-service training for new immigrant physicians to prepare and license them to work. The first group of immigrant physicians from Argentina was sent to Kaplan Hospital for this purpose because the Beer Sheva Hospital had not yet opened when they arrived. All the other 12 groups underwent their in-service training in Beer Sheva, where I had the pleasure of personally participating in their absorption, teaching two of the courses and sitting in on others.

Despite the need to curtail development budgets during my tenure as director-general, I made a special effort to ensure that completion of Soroka Hospital's second building would not be left in the air. Today the hospital is the primary hospital of the BGU's medical school. They are located back-to-back on the hospital campus. Soroka is a university teaching hospital in every sense.

Yoseftal Hospital in Eilat and the Sharm El Sheikh Area of Sinai

Eilat had an old government hospital with a low standard, skeletal operation. From the perspective of the number of permanent residents, there was no justification for opening a "real hospital." But there was a justification from the perspective of tourism. If one wants to develop tourism

89 Prof. Menachem Hersch (1926 -) was born in Romania and studied medicine at the Hebrew University, specializing in diagnostic radiology. He was among those who pioneered Soroka Medical Center and Ben-Gurion University's medical school.
90 Prof. Wilhelmina Cohen (1916-2000), born in the Dutch East Indies (today Indonesia) studied medicine in Holland and immigrated to Israel in 1950. She became Beer Sheva's first pediatrician. She founded and directed the pediatrics department at the Central Hospital for the Negev. Dr. Cohen was an associate Prof. at Ben-Gurion University and was a recipient of Beer Sheva's 1991 Key to the City award.
91 Later, the hospital's auditorium was dedicated in the name of Prof. Josef Stern.
92 See p. 35.

in an outlying area, suitable medical care must be provided. As with every medical issue during this period in Israel, Clalit volunteered to fill the bill with a cottage hospital in Eilat.[93]

The Negev region covers a full third of the surface area of Israel. It stretches some 145 miles from where I lived in Beer Sheva and my headquarters there to Eilat. I remember how as regional physician I was quite often summoned to the primary care clinic of the Eilat Hospital.

It was hard to entice doctors to go to Eilat. The physicians who rose to the challenge and volunteered to go to Eilat were Dr. Rafel Confino, who later specialized in family medicine and served as regional physician in Jaffa, and his wife, a pediatrician.

I pondered how we could serve the city with a hospital. What doctors would volunteer to go there to grow the hospital? We mobilized doctors for a combined practice in the community and at the hospital. Each department head was responsible for their specialty in the community, augmented by a young doctor. Until development of the hospital was completed, my wife and I would go down to Eilat. We would receive an apartment for our short sojourn that was equipped, in the absence of air conditioning, with a desert cooler for comfort.[94]

Not long ago, the administrative director of the hospital, Roni Mizrachi, reminded me how I convinced Dr. Edward Hardon, to come to Eilat as head of Internal Medicine. At the time, Dr. Hardon was deputy director of internal medicine at Kaplan Hospital. I went to him with a deal: "Go down to Eilat, head the department for two years, and afterwards I'll make sure you will be department head of internal medicine at Kaplan." He went down to Eilat, and stayed. He's retired now.

Moshe Soroka built the hospital, and in the last year or two of his life it already had five small departments: gynecology, maternity, internal medicine, surgery, and orthopedics. During my time as director-general of Clalit, we added a hyperbaric (decompression) chamber to the hospital, something that at the time only existed in Rambam Hospital in Haifa. We did so in recognition its being essential for Eilat, a popular destination for diving enthusiasts.

The hospital, now named Yoseftal Hospital, is undeniably a success story. It was named for Giora Yoseftal, a member of Kibbutz Gilad near Megiddo in the north. Yoseftal was a person I highly respected for his pivotal role in immigrant absorption. He was the treasurer of the Jewish Agency at the time the hospital was opened, and later, when he was serving as Minister of Immigrant Absorption and Minister of Labor, we were very close. His wife, Senetta Yoseftal, assisted me greatly in her role as head of immigrant absorption at the Labor Federation. This included her assistance in establishing a fund for immigrant doctors' in-service training and a fund that assisted groups of immigrant doctors to settle-in.

I want to say a word about establishment of the medical clinic at Sharm El Sheikh in the Sinai, Egyptian territory taken by Israel in the 1967 Six Day War. Sharm El Sheikh is a site perched on the straits at the southern end of the Red Sea, and it became a divers' paradise. Reuven Aloni served as chief administrator of Sharm El Sheikh when the Sinai was under Israeli control; and Aloni constantly badgered me to establish a clinic at Sharm El Sheikh.

93 In Chapter 2, Doron mentions visiting a cottage hospital in Sanraer, Scotland, during the period when he was sent to study in England. These small hospitals tend to be developed in rural areas.
94 Desert coolers are devices that work on the principle of evaporation. They have pads on three sides of the device. The pads are constantly fed with water either by a refillable tank above or by a pump. When the air passes through these cooling pads it becomes colder. In the Eilat apartment the desert cooler was installed in a window frame to catch the breeze and take the edge off the stifling heat.

This was at the time when it appeared that Israeli settlements in Sinai would be there forever.[95] This idea echoed in the words of Minister of Defense Moshe Dayan in the Rabin Government. Regarding the future of Sharm El Sheikh after Egypt spurned Israel's peace overtures in the wake of the war, Dayan said, "Better Sharm El Sheikh without peace than peace without Sharm El Sheik."

Aloni's pressures increased until I surrendered, even if I was not convinced that a clinic was justified. We established a first-rate clinic with offices for a family doctor, a pediatrician, and a dentist. There was also a pharmacy.[96] I invited Prime Minister Rabin to speak at the opening ceremony of the clinic.

I have no idea what became of this structure, but I'm sorry to say, today there is no genuine peace and no Sharm El Sheikh.[97]

95 The peace agreement between Israel and Egypt in 1979 returned the Sinai to Egypt in 1982.
96 In addition to the diving resort that Israel had built there from scratch and its clientele, there was an adjacent Israeli settlement called Ofira, founded in 1969
97 Relations with Egypt, despite the return of Sinai have remained cool, and the Sinai itself has become a terrorist base.

CHAPTER 7

Other Hospitals

Hospitalization in Ashdod

One Friday morning I met Ashdod's longtime mayor, Zvi Zilker, for lunch.[98] Prior to the meeting, we'd prepared the draft of a contract to build a hospital in Ashdod together. At the time, 1970, there was no justification for allocating a large number of hospital beds to Ashdod. My idea was to establish a local hospital together with the municipality -- along the lines of the Sharon Hospital.[99] The city had a smattering of medical services scattered about the city. A lab here; a specialist's clinic there; an urgent care out-patient clinic somewhere else. The mayor had earmarked land for a future hospital. We, Clalit, would open all the medical services to the community-at-large, regardless of sick fund affiliation. Clalit would build a local emergency room facility in Ashdod so that the city's residents wouldn't have to travel to Kaplan Hospital in Rechovot or Barzilai Hospital in Ashkelon for every small thing. Afterwards, according to the plan, we would begin to open departments and hospitalization beds paced to the growth of the city's population, at the beginning perhaps even applying the Eilat structural model.

At the time (1970s), Yosef Burg was Minister of Interior, and the director-general of Interior was Haim Koversky.[100] The pair rejected the plan, objecting to a local government again being involved in establishing a hospital, as in the case of the Sharon Hospital. I felt this was a myopic and narrow view since, if we, Clalit, would build the hospital, it would save the state a lot of money. I remember Zvi Zilker telling me, with candor, "I'm not you guys and you guys are not me, but I'll build a hospital only with you."[101] And what happened is that we signed the agreement mentioned above, but the government cancelled it. Our approach was mamlachti, for the greater good of the people, devoid of partisanship; and in this case, the government was acting contrary to the interests of the people and health system of the area.

Hospitals in Jerusalem

In 1854, the first Jewish hospital was established in Jerusalem, funded and administered by the Baron de Rothschild. Between the years 1854-1902, four other Jewish hospitals were established in Jerusalem: Bikur Holim, Misgav Ledach, Shaarei Tzedek and Ezrat Nashim. All the institutions operated on a philanthropic basis with funding from abroad. Most services were provided gratis, or fees were graduated according to the patient's means. In 1918, following the British occupation of Israel from the Ottomans, the Rothschild Hospital in Jerusalem was reopened under Hadassah auspices – a facility that became Hadassah's primary hospital in Israel.

Hadassah Hospitals

Clalit and the Hadassah Medical Federation were the two primary voluntary public medicine organizations during the British Mandate period (1918-1948) and even under statehood. Both played a lofty role in building the health system in the country. Of course, this was together with the government health system and other public medical institutions.

Clalit grew out of the foundations of a health system initiated by Labor Zionist-driven Jewish laborers. By contrast, the Hadassah Medical Federation was initiated by the Women's Zionist Organization of America, Hadassah. The relations between the two have witnessed ups and downs over the years.

98 Zvi Zilker, a civil engineer by training, served as mayor for 33 years, from 1969-83 and 1989-2008.
99 Today, Ashdod, with over a quarter of a million residents, is Israel's fifth largest city. It was transformed demographically and culturally by the Russians who made aliyah in the 1990s and flocked to this seashore city.
100 Burg was the all-powerful leader of the National Religious Party, and Koversky was a linchpin in decision-making on planning. He was director-general of the Ministry of the Interior between 1970-1986.
101 Their allegiances were to rival camps: Zilker was a member of the Likud party; whereas Doron and Clalit were aligned with the united socialist Labor Zionist party..

There is no question of the historically central role of Hadassah as a first-rate medical service hub and a major force in medical education in Israel. Hadassah, together with the Hebrew University, established the first medical school in Israel. This medical school trained generations of top-quality doctors, many of whom became department heads at hospitals throughout the country. And they, in many respects, set the standard for medicine in Israel.

Hadassah also played a special role in the history of medical research in the country – from the outset to this day. The partnership between the Hebrew University and Hadassah enabled establishment of other schools essential to the health system in Israel. The development of other major hospitals such as Sheba, Beilinson, Ichelov, Rambam, and Soroka was built on the foundations laid down by Hadassah. The development of additional medical schools in Tel Aviv, Beer Sheva, Haifa, and Tzfat, has contributed to the overall system for medical education in Israel; but the place of Hadassah and the Hebrew University remains unassailable.

From the beginning of the 1970s, together with a team of assistants, I began to delve deep into the heart of health economics -- hospitalization costs. At the time, we had developed a basic budgeting program at Clalit hospitals for costing hospitalization by department. It factored-in age components of the area population and average hospital stay time. At one point, my advisors pointed out to me that hospital stays at Hadassah in Jerusalem that were billed to Clalit for services to its members were inflated and out of proportion with those at other hospitals. We are talking about outlays of more than several million dollars a year, even if one deducted from the calculation the number of patients who were special cases referred to Hadassah from outside Jerusalem.

I turned to my friend Prof. Kalman Mann, director-general of Hadassah Hospital[102] and showed him the numbers. Prof. Mann requested time to look into the matter but failed to find a solution. I proposed several alternative solutions, for example, a regional hospitalization scheme or rotation among the Jerusalem hospitals, but failed to receive his OK.

Shaare Zedek Hospital in Jerusalem

Shaare Zedek (Hebrew for "Gates of Justice"] established in 1902, has been part of the Jerusalem landscape for over a century. From its inception, Shaare Zedek has treated patients of every race, religion, and nationality, but the hospital has a religious orientation, ie. It operates in keeping of Jewish medical ethics and caters to the special needs of Torah-observant patients. [103] All these years it has operated medically on a high standard.

In the latter half of the 1980s, a new building for the hospital was built in the Beit HaKerem Neighborhood of Jerusalem. It replaced the old Shaare Zedek Hospital in the center of Jerusalem. The new building had a fine and unique design, the vision of Prof. David Meir, an American-born pathologist who was director of Shaare Zedek at the time. Construction, however, caused huge debts that spiraled Shaare Zedek into a serious financial crisis, leading the board to decide to bring Prof. Meir's tenure as director to a close.

I was still looking for a solution to the matter of hospitalization costs at Hadassah for Clalit members in the capital. Charles Bendheim, and Ludwig Jesselson, two religiously observant American Jews, were holding Shaare Zedek afloat with their work and financial support, which included soliciting donations from other American Jews. I was acquainted with them, and the two were keen to establish a working relationship with Clalit that could assist Shaare Zedek

102 Prof. Kalman Mann (1912-1997) was born in Jerusalem and studied medicine in the UK, where he received dual degrees in medicine and surgery. He later received a degree in tropical medicine and hygiene. He specialized in pulmonology and returned to Israel in 1949. In 1951 he became the director-general of Hadassah Hospital and served three decades. He rebuilt the Mt. Scopus campus and developed the Hadassah Hospital in Ein Kerem. A public activist, after retirement in 1981, he served as president of Yad Sara, an NGO that lends out medical equipment, from canes and crutches to hospital beds.

103 Although Shaare Zedek Hospital is staffed by many religiously observant medical staff, from traditional and modern orthodox to ultra-orthodox, at the same time its staff is very diverse. Twenty-five percent of staff and patients are Arabs.

extricate itself from the economic morass the hospital had fallen into. A good bond developed, and my wife Neomi found a common language with Bendheim's and Yasselson's wives.

I also was always concerned with the absence of a Clalit hospital in Jerusalem, the capital of Israel. In fact, in my last conversation with Moshe Soroka at his house before he died, this very topic had been raised. Because of the evolving friendship with Shaare Zedek's people, and the outstanding unsolved issues with Hadassah, Clalit leadership embarked on negotiations with Shaare Zedek. We reach a joint management agreement that entailed joint administration without any change in ownership, something we were not interested in, in any case.

For a time, I was forced to hold up signing the agreement due to problem of Shaare Zedek's *SHARAP*.[104] Following Hadassah's lead, Shaare Zedek had also introduced a *SHARAP* for its senior physicians, on-site at the hospital. While the scope of the Shaare Zedek *SHARAP* was much smaller, in my view a *SHARAP* was a *SHARAP*; and Clalit never viewed this arrangement in a positive light. But there was no other solution because the work agreement between the doctors on staff and Shaarei Zedek couldn't be altered, and we really wanted an agreement. The agreement was signed to the satisfaction of both parties and much to the delight of Jerusalem's mayor Teddy Kollek, who was also the head of the Labor Federation in Jerusalem, and others elsewhere in the halls of Clalit.

The arrangement worked well for a decade until a financial crisis that occurred after I had left the sick fund prompted Clalit's decision-makers to abandon the agreement. In the wake of this, the heads of Shaare Zedek turned to me, requesting I personally continue as a member of their board of directors; and I agreed willingly. Thus, I continued for years to sit on the governing board on a volunteer basis.

At the outset of implementation of the joint management arrangement, the heads of Shaare Zedek requested that I recommend someone for director-general. I was searching for a suitable candidate among Clalit's physicians when a colleague pointed out to me that there was a deputy department head in internal medicine at Beilinson hospital who had distinguished himself reorganizing the IDF's Medical Corps; and, he was a ritually observant Jew. I immediately invited him for a talk. I was impressed with his suitability, both professionally and as a religiously observant person. With a nod of agreement from the doctor, I set up an interview for him with the heads of Shaare Zedek. His name was Prof. Jonathan Halevy. He had been a member of the Tel Aviv University medical school's first graduating class and was an internist with specialization in liver diseases. At the time of this writing, Halevy has to his credit three decades of excellent management at the helm of Shaare Zedek Hospital.

Bikur Holim Hospital in Jerusalem

Bikur Holim Hospital was founded in the old city of Jerusalem in 1867 and moved to the new city in 1925. For years, I was aware of Bikur Holim's situation. Its administration was controlled by an ultra-orthodox political party, and the hospital suffered from huge chronic deficits. The powers- that-be for years sought ways to solve its difficulties without much success. At some point, the moment of reckoning arrived, and for months the hospital couldn't pay its staffs' salaries. The Ministry of Finance turned to Shaare Zedek requesting they examine the possibility of taking Bikur Holim under their wing.

104 *SHARAP*: a Hebrew acronym for Private Medical Services introduced in public hospitals in Jerusalem beginning in the 1950s. From the 1920s, salaried physicians was the dominant form of medical practice. *SHARAP* was a half- way solution to keep senior physicians within the public hospitals by allowing them to receive private patients in dedicated *SHARAP* out-patient clinics after regular clinic hours. The objective was preventing the most seasoned salaried physicians from going into full-time private practice.

In internal deliberations, the board of directors at Shaare Zedek formulated the terms of an agreement to absorb Bikur Holim. The main proviso was Shaare Zedek would have the right to close or open any service at Bikur Holim. That condition was acceptable to the people at the Ministry of Finance. The personnel issue found a solution. It involved an agreement by the Israel Medical Association, the Jerusalem Workers' Council, and the administration of the hospitals that a portion of the staff would remain at Bikur Holim, another portion would be absorbed by Shaare Zedek, and some personnel would retire. Today Bikur Holim operates in an orderly fashion and with a balanced budget as a branch of Shaare Zedek under the latter's medical supervision.

CHAPTER 8

Psychiatry, Rehabilitation, Geriatrics, and Dentistry in Clalit

Psychiatry in Clalit

From its beginnings, Clalit did not fall into the trap of erroneously separating the mind and body, i.e., mental health and physical health. Both Dr. Tova Yeshurun Berman, my predecessor as medical director of Clalit, and I, emphasized mental health, both hospital-based and community-based.

With the assistance of the "Invalid Fund," Clalit built two specialized mental health hospitals, Geha Hospital in Petach Tikva and Shalvata Hospital in the village of Magdi'el south of Kfar Saba, which today is part of the amalgamated Ramat Hasharon municipality. And Clalit opened a third facility, Talbiya Psychiatric Hospital in Jerusalem's Talbiya neighborhood. It is in a building leased from the Greek Orthodox Church. These three mental health facilities were affiliated with schools of medicine and always on a high academic level. From the outset, the directors were eminent physicians: Prof. Zvi Winnick at Talbiya; Prof. Zvi Weissenbek at Geha, and R. Yafe at Shalvata. Prof. Winnick was a key figure in the development of psychiatry at the medical school in Jerusalem, and Prof. Weissenbek and Yafe did the same at the Tel Aviv University's medical school.

Moshe Soroka, when he was Clalit's director-general, was the one who built the new Geha Hospital on the Beilinson campus. It reflected the outlook that one should not separate hospitalization of psychiatric patients from other hospitalized patients, thus stigmatizing the psychiatric patients. I considered it my responsibility to establish psychiatric departments at Clalit's general hospitals. Therefore, in addition to the mental health departments in the Jezreel Valley (Emek Hospital) and in Haifa (Carmel Hospital), already discussed,[105] I also established psychiatric departments at Kaplan in Rechovot, and Soroka in Beer Sheva.[106]

We also viewed mental health as one of the important areas for family doctors to address in caring for the community and an important component in the vitalization of family medicine. The field of family medicine emphasizes mental health. Family physicians do not encounter just full-blown cases of serious mental illness that affect a small portion of the population.

Mental or emotional distress is common. The concept of mental or emotional distress includes anxiety, depression, low morale, and stress, even when the clinical symptoms don't stand up to a specific psychiatric diagnosis. Sometimes the symptoms are linked to grief, loss of a family member, a serious illness, divorce, being fired or problems in the workplace, as well as stressful economic circumstances, or flare-ups in Israel's security situation. In an in-depth study by the late Prof. Revital Gross and Dr. Shuli Brammli-Greenberg from the Brookdale Institute, twenty-five percent of the respondents reported they had sensed such feelings of mental or emotional distress in the past year, and thirty- two percent reported they had experienced such feelings at some time in their lives. Forty four percent of the respondents said they had sought professional help, and thirty seven percent turned to their family physician. Therefore, the role of the family physician in such situations is important, even very critical.[107]

As a member of the Ministry of Health's health council at the time mental health services in Israel were being reformed, I criticized the fact that those leading the reform had not given ample attention to the need to prepare family physicians for their mental health role.

105 Re Emek and Carmel hospitals: see chapter 6

106 Soroka's inpatient department existed until 1978 when the government opened a mental health hospital in Beer Sheva. After that, Soroka medical center provided only ambulatory psychiatric services.

107 Revital Gross, Shuli Brammli-Greenberg, Bruce Rosen, Nurit Nirel, and Ruth Waitzberg. "Mental Distress and Patterns of Getting Help Prior to the Transfer of Responsibility for Mental Health to the Health Plans: A Service Consumers' Perspective," Myers, JDC Brookdale research report, 2009. Available at: https://brookdale- web.s3.amazonaws.com/uploads/2018/01/538-09-Mental-Distress-ES-ENG.pdf

After making aliyah in 1933, Prof. Franz Bruhl, driven by Zionist zeal, dedicated his life work to mental health in the community and was one of the leading developers of community-based mental health services in Israel. He headed Clalit's mental health committee which included hospital directors Winnick, Weissenbek and Yafe as members. As Clalit medical director, I always participated in the deliberations of the committee and took their recommendations very seriously. Prof. Bruhl established a mental health center in Ramat Gan's Ramat Chen Neighborhood that was the most important community-based mental health center in the country.

I would often go out with Prof. Bruhl to meetings at community clinics where cases concerning the mental health of specific patients were raised by the clinic's family physicians for discussion with the specialist. Later, other psychiatrists became very devoted to such consultations with family doctors in the community.

For the development of pediatric psychiatry, we brought in two experts from abroad. One was Prof. Albert Solnit, a child psychiatrist from Yale, who spent a sabbatical in the Negev and visited kibbutzim across the region. When he visited Kibbutz Be'eri, he said to me tongue-in-cheek that much to his pleasure he had not encountered even one kid who hadn't been referred to a psychologist. The other expert was Dr. Nachama de Shalit took child psychiatric treatment forward in Jerusalem.[108]

When the reform effort in mental healthcare began in 1994, it became evident that there was a significant gap between the existing, highly developed mental health arm of Clalit and those of the other three other sick funds. Under the national health insurance system that was adopted in 1995, all the sick funds would need to provide mental health services.

Rehabilitation and Rehabilitation Geriatrics

Loewenstein Rehabilitation Hospital in Ra'anana[109]

Clalit always gave rehabilitation medicine the place it deserves, and built the Loewenstein Hospital from our 'Invalid Fund'. The hospital's first director was Theodore Nachenson,[110] who is considered a pioneer in rehabilitative medicine. He worked closely together with Prof. Avi Ohri.[111]

As has been mentioned, with the outbreak of the Yom Kippur War, Prof. Baruch Padeh and I took steps to free up hospital beds for the wounded.[112] As part of this endeavor, we shared the rehabilitation burden. We split it functionally. Persons with head injuries were hospitalized at Clalit's Loewenstein Hospital. Other war wounded were hospitalized at the Sheba Medical Center, with the Ministry of Defense picking up the tab.

108 Dr. Nechama de Shalit-Argaman (1927-1998) studied medicine in Geneva and specialized in pediatrics. In the 1950s, she underwent a career switch to psychiatry with sub-specialization in child psychiatry. She first worked at Beer Yaakov Psychiatric Hospital, south of Tel Aviv, then in the Ramat Chen clinic directed by Prof. Bruhl. She also served on various Clalit and Ministry of Health committees on mental health matters.

109 Loewenstein Hospital was named for Yitzhak Loewenstein, one of the heads of the Labor Federation's "Invalid Fund." The hospital was founded by Clalit in 1945 as a tuberculosis hospital. In parallel to this, Clalit founded Feinstone House, a long-term care facility for the chronically ill that over time was transformed into a rehabilitation hospital. In 1958, the two facilities were amalgamated and the hospital's new building was completed in west Ra'anana. Loewenstein Hospital is affiliated with Tel Aviv University's medical school as part of its continuing education study program for doctors and is also a site for training of nurses and other health professionals.

110 Prof. Theodore Nachenson (1920-2016) was born in South America and studied medicine in Argentina. He immigrated to Israel in 1951 where, at the beginning, he was a member of Kibbutz Dalia. Feinstone House in Moshav Ramot Hashavim, not far from the town of Ra'anana, was established in 1944 to treat patients with psychiatric problems, tuberculosis, paralytic poliomyelitis, and the chronically ill. In 1959, Nachenson joined Dr. Ludwig Ginzburg at Feinstone House as a department head. Details can be found in Ohry, A., "Mavo l-Toildot ha-Refua ha- Shikumit b-Israel" (Introduction to Rehabilitation Medicine in Israel), Tel Aviv University Press, 1996.

111 Prof. Avi Ohry (1948-) was born in Natanya, studied medicine at Tel Aviv University. He was an injured POW in Egypt in the 1973 Yom Kippur War. Afterwards, he joined the military department of neuro-rehabilitation at the Sheba Medical Center under Prof. Rafi Rozin. He did specialized training in spinal cord injury (UK 1979-1980) and brain injury (US 1980). He is now a professor of rehabilitation medicine at Tel Aviv University.

112 Collaboration between Doron and Padeh is first mentioned in Chapter 4.

It was not easy to fill urgent needs at Loewenstein Hospital for medical staff during the Yom Kippur War. It was not easy for doctors who up until then worked in a totally different field of medicine to suddenly define themselves as doctors dedicated to rehabilitation medicine -- all the more so since at the time, this field was still in its early stages in Israel. Many of the doctors from the Latin America aliyah in the Negev[113] rose to the challenge and some have continued at Loewenstein to this very day.

When Prof. Nachenson retired after 20 years as director of Loewenstein Hospital, a disagreement broke out between the Clalit directorate and Loewenstein Hospital's scientific council headed by Prof. Shmuel Tiyano. Our candidate to direct the hospital was Prof. Reuven Adler who was a neurologist. He had been chief medical officer of the IDF and dean of the Beer Sheva School of Health Professions. He also engaged for years in research. I thought he was the most suitable, but the Loewenstein doctors opposed this. They argued through their scientific council that the director should come from within the hospital. The disagreement was fierce. Opposition to Adler's appointment had nothing to do with the heart of the matter and was unreasonable. It rested on vested interests -- union issues -- of the doctors on staff, who were pressuring to appoint one of their own people. Ultimately, the doctor's union lost, and Prof. Adler became the director of Loewenstein Hospital. Nonetheless, I view the fact that the scientific council operates as part of the doctor's union representation as a flaw. I also object to the prevailing model within the doctor's professional organization where at the Israel Medical Association's convention, representatives on the scientific council are voted on in the same fashion that the doctor's union representatives are chosen. Although past chairs of the scientific council also pointed out this defect to me in private conversations, those conversations were only after their term of office was up.

I was also convinced that a professional ambulatory rehabilitation center needs to be located on- site of a rehabilitation hospital. My logic was that it was important to forge continuity in rehabilitative treatment so that persons still hospitalized can begin as soon as possible to take their first steps forward rebuilding their lives. On this point I had differences of opinion with members of the management, primarily Yoel Palgi who was in charge of construction. He argued that there were budgetary constraints and that it was impossible to build a professional ambulatory rehabilitation center in the hospital. There were, indeed, merits on both sides. I said I would ask the government for a budget.

I met with Minister of Labor Moshe Katzav to convince him that National Insurance should underwrite establishment of an ambulatory rehabilitation center at Loewenstein. It worked, and he decided to budget the necessary funds. Anyone who visits Loewenstein Hospital can't miss the professional ambulatory rehabilitation center in the main building that was built in partnership with the Ministry of Labor and the National Insurance Institute.

Beit Rivka Geriatric Hospital[114]

Clalit's "Invalid Fund" established Rivka House as a nursing home facility in Petach Tikva. It is the nature of geriatric hospitals for long-term nursing care that they need to become rehabilitative geriatric hospitals - otherwise they have no future. During my tenure at the helm, I took it as a personal mission to establish a new building and to bring a specialist in geriatrics to serve as director. I brought Dr. Shai Brill,[115] who was previously a geriatrician at Sheba Medical Center and continues to serve as director of Rivka House to this day.

113 See Chapter 2, The Plan to Bring Doctors from Latin America to the Negev.

114 Rivka House (*Beit Rivka* in Hebrew, today Geriatric Medical Center Rivka House) was founded in 1957 by the *Clalit* and the 'Invalid Fund'. The hospital was named after Rivka Novak, a social worker and chair of the Women's International Zionist Organization (WIZO) during the pre-state period. She was a member of Petach Tikva's second governing council and an activist in welfare and long-term healthcare needs.

115 Dr. Shai Brill studied medicine at Tel Aviv University. He then specialized in internal medicine at Beilinson hospital and geriatrics at Sheba Hospital. He served as a physician in the IDF in a variety of posts. Since 1990, he has been hospital director and director of the geriatric rehabilitation department at Rivka House.

Harzfeld Geriatric Hospital in Gedera[116]

Avraham Harzfeld was the head earlier of the powerful central governing board (HaMerkaz HaHakla'i, in Hebrew) of Israel's farmers and one of the founders of Clalit.[117] Acutely aware of the circumstances of his aging comrades and their need for eldercare, Herzfeld approached Clalit declaring: "I'll give you the land and you'll establish a hospital so there will be somewhere to die." But, as I noted earlier,[118] the antagonism between Prof. Sheba and Moshe Soroka, a combination of personal animosity and political rivalry, boiled over regarding the best location for the convalescent-eldercare facility, with Sheba daring Soroka publicly to have me, the regional physician for the Negev at that time, to decide who was right. This was the last thing I needed since I felt Sheba was correct, objectively speaking, but Soroka was my superior and there were additional issues: Sheba ignored the fact that the convalescence-eldercare facility was Harzfeld's personal project, that Harzfeld had proposed it, took it forward, and was, in essence, underwriting its construction and calling the shots, including providing the land in Gedera where it would be located. As a result, Clalit was only the executor of the facility. Publicly, I kept mum. But I didn't think twice about expressing my position on the location in private conversations: All things being equal, I felt it would be best to establish such a facility on the Kaplan Hospital campus as Prof. Sheba had recommended.

Dr. Tova Yeshurun Berman had been instrumental in triggering Prof. Arnold Rozin's aliyah.[119] He became a pioneer of geriatrics in Israel and I brought him to Harzfeld to become its director. He then made it into a top-notch rehabilitative facility.

Dentistry in Clalit

From the standpoint of a public health care system, dentistry has always been a neglected weak point in Israel's social insurance coverage. For years, Clalit has opened many public dentistry clinics. While treatment at these clinics is covered only for certain age groups as part of Clalit's basket of services, fees for all are lower than in private dental practices.[120] Although there are three Clalit dental clinics in Tel Aviv, clinics were established particularly on the periphery and in immigrant communities where the need was most critical.

Dentistry has always been in the hands of the private sector in Israel. Until the 1980s, there was a shortage of dentists in the country, and we took in immigrant dentists, some of whom were specially imported from their country of origin. Alas, it didn't take such newcomers much time to grasp the economic advantages of opening a private practice in lieu of having modest salaried positions at public clinics. Thus, staff retention in the public clinics was poor.

There was also a problem of dentists from Romania who did not possess the proper credentials. They did not have conventional dental school degrees. We needed to prevent such individuals from practicing dentistry. This posed a major problem on a national scale because it ran contrary to, and undermined, another national objective – immigrant absorption, or integration of immigrants into the country.

116 Harzfeld Geriatric Medical Center was founded in 1969 to serve as a convalescence home for elderly immigrants and to provide long-term eldercare. Avraham Harzfeld mobilized the resources needed, and Gedera's local council provided the land. The first director of the hospital was Dr. Arnold Rozin who in 1969 had made *aliyah* from the UK with his family. In 1983 the convalescence home became a geriatric hospital, and in 1994 its management was integrated with Kaplan Hospital.

117 https://boydellandbrewer.com/9781580461221/the-workers-health-fund-in-eretz-israel/

118 See Chapter 2

119 Prof. Arnold Rozin (1930-), born in Scotland, studied medicine in Glasgow and then specialized in geriatrics in London. He immigrated to Israel in 1969. He directed Harzfeld Geriatric Medical Center from 1977-1996 and then the geriatrics department at Shaare Zedek. In 1985, he became a professor at the Hebrew University medical school. In 1982, he founded the Center for Eldercare in the Community to assist Alzheimer patients in Jerusalem, for which received 2010 Jerusalem Key to the City award.

120 For many years the only dental services covered in the market basket of services mandated under Israel's National Health Insurance Program were treatments for oncology patients prior to and following chemotherapy or radiation treatment. Then in 2010, dental care for children up to age 8 was added to the market basket. This has been expanded progressively over time so that by 2019 children up to age 18 could receive dental care through their health plan. The preventive treatment is free; whereas there is a small charge for treatments considered "preservation." Then in early 2019 preventive and preservative treatments for persons 75 and older were added to the basket of services. Thus, the coverage of dental services has been expanding but remains incomplete.

During my tenure as medical director and as director-general of Clalit, Dr. Meir Goldenberg was the head of the sick fund's dentistry department. His contribution to forwarding public dentistry was great. First of all, he brought dentists from abroad, particularly from Latin America. But as noted, many quickly moved into private practice.
Secondly, we instituted two revolutionary steps in dentistry:

I approached Prof. Shlomo Simonson, the rector of Tel Aviv University, and together we decided to establish a school of dentistry, a partnership between Clalit and TAU. Up to this point, the only school of dentistry was in Jerusalem. How could Simonson justify Clalit's participation in such a venture that included establishing a building on campus to house the school? Dental education in Israel, like medical education is a six-year curriculum after high school. The first three years are considered to be pre-clinical, or undergraduate, education. According to the original plan, initially, enrollment in the new school would consist of students who had completed undergraduate dental education in some other country.[121] This option led to the return of many Israelis studying abroad. In addition, the students in the new school had to make a commitment to serve for three years as dentists in the periphery - in villages, frontier areas, and development towns. They signed contracts to this effect, and the contract was upheld by the courts when someone challenged it. Dozens of dentists completed their training in this manner and served for a period in underserved communities.

Eventually, shortly before my tenure as director-general was drawing to a close, the Tel Aviv University dental school wanted to change its curriculum and operate a six-year program, as in Jerusalem. Clalit cancelled the partnership with the school since there was no longer any justification for it. In the aftermath, the Tel Aviv University dental school entered a period of serious financial crisis. For a time, there was a real danger, barely avoided, that it would be forced to close.

Another step taken by Clalit was to promote and establish dental insurance, a partnership between Clalit and the Labor Federation-owned insurance company HaSneh. This insurance scheme was called Dikla, and through the Dikla Insurance Company Ltd. we were able to provide dental care to groups of employees through their place of employment. We even established on-site clinics in certain large workplaces. However, HaSneh ultimately ceased to exist. Dikla today is no longer a dentistry plan. It underwrites long-term eldercare, under a private insurance company, Harel. Operation of a country-wide public dentistry network would be very costly. In my opinion, it is far more important to provide coverage for long-term eldercare. Nevertheless, as time goes on, I believe dental care will have to be covered. The most pressing issue today is dentistry for seniors. Countless elderly persons in their last years are walking around toothless, without means to pay for dentures, a situation that has serious gastroenterological ramifications and impacts negatively in other health realms. I believe insurance covering children and seniors should take priority over insurance for the general public as a whole.[122] In this respect, I have high regard for previous deputy minister of the MOH Yaakov Litzman's efforts to institute dental care for children and youth. Unfortunately, this doesn't solve the problem of dental care for adults, particularly seniors in Israel. This is an acute issue that has yet to be addressed.

121 Shvarts S., Rusetska A., "Advertising in the Health Care System: Competition in the Era of the Compulsory Health Insurance Law", in The Health Care System- Where To? (Doron H., editor), Ben Gurion University Press 2009, pp.275-292 (Heb.)
122 As noted in Footnote 120, by the time Prof. Doron created this memoir, coverage for children and adolescents were being added. Since his death, coverage for the elderly has become a reality. Nonetheless, there is not yet coverage for the general adult population, and failure to cover services for that population contributes to the great need of seniors for dental care.

CHAPTER 9

Stages towards a National Health Insurance Law

Background: Clalit and the Labor Federation

Clalit as a Subordinate Entity to the Labor Federation

Clalit Sick Fund was founded in 1911. For 75 years it belonged to the Histadruth, the General Labor Federation, subordinate to the Federation's principles and institutional decisions.[123] Its subordination to the Federation was expressed particularly in salaries and work conditions of Clalit employees, later with the exception of the sick fund's physicians. But in matters of health policy, Clalit always had absolute independence. In all my posts and in all my years managing Clalit's affairs, Clalit health insurance hinged on membership in the Labor Federation and payment of dues called *Mas Achid* (Unified Dues).

There were some advantages in combining Federation membership and Clalit membership, particularly in the first decades of the sick fund's existence. The advantages were mutual: The combination strengthened the Federation by including health insurance in its services; and it strengthened Clalit by broadening its base to include all members of the Federation. But, over time, this partnership turned into a yoke. This was particularly burdensome when the question surfaced and became a sore point: Why did a person have to be a member of the Labor Federation just to procure health insurance if the person didn't identify with the ways of the Federation? As a result of this undercurrent of dissatisfaction, people began to leave the sick fund, and others refrained

from joining it as an expression of protest against being forced to be a member of the Federation. Not all the cancellations stemmed from this sentiment. After all, Clalit was a massive entity, which, by its very nature, was going to experience members leaving. But a large proportion of the departures were tied to unwillingness to be Federation members. As a result, there was growth in the membership rolls of the Maccabi Sick Fund at the expense of membership numbers in Clalit.

The Problem with the Premium Collection

The most difficult problem in the partnership between the Labor Federation and Clalit lay with dues collection. The Federation's dues collection apparatus would collect dues from the membership and distribute the money between itself and Clalit. How it was distributed was never entirely clear to us. It lacked transparency.

Moreover, from time to time a levy was imposed on all the Federation's entities, with the tax being for various objectives or activities the Federation wanted to promote. The Federation had Clalit's hands and feet tied when it came to dues collection and instituting steps to rectify things. A good example was the Federation's opposition to imposing a tiny, symbolic co-payment on all drug prescriptions – a measure to discourage members from filling, then throwing out, unwanted prescriptions. Clalit suffered from massive wastage of this sort. For example, we knew that at the clinics in Bnei Brak, a city with a religiously observant population, hordes of people were frequenting the clinics just prior to Passover to dispose of huge quantities of drugs that they didn't want to have in their houses because the prescription wasn't considered "kosher for Passover."

123 The sick fund was founded by members of the Second Aliyah, the second wave of Zionist-motivated immigration (1904-1914) that included many of the 'movers and shakers' that dominated and shaped the Jewish homeland as a state-in-the-making. It started as a local sick fund for laborers in 1911, operating as an independent entity until it was incorporated into the General (*Clalit*, in Hebrew) Labor Federation in 1921, which had been founded a year earlier - in 1920. Still, up until 1936, membership in Clalit operated separately from membership in the Federation. In 1936 membership dues to the sick fund was combined within dues as a Federation member, and it was labeled *Mas Achid* or Unified Dues. Clalit was one among many Labor Federation enterprises such as industrial plants and marketing coops, financial institutions, and cultural institutions. For details see, Haim Doron and Shifra Shvarts, *Refu'a b-Kihila*" (Medicine in the Community), Ben-Gurion University Press, 2004, pp. 13-21. See also: https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.89.2.248

To drive the point home about wastage, I once shared in an article in a Clalit periodical how a group of kids once brought their teacher a birthday cake decorated with blue-and-yellow capsules of the antibiotic Achromycin (tetracycline)! It was clear we faced a phenomenon that needed to be reined in because it undermined public health and led to a huge loss in public funding. Therefore, I wanted to introduce this small co-payment on prescriptions to discourage such practices. Just to be clear, the payment had no connection to the cost of a particular drug, unlike the situation today where there are tiered co-payments based on drug cost. Rather it was a symbolic payment to deter wastage. Such an idea had been raised in the past before I took office; but it took time to implement it due to the Federation's objections. Eventually, and only after repeated attempts, were we able, with difficulty, to get this decision passed.

Labor Federation Fund-raising in the United States and Clalit's Independent Fundraising Activities

The Federation conducted a donation campaign in the United States, using the sick fund as leverage to urge-convince people to donate to Israel's health needs.[124] In practice, for years the percentage of the take that Clalit would receive was minuscule, if it received anything at all. Moshe Soroka tried to revolt against this state of affairs. He opened an independent office in Chicago and sent the administrative director of Kaplan Hospital, Zvi Goldwasser, there. The Federation's general secretary at the time, Mordechai Namir, ordered the office closed immediately. Soroka had no option but to do so, and Clalit's representative returned to Israel.

At the end of the 1970s and in the 1980s, while many Israeli hospitals had embarked on mobilizing donations in the United States, the Federation's financial reservoirs for underwriting its ongoing operations and for development of Clalit plummeted. Some activities came almost to a standstill. I decided to revolt on this score. I visited America and established a non-profit in New York called Medical Research Foundation for Israel (MEREFDI) which was designed to collect donations for Clalit.[125] I was delighted that Jerry Zilber, a New York attorney who previously had donated to Soroka Hospital, agreed to serve as chair of the new entity. With his help and the help of the Israeli consul in New York, Uri Bar Nir, I succeeded in putting together a management team and setting things in motion.

There were a number of reasons - some objective – why the Federation's donor campaign was beginning to unravel: The younger generations of Jews in America were different from the generation of Jews who had stood at the head of so many American labor unions. They didn't speak Yiddish; and they were not particularly interested in donating to Israel's Labor Federation. Perhaps there were other reasons afoot behind the disintegration of the Federation's campaign. Apparatchiks in the Federation's campaign machinery charged that the actions of Clalit contributed to the demise of the Federation's donor drives. This is untrue. For example, in taking the children's hospital initiative forward, the Federation was not the one who found Irving Schneider. And Schneider most certainly wouldn't have donated such sums to a Federation donor drive. His interest was specifically in hospitals for children.[126]

Conflict of Interest between the Labor Federation and Clalit

At the top of the Federation's priorities stood its own needs as a union to be a robust body in representing the interests of working people, while the interests of Clalit were a secondary component. On the other hand, Clalit was an institution that was almost state-like in size. Moreover, from a management perspective it was mamlachti, statist in approach -- the good of the whole health system being its top priority. Thus, there was a conflict of interest and built-in antagonism between the Federation and Clalit.

124 See: S. Shvarts, Shvarts S., Health and Zionism, The Univ. of Rochester Press, 2008, pp.249-251. https://boydellandbrewer.com/9781580462792/health-and-zionism/
125 See also: Chapter 2, p.84
126 See: Chapter 2, Section on Schneider Children's Hospital, pp. 84ff

During the difficult period when the Federation faced serious membership retention problems, some people in the Federation sought to pin the blame on Clalit. I can't forget how at the dedication of Clalit clinic in Katzrin on the Golan Heights, the head of Katzrin's local council presented me with a framed photo of the ancient synagogue found by archeologists at the site. This brought down on me the rage of the Federation's chair: How could it be that Clalit and I were the focus and recipient of such a gesture of appreciation for our endeavors, and there was no mention of him and the Federation?!

When I convinced Irving Schneider to donate the money, so generously, to establish a children's hospital, I receive an angry telephone call from the chair of the Federation accusing me of dealing a blow to the Federation via this initiative as if it came at the expense of the Federation's own donor campaign. Following this telephone call, the chair of the Federation initiated a string of meetings, both of the Federation and of Clalit, in which he personally participated. The object of the gatherings? To point out real and imagined flaws in Clalit as the primary reason for so many members abandoning the Federation.

Up to 1977, in Clalit's annual negotiations with the Ministry of Finance, there were distinct advantages in the linkage between Clalit and the Federation. The Ministry of Finance could exhibit more flexibility vis-a-vis Clalit's needs and requests in expectation that the Federation would be more flexible in its demands for cost of living increases for workers, and so forth. But after the Labor Party fell from power in 1977, relations with the Ministry of Finance changed.

At first, in the days of Minister of Finance Simcha Erlich, relations were more positive. But after a short time, particularly during the tenure of Yigal Horowitz, the relations were marked by opposition and extreme clashes that made negotiation nearly impossible. Clalit became a political football, caught at a time of economic chaos between the Labor Party's remaining power base, the Federation, and the Begin government.

Besides differences in personality and party affiliation -- Erlich from the Liberal Party, Horowitz from the Likud -- the transition in the Begin years from a closed centralist, socialist economy to an open liberal market economy, led to deterioration of the balance of payments. This was fueled by a mass increase in importation of goods and a sharp rise in inflation that under Horowitz became hyperinflation, an annual 444 percent rate. At the same time, wages were automatically tied to the cost of living. One fed the other as the economy spinned out of control.

In terms of wages, there is an incident that demonstrates the limitations that arose largely from Clalit's ties to the Federation, particularly in the period of regime change. Around that time, Federation general-secretary, Yisrael Kessar, had agreed with Likud's Minister of Finance, Moshe Nissim, not to raise the wages of Clalit doctors. But, in the hospitals, as well as in clinics, there was very expensive equipment that was not utilized in late afternoon and evening hours due to work condition agreements; and simultaneously, the doctors were pressuring ceaselessly for improvements in their earning power. As a way of addressing these issues, I introduced what is called a *"sesión"* - Spanish for a meeting or work meeting. I translated this concept into designated work hours in the afternoon and evening, paid for by Clalit as overtime, during which the equipment would also be ultilized as part of the delivery of appropriate medical care.

The doctors saw these work hours a vehicle for enhancing their earning power, rather than as a key economic solution to wastage of medical equipment and long queues for such procedures.

I was summoned to clarify things at a meeting at which Minister of Finance Nissim, Federation secretary Caesar, and I, were present. Subsequently, the Minister of Finance summoned his

colleague, the chair of the Knesset finance committee, and they immediately passed an ordinance stipulating that an institution that received state funding couldn't raise the earning power of its employees. Thus, they tied the hands of Clalit and in one stroke had abolished the *sesión*.

Another problem with Clalit's subordination to the Federation was that criticism of the Federation and the struggle against it led to unnecessary and undesirable criticism of Clalit. Such flak was reflected in part of a conversation I once had with Yitzhak Navon[127] in a visit at his house. We were on friendly terms, and Navon said to me, "You go to crazy lengths and invest great efforts in strengthening the Sick Fund, but the Sick Fund is 'Federational', and the Federation is hated by the public". If I had to boil down Clalit's subordinate status under the Federation to one sentence, I would say that Clalit was a non-governmental institution of almost governmental magnitude and outlook. That was the biggest inner contradiction why Clalit couldn't remain forever and ever subordinate to the Federation.

Bills to Legislate National Health Insurance

Social insurance and national health insurance were always a central issue in my thoughts. The first commission that dealt with proposing a National Health Insurance Law was appointed in 1957. It was headed by Yitzhak Kenev;[128] and it presented its conclusions in 1959. The commission's conclusions led to establishment of Israel's National Insurance, or social security scheme, called Bituach Le'umi. Legislative proposals for health insurance then became a core political issue and one of the major differences in the platforms of the various parties.

In the first decades after statehood, Ben-Gurion championed the "scaffolding doctrine". He held that after establishment of the state there was a need to dismantle the scaffolds, and all systems needed to become state systems. Ben-Gurion dismantled the Jewish community's leading pre-state militia, the Palmach, to create one army, the Israel Defense Forces (IDF); established a state-run labor exchange; and abolished separate educational streams by putting in place a free state public education system. Ben-Gurion held the same position regarding a national health system. His outlook stood contrary to the interests of the Federation and "United Dues."

Over the years, there were various committees to propose health insurance legislation. Based on the identity of the chair and his or her political views, one could know what would be the conclusions. Persons from the right wing favored nationalization of medicine. For example, the 1977 committee was headed by Prof. Ezra Zohar, an internal medicine department head at the Sheba Medical Center with right wing views who championed nationalization of medicine. And so, it usually went. Yet, Victor Shem-Tov[129] was a Minister of Health who advanced the cause of a national health insurance law even though such a stance was contrary to his political affiliation as the leader of Mapam party.

The crux of the differences among all these committees focused on the question of whether health insurance would be carried out through the existing sick funds, or ones that would be established for this purpose, or by nationalizing medicine along the lines of the National Health Service (NHS) in the United Kingdom. What was the difference between the two? The character of funding sources. In the United Kingdom there were not, and are not, multiple sick funds as service providers – only one monolithic state-run service, the NHS. In addition, the source of most of the NHS's revenue comes from state budgets. In contrast, among sick funds in the western world operating within the framework of social insurance, financing is based in part on the insured and in part on the employer.

127 Yitzhak Navon (1921–2015) was an Israeli politician, diplomat, and author. He was a member of the center-left Alignment Party and served as the fifth President of Israel between 1978 and 1983.
128 Yitzhak Kenev (1896-1980), formerly Kenyevsky, was an Israeli economist, among the leaders of the Labor Federation, and a *Mapai* Party parliamentarian in the first Knesset. He served as chair of Clalit, director of the Labor Federation's social research institute, and was among the architects of Israel's National Insurance Institute. In 1962, he was awarded the Israel Prize in social sciences.
129 Victor Shem-Tov (1915–2014) was an Israeli politician who held several ministerial portfolios in the late 1960s and 1970s. Shem-Tov was from the most doctrinaire faction of the Ma'arach Labor Alignment Party and the Federation's collectivist worker-owned economic and social entities.

Clalit was always in favor of national health insurance through the auspices of the existing sick funds. Moshe Soroka, who was not only a wise man but also a courageous one, once wrote a landmark letter to the Federation secretary, Yitzhak Ben-Aharon. In the letter, Soroka railed against two things: First, foot-dragging by the Federation when there was the urgent need to renew deliberations on national health insurance even it if went against the interests of the Federation; second, the problem of medicine in the community and Ben-Aharon's opposition to the idea that medical education in the country should invest in promoting community medicine. My own proposal for national health insurance, formulated together with others, is not well known, though I maintain it was an important one. In 1965, Ben-Gurion split the *Mapai* party, and formed the Israeli Workers' List, or *RAFI* party.[130] I supported Ben-Gurion in this move. *RAFI's* people turned to me as a physician, and to Joseph Ciechanover, the Ministry of Defense's legal counsel, as a jurist, requesting that the two of us propose draft legislation that *RAFI* could sponsor in the Knesset. Our draft legislation dealt with organizing the health system through the auspices of the existing sick funds and hospitals. It was built on regional districts - a central hospital in each area, with a network of surrounding community clinics. This principle was the basis of the regional district structure I would later develop within Clalit.[131] It reflected my belief of the centrality of continuity of treatment between the community and the hospital. To the best of my recollection, this draft legislation was the only one that wasn't political but but based on providing the best arrangement for the people. It was part of the *RAFI* party's platform in elections. And when the *RAFI* list won seats in the Knesset, every time they wanted to present draft legislation for national health insurance, *RAFI's* parliamentarians would request that I prepare the requisite materials, which I did gladly.

Thus, the draft legislation of Clalit and *RAFI* was based on the following principles:

1. Dependable financing would be ensured. It would be based on dues paid in part by the insured and in part by the employer.
2. The sick funds, as service-providers, would develop their own independent services and be held responsible for their quality. This would differ from the German sick funds which have been built solely on reimbursement for fees paid out-of-pocket by the insured.
3. The sick funds would be founded on the principle of mutual liability between the periphery and center of the country, and between the strong, economically established sector of society and the socioeconomically weak ones. To do this, the burden would be shared via graduated health tax payments based on income.
4. Money would not be a factor in relations between patient and physician; rather, service fees would be underwritten by the public-at-large. In this manner it would be possible to be flexible and engage in long-range multi-year planning so crucial for a health system.

The Establishment of the Netanyahu Commission - an Inquiry into the Role and the Efficiency of the Health System

There were several factors present in 1988 that lay behind the establishment of the National Commission of Inquiry to examine the performance and efficiency of the health system in Israel. It was headed by supreme court judge Shoshana Netanyahu, and thus called the Netanyahu Commission.

First of all, there was shame at the financial crisis in the health system, which consisted of rising costs of medical care in parallel with failure in, in fact opposition to, government's participating adequately in health expenditures. Secondly, there was a general economic crisis in Israel. One cannot ignore that in the latter half of the 1980s Israel suffered from hyperinflation. Thirdly, a less known factor, the internal struggle within *Mapai* between the Federation and the heads of *Mapai* - Shimon Peres and Yitzhak Rabin. The struggle got worse and worse. Peres and Rabin

130 *RAFI* is, in Hebrew, an acronym for Reshimat Poalei Yisrael, the. Israeli Workers List. It was a center-left political party founded by former Prime Minister, David Ben-Gurion in 1965. In 1968 it was one of three parties that merged to form the Israeli Labor Party.
131 Doron discusses his regional district structure in Chapter 4.

were in favor of national health insurance through the existing sick funds, but the two were definitely against including a Federation-tied sick fund.

I had a discussion related to the financial crisis in health care with Shimon Peres at one point during his tenure as prime minister (1984-1986). He told me: "You have 40 million doctor visits a year; charge a co-payment for them." But he knew well that the Federation didn't allow me to charge patients. I also had a very amicable talk with Yitzhak Rabin about the budget problems, but that didn't lead to a solution either.

In one of the annual budgets that Peres formulated, I learned that Clalit was completely absent. There was no allocation whatsoever for the sick fund. Moreover, there had been a cut in all the health expenditures for the services that the Ministry of Health was entrusted with providing. Minister of Health Motta Gur suggested we go together to *Mapai*'s secretariat, where both the heads of *Mapai* and the heads of the Federation sat, and seek a solution. We got there and told them about the situation. Peres took this personally: Once, previously, when Clalit needed a very large loan from Bank Hapoalim and the bank hesitated, Peres had weighed-in as prime minister, recommending the bank approve the loan. He had also recommended a donation to the sick fund. Therefore, at this juncture he expected me to back him, and he saw my objections to his budget as a personal betrayal. But I had to stick to my guns and side with the best interests of Clalit, without room for personal accounts. I was never in anyone's corner and my actions were always based on what I saw as the best interests of the issue or project at hand. I admit that I wasn't very good at politics.

Finally, I believe my resignation as director-general of Clalit also contributed in some form to the decision to take such a step. I don't think I'm exaggerating in saying so, since my resignation expressed the severity of the crisis that Clalit and the Federation were facing.
Composition of the Netanyahu Commission In addition to the chairperson, Supreme Court Justice, Shoshana Netanyahu, members of the Commission were Prof. Mordechai Shani, Prof. Shmuel Pinchas, Prof. Arieh Shirom, and Prof. Dov Chernichovsky. Prof. Shirom was at Tel Aviv University, and Prof. Chernichovsky, an economist, was at Ben-Gurion University of the Negev. At the time (1988), there were three streams in the Israeli hospitalization system: the government one -- reflected in the appointment of Prof. Mordechai Shani to the Commission; the public hospitalization system that included Hadassah and Shaare Zedek hospitals -- reflected in the appointment of Prof. Shmuel Pinchas, director of Hadassah; and a stream that included hospitals of the country's sick funds, particularly those of Clalit with its 14 general hospitals throughout the country. While I had resigned and left Clalit, I was pained by the fact that there was no representation of Clalit's hospitals on the Commission.

Recommendations of the Netanyahu Commission
Just before leaving on a sabbatical, I appeared before the Netanyahu Commission in testimony spread over several days – hours and hours of testimony. I think my testimony did influence the conclusions of the Commission.

What do I think about the conclusions in the majority report of the Netanyahu Commission?

The Commission recommended universal insurance for the entire population, and one should view this in perspective: Prior to this enlightened proposal, there was already health insurance in a non-governmental framework, with Clalit at the hub. This led to 86.4 percent of the population in the country being insured. In my years in Clalit, I sought to expand the sick fund's membership without requesting the Federation's approval. For example, through various

means, I brought *Poalei Agudat Yisrael* under the Clalit umbrella.[132] There were also agreements for new immigrants, and these were handled by Israeli diplomats abroad as part of a person's preparations for making *aliyah*. At one point Clalit covered 85 percent of the insured persons in the State of Israel. Over the years, the other sick funds also grew. The Netanyahu Commission recommended insurance for 100 percent. This was a fine accomplishment.

One of the topics I emphasized in my testimony before the Commission, and that the Commission itself recommended, was addressing all stages of health of the population including preventive medicine, medical treatment in the community, general hospitalization, specialized hospitalization, and rehabilitation.

The Netanyahu Commission stated that the Ministry of Health must stop functioning as a service provider. Its role should be to serve in a supervisory role, to set policy, to plan, to oversee, inspect, and control the performance and quality of the operations of the service providers. I identified completely with this conclusion. There wasn't an interview on radio during my tenure as medical director and director-general of Clalit where I didn't argue that the role of the Ministry of Health as an operator of medical services stood in contradiction to its roles governing and supervising all health services in Israel. I felt that the Ministry of Health could not properly carry out its primary oversight functions while at the same time operating government hospitals, services for new mothers and infants that were delivered in *Tipat Halav* (literally, Drop of Milk) clinics, and preventive medicine services. My predecessor, Dr. Tova Yeshurun Berman argued that personalized services of preventive medicine, and monitoring of pregnant women and newborns should not be separated from the rest of the services of the sick funds. For years, I, too, fought for integration between these functions. For example, I saw no justification that in Ofakim, a tiny development town in the Negev, there would be a pediatric clinic run by Clalit and also *Tipat Halav* services run by the Ministry of Health. The absurdity of this state of affairs was reflected in a directive penned by the chief supervisor of nursing at the Ministry of Health ordering that Ministry of Health nurses refuse to make coffee for Clalit nurses under the same roof! While there had always been *Tipat Halav* clinics run by Clalit, the Ministry of Health saw to it that their numbers wouldn't grow. In my opinion, such a situation ran counter to the medical and economic interests of the health system. To this day, however, and despite the Netanyahu Commission's recommendation, the Ministry of Health continues to function as a health services provider.

The Commission proposed that the country be divided into five or six regions, with regional sick funds. I took issue with such a concept. I had always been a proponent of regional organization of health services and had put that into the draft legislation I formulated together with Joseph Ciechanover. But I strongly disagreed with this proposal to divide the sick funds according to region, where each region would have its own separate sick fund as a service provider.

Among the Commission's recommendations was free transfer between sick funds and that all the sick funds would have to accept any insured person who wanted to move from one sick fund to another. In fact, I had already instituted free movement between clinics at Clalit which did not require changing sick funds: There was a time when people were assigned to one clinic only. Then later, they could choose between three clinics; but I set in motion unfettered movement between clinics and the ability to receive medical assistance in the community at any Clalit clinic and from any doctor one preferred.

132 *Poalei Agudat Israel*, in Hebrew, or *PAGI* (Workers of the Union of Israel), is a Jewish political party of ultra- Orthodox *(haredi)* workers that had a socialist bent. Initially, it was a faction of the ultra-Orthodox *Agudat Israel* (Union of Israel) party sometimes in the past called 'the Aguda'. *PAGI* was tied to the Federation of Labor by special arrangement. Under the agreement, *PAGI's* members were eligible for membership in Clalit.

The Netanyahu Commission recommended that the financing of health insurance be via a health tax for the public, plus the Parallel Tax *(Mas HaMakbeel)* that had been legislated in 1973. Indeed, we viewed the compulsory Parallel Tax Law payed by the employer as the first step towards national health insurance. However, the existence of the Parallel Tax only *supplemented financing* sources. It was not the basic-primary source of financing.

The Commission recommended that the money from the Parallel Tax would be obtained by Israel's social security agency, the National Insurance Institute (*Bituach Le'umi*, in Hebrew). This was a very positive recommendation, because their collection of social security funds was so advanced and efficient.

The Commission had a positive attitude towards the *SHARAP*, which mixed private practice with public medicine. It was true that Clalit was in the practice of purchasing necessities from private sources when something was lacking and there was no other alternative. But this was a marginal phenomenon. Clalit's opposition to private medical services in public hospitals and private practice persisted down the years. There was also a minority opinion submitted by Prof. Arieh Shirom, a member of the Netanyahu Commission. He put emphasis on a vision of public medicine versus private medicine; and he opposed, completely, private medical services. I agreed with Prof Shirom, generally; but I did not entirely agree with him: Shirom argued that the culprit behind the crisis in the health system was not the state of the law. Rather, it was government policy on financing. Between the lines of his minority opinion report, it becomes apparent that Shirom felt the structure of a Federation sick fund could continue, whereas I felt that this construct had reached the end of the road.

Among the Commission's many recommendations, it said it wanted "To promote family medicine and the status of the family physician as gatekeeper, to avoid overuse of healthcare services and unnecessary usea and expenditures." Vitalization of family medicine was a core aspect of my career in Clalit. But there were differences in the approach of the Commission members, and my approach. The argument behind this clause according to the Commission members was purely economic; whereas, my primary argument was on medical grounds not just on economic ones. I think that vitalization and advancing family medicine has led to a tremendous change for the better in the level of primary medicine in Israel, compared to the prevailing situation beforehand.[133]

The 1994 National Health Insurance Law

In order to get passage of the national health insurance law, Minister of Health Haim Ramon resigned, ran for office as secretary of the Labor Federation, was elected, and then separated Clalit from the Federation.[134]

Principles of the National health insurance Law

The following are the principles anchored in the national Health insurance bill as originally stated and prior to the changes and amendments that preceded its passage into law.

The foundation of the law already appears in the first clause, "justice, equality, and mutual liability," as well as ensuring health services to all residents as a fundamental entitlement, not as a consumer good. Thus, the law was founded on a clear and unassailable principle -- that health insurance would be universal for the entire population.

133 See Footnote 67 re the 2012 OECD report on health care in Israel. The OECD praised the strength of the Israeli primary care system and its effect on overall system performance.

134 For more on this process see: Yaffa Moskovich, "Goal Displacement in the New Israeli Labor Unions: Lessons Learned", *Current Politics and Economics of the Middle East*; Hauppauge Vol. 10, Issue 4, (2019), pp. 411-439; Yaffa Maskowich, "Activist Leadership in the New Israeli Labour Unions — The Histadrut. Bringing about Privatisation, Downsizing, and Goal Transformation: An Israeli Case Study" , *Journal of Organisational Transformation & Social Change*, 2015:12(2):159-177; and Yaffa Maskowitch, "Transition from the old to the new: lessons learned in the Israeli Histadrut during the Ramon leadership," *Journal for Labour and Social Affairs in Eastern Europe*, 2011:14(4):571-588.

The law states that the insured persons will have free choice of the fund they are interested in, with the ability to transfer from fund to fund. This was a logical decision to prevent "cream skimming" by a fund.[135]

According to the law, every resident was entitled to a basic basket of services. The basket was based on the basket of health services of Clalit. This fact is a testament to Clalit's basket being seen as balanced from both a medical and an economic standpoint. Indeed, I feel that Clalit's conduct in this respect was always fair and fitting on both counts.

The law stated that collection of tax would be carried out through the National Insurance Institute, based on the income of the insured. Indeed, this decision both reduced collection costs and made health premiums more progressive.

The law stipulated that division and allocation of fiscal resources to the sick funds would be calculated *per capita.*[136] However, despite the great importance of the Parallel Tax as a source of funding to underwrite the sick funds, there was a flaw in allocation. Initially, the Parallel Tax would be allocated only according to the number of members, while ignoring the factor of age. This was the practice for many years until finally they began to take age into account. According to the law, the state budget would be the source of supplementary funding to underwrite health insurance. It would not be the prime source of funding. This did not remain the case.

The law set down a mechanism for changing the basket of health services and provision of its components based on quality of service, with acceptable standards of accessibility for all insured persons in terms of time and distance. There had always been criticism of Clalit about why it established clinics in every community, moshav, or kibbutz. The truth is that this policy, the configuration of Clalit operations, became one of the advantages of the National Health Insurance Law.

A word about the Basket of Health Services Committee: When that committee meets annually to discus the basket, taking into account technological and other changes and developments in the health realm, it is functioning as a serious body that operates well. The committee does its work faithfully, squarely facing difficult quandaries of what to add. It makes decisions that encompass the philosophical-moral plane, not just the medical and fiscal perspective. But by transforming the state budget into the prime financing source of the health basket, instead of the Parallel Tax, this good and important committee has been required to compete with endless other pressing needs for state funding. This has made it impossible for the Basket of Health Services Committee to fulfill its function properly for lack of a budget of the size it needs to carry out its mission.

With these principles, the National Health Insurance Law in its original form, prior to undergoing changes and amendments, was solidly on the side of public medicine. It sounded like competition for members among the sick funds would be according to the quality of their service -- that the sick fund with the best medical services, the best access, and highest quality would enjoy public admiration and attract more members. Also, importantly, clause 52.2 of the Low mandated establishment of a National Institute for Health Policy Research. This did come to pass, and the Institute has played a cardinal contribution, encouraging health management and development of health research that subsequently have been reflected in an impressive improvement in the management of health services in Israel.

135 A sick could could practice "cream skimming" by having selective criteria to allow only the more profitable clientele, e.g., young, healthy, or well-off people, to be accepted as members of that fund.
136 *Per capita*, from the Latin: Payment per person or capitalization, employed as a formula for setting allocation of sources of funding for the four sick fund 'service providers' under the National Health Insurance Law. Under this formula, allocation of funds to each of the four sick funds is shared proportionally by the number of individuals covered by each sick fund, factoring in the age of each insured person and other additional factors updated from time to time.

Elements Missing from the Law

Together with the positive elements, there were also elements that were absent from the original law, as passed. These were shortcomings that the State of Israel, to this day, suffers from. The National Health Insurance Law made no mention of the linkage between hospitals and the sick funds. It entirely ignored the 1981 agreement to open all the hospitals within a regionally based hospitalization system to the insured persons of all sick funds. This would have given freedom to a physician to weigh hospitalization for particular patients in different hospitals in special circumstances. Instead of implementing this agreement, to this day Israel has a patchwork system based on improvised and makeshift solutions. Members of the Knesset on the finance committee are split in two: Those who are for the sick funds are in favor of deeper discounts on payments for acquisition of hospitalization services, and those who are for the hospitals are in favor of more modest discounts. The real solution lies in opening all the hospitals to all the sick funds equally on a regional basis. Under the existing scheme, patients are moved from pillar to post, from one hospital to another, since it is worthwhile to refer them to a hospital where their sick fund pays less. Such "economic sense" often results in the new hospital redoing tests. Thus, the total cost is actually higher.

Also, mental health was not included under the original Law. Fortunately, this was corrected in the past years (2015) with the reform in mental health care. I have previously mentioned that in Clalit there was never any division between physical health and mental health.[137]

Clalit's "Invalid Fund," which underwrote the opening of psychiatric and rehabilitation hospitals, was established quite early in the sick fund's existence. That was coupled with Dr. Bruhl's program of mental health doctors conducting visits to community clinics to discuss cases being handled by family physicians, which I adopted for Clalit as a whole; and it was coupled with the development of the teamwork model in Clalit clinics which helped further integrate mental health with the physical aspects of community-based care. For the other sick funds, mental health has amounted to a new topic.

Long-term care in Israel should also receive greater attention: Recently, the media, after visiting 14 long-term nursing facilities, broke a story about their horrible state. This was no surprise. For years I have known that in contrast to Clalit's long-term facilities (Harzfeld Geriatric Hospital, Rivka House, and Loewenstein Rehabilitation Hospital) the government-run nursing homes, due to meager government funding, were operating on a very low level. I think, in general, that in the face of increasing longevity accompanied by an increased prevalence of chronic illness, the State of Israel's approach to the issue of providing long-term care is truly deplorable. I have made a proposal to the current deputy minister of health, Yaakov Litzman, to raise the health tax by half a percent or more. The increase would make it possible to institute long-term care insurance as a part of national health insurance. I am at a loss of words when it comes to my feelings about the fact that this proposal has not been accepted. Willingness to do so hinges on the degree of compassion we as a society have towards elderly people of meager means living among us. The number of these people is growing fast. And this is relevant not only for seniors whose condition requires intensive nursing care, but senior citizens as a whole.

For example, the matter of dropping co-payments on prescriptions by senior citizens was not addressed by the Netanyahu Commission among its recommendations, out of fear of the high cost. Economics were the decisive factor, and they wanted at least the clauses they had recommended for health reform to be adopted. The truth is, even in the period when the Parallel Tax existed (1973-1997), it would have been possible to solve this issue.

Dental care was also not included in the original Law. Deputy Minister Litzman, to his credit, has introduced free dental care for children up to the age of 14. Prior to this, 95 percent of the

[137] See Chapter 8

outlays for dental care in Israel were out-of-pocket, without any consideration of the financial burden of paying for dental care for sectors of the population of meager means. Today the most outstanding injustice is the issue of dental care for seniors. Again, I believe there is a crying need to squarely face the problem and budget resources to address it.[138]

National Health Insurance also didn't include preventive medicine, and as a result of this flaw, the health system in the State of Israel is more and more conducted by the Ministry of Finance, not the Ministry of Health. For example, Finance seems to feel that is it possible to privatize preventive medicine services for school children. This approach testifies to the fundamental lack of understanding of the importance of preventive medicine and the likelihood that when such services are privatized not all can afford them.

The Fate of the National Health Insurance Law

The "Arrangements in the Economy" Law

Between the years 1996-1998, a major process was afoot that greatly eroded the principles of the original National Health Insurance Law. This was carried out through the annual Arrangements Law *(Chok Hesderim)*.[139] The Arrangements Laws for the Economy were spawned in the mid-1980s when Israel grappled with hyperinflation and there was a need for drastic emergency measures that would take effect immediately. The Arrangements Law did not have to go through any lengthy and thorough parliamentary process prior to the first vote. The yearly Arrangements Law is an appendage, a 'tag on law,' that is passed together with the vote on the state budget. If party discipline in passage of the state budget is maintained by the ruling coalition's whip, then, when the last clauses of the state budget are finally passed with the Arrangements Law right behind, it is usually late at night. At that hour, no one in the Knesset is in any condition to read the small print, certainly not the small print of the Arrangements Law which often runs into hundreds of unrelated clauses.

What is relevant to health matters is the fact that the Ministry of Finance used the Arrangements Law to change much of the ideological, medical, and social security aspects of the National Health Insurance Law. What has run like a thread through all the changes introduced through Arrangements Laws has been drastic reduction in financing of the health system from public funding and a dramatic increase in financing the health system by out-of-pocket expenditures. It is for this the reason that I say the Ministry of Finance is the real director of health in the State of Israel; and it bears responsibility for the results. I'm not saying that the health system, or the National Health Insurance Law, as part of Israel's network of social insurance legislation, can be conducted without taking into account the country's economy as a whole. But at the same time, one needs to strike a balance between medical and social considerations on the one hand, and economic considerations on the other. Today there is no balance in weighing the two sides, and the Arrangements Laws has played a decisive role in upsetting the balance between public and private funding.

Abolition of the Parallel Tax

The original National Health Insurance Law made payment of the Parallel Tax by employers compulsory. Prior to that, the Parallel Tax was part of wage agreements between employers and employees. The process of negotiation of these agreements carried a huge advantage from other perspectives, as well.

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138 Changes in dental coverage since Doron's death are mentioned at the end of Chapter 8 in Footnote 122.

139 "The Arrangements Law is a government-sponsored bill presented to the Knesset each year alongside the State Budget Law. It incorporates government bills and legislative amendments that are needed in order for the government to fulfill its economic policy. The law is also referred to as the "Economic Policy Law" and the "Israeli Economic Recuperation Law." Knesset. Lexicon.
See: https://m.knesset.gov.il/en/about/lexicon/pages/hesderim.aspx#:~:text=The%20Arrangements%20Law%20is%20a,t o%20fulfill%20its%20economic%20policy

The Parallel Tax was abolished through the 1997 Arrangements Law. The significance of this was, first of all, conversion of the health insurance law from a law that realizes social security principles, to a law that only half realized social security, and half nationalized healthcare. It was nationalization because the health tax became part of income tax, only under the heading "health tax." I have already mentioned that in western countries where the system is organized through national health insurance involving sick funds, the funding comes in part from the employer, and in part from the insured. With the 1997 Arrangements Law, Israel was the first country to abolish the part of the employer. At the time this was discussed, there was talk that abolition of the Parallel Tax would lower labor costs. In fact, it has been proven by Prof. Gabi Bin Nun that labor costs weren't lowered by even a cent.[140] What the Ministry of Finance wanted, and succeeded in achieving by abolishing the Parallel Tax, was linking the health insurance law's resources to the state budget, with its cuts and various priorities. The outcome of abolishment of the Parallel Tax was that the part of the health budget that the state budget earmarks for the health system doesn't increase almost at all, while the scope of participation of the citizenry to underwrite health expenditures out-of-pocket continues to grow. Under the Parallel Tax Law, gradually, the employer came to pay 4.95 percent of wages towards health insurance. According to Prof. Bin Nun's research, by the year 2000, the Parallel Tax would have contributed 40 percent of the outlays of the sick funds. In 2000 there would have been no need to top off funding for operation of the health system from the government budget, because revenue from the Parallel Tax (the employers' payment) and from health insurance dues (the employees' payment) would have been sufficient.

It would be fitting here to discuss one of the lesser-known aspects of employers participating in health expenditures. The great importance of the employer participating in health outlays, even if it is only one percent, stems from the fact that a person spends at least a third of the day in the workplace. The workplace is a good place to educate about good health habits; and there are workplaces where this is done. I believe it is important to encourage an employer's interest in the health of their workers. This is reflected not only in things like asbestos exposure in the workplace, but also many other aspects of industrial health and work safety.

When we began to develop dental healthcare insurance in Clalit, I invited the chair of the secretariat of the workers' committee at Israel Military Industries to meet, and we jointly established a dentistry clinic on-site. The clinic, due to its convenience, was associated with improved frequency of employees' dental visits. At the same time, sick leave absences from work due to dental problems were reduced.

At the time the Parallel Tax Law was being considered, Prof. Yuval and I advocated for it to include an 0.01 percent budget for industrial health research. This was incorporated into the law, and with the funding we were able to establish two research institutes: The first, an institute for employee health and rehabilitation at Loewenstein Hospital; the second, a more general research institute at Tel Aviv University's medical school that deals with work injuries, occupational diseases, and work safety issues. After abolition of the Parallel Tax, the two institutes for research of occupational health were closed, dealing a blow to workers' health and safety. There isn't a day that one doesn't hear on the radio or read in the papers about a worker falling in the workplace. In the absence of the institutes, it is now hard to know the state of work safety in Israel.

140 Gabi Bin Nun, *"M-Hok Bituach Bri'ut Mamlachti ve'ad- Edan ha-Zahav veha-Platinum"* (From National Health Insurance to the Age of Gold and Platinum) in Haim Doron (ed.) *Ma'arechet Ha-Bri'ut L'ann?* (Whither the Health System) Ben-Gurion University Press, 2009. pp. 7-48. Gabi Bin Nun, the author of this chapter and the study referred to above by Prof. Doron, is an economics graduate from the Hebrew University and health systems management graduate from Brandeis University. He is among the architects of Israel's national health insurance law and one of the founders of the National Institute for Health Policy. Up until 2008, he served as deputy director-general for economics and health insurance at the Ministry of Health. Today, he is a lecturer in the department of health system management at Ben-Gurion University. He also is a co-editor of this book.

The reader might be wondering how such a thing as the abolition of the Parallel Tax happened in the State of Israel without a satisfactory response from the health system. As I understand it, the process leading up to the Arrangements Law of 1997 involved the Ministry of Finance's advisor on health affairs going to a meeting of the Knesset's Finance Committee where only the committee chair, Rabbi Avraham Ravitz, was present. The advisor explained to Ravitz that this was merely a technical change since the state budget would be allocating the identical sum, and the change in the funding source would only lower the cost of the work, which, we now know was erroneous. The chair, Ravitz, had replied to the Finance advisor: "I don't understand a word you said, but if you say this is solely a technicality, then I accept it." Ravitz then voted in favor of abolishing the Parallel Tax!

Then, when the Minister of Health, Yehoshua Matza,[141] came and reported to the Ministry of Health's health council that the Ministry of Finance was thinking of abolishing the Parallel Tax in the framework of the Arrangements Law, I was a member of the health council. My spontaneous response was, "The system will yet 'sit *shiva*' ('mourn') on abolition of the Parallel Tax." There were others who also spoke up against abolition of the Parallel Tax; and Minister of Health Matza took it upon himself to investigate what could be done. He returned to the council saying nothing could be done to roll things back.

Thus, four scant years after passage of the historic 1994 legislation that launched a national public health insurance system in 1995, Israel's national health insurance law underwent a change from a law that fulfilled the promise of social security in the health sector, to an insurance law that depended on, and was subject to, the whims of the state. It accelerated the slide towards the health system being managed by clerks in the Ministry of Finance. It's hard to believe, but that's the way it happened.

Introduction of Supplemental Health Insurance Plans

A so-called "achievement" of the Arrangements Law in 1998 was introduction of Supplementary Health Services (*Sherutei Briut Nosfim* or *SHABAN*, in Hebrew). In practice, this was supplementary health coverage paid out-of-pocket for services above and beyond the basket of services covered by the law. The late, Prof. Zvi Adar, a member of the executive of the National Institute for Health Policy Research, and one of the best health economists in the country, branded the *SHABAN* "one of the fathers of the blasphemies of the health system." Realities prove the truth of this charge. First of all, the *SHABAN*, in practice, divided insured person into those of means, and those without means. While it's true that statistically, some 75 percent of the population pay for this additional medical insurance, such reports cover up the fact that in high socioeconomic geographic areas there may even be 90 percent enrollment in *SHABAN*; but there are also problematic areas, not only from a socioeconomic standpoint but also when the yardstick is on medical grounds, factors that are often co-related with poverty, where the percentage of the population with such coverage is much lower. In essence, insured persons in Israel are divided into those with the ability to pay who have both public and supplementary insurance coverage, and those without the ability to pay who have only the public coverage.

The Maccabi sick fund had a program called "Maccabi Shield" that was a form of supplementary insurance before *SHABAN*. As a result, Clalit introduced supplementary insurance in order to be able to compete with Maccabi. And, in the beginning, it was claimed that the *SHABAN* was designed only for non-essential, elective, health needs. But it was clear to me, that over the years this would come to include essential health needs, and so it was. According to a 2015 government statistical report, the percentage of the health budget coming from the private resorces stood at 38 percent; the *SHABAN* has made a huge contribution to this increase. We

141 Matza had been a Likud MK from 1988 to 2002, an accountant by training, who served on many economic committees and was Minister of Health between 1996-1999.

in Israel rank together with the United States and South Korea and few other countries among the top countries in the OECD in the percentage of total national health expenditures that come from private resources.

It was clear to me from the start that supplementary insurance would lead to further services requiring supplementary coverage and would lead to even greater discrimination by means. Today, when Israelis call to set up a doctor's appointment with their sick fund in the regular public health system, before they can do so, there is a pitch for a host of special "platinum services" of one kind or another. Today it is being suggested that such 'Platinum Plans' include life-saving pharmaceuticals, with everything such means-based accessibility entails.

Another grave result of introducing SHABAN plans was the change from a concept of competition on level of a sick fund's service in the public basket, to a concept that generates competition among SHABAN plans. Put bluntly, we have gone from competition on quality of health service as an entitlement, to competition on a comfort commodity one consumes.

Introduction of Co-Payments

Another item, added to the 1998 Arrangements Law was specific co-payments. In the past, Clalit had a policy of symbolic co-payments for prescriptions, a nominal sum. But there were never co- payments for visits to doctors, and even today there is no co-payment for visits to one's primary physician. By contrast, Maccabi does have a nominal co-payment for visits to doctors. The Arrangements Law of 1998 converted the concept of symbolic, nominal co-payments, into payment of a specific percentage of the actual cost of a given pharmaceutical. This change led to a rise in the sick funds' revenues from selling pharmaceuticals from 5 percent to 11 percent, plus additional income from their pharmacies. While there were ceilings on patient expenditures, nevertheless, out-of-pocket outlays on pharmaceuticals can accrue to substantial sums.

Today, when I pay for my and my wife's prescriptions, and we enjoy a 50 percent discount as employees of Clalit, I ask myself how a senior of limited means can pay such sums. More than once the pharmacist has told me about insured persons who don't have the money to buy the pharmaceuticals they need. Then the insured person says: "This month I'll take my prescriptions, and next month I'll take my wife's"; or "I won't take such-and-such because I don't have the money." I know there is a portion of the population that vacillates between buying medicines and buying bread at the grocery.

In the years when I was a member of the Ministry of Health's health council, I often spoke against this state-of-affairs, where low-income seniors must pay for prescriptions. Each time, I was promised that this injustice would be rectified, but it has never been addressed. This appears to be the upshot of a situation where the Ministry of Finance manages health, and there is no balance between the economic considerations for the state vs. medical and social considerations for the individual.

Israelis are proud of the longevity we enjoy. Our life expectancy is one of the highest in the world for both men and women. When talk turns to the shortage of hospital beds and staff, immediately someone changes the discussion and starts to speak of the achievements of the health system. True, the achievements are impressive, but if the policies of Arrangements Laws from the mid-1990s continue, there will be a deceleration of improvements in morbidity indexes and longevity.

Proposals Not Adopted in the Arrangements Law

Ironically, things could be worse. I want to note two proposals that I am happy to say, didn't pass into law through the Arrangements Law. But, the fact the people at the Ministry of Finance dared to propose them is indicative to what an extent they were prepared to retreat from a public health system.

One proposal was to establish a for-profit sick fund. This proposal arose from the insatiable ambition for competition, and I would even label this an obsession with competition. We all know about the high costs of healthcare in the United States, the highest in the world. There is no question that had this proposal been accepted, it would have led the State of Israel down the road to a similar situation.

Another proposal that did not become law was for a differential basket of services, that is, the sick funds, as service providers would compete among one another over the types of services and pharmaceuticals they would offer. There would be competition on who offers more pharmaceuticals, who offers the newest, and so forth. This proposal is also linked to the Ministry of Finance's obsession with competition and the American perspective.

I want to share a story: When the National Health Insurance Law was passed, I was on sabbatical. I was walking the streets of San Francisco, accompanied by Prof. Mordechai Shani. He told me about the latest deliberations following passage of the Law. Among others, Shani told me that health insurance would be based on the four existing sick funds. I retorted spontaneously with a question: "Why four?!" And Shani said it was for competition. I thought then, and I still think to this day, that competition needs to be within the clinics and between medical teams.

Also, after the bill was passed into law, when we convened in New York as the international advisory committee of the National Institute for Health Policy Research, one of the participants was Prof. Stuart Altman, an internationally renowned health economist. At one point, the two of us were together. I turned to Altman and asked his opinion of health insurance being based on four sick funds. He replied: "No, you'll see. There will be many sick funds, and there will be competition." I said that with all modesty, I doubted this would happen. Today, over twenty years later, just four sick funds exist. Let me reiterate: In my view competition in the health system needs to be competition over the quality of service of the staff teams in the clinics, not competition of the type of services covered by *SHABAN's*."

Erosion of Machinery for Updating the Cost of the Basket of Health Services

It's a matter of fact that if one wants the preserve the level of the health system, it is imperative to update costs annually. In the first years of operation of the National Health Insurance Law the costs of the basket of services was only partially updated, solely accounting for population growth. Afterwards. other components were taken into account, such as age of the insureds, cost of medical equipment and pharmaceuticals on the market, wages, as well as technological changes. Updating the basket was tailored, or, more accurately, cut, to fit into the budget, not to fit the health needs of the people. This left the health system without a budget the size it needed to carry out its mission.

Privatization

Since Arrangements Laws were first introduced in the mid-1980s, the Israeli economy has witnessed creeping privatization in health matters. If this trend continues, nothing will remain of public medicine in Israel. And, it is well known that in many cases private medicine does not ensure a fitting level of medicine for all of the people who need care.

In 2015, health expenditures were 7.5 percent of the GDP in Israel at a time when the mean average for OECD countries in 2014 was 9.4 percent of the GDP. Israel is falling behind. Moreover, as already noted, in Israel in 2015, the source of total health expenditures that are private already stood at 38 percent.

To this day, those at the head of the Ministry of Finance allow the sick funds and hospitals to fall into deficits. Recently, the Minister of Health announced that a hospital that went over budget would not receive compensation to cover this. As I write, the Finance Committee of the Knesset is discussing the 90 million NIS (approximately 26 million dollar) deficit at the government-run Rambam Hospital in Haifa, and an additional deficit at the smaller Nahariya Hospital. At the end of the year, after all the deficits are closed, the horse trading with all the sick funds and hospital begins, with the government trying to pay out as little as possible. This results in deficits being carried forward for years. All this comes from the practice of only partially updating the cost of the health basket.

Another expression of this situation is the ratio of hospital beds per population, particularly in hospitals in the periphery. The winter months in particular are marked by scenes of more and more people turning to private medicine for service due to lengthy waits for the same service through normal channels of the public health system. One should keep in mind that public hospitals still lead in levels of service. When complications develop at the private hospitals, the patients are transferred to the public hospitals. While a high level of medicine still exists in public hospitals for regular patients, there is erosion of bed availability within the public system, with private beds bing supplied for patients entering under the sick funds' *SHABAN* supplementary coverage. The Maccabi sick fund was a leader in this practice when it established its network of Assuta hospitals as private hospitals funded by the commercial insurance company, Clal. Several years ago, I was very pained to hear that, fueled by competition issues, Clalit purchased private beds in the private Herzliya Medical Center.

Those who champion private medical services argue that the biggest flaw of public medicine is the lack of free choice of doctors and hospitals. This was one of the arguments in favor of the *SHABAN* plans, since they include the option for a second opinion, and choice of private surgeon, with reimbursement of some sort. In my opinion, a second opinion could be incorporated into basic insurance coverage. It is not a major expense, and it would be preferable to bolstering *SHABAN* services and private medicine.

The situation today has reached such a state, is so over the top, that prior to the opening of the new hospital in Ashdod, the Ministry of Finance agreed to Assuta's receiving public permission for building the 300 bed hospital including allotting 25 percent of the new hospital's beds as private beds. At one point, in a meeting of the health council, I proposed to the Minister of Health that this 25 percent of Assuta Ashdod's beds serve 'medical tourism' only,[142] and not divide Israeli inhabitants into "haves" and "have-nots". This year, the Ministry of Finance paid approximately 340 million NIS (98 million dollars) to Assuta so it all is beds would be public.

Summing Up the State of National Health Insurance Law Today

I was educated in the spirit of Dr. Yosef Meir's doctrine based on the principles of public medicine: an appropriate medical level; mutual liability; seeing to it that all stages of health are addressed; and ensuring money would not be a factor in relations between patient and physician. Only in the framework of a social security system and its sources of funding, can one ensure the fundamental conditions of flexibility in provision of service and long-range planning essential for maintaining such a health system.

142 For general information about medical tourism in Israel, see: https://en.wikipedia.org/wiki/Medical_tourism_in_Israel

Due to the changes in the first three years following legislation of the National Health Insurance Law, the medical system faces contradictions in the original objective of the Law. It will be difficult for the State of Israel to return to principles of justice, equality, and mutual assistance in national public health services. We cannot extricate ourselves from the complex situation the health system has fallen into by the patchwork solutions now being pursued, such as cancelling 25 percent of the private beds in Assuta Hospital in Ashdod, or other specific injustices in the *SHABAN* system, or throwing 900 million NIS (approximately 260 million dollars) at eliminating long queues.

When the doctors in the Israeli Doctors Federation wanted to organize a strike in 1983, suddenly there were loads of appointments, and after the strike suddenly there weren't appointments. In the last analysis, the doctor is the one who decides whether there is a need for any follow-up appointment and whether to summon a patient for follow-up once, twice or three times. The yardstick for such decision should be purely medical; but unfortunately, in a materialistic society, yardsticks are liable to change accordingly.

A simple patch to solve the queue problem may succeed for a few months, but it will not provide a genuine answer to fundamental problems. The true answer to the situation is to establish a new national commission of inquiry. Only such a new national inquiry commission that will examine things thoroughly can put the Law back on track to realize its original objectives.[143]

143 For further information about privatization of health care in Israel and its risks, see, pp. 25-29, in: Swirski B, Kanaaneh H, Avgar A. Health Care in Israel. The Israel Equality Monitor. Issue 9, November 1998. 32pp. Available at: https://adva.org/wp-content/uploads/2014/09/health98-eng.pdf

CHAPTER 10

The Physicians' Strike: Causes and Outcomes

Public Medicine and Private Medicine - the Backdrop to the Doctors' Strike Physicians' Salary Demands from the Public Health System Over the Years

During my medical studies, I got to know the darker side of Argentine private medical practices and totally disapproved of them. I knew what an appendectomy was, whether it was warranted or not, and other such issues.[144]

In the course of the history of the medical system in Israel, there were various changes that took place in regard to private practice. Public medicine in Israel was primarily developed by salaried physicians. Limitations on raises in salaries, attributed to concern about a domino effect on the rest of the economy or to overall budgetary limitations of the health system, created a series of crises in public medicine. In addition, one needs to take into account waves of mass immigration of doctors from Germany in the 1930s, of doctors from Russia at the end of the 1980s and early 1990s. In these waves of aliyah, the very matter of finding employment for all such immigrant physicians was very problematic. This was exacerbated by the fact that the Ministry of Health in Israel didn't engage in supervision and regulation of the health system as a whole, only in the daily management of its own hospitals. The split among government hospitals and hospitals of the sick funds and other public hospitals had an impact on disparities in the wages of doctors.

In the early years of the health system there were two cases of rebellion among the doctors. These involved their demanding the option to engage in private medicine. In 1920, there was a rebellion of Hadassah doctors against their director Dr. Iitzhak Rubinow, who championed comprehensive social security, including health, and fiercely opposed private medicine.[145] And, in 1946, at Beilinson Hospital, Dr. Sheba headed a rebellion of a group of doctors in favor of private medicine.

It was against Clalit's policy-makers.[146] The common denominator in the two events was the agreement of the doctors' employers, Hadassah and Clalit, to all the wage demands except one: private practice within the public system. Historically, Clalit has always been highly sensitive to blending and mixing public medicine with private medicine. Thus, I was very sorry when Maccabi acquired a private hospital, Assuta. And I was even sorrier when Clalit acquired beds in the private Herzliya Medical Center hospital as leverage in the competition among the sick funds.

In its first years, Clalit handled negotiating wage agreements with the personnel in its hospitals. On the other hand, government hospitals conducted wage agreements with the officer of wage control or "governor of wages" in the Ministry of Finance.[147] This led to much resentment on the part of government employees who staffed the government hospitals and fueled a sense of unfair discrimination compared to Clalit doctors.

144 According to Doron, under Argentine private medical practices there were doctors who removed appendixes based on economic considerations, even if from a medical standpoint this was unnecessary.

145 On the Hadassah doctors' revolt see: Shvarts S., De Leeuw L.A., Granit S., Benbassat J., "From Socialist Principles to Motorcycle Maintenance: The Origin and the Development of the Salaried Physicians Model in Israel Public Health Services, 1918 to1998." AJPH, 89(2)248-253, 1999, https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.89.2.248
and Ran Lachman and Shlomo Noi, Ketem Shachor al Chaluk Lavan, *Refu'a Shcho-rah b-Israel* (A Black Stain on a White Coat: Under-the-Table Medicine in Israel), Ramot Publishers and Tel Aviv University, 1998, pp. 17-26.

146 On the doctors' revolt at Beilinson, seen also Shvarts S., Health and Zionism, The Univ. of Rochester Press, 2008, pp.31-57, https://boydellandbrewer.com/9781580462792/health-and-zionism/

147 The head of the Wage and Labor Accord Unit of the Ministry of Finance is an official with legal authority under the Foundations of the Budget Law 1985 to prevent changes in wages in the public sector. The Law was enacted during the period of hyperinflation in Israel.

When I was appointed to run the medical branch of Clalit in 1976, the Minister of Finance was Yehoshua Rabinowitz, and during his tenure there was a doctor's strike. Rabinowitz appointed me the chair of the committee mandated to reach a new wage agreement. During the negotiations, I succeeded in inserting into the agreement concepts whose ramifications were a rise in doctor's earning power while at the same time being concepts that enabled one to better organize work in hospitals. These concepts remain valid to this day.

Changes in Opportunities for Private Practice

Over the years there were various developments in private medicine verses public medicine. At times, the doctors proposed permitting part-time work. But, in my opinion, there is no way one can operate a public hospital on a high level on the basis of part-time physicians. Moreover, one needs to keep in mind that the doctors didn't propose this in order to engage in a second part-time salaried position in another medical role. Rather, they wanted to engage in the identical field, only in private practice. Had this proposal been accepted, it would have led to erosion, mixing of private medicine with public medicine.[148] In the governmental system as well as in Clalit, even prior to my tenure as director-general of the sick fund, and a little, but only a little, during my period at the helm, surrender to this concept was a gradual matter. We allowed department heads to engage in a 95 percent salaried position and the rest of the time to engage in private medicine. During my tenure I narrowed this arrangement and permitted only a handful of department heads to do so, to prevent losing key staff. I made one major attempt to raise the percentage of salaried positions in the public system, in return for abolishing the right to a private practice, i.e., in exchange for raising the individual's earning power.[149] I began this kind of agreement with doctors in the Negev, but within days, the Ministry of Finance vetoed it, just as it had previously vetoed the sesión I had introduced both to fully utilize expensive hospital equipment and to have the bonus effect of raising staff wages from overtime in afternoon hours.[150]

In my view, the beginning of incursion of private medicine was the decision passed by one of the Israel Medical Association's committees decades ago. The decision was that it is none of the health system's business what a doctor does after hours. After a physician fulfilled their duties as a full- time salaried physician in a public clinic, they were free to engage in private practice. It led to a huge gap in earning capacity between various doctors, even for senior physicians and department heads who enjoyed high status in the public system and academic privileges, and so on. This was the first break in the dam that opened the floodgates to blending public and private medicine.[151]

Constant demands to enhance earning capacities, benchmarked against others in totally different lines of work, has a negative impact that is counterproductive to the objective to improve service quality.

As Israeli society has become more materialistic, the grave phenomenon of "under-the-table medicine" or "black market medicine" (refu'a schorah) has developed: There is no difference whether this occurs through a direct cash payment pocketed by the physician, or in the form

148 The term Doron uses in all his discussions of "mixing" or "blending" public medicine with private medicine refers to the prohibition of wearing garments that are a mixture (sha'atnez) of wool and linen (Leviticus 19:19). This is not merely about trying to mix technically incompatible elements, such as 'mixing oil and water'. *Sha'atnez* signals a breach of conduct that connotes adulteration of something pure.

149 The German Commission to Strengthen the Public Health System in Israel (2015) headed by Minister of Health Yael German includes the following recommendation: "Private medical services *(Sharap)* will not be allowed to expand to public hospitals -The hospitalization system will be funded from public sources."
https://www.health.gov.il/English/News_and_Events/Spokespersons_Messages/Pages/5062014_1.aspx

150 For more on this see chapters 5 & 7.

151 As for the effect on relations in the workplace, there is a particularly Israeli malady best diagnosed as a form of torticollis ('wry neck') -- everyone perpetually perking up their heads at an abnormal angle to check out the lay of the land. Each person is surveying another, then demanding for themselves the other individual's wages: The social worker is looking at the teacher, the teacher at the doctor, the doctor at the judge, and so forth. It's a hard malady to cure. The objective of work contracts is that in addition to benefits gained by the recipient, special occupational perks are also thought to enhance the service the employee renders.

of a "donation" to a departmental "research fund" or some other creative form of benefit.[152] I'm glad to say, at the community level of the health system that I was so intimately involved with for so many years, this brand of mixing of private and public medicine occurred very little.

Allowing Private Medical Services in Public Hospitals

There is an internal arrangement within each hospital as to the nature of its *SHARAP*, i.e., the private medical services that operate within the halls of public hospitals. Free choice of physician is the main principle of *SHARAP*.

As already noted briefly, the beginning of private medical services operating within public hospitals began in 1954 at Hadassah Hospital. The arrangement was introduced by Hadassah director, Prof. Kalman Mann, and later copied by other hospitals not affiliated with the Ministry of Health or Clalit, such as Shaare Zedek in Jerusalem, Laniado in Natanya, and others. The fact that the Ministry of Health did not deal with supervision and regulation of hospitals, only their daily operations, prevented the Ministry from taking a very simple and necessary step. In my opinion, it should have been able to declare that any hospital receiving patients in the framework of the sick funds, even when health insurance was voluntary, would not be permitted to have a *SHARAP*. If the Ministry could have been able to make such a decision, it could have solved the problem of earning gaps that accompanied mixing, or polluting, public medicine with private practice.

There were demands to establish a *SHARAP* at Clalit hospitals as well, but there never was a green light to do so. During my tenure, I could not conceive of such a thing as private medical services in public hospitals. I always rejected a *SHARAP* hands down, and I'm glad to say that to this day Clalit hospitals don't have them.

There have been Ministers of Health who were inclined to view the *SHARAP* as a solution to various problems, and even promised doctors such a thing in negotiations with them. That was the situation until the legal advisor to Attorney General Elyakim Rubinstein issued a clear directive to the Ministry of Health to prohibit operation of a *SHARAP* in a government-run hospital. I'm only sorry Rubinstein didn't have the authority to broaden the prohibition to encompass public hospitals. Had he been allowed to do so, the entire health system would be far more homogeneous on this score.

I already noted the signing of an agreement between Clalit and Shaare Zedek was held up precisely due to the presence of a *SHARAP* at Shaare Zedek.[153] But in the end, I had two options. I could either sign the agreement and accept the hospital's status quo, or I could abandon the idea of joint management of the hospital. We decided to sign and accept the Shaare Zedek *SHARAP*. Today, in the materialistic milieu that exists and aware of all the opportunities now for private medicine, I think the Shaare Zedek's *SHARAP* is probably the lesser of all evils. But I still don't agree with it, and I still would never initiate such an arrangement at any public hospital.

Those in favor of the *SHARAP* and private medicine in general, base their position on the argument that the patient should be allowed free choice of doctor and surgeon. They say that a person facing major surgery or a grave diagnosis will pay any sum in order to procure the best physician there is and won't stick to lofty ideologies of public medicine. They uphold free choice above the value of equality.

152 Doron is referring to what was a widespread practice -- senior physicians taking what, in essence, were bribes or extra payments for their services. These payments then become unreported income. The patient's objective in seeing these physicians and making the payments is either to cut queues and/or ensure that the senior physician would be the staff member performing a patient's operation within the public health system, not someone else on staff, such as a resident.

153 This agreement is discussed in Chapter 7

People need to understand that the capabilities of private hospitals in Israel are limited. When an operation encounters complications, the patient needs to be taken immediately to a public hospital that has all the treatment options. In addition, all the public hospitals in Israel are academic and all the departments are recognized sites for specialization -- that is, they operate on a top level, medically speaking. When a patient faces a grave diagnosis, the patient will be operated on by a highly-skilled senior surgeon.

In the conflict between free choice and equality, in my opinion, there is no reason to forgo striving for equality. Yes, there is some conflict. There are conferences on equality that are held, research on equality conducted, but no concrete steps are taken that bring equality closer and cancel inequalities in a systematic manner. Just the opposite -- steps are being taken that actually worsen inequalities.

As a member of the health council for 17 years, all the time I argued that one can rectify injustices, such as senior citizens forced to choose between groceries and prescriptions, with minimal measures. But even this injustice remains. As previously stated, the reason, unfortunately, is that the Ministry of Finance runs the health system more than the Ministry of Health does.
In my opinion, it is possible to make a number of changes that will allow choice in the public system. For instance, I don't see any objective reason against transfering the right to a second opinion from supplementary insurance, *SHABAN*, to the basic basket of health services. The only reason it remains as is, is the tremendous profits of the supplementary insurance plans from this item. A second opinion as a basic entitlement would strengthen the public medical system. Nevertheless, and despite all the talk about the danger of private medicine overwhelming public medicine, this has not been done.

I feel bound to note that free choice of hospital at the discretion of a patient's primary physician was part of the 1981 agreement between Minister of Health Eliezer Shostak and Clalit. The current way – where the sick funds pay the various hospitals – stands contradictory to such free choice. Despite speeches about equality, those who could make such reforms, do the exact opposite. It is absurd that the economic factor is the only decisive one, because in the long run, it isn't even economic We're talking about "capping".[154]

The 1983 Doctors' Strike

The Israeli Medical Association (IMA): A Professional Scientific Society or a Union for Leveraging Salary Issues?

The doctors strike between March and June of 1983 was a very painful event. I would define it as "an earthquake in the health system" that dealt a major blow to public medicine.

Yes, struggles over salary levels were always part of the health system in Israel. During my period as a primary doctor in the Negev, I experienced firsthand the struggle of Clalit's physicians. There were two facets: The first was a justified battle over wages. This emanated from the fact that during this period, the Labor Federation championed a policy of equal wages where a public bus driver and a Clalit doctor made identical wages; and the doctors revolted against this policy. Secondly, there was a struggle against the "clerks' regime" in the management of Clalit in those times.[155] The doctors viewed the clerks and administrative directors as the source of their subjugation, although this was not accurate.

154 Capping is an accounting methodology between the hospitals and the sick funds, where a consumption ceiling is set down in advance for all hospitals vis-à-vis each of the sick funds. Consumption of services beyond the ceiling is billed at a reduced rate.
155 "Clerk's regime" is what elsewhere Doron labels "the reign of the functionaries." This was essentially a regime by apparatchiks. See chapter 4, footnote 56.

At the same time, the IMA was gaining ground as a scientific union for in-service training, licensing of doctors, and so forth. Wages and working conditions of Clalit employees were handled by the union of Clalit doctors, while those of state employees were negotiated by the union of government physicians. For decades, wage issues of community doctors were negotiated directly between Clalit headquarters and doctors in the community. After Clalit doctors reached an agreement with Clalit, the agreement was applied to, and adopted by, the salaried physicians of the other sick funds.

When there were struggles, it was the Labor Federation that had the final word between Clalit doctors and the sick fund. But the Federation had a serious conflict of interest: On one hand it represented the doctors, on the other hand Clalit. This situation led Clalit doctors to distance themselves from the Labor Federation and turn to their professional organization -- the IMA -- to represent them. Over time, the IMA came to be viewed as the definitive professional representative of Israel's doctor community as government physicians followed suit. Over the years, I learned that combining a labor union that deals with wages and employment conditions and a scientific council that deals with specialization, as is the case with the IMA, is inappropriate.

The IMA was no different from other unions in suffering from the torticollis ('wry neck') malady cited at the opening of this chapter -- everyone perpetually perking up their heads at an abnormal angle to check out the wage situation next-door. Thus, the Doctors Association couldn't consummate a new agreement that raised the wages of one sector, without raising the wages of all physicians. This included department heads with private practices. In practice, this deepened the inequality in earning power of employees.

The Strike Methodology

It wasn't wage demands that bothered me, but rather the methodology of the strike. It wasn't a strike in the classical sense and structure. At the beginning, patients were treated after paying the doctor a 600 NIS fee for a hospital visit. Though there was supposed to be a fee paid to the doctors even at clinics, the clinic doctors did not identify with this idea.

When they began charging per visit, the Ministry of Health turned to the labor courts, which ruled that doctors were forbidden from charging money at hospitals. When they couldn't continue to charge at hospitals, they opened treatment service centers in hotels and similar places where they charged 600 NIS per visit.

Parallel to this, a significant number of hospital doctors just walked out, i.e., they didn't show up for work. The ramifications being clear, the Ministry of Health got no-strike restraining orders that considered doctors as essential workers forbidden to strike, and the doctors refused to honor them. In the middle of this tug-of-war, an agreement - ground rules for the strike -- was reached by Minister of Health Eliezer Shostak, and the Attorney General, Yitzhak Zamir. The principles were as follows: Hospitals could work at a third of normal capacity; all community clinics, without exception, would be closed; and the authority of hospital directors would be curtailed.

I don't know how any Minister of Health could sign such an agreement; but he did. I viewed this agreement as a calamity, and fought it tooth and nail. First of all, I saw the closure of clinics as totally irresponsible and a gross injustice from a medical standpoint. In 1983, things were not yet computerized, and the ramification of closing the clinic doors was locking-up all the medical records of patients. If prior to the strike, a person had an x-ray that showed a suspect finding, then with the clinic closed, there was no way to access the x-ray, or even to know what had

been found. Not to mention the patients who did not have 600 NIS at hand to put out for a doctor's visit to investigate or find out what was wrong.

Secondly, the agreement was riddled with contradiction and with friction between Clalit and the Ministry of Health. A situation where the Minister of Health signed an agreement to close all of Clalit's clinics was hardly conductive to amiable relations and cooperation between the Minister and the heads of Clalit. One day Minister Shostak invited himself to my office. He tried to convince me to agree to accept this agreement and fight for renewal of negotiations with the government. I refused, and told him as long as he backed closure of clinics, I couldn't accept the agreement. If he would step back from this, I could cooperate with him in anything he wanted. In retrospect, I believe closure of the clinics was an attempt to undermine Clalit, because anyone who paid the 600 NIS went to the sick fund after that to receive reimbursement. As for undercutting the authority of hospital directors: In the agreement between the Minister and the Attorney General it was also agreed that alongside each hospital director, a representative of the IMA would be appointed who would monitor the situation to ensure the director was operating according to the terms of the agreement. At the same time, a private management organization company and a public relations firm were hired by the IMA. In practice the IMA had established the machinery to replace public medicine in Israel! If this was so, at least for some of its proponents, this was not just a regular strike only to raise wages, but an attempt to undermine the very foundations of public medicine and replace the system with the "pay-for-service" system that operates in private medicine.

Before the strike broke out, I met with the chair of the IMA, Dr. Ram Yishai, whom I knew well from his years as a physician in the Negev when I was the regional director. In this meeting he didn't reveal all his cards, but he did lead me to understand the methodology of the strike, and what stood to take place. I can't forget my spontaneous reaction to his words: "If you organize the strike like all strikes, I can't support it as the employer; but all told, I'll try to help as much as possible. On the other hand, if you do so with the means you are hinting of, you should know that I'll fight it with all my might." And so it was. I'm sorry to say, I didn't have many partners in this battle.

When the strike began, I discovered that the doctors were divided in their attitudes: a portion were indeed interested in striking the system, and some viewed the strike solely as a vehicle to improve their working conditions and wages. The approach of some others took the form of a doctors' hunger strike in Beer Sheva to bring the general strike to an end.

During the strike, the Labor party was in the opposition, and Shimon Peres was the head of the party. In that Ram Yishai and I were both members of the Labor party, although not actively involved, Peres thought he could mediate between us and invited the two of us to meet with him. Nothing came of this meeting. The points of confrontation were sharp, and there was no basis for reaching an agreement between us.

Attempts to End the Strike

In light of the deadlock, I tried to think what I could do towards ending the strike, and I went about conducting negotiations with Clalit's doctors in the community. Of course, conducting negotiations with doctors in the community during a strike was nothing new or out of line. Rather, I was continuing the accepted practice of negotiation between Clalit's headquarters and its physicians. At the same time, the negotiations with the hospital doctors had been turned into negotiations between institutions: between the IMA and government ministries, first and foremost with the Ministry of Finance.

As I already noted, there were two kinds of doctors: Those who were in favor of striking the health system and those who were interested in ending the strike as fast as possible. With the latter I could engage in negotiation. The strike began in the midst of the period when I was engaged in an all- out effort to vitalize family medicine. Therefore, I had a very close partnership with doctors at the clinics, particularly with their chair, Dr. Miriam Tzangen, who was very dedicated to the principles of primary care medicine. Most of the clinic doctors who participated in the strike did so as if whipped into doing so. They were the strike's primary injured parties, since, if a patient had to pay 600 NIS for a doctor's visit, people preferred to go to a hospital doctor. Thus, the doctors at the clinics were the ones losing wages.

I conducted negotiations in coordination with the director-general of the Ministry of Health, Prof. Baruch Modan, because I knew if I would go over one of the government's "red lines," they would surely reject the agreement. Of course, in conducting negotiations with the doctors in the community I had no intention to do damage to the IMA or the hospital doctors. I fought to end the closure of the clinics, and was not in any way, shape, or form, fighting the hospital doctors. Just the opposite. I was interested in improving their wages through compensation by the government. One should not forget that at that time, Clalit had 14 hospitals.

The crux of the agreement I achieved with the clinic physicians was as follows: A marked improvement in wages; improvement of working conditions of doctors in the clinics; and progress in vitalization of family medicine. Dr. Miriam Tzangen, as chair of Clalit Physicians Association, wasn't compelled to bring the agreement for approval of the IMA because there had never been such a thing in past negotiations. But she was straight as an arrow; and she did not want the agreement to appear in any way as a stab in the back to the hospital doctors. In a small forum of the IMA's leaders, the agreement squeaked by, by a margin of one vote; and in a broader forum, it failed to pass. This was not because they objected to the agreement itself, but rather out of fear it would undermine the struggle and the negotiations with the hospital doctors. In the meantime, the clinics remained closed. It should be kept in mind that after the strike, all of the sectors of the IMA voted unanimously in favor of Dr. Miram Tzangen chairing the organization.

In other words, I fought almost single-handedly against this strike. The Labor Federation took a neutral stand vis-à-vis the strike, in a best-case scenario, taking no part in events.[156] After a time, the Labor Federation's secretary convened a meeting with the most militant doctors, as if to signal that it was Clalit that should have made accommodations with them.

The doctors who wanted a swift end to the strike because they were pained by the damage it was rendering to public medicine, chose to declare a hunger strike. It was not coincidental that the hunger strike broke out in Beer Sheva where we established a school of medicine infused with the spirit of community medicine and dedication to the health needs of the public-at-large. In fact, the hospital doctors in Beer Sheva demanded the strike be ended quickly in the interest of public medicine. Out of the blue, the Labor Federation secretary at the time, Yeruham Meshel, convinced me to visit the hunger strikers in Beer Sheva. This meeting was rife with a sense of deep anguish and tremendous sorrow.

When things became too much, Prof. Mordechai Shani, director of the Sheba Medical Center, and I, went to Jerusalem to meet with Prime Minister Menachem Begin. It was evident that Begin found it hard to hear us, but made a great effort to listen; and the meeting had a positive effect. I don't know if it was because the two of us appeared together[157] or some other reason. Whatever was the case, together, we convinced him that from a medical standpoint the strike

156 Doron, by mentioning "best case scenario" seems to be alluding to what worried him if the Labor Federation got involved, namely, that the Federation would have exploited the strike as part of the political opposition to Menachem Begin's government and the Likud Party. In contrast, Doron's concerns were what he believed to be in the best interests of an enlightened public health system.
157 Doron and Shani represented rival camps of government doctors and Clalit doctors that had joined ranks for this meeting.

could not continue. Several days later, Begin headed a meeting of the cabinet where he ordered the Ministry of Finance to end the strike.

The Results of the Strike

Did I err in seeing the strike as so grave? First of all, it is my duty to say that this strike caused something appalling. It led to poorer health status of some patients, failure to diagnose disease, and more.

Researcher Yael Yishai wrote in her work, The Power of Expertise, "The doctors strike accelerated the phenomenon of under-the-table medicine, because each person needs to take care of themselves in whatever form that appears appropriate to them, and many times without taking into account ethical qualifications, work norms and work discipline, without which good medicine will not be provided."[158]

The aspects of this strike that led to such deep pain were, first, the grave blow to public medicine. Secondly, opening the floodgates to monetary greed in public medicine in the State of Israel. Thirdly, failure by close associates of mine to see what it would give birth to. These were people I appointed and was genuinely close to, and they believed, like me, in public medicine. But in the end, I was almost alone in this struggle.

After the strike, I appointed a committee, headed by Prof. Lechaim Naggan who was the second dean of the school of medicine in Beer Sheva. It was called the "Committee to Reevaluate [Clalit] Sick Fund Services." It was comprised of some of the best people in the system, and its recommendations were to continue the reforms we had dealt with prior to the strike. There were also other serious reexaminations of the situation in the health system, including those of the Beer Sheva medical school's department of epidemiology and evaluation of health services, research that provided proof of the genuine medical damage to patients during the strike.

Prof. Shimon Glick, the third dean of the Beer Sheva medical school wrote in the Journal of Medical Ethics in 1985: "There is little justification for strikes in general, still less for doctors' strikes." He asks, "Should not doctors rather 'stand above the common herd' and set an example?" Furthermore, Prof. Glick feels that the whole idea of strikes in which a third and innocent party is deliberately punished in order to apply pressure on someone else is "a bizarre ethic indeed" and not to his knowledge justified under any ethical theory.[159]

I want to add a closing personal comment about the strike: My hair never turned gray over decades. But if I have any gray hairs on my head, they were caused by the strike. This was a crisis that is hard even to describe.

My Resignation as Clalit's Director-General in 1988

There were several reasons for my resignation as director-general of Clalit. There was a man in Argentina whose name was Vito Dumas who, in 1942, wanted to sail the seas single-handed, passion-driven by this pursuit. At one particular point, I likened myself to Vito Dumas, in 'staying the course' in my responsibility for Clalit. The reasons behind the establishment of the Netanyahu Commission were the same reasons that led to my resignation: The situation was that there was an inadequate budget and no chance of getting an adequate budget. The Labor Federation was a poor source of support, and I didn't receive enough support from the Prime Minister either. In the end analysis, it wasn't in my power to bring about change in the situation. Adding to this, due to the strike of 1983, I was deeply disappointed by the physicians.

158 Yael Ishai, "Interest groups in Israel: a test of democracy", Am Oved, 1987.
159 Glick SM. "Physicians' strikes--a rejoinder", *Journal of Medical Ethics*. 1985;11(4):196-197. https://jme.bmj.com/content/medethics/11/4/196.full.pdf

I consulted with a relative who at the time was a senior lecturer in organizational science at Bar- Ilan and Tel Aviv Universities. I described my predicament to him. It took him several days to analyze the situation. He returned to me saying: "Haim, you have no chance of changing the situation in your position. Resign." The next day, at 7:00 AM, I called my secretary, Shoshana Kozak, into my office and dictated my resignation letter to her. I didn't want my resignation to be interpreted as a struggle against certain people or certain institutions. I said that after 35 years at Clalit, it was time for a change at the helm, and since in another few months Clalit would be holding its convention, I was announcing now that I would not be standing for reelection during the convention.

My resignation reached the secretary of the Labor Federation, Yisrael Kessar, the same morning. He summoned me for a talk, seeking to find out whether in this move I was going against him or against the Federation. He asked me why I was resigning, and I told him exactly what I had written in my resignation letter - no more, no less. I didn't leave any leeway for arguing or for misinterpretations. Nevertheless, I went to be interviewed on the Voice of Israel radio and shared my decision not to stand for reelection at the upcoming convention with the public. Thus, I completed 35 years of service in Clalit, and I don't feel I had any other choice. I viewed my resignation as the end of a certain chapter in my work within the health system in Israel, but not the last chapter.

CHAPTER 11

Health Policy and Health Services Research: My Endeavors after Leaving Clalit

Israel's National Institute for Health Policy and Health Services Research
Efforts to Guide Health Policy Issues during my Tenure at Clalit's Headquarters

In the first stages of establishing a medical school in Beer Sheva, I got to know Prof. Cecil Sheps[160] who was an eminent American figure in public health. We became acquainted at the University of North Carolina and became good friends. During my tenure as the medical director and then as director-general of Clalit, I recognized the need to appoint someone of Sheps' stature as an advisor for the organization of the sick fund's health services.

One day, I was sitting in a consultation meeting with Sheps, and I told him that Clalit had 30,000 employees in all positions. I wanted to ask his advice about how to organize their training. With this objective in mind, Sheps brought with him one of the senior directors of health in the United States. They traveled across the country together, visiting Clalit's institutions and submitted a report. In accordance with the report's conclusions, I established an institute for employee training, and located it in the training center's prefabs, facing Beilinson Hospital in Petach Tikva.

When I left Clalit, I was presented with an office in this training center where I worked for several years, a room with a secretary and another room that served as an archive. I appointed an international advisory commission headed by Prof. Martin Cherkasky, who for many years was director of the Albert Einstein Hospital affiliated with Yeshiva University in New York.

Prof. Saul Farber, Dean of NYU's School of Medicine, and Prof. Howard Newman,[161] an expert in the field of healthcare administration and Dean of NYU's Wagner School of Public Service, served on the committee. The committee would convene approximately once a year and all the members were consultants to Clalit. It never occurred to those who had preceded me in my senior posts at Clalit headquarters to consult with an outsider or have an advisory panel of international experts. They viewed the sick fund and its problems within the boundaries of local realities, and they approached such problems from a day-to-day operations perspective. But I had a broader mamlachti approach to the role of the institution. This was the first step leading to establishment of a national institute to examine health policy and health service performance.

I completed my leadership roles in Clalit with the convention held in May 1988. After twenty-seven years of service in three key roles in Clalit, and in light of the experience I had gained, I believed health policy and research of health services was an important topic that the State of Israel needed to develop. I also felt this realm was germane to the health system as a whole in Israel, not just Clalit, and I decided to focus on this matter after I left Clalit. In short, I felt that what I and my predecessors knew about the system, gained from our experience and dedication to health matters, was not enough. There was a need for research and analysis of the data to inform development of health policy and further development of management tools for the future.

160 Prof. Cecil G. Sheps (1913-2004) was a physician and scholar who founded the Center for Health Service Research at the University of North Carolina - Chapel Hill (UNC-CH), which, in 1991, was named for him. Between 1980- 1988, he served as organizational advisor to Clalit.
161 Prof. Howard Neil Nauman (1935-2011) was a specialist in health systems management and public health. He was a manager in the Health Care Financing Administration in the US during the Carter Administration (1976-1980). He later served as dean of NYU's Robert F. Wagner School of Public Service (1988-1994) and was a professor of healthcare administration. He was knowledgeable about the Israel health system and served on the American advisory council of the Brookdale Institute in Israel.

I had already been involved in the issue of management tools while still at Clalit. Even prior to establishment of a national institute to inform health policy, Mordechai Shani, the director at Sheba medical center, and I had established a center for public health that operated for a short time. We asked Shmuel Pinchas, director-general of Hadassah, to prepare the first study under its auspices, a study on medical personnel planning for Israel. After several months of operation of the center, Prof. Dan Michaeli, director-general of the Ministry of Health at the time, vetoed the plan. He felt establishment of an institute for health policy trespassed on roles that belonged to the Ministry of Health. In this, deputy director-general Shraga Haber also agreed. This, I dare say, involved a total lack of understanding of the role of such a center or institute. While Motta Gur, who was Minister of Health, agreed with us, he was unable to convince Michaeli.

Three weeks before I left my post as Clalit director-general, I convened a day conference at the Arza Rest & Recuperation facility in the Jerusalem foothills. The group devoted a full day to discussing health policy and health services research in Israel. In addition, I convened at Arza a meeting of Clalit's advisory committee. Also present at the gathering were John Beck, a distinguished academic physician, who at the time was the chair of an international advisory committee of the school of medicine in the Negev; Prof. Shimon Glick; Prof. Mordechai Shani;

and several other individuals whose experience and expertise could make a significant contribution to such a gathering. The main conclusion of the conference was that there was a need to establish a center to discuss health policy and research of health services in Israel on an academic level. Incidentally, I thought it needed to be situated in the Negev.[162]

A Sabbatical Invested in First Steps towards Founding a National Institute for Health Policy
With my retirement from Clalit in 1988, I went on sabbatical. I decided to devote my sabbatical year to health services research and the establishment of a health policy institute in Israel. I asked my friend Prof. Sheps to assist me organize a suitable sabbatical program. He not only did so, he got in touch with the heads of all the centers I was scheduled to visit during my sabbatical, and developed a coordinated program at the four centers: In addition to the University of North Carolina, there were the Kings Fund in London; Brandeis University's Heller School for Social Policy and Management in the Boston area, headed by Prof. Stuart Altman; and the University of California San Francisco (UCSF). All four arranged lodging and everything else. Sheps even set up meetings at various institutions, as well including, importantly, the NIH (National Institutes of Health) in Washington.

During the year, at NIH, and during visits to the other institutions set up by Sheps, I learned a lot in the course of a series of face-to-face meetings with researchers in various aspects of healthcare and management. At the same time, I began to investigate where we could find funding for establishing our own modest NIH for health policy and health service research. In this endeavor, my first step was to contact Prof. Martin Cherkasky. Parallel to his position as director of Albert Einstein Hospital, he was involved in the American Jewish Joint Distribution Committee (JDC),[163] where he tried to mobilize funding, without success.

In San Francisco, I was an official guest of UCSF's Institute for Health Policy Studies, and in the course of my sojourn I encountered a number of researchers who subsequently I would invite to our conferences on healthcare in Israel. Among them was Prof. Philip R. Lee, who founded the Institute in 1972 and served as its director until 1993. In retrospect, he was the most impressive individual I would encounter during my sabbatical. Prof. Lee was a great admirer of Israel. He invited me to teach a seminar at the Institute on the health system in Israel. Afterwards, in 1993, Lee was tapped to serve as United States Assistant Secretary for

162 Prof. Doron stated that "My ties with the Negev remain unbroken to this day, even if physically I don't live there today." As noted in Chapter 2, he was forced to leave Beer Sheva due to his working long hours in Tel Aviv.
163 The JDC was founded in 1914, initially to provide assistance to Jews living in Palestine under Turkish rule. https://en.wikipedia.org/wiki/American_Jewish_Joint_Distribution_Committee

Health and Scientific Affairs under President Bill Clinton. He had served in the same capacity under President Lyndon B. Johnson from 1965 to 1969. During the years Prof. Lee was in Washington as Assistant Secretary, I visited him many times. He was very supportive in many ways, one evening even holding a reception at his house for me and my wife with dozens of people in attendance whom it was important to know. Among those Lee had invited to meet me was the head of the San Francisco- based Koret Foundation. Lee expected the Koret Foundation would want to underwrite our national institute. After I met the Foundation's people, I set up a meeting with them in San Francisco.

As I've said before, I believed that establishment of a national institute for health policy research wasn't just the province of the sick funds and health insurances. I held that such an institute needed as broad a coalition as possible within the health system, and I aspired to make the government medical institutions an integral part of this endeavor. Therefore, I didn't want to negotiate with the Koret Foundation on my own.[164] I approached Prof. Mordechai Shani, who was already involved in preparations and consultations surrounding the national health insurance bill, requested he come to San Francisco to get acquainted with Prof. Lee, and indicated that together with Prof. Lee we meet with the heads of the Koret Foundation. And so it was.

Prof. Lee was pleased to meet Shani, and the three of us went together to meet with the Foundation heads. But at a certain stage, another Israeli entity had approached the Koret Foundation seeking their support, and the Koret Foundation heads decided the other group's objective was more important to them than a health policy institute in Israel. Thus, the initiative to obtain Koret Foundation backing ended, and the "romance" petered out.

The year was 1989, and we returned to Israel empty-handed. At this time in my life, I was engaged in three areas on a volunteer basis: health policy in the Negev; absorption of new immigrant doctors; and continuing development and research of family medicine in Israel, including establishment of the Rambam Network.

The Center for Health Policy in the Negev

A core initiative that occupied me at this time was the establishment of the center for health policy in the Negev. In the first stages, the center's main thrust was tied to vitalization of family medicine. Prof. Lechaim Naggan, who had become vice president for research at BGU, introduced me to a South African philanthropist whose husband had donated in the past to the University. She gave a generous donation that could be invested in family medicine research. With it we established the Rambam Network for Family Medicine Research that operates to this day, and also carried out discussions of health policy in Beer Sheva.

In the framework of the Center for Health Policy in the Negev, we organized the SELA program which I linked to absorption of immigrant physicians from the Soviet Union. After careful selection, a group of young doctors from the Soviet Union received funding under the program to specialize in family medicine. It included two years of specialization in a hospital and two years in a clinic. They had to pass the two-level medical boards for specialization, but once they passed, we ensured them employment in whatever area of the country they chose. One of the Beer Sheva people did a study that revealed the exam scores of this group of immigrant doctors were higher than those of native Israelis sitting for the exams.

During this period, I also taught in the department for health systems management at the Faculty of Health Sciences at BGU. At the time, there was only an undergraduate degree in

164 Koret Foundation: a private foundation established in San Francisco, California in 1978, is dedicated to strengthening the local Jewish community and continuity of the Jewish People worldwide.

health management. The courses I taught dealt with international health systems, and other relevant topics.

Establishing the National Institute for Health Policy and Health Services Research in Israel At the same time that I was actively involved in absorption of immigrant doctors and with establishing the Rambam Network for Family Medicine Research in Beer Sheva, I also was promoting the establishment of a national institute for health policy research. We were a handful of people who championed this idea: Prof. Mordechai Shani and Prof. Gabi Bin Nun were partners with me in this initiative. We formulated the objectives in the field of health policy and the field of health services research.

And, of course, we thought a lot about how to fund such an institute. At the outset of preparation of the national health insurance law, clause 52 of the draft addressed only the role of a health council. We decided to incorporate a research institute into the law, via this clause: Back in 1973, the compulsory Parallel Tax Law had been passed. The Minister of Labor at the time, Yosef Almogi, viewed it as one of the first laws paving the way for a full-blown National Health Insurance Law Through this law, he sought to bypass the opposition of the Labor Federation to a national law. At the time the 1973 legislation was being formulated, he came to consult with us at Clalit about the bill. I went to talk to the president of Tel Aviv University, Prof. Yuval Ne'eman. I told him we needed money for occupational health research - that it was a shared interest of the University and the sick funds. Therefore, I suggested we both press the idea that the Parallel Tax law carry a clause with a reasonable sum, 0.01% of the budget, being earmarked for research. He was very taken by my suggestion and succeeded with my active support in inserting this clause in the Parallel Tax Law.

When in the mid 1990s, the time was finally ripe for passage of a national health insurance law I told Prof. Mordechai Shani that this model was the way to go and we should press for inclusion of a clause such as this in the national health insurance bill. We succeeded in inserting the clause about the need for a health council and that a research institute would be funded to serve it. The National Institute's operations hinge on the health council and are funded under clause 52 of the National Health Insurance Law. Formally, the health council is the public body within whose framework the National Institute operates. This clause in the Law enables the National Institute to support its research and publish its reports to this day.

I was a member of the health council from 1999 until 2016. I was repeatedly appointed for an additional term although I never asked for this position. The composition of the council, however, was politicized according to sick funds, and so were its deliberations: The controversies and positions were often along party lines between MKs (members of the Knesset) from the Coalition in power and MKs from the Opposition. I didn't think the council's structure was a good way to operate, but that was Israeli reality. Thus, at the center of the health council stood long-existing antagonisms and differences between Clalit and the Ministry of Health, and between the rival party affiliations that colored each institution on the council. I believed one of the most important objectives was to create a neutral place where everyone could fit, including all the sick funds, all the medical institutes, all the schools of medicine, and all the research institutions dealing with the health system. This was a central objective of the National Institute, and one of its primary achievements. In all the operations of the Institute, all participate. The Institute carries its own "National Institute spirit," one of collaboration and cooperation; and future generations must know that this important objective should never be compromised.

Among other roles, the Institute is responsible for operating the national Program for Quality Indicators of Community Medicine[165] that was spawned by research on the feasibility of formulating community health quality indicators. The research originated in Beer Sheva. The Program was set in motion by the National Institute in an agreement with the Ministry of Health that the Program's budget would come from within the Institute's budget. There are those who give more weight to competition among the sick funds than I do, and there are those who give it less weight, but all would admit that the Indicators Program played a major part in the OECD's praise of the community health system in Israel, defining it as one of the best among among OECD countries, an achievement that shouldn't be belittled.[166] Even China has approached the Institute requesting to learn from Israel how to organize community health indicators.

The Work of the National Institute

The National Institute holds an international conference. The conference has a history going back to my years at Clalit as I strived to broaden the perspective of discussion on problems in the health system. Because many of the problems in the health system are shared by various other countries in the world, I viewed an international outreach as a very important matter; and up until a number of years ago, I coordinated this endeavor. Today, responsibility for it rests with Prof. Shlomo Mor Yosef.[167]

But I need to back up a bit to share some additional information on how the National Institute came into operation: During my sabbatical in the USA and the UK, I decided to stop at the World Health Organization (WHO) headquarters in Geneva, in order to meet with an Israeli serving in a senior position there, Dr. Yehoshua Cohen. Cohen had been a veteran in the Israeli Ministry of Health, dealing with hospital planning. He collaborated closely with Moshe Soroka in this area; and unlike others, his relationship with Clalit's people was very good. Afterwards, for 19 years Yehoshua Cohen had served as the right-hand man to the director-general of WHO.

His experience was unique. As the senior health policy advisor to the director-general, he was the one who formulated WHO's "Health for All" program. I knew of him and we were sightly acquainted. Prior to my sabbatical I called Cohen and requested to meet with him in Geneva to consult with him about the international activity of the future national institute. At this point, plans for the Institute were only in the thinking stage. As we sat, he told me he would be returning to Israel soon. I told him, if so, I wanted him to join our work establishing the Institute. He arrived back home when the Institute was already in existence, and he joined its operations. He was responsible for running the National Institute's first interntional conference, which was very successful.

The head of the international department at the Institute was Pnina Herzog.[168] She had a warm attitude towards Clalit, and we were close on a personal plane. Pnina Herzog would invite us as guests to receptions at her home. At one juncture, she asked me to act as a state envoy to the WHO Office for Europe in Copenhagen on a particular apect of primary medicine and I did so. She also requested we at Clalit prepare an annual report on the state of health in Israel for WHO, which I did collaboratively with Dr. Yehoshua Cohen.

165 The Program for Quality Indicators began as an initiative of a group of scholars at Ben-Gurion University of the Negev in collaboration with the four sick funds. It was underwritten by the National Institute for Health Policy Research. The underlying research developed a system of uniform indicators for measuring the quality of community medicine in a manner that would enable reliable evaluation of the quality of care, based on national and international goals and benchmarks, as well as trends in performance over time. In 2004, the quality indicators were adopted by the Ministry of Health and became a national program operating on a permanent footing.

166 See Chapter 5 and Footnote 67.

167 Prof. Shlomo Mor Yosef (1951-) is a 1980 graduate of Hebrew University's medical school. He was Director- General of Hadassah Hospital for 11 years, concluding in 2011. Between 2012-2016, he was the Director-General of the Bituach Leumi, the National Insurance Institute of Israel, and from 2017-2021, he was the Director-General of the
Population and Immigration Authority. He was the Chairman of the Board of the Israel National Institute for Health Policy Research between the years 2008-2014.

168 Pnina Herzog (1925-2005) was a pharmacist and a PhD. She worked in public health in Israel in various positions related to drugs and drug trials. This led to her having several roles with the World Health Organization.

The National Institute's annual Dead Sea Conference has allowed many deliberations on aspects of operations. The structure of the gatherings that exists to this day did not evolve in stages as conferences were held. Rather the structure of deliberations was built after careful planning by committees. Of course, each conference involved small changes here and there, but the general framework was to choose a core topic that concerned the health system, and afterwards to break into workshops, sometime with guests from abroad, to share ideas and experiences of experts from other countries.

There was also a second local conference of Israelis hosted by the Institute annually and attended by some 700 participants from all the relevant occupations. It was an example of how the work at the Institute seeks to integrate all the professions in the health system. It is reflected in the participation of everyone, that is, people from different disciplines coming from different perspectives of the system to have discussions of research studies that the Institute has promoted.

As for the topics for research, from the start the Institute defined three core research areas: organization of health services, health economics, and quality of health services. Today, in addition, one special topic is added every year devoted to a current need. Sometimes, the Institute asked the health council to recommend topics for research, but there was not much response to these requests. Today the director-general of the Ministry of Health is cognizant of the Institute's work and its achievements, and sometimes raises topics for study that the Institute is glad, of course, to incorporate in its work. The deliberations at the Institute's conferences are published, and there are platforms for further discussion. such as the Scholars' Forum.[169]

If there is a message here for future generations, it is that the following things fundamentally changed the character and quality of health management in Israel: The presence of the Institute and its work; inauguration of studies in health management in all institutions of higher learning, a process impacted, without question, by the Institute; and changes in health management that I embarked on at Clalit. All three set in motion what I would label a Renaissance of enlightened health management in the State of Israel.

Absorbing Immigrant Physicians from the Former Soviet Union

In 1988, a short time before my service as director-general of Clalit drew to a close, or a bit afterwards, I was invited to a meeting at the Ministry of Health with two government ministers: Minister of Health Yaakov Tzur and Minister of Immigrant Absorption Yitzhak Haim Peretz. We discussed the question of how best to absorb the huge number of physicians expected to arrive in the approaching wave of mass aliyah from the Soviet Union. A committee was appointed and I was asked to head it. I proposed the composition of the committee members be Prof. Shimon Glick from Beer Sheva; Prof. Arieh Harel,[170] the director of Ichalov Hospital in Tel Aviv and a former ambassador to Moscow; and Dr. Peter Vardi, the head of the Ministry of Health's medical personnel department, whose participation was clearly essential. After my resignation as director- general, we began work, setting up shop in Clalit's training center where I had been given an office. Originally, we were told that positions (job slots) had been found for two thousand doctors. But then every week, I was receiving a call from Yossi Kochick, deputy director-general of the Ministry of Health, to find "solutions" for another five hundred doctors, then another five hundred, based upon the updates they were getting from inside the Soviet Union.

169 In the first year of the Institute's operations, the Scholars' Forum (in Hebrew, moadon chokrim or "Researchers' Club") was founded. The objective of the Scholars' Forum was to facilitate open discussion on a range of problems in different realms of health policy and health services. with expectations that the interaction among researchers and senior officials would lead to fertile discussion – to reach conclusions, map avenues for implementing the findings of the research, plot future policy, and use the input to continue discourse.

170 Aryeh Harel, formerly Sternberg (1911-1998) was born in Kyiv and studied medicine in Imperial Russia. He immigrated to Israel in 1937 and was both a hospital administrator and professor of endocrinology. He was the director of Ichalov Hospital and president of the Magen David Adom. He served as Israel's ambassador to the USSR from 1959-1962.

We faced a difficult problem since Russia gave three, very different, doctor of medicine degrees: MD; geriatrician; and "hygienic doctor of public health." a doctor in preventive medicine. We could do very little with such public health doctors.

We opened a special program based on my previous experience in absorbing doctors from Latin America. It consisted, first of all, on attaining Hebrew mastery in intensive ulpan; afterwards courses to familiarize the doctors with the Israeli health system; and then a year of hands-on experience. In this manner, some 20,000 doctors were absorbed out of one million immigrants from the former Soviet Union who made aliyah in the early 1990s! This period was marked by receipt of countless distraught phone calls from immigrant physicians: "I'm, a doctor and I'm sweeping streets for a living" or "I'm unemployed" and so forth -- that needed to be addressed as best as possible.[171]

The School of Health Professions at Tel Aviv University

One night when I was on sabbatical in San Francisco, I received a telephone call at 3:00 AM from the dean of Tel-Aviv University (TAU), Prof. Oded Sperling. Sperling explained to me (still half- asleep) that he was interested in establishing a school for health professions at his university, and various individuals had suggested he turn to me to head it. I told him that I was focused on dedicating my work to health policy, and not this subject. If he needed an immediate answer, my answer was "no," but when I got back to Israel, we could discuss the matter so I could evaluate what was involved.

When I did return to Israel, I learned that between 1968-1985, four study programs had been established in the Faculty of Medicine at TAU: nursing, communications disorders, physiotherapy, and occupational therapy. The driving forces behind these departments were Prof. M. Rubinstein in communication disorders, who today is head of the audiology institute at Sheba Hospital; Prof. R. Rozen in physiotherapy and occupational therapy; and Prof. Rivka Bergman, a pioneer in academization of nursing in Israel, for whom I had the utmost respect. I also had great respect for such departments because in an era of chronic diseases, collaboration between medicine and these professions is critical. This was the primary reason I looked favorably on the offer. It resonated with my belief in teamwork. A physician working together with other health professionals, mainly the nurse, was essential in primary medicine. Therefore, I embarked on negotiations with Tel Aviv University's people, and in the end accepted the position to establish the new school within the Faculty of Medicine.

Once a week I would commute between Tel Aviv University and Beer Sheva to take forward the topic I most wanted to address – health policy. I established the center for health policy in the Negev, and for a time, even lectured in a course in health management in Beer Sheva.

The first thing I did at Tel Aviv University was to banish the terminology I opposed: I felt the term in parlance at the time, "paramedical professions," conveyed that these professions served medicine in some way. But the term "health professions" conveyed the correct status of these professions in the health system, all the more so in the rehabilitative realm.

I set down for myself the requisites for establishing a school of health professions. First and foremost, its organizational structure, founding standards, and of course, building its budget. Temporarily, we housed the faculty of occupational therapy in the dentistry building. I knew from the outset that the already crowded physical plant of Tel Aviv University's Faculty of Medicine was not suitable for these subjects; and I invested all my powers and prowess in obtaining backing for construction of a new building for the School of Health Professions. After

171 Nurit Nirel and Baruch Rozen *"Ha-Migamot b-Ha'asakat Rof'im b-Edan shel Yisum Chok Bituach Bri'ut Mamlachti"* (Trends in Employment of Doctors in an Era of Implementation of the National Health Insurance Law) Bitachon Sotzi'ali, March 2004, No. 65, pp. 55-83.

great efforts over several years, I succeeded in obtaining the money. We established a special planning committee,

which I chaired, that guided construction of the 3,000 square-meter building. The cornerstone was laid in May 1996, and today the School of Health Professions stands proudly on campus flanked by the buildings of the medical school and dentistry school. The building serves three majors: nursing, physiotherapy, and occupational therapy. The program in communication disorders operates primarily out of the audiology institute of Sheba Hospital.

We established a research unit. One of its functions was mapping the needs for faculty research. There was an interdisciplinary research committee that had members from all the fields. I considered it to be very important. Another function was providing faculty assistance in their research. We consolidated statistical support for the school faculty. The research unit also collected and disseminated data on research methods; and it created workshops for faculty and graduate students. A special grant fund was set up to assist in research work. The fund was graciously backed by philanthropist Irving Schneider whose one proviso was that funding for research be earmarked for pediatric health research.

I viewed with favor joint coursework across majors. This is still my position, but such shared curricula did not take off. I tried, but each major in the university is very "patriotic" about its profession and jealously guards its turf as unique to the specialty. I was unable to break down the walls that separate these health professions. I visited a university near Stockholm that had developed this concept within the framework of the World Health Organization, but my successes in Israel in this regard were limited.

Nevertheless, there were joint studies among students in physiotherapy and occupational therapy in the fields of anthropology, sociology, pathology, neurology, physiology, neuroanatomy, and introduction to psychology. In the nursing major, there was a course labeled "holistic treatment of the person and his family by health professionals." But beyond this, to be honest, I did not succeed in integrating studies between the majors. I tried to establish an additional major, optometry, on a high level. At the time, this specialty was not studied on a high level in Israel, and there was only one school of this profession in the country. But this initiative clashed with aspirations of the Minister of Education, Amnon Rubenstein, to develop, or upgrade, the regional colleges in Israel. He held that such studies as optometry needed to be conducted in the colleges, not in the universities. I believe this is a mistake: These specialties can be equally taught at colleges or universities. Be what may, his stand on this issue put the brakes on my aspirations to further expand the School of Health Professions.

In the seven years of operation during which I served as dean of the School of Health Professionals student enrollment rose from 941 to 1,607. These numbers don't include immigrant medical students taking introductory courses, and students enrolled in ongoing education programs. Although the university offered me the option to continue as dean, l proposed that Prof. Hanan Munitz take over the deanship of the school and I turned to focusing on health policy on a volunteer basis.

EPILOGUE

Looking Towards the Future

If I had to relay to the coming generations some of the perspectives and basic conclusions that I have arrived at in the course of my work in the Israeli health system, as traced in this book, I would sum them up as follows:

Family medicine as a recognized specialization is the foundation for good public medicine. This is all the more so in an era of super-specialization and technological developments that fragment medicine more and more. One should view the future of family medicine as a national priority that to a large extent will determine the quality of medicine in the State of Israel. The future of specialization in family medicine hinges to a great extent on incentives that it is imperative the state give to training and practicing in the periphery vs. the center of Israel. The incentives can be general for all fields of specialization. There is special importance of the role to be played by the medical schools in Israel. They need to strengthen their departments of family medicine.

The establishment of the Faculty of Health Sciences in the Negev, within the flourishing university in Beer Sheva with its high educational standards, is not just a contribution to Beer Sheva and the Negev. This Faculty contributes to medical education in Israel as a whole and to the level of medical services, education, and research in the State of Israel. The concept "the Beer Sheva spirit"[172] is reflected in the character of the work of every Ben-Gurion University medical school graduate in hospitals and the level of services of community medicine in the Negev. This is not diminished, even if I may have had higher hopes in this regard.

Among my endeavors in Beer Sheva, I should cite the first organized initiative to absorb new immigrant doctors, a revolutionary program that became a model for absorption of immigrant physicians from other countries. It was so successful that 90 percent of participants in the original Latin American program stayed in Israel.

As for the National Health Insurance Law, I see special importance to my testimony before the Netanyahu Commission, and the impact of Clalit in testimony presented to the Commission. I believe such testimony was not in vain and influenced the conclusions of the Commission. This was particularly in regard to the clause on personnel.[173] Vitalization of family medicine was a core matter in the operations of Clalit, and I imagine my testimony before the Commission had an impact on this section of their report.

The National Institute for Health Policy Research is a central body that unites all sectors of the health system in the country and incorporates all health professions. It has led to both development of research in the health services field and development of health management studies at the universities. These have contributed to a complete revolution in medical management becoming a profession, not merely an occupation.

All these need to be further strengthened. With them it will be possible to preserve egalitarian public medicine that has been and must continue to be, a source of pride for generations to come, and a benchmark and model for others around the world.

172 See Chapter 3, Footnote 38.
173 "The status of family medicine and the family doctor must be strengthened...Shifting the center of medical care to the community..." in The Netanyahu Commission - an Inquiry into the Role and the Efficiency of the Health System, Jerusalem, 1990, page 379

PHOTOGRAPHS

Haim Doron and Neomi Gutman Doron - wedding celebration
Buenos Aires; October 18, 1952 *

The Dorons, with their oldest child, Yeshayahu, visiting a Clalit clinic
in an immigrants' village in the Negev - Moshav Nevatim, 1955 *

With David Ben-Gurion – 1965 *

Speaking at the opening ceremony of the University Center for Health Sciences in the Negev – November 19, 1974. Sitting to the left of Prof. Doron: Moshe Prywes, founding dean; U.S. Senator Edward Kennedy; Golda Meir, Prime Minister of Israel; Prof. Rosen, Rector. *

Touring a newly constructed Clalit clinic with Prof. Shmuel Reis and planting a cedar tree. Misgav, Northern Israel. 1984 **

Speaking at a conference of the National Institute
for Health Care Policy. 2005 ***

Discussion at the National Medical Education Workshop – 2009. Prof. Mordechai Shani on the dais, Haim Doron, first row on the left; Prof. Shimon Glick, second row on the left. ***

Prof. Mordechai Shani ***

Neomi & Haim Doron, Prof. Shifra Shvarts ***

With Shlomo Mor Yosef at the National Medical Education Workshop ***

With Gabi Bin Nun and Jonathan Halevy at a Dead Sea Conference ***

Haim & Neomi Doron with their children, grandchildren, and great-grandchildren
2016, Kibbutz Lavi *

Photographs courtesy of:
Hana Holland, daughter of Neomi & Haim Doron *
Prof. Shmuel Reis **
Ziva Litvak, managing director, National Institute for Health Policy Research ***

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