Health Services*

Survey findings indicate that Israelis are satisfied with the health services provided by the health system. Various indicators of the health status of Israelis are also satisfactory, from an overall point of view. However, various elements in the Israeli health system need improvement. It was on these elements that the CSPS health team focused its work.

One of the goals of the State Health Insurance Law, implemented in 1995, was to lead the health funds to financial stability and economic strength. Another goal was to create an inclusive and comprehensive package of services – including components that the health funds had not offered before the law was enacted – to which all residents would be entitled. Has the law attained these goals? Not yet. Most of the recommendations of the CSPS health team wish to make progress toward these goals. The recommendations also explain the main reasons for the non-attainment of these important goals thus far.

The State Health Insurance Law hardly deals with the inpatient segment of the health system. The law makes no mention of hospitals at all. Accordingly, many of the CSPS health team's efforts and recommendations pertain to this part of the health system, that of the hospitals. Additionally, Israel's public-health system excludes dental care and long-term inpatient care for the elderly – services that are considered essential components of a sound public-health system in many countries that Israel wishes to resemble. Another problematic

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* The health-services plan includes the recommendations of the CSPS health team, chaired by Arie Shirom, who prepared the final version of this paper.

link in the health system is mental-health services, for which delivery to citizens is still entrusted to the Ministry of Health.

A more general aspect of the health system that commanded the attention of the CSPS team was the process of amending the State Health Insurance Law. In the past few years, most amendments to this law were made by means of the Economic Arrangements Law, which the Knesset passes along with the budget bill. This process has obvious negative implications.

1. Rules for Adjustment of the Funding of the Health System

Funding of the public-health system should be based on an annual adjustment mechanism that accurately reflects the array of health services that the health funds provide. The State Health Insurance Law was supposed to stabilize the funding of the health system, but since it was implemented the health funds have run up large deficits that have been covered only partly by recovery plans or balancing arrangements concluded each year between the funds and the Finance Ministry. It is widely agreed that the instability in sources of funding has led, and will lead, to financial crises in the public-health system. Accordingly, a mechanism to keep the system's finances in balance is urgently needed.

The negative cash flow in 1996, 1997, and 1998 traces to factors on both the expenditure and the revenue sides of the health funds' balance sheets. It transpires that the process of erosion – in per-member terms – is built into the mechanism used to adjust funding under the law. Two main factors contribute to this erosion:

One is the absence of a mechanism to adjust total resources to reflect population increase, population aging, and new technological developments that have been tested for effectiveness and applicability and approved for use. The State Health Insurance Law allows the ministers of Finance and Health to adjust the cost of services insured by the health funds

to reflect demographic changes. In fact, the adjustment has not been complete. Adjustments of the service package to reflect new technologies are still not based on a decision-making process that is multi-annual, transparent to the public, and rooted in medical, social, and economic considerations.

The second factor is the mechanism used to adjust the framework of resources (the cost of the insured services). In 1995, the first year of National Health Insurance, the cost of insured services was set on the basis of the health funds' actual expenses in 1994, plus funding for technological improvements and growth of the insured population, less a deduction to force the funds to make efficiencies. Since then, the adjustment mechanism has been eroding the package of insured services deliberately, since the actual components of the health funds' inputs are very different from those of the cost-of-health index as defined in an appendix to the law. The resulting disparity, to the disadvantage of the health funds, focuses mainly on the omission of the per-day rate for inpatient care in the cost-of-health index, even though this item accounts for one-third of the outlays of Clalit Health Services, for example. Consequently, real resources available to health-fund members, in per-capita terms, have been eroding by more than 3 percent per year.

2. Regressive Funding of Health System: Charging for Physician Visits

The charge for physician visits should be abolished and replaced with a more progressive source of funding. It is a matter of consensus among experts in health economics and health-service management that this fee, introduced in 1999, is an inefficient, unjust (regressive) tax that is detrimental to the population's health.

Several alternatives may be considered: raising the health tax that all residents pay, restoring the "parallel tax" paid by employers (a measure that has other salutary rationales), or allowing the health funds to charge their members a complementary tax.

The health funds began to charge this fee after a legislative change in 1998 (included in the Economic Arrangements Law for Fiscal Year 1998) allowed them to do so. The arguments against this kind of health-system funding are well known in the world literature. Primary physicians should engage in preventive health services, including prevention of chronic illnesses such as heart disease, and preventive care for the chronically ill, such as hypertensives and diabetics. Such physicians are expected, among other things, to encourage people in high-risk groups to visit them for checkups. When a fee is charged for visiting doctors, including primary physicians, this goal in community primary medicine cannot be attained. Those liable to the fee are the ill, who usually lose income because of their illness. The incidence of payment is higher in low income deciles than in high deciles, because low-income earners are in poorer health. Because the fee is collected at the time the service is rendered, it may deter poor consumers, of all people, from visiting their doctors when they should, including visits that may obviate the need for expensive inpatient care later on.

Advocates of co-payments for health services rest their case on the findings of studies conducted in the United States.

According to these studies, co-payments restrain health expenditure with no proven adverse effect on the health of those charged. However, since the research population in these studies excludes the elderly and the poor – the main consumers of health services – one cannot automatically apply these findings to the Israeli case. In Israel, it also transpires that the fee has an ethnic aspect, since Israelis of Asian-African origin visit their doctors more frequently than others do.

The Economic Arrangements Law allowed the health funds to set the level of the fee; some funds (including the largest, Clalit Health Services) chose to waive the charge for visits to primary physicians in its clinics. The fee is also very expensive to collect, especially since the law created various exemptions, including a maximum family outlay per quarter.

Several alternatives ways to fund the health system may be considered; they include restoring the "parallel tax" charged to employers and allowing the funds to charge a monthly fee up to a certain limit, without allowing them to discriminate in choosing whom to insure.

3. Inclusion of Dental-Health Services in National Health Insurance

National Health Insurance should be expanded to cover dental-health services for adolescents up to age eighteen and preventive care. The market mechanism, by making dental-health services both expensive and poor and problematic in terms of results by Western European standards, has failed in the Israeli case. Studies on dental health services in Israel have identified this field as one of the most problematic.

The Israeli way of providing dental-health services is a "real-life experiment" of sorts, conducted following a decision (perhaps unwitting) by Israeli governments. The point of the experiment is to see what will happen in an important field of health services when it is entrusted to market mechanisms. Throughout Israel's fifty years of statehood (and previously),

dental-health services have been based on competitive free-market principles, with rather minimal involvement and regulation by the Ministry of Health. The State Health Insurance Law, adopted in 1995, left this state of affairs unchanged. With the exception of preventive dental checkups for children, dental services are not covered by National Health Insurance.

This strategic decision by Israeli governments has generated a very significant flow of resources to dental medicine, mainly from citizens' pockets. This is reflected, among other things, in a high proportion of dentists in the population, a rather large share of national health expenditure for dental care, and higher costs of dental care in Israel than in other developed countries.

Various approaches in assessing the efficacy of health services rank Israel's dental-health services among the worst in the West by almost every criterion – even relative to the United States, where dental services are also private. This is because Israel's dental health services focus overwhelmingly on treatment and hardly at all on prevention. Even in fluoridation of drinking water, only part of the country is served.

4. Inclusion of Geriatric Inpatient Services in National Health Insurance

Compulsory insurance for long-term inpatient care should be built into the State Health Insurance Law. This recommendation rests on two value considerations – social solidarity and the Jewish tradition of treating the elderly with dignity – and on considerations of reducing national health expenditure. The inclusion of these services should be financed by a small increase in the health tax that every citizen pays and/or by raising the "parallel tax" that employers will have to pay for their employees. Although this measure would increase public funding of the health system, including that administered through the State budget, it would reduce total national health expenditure.

(See separate chapter below.)

5. Mental Health

A decision should be made, as promptly as possible, to implement the reform in mental health services that has been on the drawing board for the past four years. In this reform, responsibility for providing mental-health services, including inpatient care, would be assigned to the health funds. This decision should include an appropriate allocation of resources for an infrastructure of community alternatives to inpatient care.

The relevant rationales in this matter, as in the previously discussed case of long-term inpatient services, are related to continuity of care, shifting the focal point of services from hospitals to the community, and a holistic view of the health needs of health-service consumers. Each year, approximately 4,000 Israelis are committed to psychiatric hospitals. Most are released within less than a year. Many of those discharged have no appropriate opportunities for rehabilitation in the community. The Ministry of Health continues to fund inpatient care for many hundreds of psychiatric patients who do not need this kind of care, mainly because no appropriate community setting for them is available. These figures, included in the State Comptroller's report for 1998, show how urgent it is to provide funding for community alternatives to the hospitalization of the mentally ill, at the responsibility of the health funds. The aforementioned State Comptroller's Report depicted the current situation in the field of mental-health services as a moral and professional failure.

A CSPS position paper on the mental-health services stressed that although a majority of Israel's 36,000 mentally ill citizens reside in the community, only several thousand receive rehabilitative and preventive care from associations such as *Enosh, Hitmodedut,* and *Benafshenu.* We present this recommendation in the context of a comprehensive reform in the mental-health services that the Health Ministry has been planning for the past five years.

6. How the Hospitals Are Organized: the Future of Incorporation

The process of incorporating hospitals owned by the government and Clalit Health Services should be completed in accordance with one of the alternatives recommended in a CSPS position paper on this topic. This would create an internal market of sorts in the hospital system and absolve the Ministry of Health from the burden of macro-managing dozens of hospitals. After this change, the Ministry of Health would focus on its ministerial duties, including policymaking in the field of health, regulation of agencies in the system (health funds and hospitals), and setting rules for their behavior.

The issue of incorporating the government and Clalit Health Services hospitals is still part of Israel’s health policymaking agenda.

A 1997 position paper by the CSPS reviewed the actions taken to incorporate the government hospitals, explained why this process has failed, and offered alternatives for continued action: continuing and completing the “creeping incorporation” process, establishing a central authority for inpatient care, and creating a hospital authority in which all hospitals would be given quasi-corporate status. The position paper examined the current situation and found it highly problematic, the creeping incorporation moving ahead with no determination of clear phases of progress and, more important, with no setting of goals and clear rules of conduct for government hospitals in the midst of this incremental process. An example is the development and diffusion of private medical-care arrangements within government hospitals.

The rules of conduct (or “ground rules”) to be established should include a new method of remunerating the hospitals. The current method is based on a daily hospitalization rate and a predetermined schedule for some thirty inpatient activities. Among the severe side-effects of this method (described in the

position paper), one may mention the development of specialist medical practices in hospital outpatient clinics. This results in serious redundancies in a secondary-medicine service that is developing concurrently in the community.

The rules should also be tailored to the nature and substance of competition among hospitals. World literature shows that this competition often coincides with the development of “profitable” inpatient services, such as various kinds of private medical care. A CSPS position paper in 1996 dealt with the adverse effects of private medical services in public hospitals. It seems that the marketing behavior of public hospitals that introduced institutionalized private medical service led to the development of those services that were profitable and not necessarily to those of importance to the public’s health. As a result, national health expenditure increased. The 1996 position paper also documented the way that hospitals that introduced these services, especially public hospitals in Jerusalem, developed a stratum of medical services for the wealthy.

7. Public Debate over Changes of Principle in Legislation Pertaining to Health Services

Changes of principle in legislation pertaining to health services should be debated by the relevant public entities, with the participation of major players in the health system, as part of the ordinary legislative process. No additional legislative changes – of principle or of substance – should be made by means of the Economic Arrangements Law that is attached to each year’s budget bill. In the past few years, the Arrangements Law has become a legislative tool that modifies the principles of various statutes, including legislation as fundamental and basic as the State Health Insurance Law. The result is legislation without appropriate public debate and participation of representatives of important players in the health system.

Governmental measures of principle in making health policy, including proposed legislative amendments that modify the health services in substantive ways, should be discussed in their various aspects by entities such as the Health Council. The current "policymaking" method invites the government to make decisions on legislative programs without thorough examination and verification of their implications for national health spending and equitable apportionment of health-system resources among the citizens. The 1998 Arrangements Law, for example, proposed to recognize for-profit health funds and to make the list of insured health services less definitive by allowing each fund to modify it. (This provision of the bill did not pass.) Another example is the elimination of the "parallel tax" (paid by employers) by means of the 1997 Arrangements Law, even though it had been an important component in health-system funding since 1974.

The lack of debate by and accountability to the public concerning the significance of decisions are also blatantly evident in policy changes made jointly by the ministries of Finance and Health. The decision to add thousands of beds in general hospitals, under which 300 beds were added to such hospitals in 1998 – all in government-owned facilities – is a very conspicuous example. This costly decision affecting the total budget for public health services, and experts, representatives of the health funds, and representatives of health-service consumers were not invited to participate in making it.

8. Compulsory Health Insurance for Foreign Workers by Employers

All employers of foreign workers, legal or illegal, should be required by law to cover them with health insurance that includes their families. Today, illegal foreign workers have no health coverage whatsoever. Irrespective of the diverse estimates of their numbers, it is clear that when they become ill or have an accident, these workers are treated by the health system, e.g., in emergency rooms of general hospitals. This makes them a burden on the public health system – a burden for which there is no budget coverage.

The foreign workers' living and working conditions – including overcrowded and rundown housing and exposure to relatively high levels of crime – have made them into a group at high risk of illness and accidents. Legal foreign workers have partial health insurance that rarely covers accidents, maternal and neo-natal services, and inoculations for family members. The recommendation is to require employers of foreign workers, by law, to provide them with full health insurance or to be fully liable for the costs of such health services as the workers may need. This obligation would also reflect the true cost of foreign workers to the national economy in employers' expenses for this labor.