

# **Health Care Services**

## **Introduction and Summary**

Since 1995, Israel's health care services have been operating under the State Health Insurance Law. The performance of the system and the population's satisfaction with it are impressive. The system accomplishes this through large-scale and high-quality resources, especially human resources. The challenge facing the system, primarily in view of changes towards increased private funding, is to maintain and improve the level of service. Following these changes, satisfaction with the system has declined somewhat and there is concern that the changes in the composition of funding will impair the health of weak population groups, since these groups' access to medical services is declining relative to others.

This year marks the tenth anniversary of the enactment of the State Health Insurance Law, which established every resident's basic entitlement to a "basket" of medical services and created a funding system that would assure the fair and equitable realization of this entitlement. The law marked the first stage in the reform of the Israeli health care system as originally proposed by the Netanyahu Commission and, more recently, by the Amorai Commission. Other important elements of the reform, which pertain to the law directly and indirectly, concern issues that are not being implemented even though the system deals with them extensively. Three such issues are discussed in the second part of this chapter.

The first part of the chapter reviews the recent performance of the health care system on the basis of the available data. First, several indicators of the level of the Israeli population's health, i.e., mortality rates at various ages, life expectancy, and healthy life expectancy are presented. Second, there is an assessment of the level and composition of health expenditures and changes in these parameters from the individual and the public standpoints, in national terms and in the household budget are tracked. Third, the effects of the funding changes on system equity and the trend in real basic inputs such as changes in the number of physicians employed in the system and the number of inpatient beds are presented. Finally, the public's satisfaction with the health care services is examined.

The second part of the chapter discusses three basic problems of the health care system that remain unresolved. The first is the capitation mechanism that directs most of the public funding for health care services. The mechanism has been neither improved nor updated in a decade. The second concerns the unflagging and frustrating efforts to transform the hospitals, or at least the government owned hospitals, into corporations in order to improve the operation of the Ministry of Health and the system at large. The third topic is controversial: private medical services (*Sharap*) in the framework of public facilities. A fourth health care issue, the reform of mental health care services, is the topic of a separate chapter in this book.

## **A. Trends in the Health Care System**

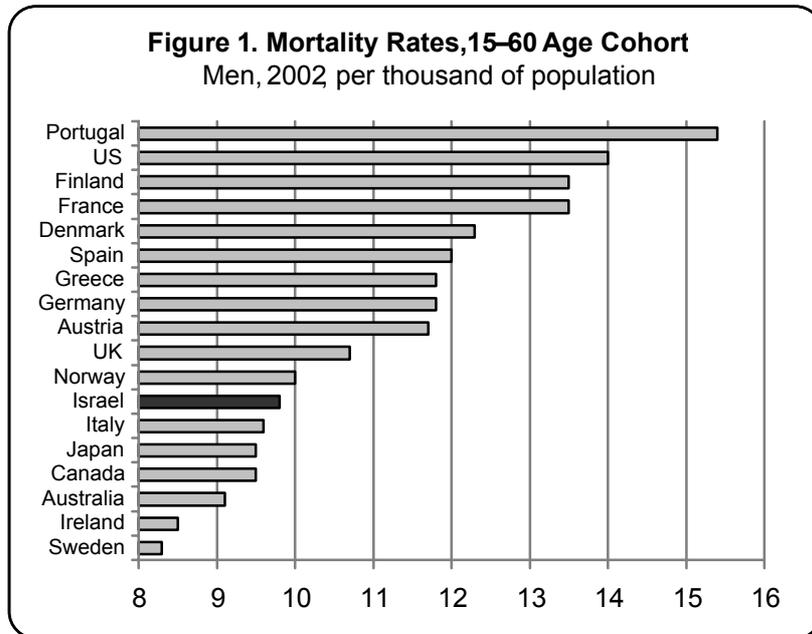
### **1. Health of the Population**

In Israel, as in most countries, the population's health has been improving significantly in terms of general and infant mortality rates, life expectancy, and healthy life expectancy. Changes in these parameters do not necessarily attest to the effectiveness of

the health care services because the exact correlation between the two is unclear. Many factors apart from curative and preventive services – related to genetics, environment, culture, lifestyle, and nutrition habits – contribute to improvements in these indicators.

**a) Mortality Rates**

Among developed countries, Israel ranks in the group that has the lowest mortality rates. Few countries (e.g., Japan, Australia, Italy) have lower mortality rates than Israel's. In Israel, as in other countries, the mortality rate in the 15–60 age group is almost twice as high among men than among women – 9.8 per thousand as against 5.3 per thousand, respectively. The most common cause of death in Israel in this age group is cancer (“malignant neoplasms”), followed by heart disease, in which the rate for men is more than three times that for women.



Unlike its relatively low mortality rates in the middle-age group, Israel lags behind other developed countries in mortality rates of children up to age five. Five of every thousand girls up to age five and seven of every thousand boys in this age group die in Israel. Finland and Ireland have the lowest rates among developed countries, at three and four per thousand, respectively. The United States has one of the highest mortality rates to age five, at seven per thousand girls and nine per thousand boys, and the European average is 5.5 per thousand boys and 4.6 per thousand girls.<sup>1</sup>

Israel's infant mortality rate, expressed in deaths per thousand live births, is also high relative to the European average. In 2002, the average in Israel was 5.4 per thousand as against 4.5 per thousand in Europe. Israel's average combines the rates of two main population groups that have different levels – Jewish and Arab. (The data in 2002 show four deaths per thousand among Jews and 8.6 per thousand among Arabs.) Only a few countries – Iceland, Sweden, Finland, Japan, and Spain – have lower infant mortality rates than that of Israel's Jewish population.

Although mortality rates have shown a downward trend in both population groups, those in the Arab sector remain much higher than those in the Jewish sector and in other developed countries. In 2003, infant mortality rate was 4.9 per thousand live births—3.6 among Jews and more than twice as high, 8.2, among Arabs. The main cause of infant mortality up to age one, in both the Jewish and the Arab population groups, is perinatal complications. The rate of perinatal mortality is 2.6 per thousand live births in the Jewish sector and 2.8 in the Arab sector. The second most common cause of infant mortality is congenital defects. Here there is a significant difference between

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<sup>1</sup> Here and below, the data for “Europe” refer to arithmetic averages of the fifteen veteran member states of the European Union.

both population groups – 0.9 per thousand live births among Jews, 2.5 among Arabs.

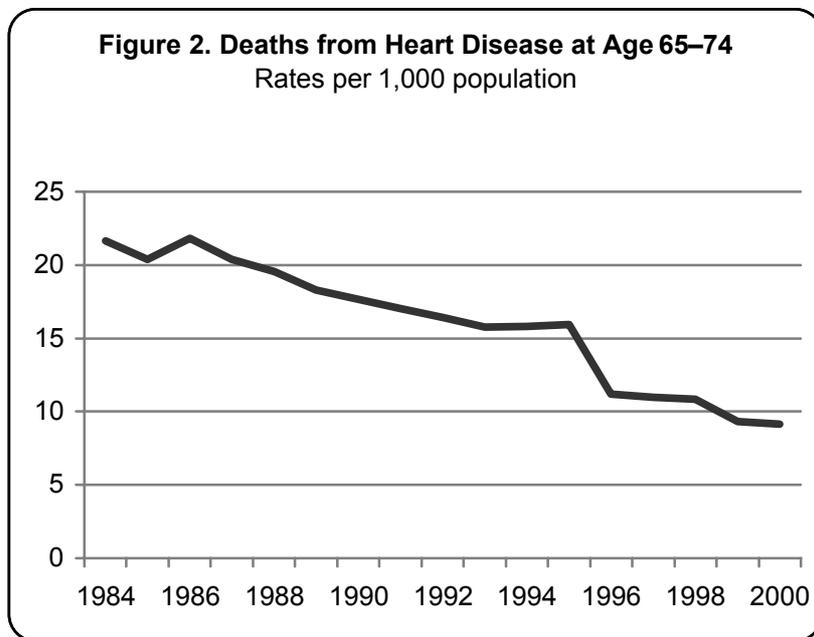
A study by the Community Genetics Department of the Ministry of Health, published in June 2004, shows that in recent years (since 2001) the frequency of births with severe congenital defects of the nervous system has declined significantly. The congenital defects surveyed were open malformations of the central canal of the spinal cord. Defects of this kind generally result in miscarriage, death immediately after birth, or severe disability. The study relates the decline in incidence to a decision by the Ministry of Health to recommend the use of folic acid as a preventive measure. In 1999–2000, before the recommendation was published, the rate of such defects was 1.46 per thousand live births in the population at large. In 2002–2003, it declined to 1.03. The study also addressed itself to the especially high rates among the Negev Bedouin and traced them to genetic factors and, perhaps, to different use of foods enriched with folic acid. The study illustrates the potential influence of Ministry of Health policy on indicators of the public's health.

***b) Life Expectancy and Healthy Life Expectancy***

Israel ranks high among countries in terms of average lifespan. Its ranking is strongly influenced by the long life expectancy of Israeli men as against men in other countries. Generally speaking, life expectancy of women and men in Israel has long been rising. The average life expectancy of men rose from 72.1 years in the early 1980s to 77.5 in 2002 – a gain of 5.4 years. During the same years, women's life expectancy increased steeply – from 75.7 years in 1980 to 81.5 in 2002. (Life expectancy is lower in the Arab sector than in the Jewish sector – 74.7 for men and 77.9 for women.) Overall, for 2002, irrespective of differences between the sexes, life expectancy was 79.4 years in Israel as against an average of 78.6 in Europe.

The countries most similar to Israel in this respect were Austria (79.4), Spain (79.6), and Italy (79.7).

The computed life expectancy of the elderly population has also been rising significantly in recent times. In the late 1970s, men aged 60+ could look forward to another 17.6 years of life and women 19.4 years. By the beginning of 2000, the number of expected years had climbed to 20.2 and 22.6, respectively. The main explanation for this change is the decrease in mortality rates from heart disease. This is due to two complementary or compensatory developments: a decline in the frequency of morbidity from heart disease and improvements in the efficacy of therapeutic and surgical treatment and prevention.



Another relevant indicator is the functional state of people aged 60+. One goal of the social system, of course, is to prolong human life, but it is also very important that this be

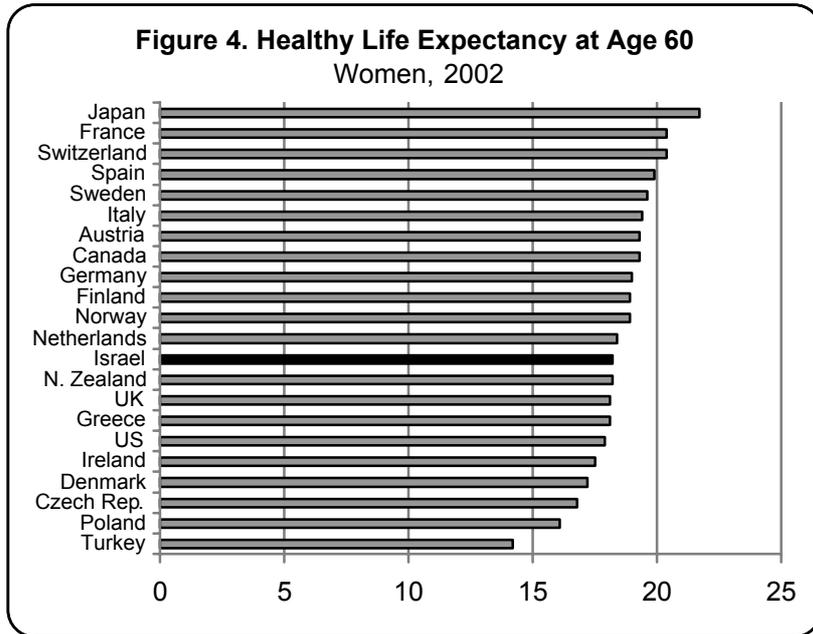
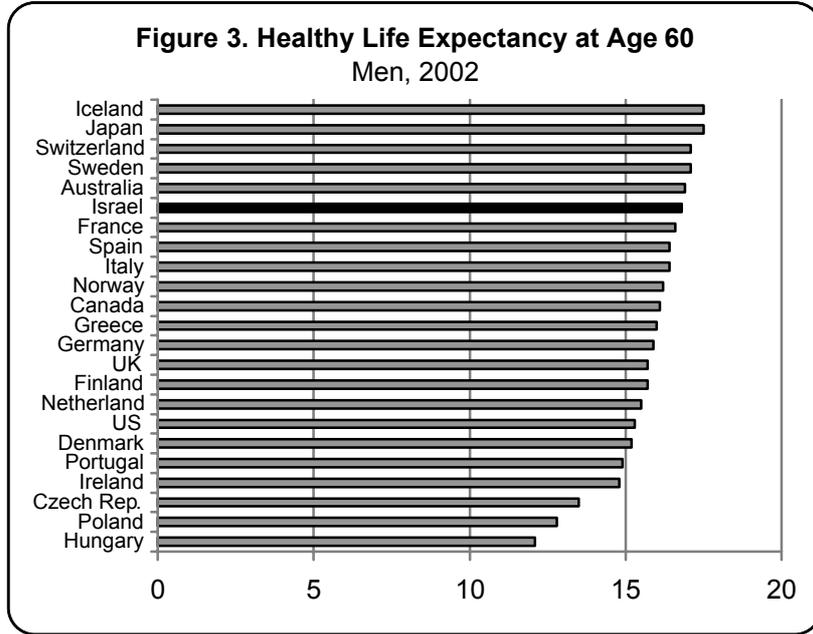
accompanied by the ability to function independently or nearly so. The World Health Organization gathers data on “healthy adjusted life expectancy” (HALE), using a method that calculates the number of years in which a person may expect to live in good health, based on life expectancy at birth and an adjustment for time spent in poor health.<sup>2</sup> The data gathered in regard to developed countries show that the healthy life expectancy in these countries has been rising in recent years but that overall life expectancy increased even more. Thus, prolonging life has not necessarily been matched by an improvement in “average” health.

As for Israel, men rank in a respectable sixth place on the global scale of healthy life expectancy at age sixty. When they reach this age, they can expect to live another 16.8 years in good health. Japanese and Icelandic men are the world’s leaders in healthy life expectancy, at 17.5 years.

Regarding women, Israel ranks much lower – seventeenth among developed countries. An Israeli woman, on average, can expect to live another 18.2 years in relative health and independent life style after turning sixty – about 1.5 years more than men. Japanese women are the world’s leaders in healthy life expectancy at age sixty, surpassing their Israeli counterparts by 3.5 years. Generally speaking, in Israel, as in other countries, women outlive men but are also less healthy. In Israel, for example, women aged sixty may expect to live 1.8 years longer than men but to be in poor health for a longer period of time than men – 1.2 years as against 0.8 year, respectively.

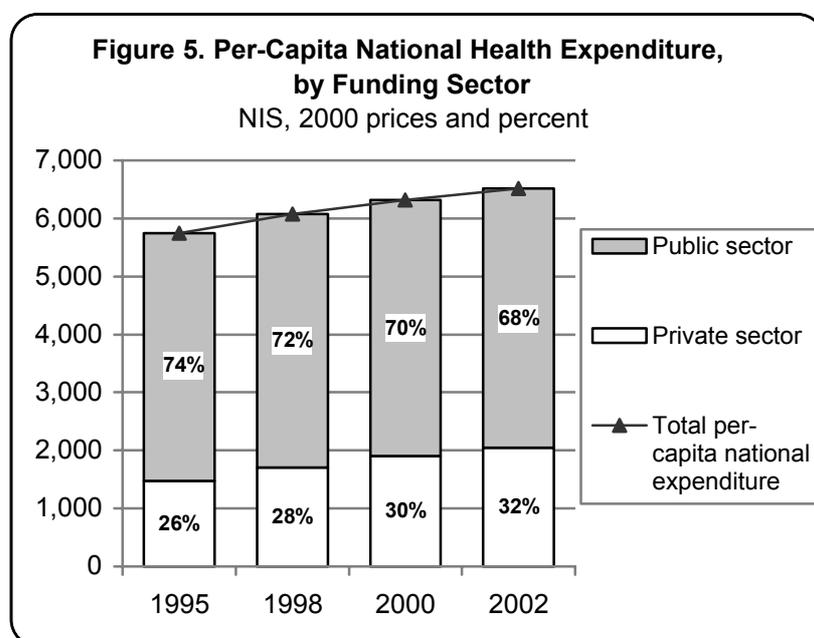
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<sup>2</sup> For a description of the research method, see WHO, 2004, *The World Health Report*, Statistical Annex, p. 94.



## 2. How the Funding of Health Care Services Affects Equality

The slowdown in the state financing of health expenditure and the expansion of private funding methods for public health services – co-payments and optional private insurance – have changed the composition of health care funding. The share of private expenditure for medical services in Israel climbed from 26 percent of national health expenditure in 1995 to 31 percent in 2003<sup>3</sup> – one of the highest rates among countries that have established public entitlement to medical services. The items that increased the most in private expenditure for medical services, in all income quintiles, are “supplemental insurance” and “medicines” (according to 1997–2000 data).



<sup>3</sup> Central Bureau of Statistics (CBS), 2004.

National health expenditure has been rising more quickly than GDP, especially since 1998, with its share in GDP climbing from 8.0 percent in 1998 to an estimated 8.8 percent in 2003. The trend seen in the past year's data focuses concern on per-capita expenditure. Despite the increase in the rate of national health expenditure in GDP, between 2002 and 2003 per-capita health expenditure decreased by 1.25 percent and per-capita GDP slipped by only 0.5 percent (both measured in 2000 prices). Thus, it is hard to blame the outcome on falling GDP. Health care prices, in contrast, have been rising more rapidly than GDP prices since 1998. Notably, unrestrained growth in the share of national health expenditure, especially if accompanied by inflation, may be adverse to economic growth and employment because it reflects a decrease in household saving coupled with a potential rise in labor costs.

The changes in the composition of funding are seen in a proportional decrease of public funding in the budgets of the Sick Funds, which are increasingly reliant on revenue from member co-payments (Figure 6). The share of health care expenditure in the household budget has also been climbing, from 3.8 percent in 1977 to 4.8 percent in 2002. The rate of increase in this item varied by income levels, from 85 percent in the two lowest deciles to 64 percent in the two uppermost deciles.<sup>4</sup>

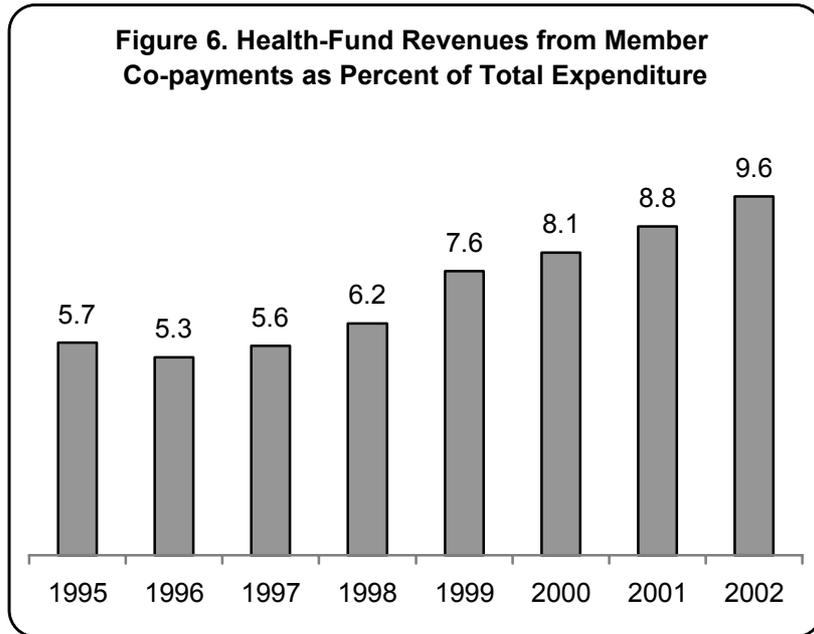
In 2001, about three-fourths of the population had privately funded optional supplemental health insurance, either through the Sick Fund or commercial insurance companies.<sup>5</sup> At the end of 2002, 66 percent of Israelis had supplemental insurance, 4 percent more than in the previous year. More than 20 percent of

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<sup>4</sup> State of Israel, Ministry of Health, 2004.

<sup>5</sup> The private insurance data were taken from the following sources (unless stated otherwise): Gross, Brammli-Greenberg, 2001; National Institute for Research of Health Services and Health Policy, 2003; and Gross and Brammli-Greenberg, 2004.

the population had both types of insurance – supplemental and commercial.<sup>6</sup> The proportion of those with private insurance almost doubled between 1995 and 2002. About 50 percent of the population in the two lowest income quintiles had no private insurance; only 20 percent in the two uppermost quintiles were in this situation.



<sup>6</sup> According to CBS, 30 percent of those aged 20 + had no supplemental insurance (CBS, 2004).

The increase in supplemental insurance and co-payments is obviously detrimental to vertical equity since both, even if charged on a group basis, are regressive.<sup>7</sup> The portion of the family budget that goes for health care is expanding and is doing so more noticeably among the lower income quintiles than among the upper ones, as noted. Furthermore, at least in regard to private insurance, stronger socio-economic groups make more use than weaker groups of the service that the private insurance offers. Thus, the weaker social groups are essentially subsidizing the stronger ones in the various insurance arrangements.

This state of affairs has aggravated the problem of horizontal equity: accessibility to services for weaker groups and residents of poor areas was lower even before 1998.<sup>8</sup> These problems have only become more acute. Today, co-payments are a cause for patients, especially those in weaker groups, to forgo medical care. According to the Central Bureau of Statistics (CBS), 16 percent of persons in need of prescription medicines went without them and 50 percent of those who lack supplemental health insurance did so due to cost.<sup>9</sup> This was also found in the Taub Center Social Survey where 22 percent of the public had gone without a necessary visit to the physician or an essential

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<sup>7</sup> “Vertical equity” – in the context of **funding of health care services** – means that people of different economic ability pay at different levels, mainly by means of progressive taxation. This is why the State Health Insurance Law based the funding system on general taxes and on a health tax, both of which are progressive. “Horizontal equity” – related to the **delivery of services** – denotes equal access to health care and services for people who have equal needs. Accordingly, the law predicated the allocation of funds on an age-based capitation mechanism that allocates the Sick Funds their budgets in accordance with the size and age distribution of their membership, irrespective of the origin of the resources. Equitable resource allocation is not a sufficient condition for horizontal equity.

<sup>8</sup> Chernichovsky et al., 2004.

<sup>9</sup> CBS, 2004b.

medical service in the past year due to the additional cost.<sup>10</sup> The relatively low proportion of privately insured in the two lowest income quintiles makes the same point. The problem is especially acute when the access of weaker population groups to services covered by national health insurance is conditioned in one way or another on having private insurance. This happens due to the especially strong integration in Israel of public and private systems at points of service delivery.

### 3. Health Care System Inputs

It is difficult to examine productivity in the health care system due to the difficulty in establishing a relation between a given level of health and a given level of medical service. Thus, the discussion is confined to examining the trend in health system inputs from an international perspective.

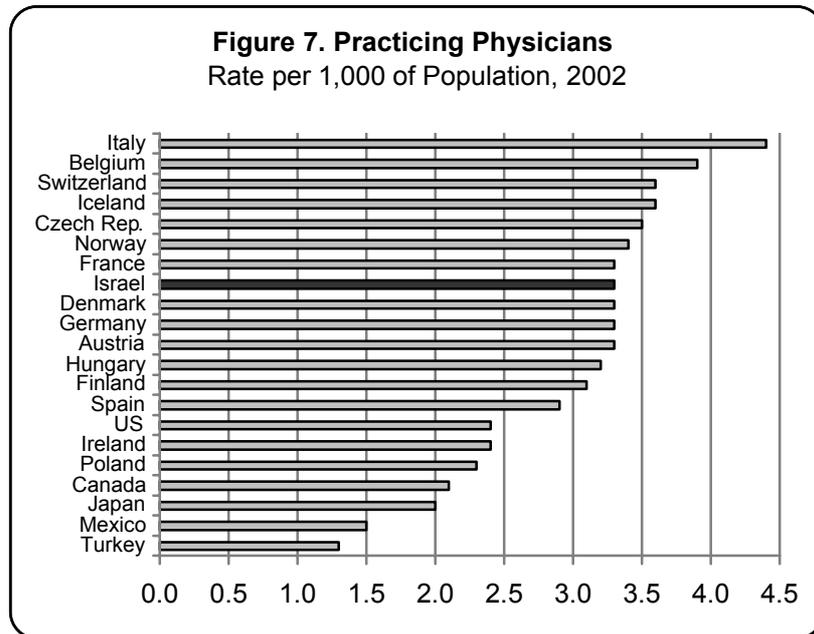
#### *a) Physicians*

In 2002, 21,700 out of a total of 24,400 physicians up to the age of sixty-five licensed to practice medicine in Israel were actually practicing. That is, less than 90% of those licensed. This is an important point because most available data pertain to the overall number of physicians up to age sixty-five and not to those actually practicing, and so there is something of an upward skew. For example, Israel had 3.3 practicing physicians per thousand population in 2002 while the number of physicians up to age sixty-five was 3.7 per thousand.

In 2003, the number of licensed physicians up to age sixty-five rose to 24,600. Some 40 percent of them – and, interestingly, almost half (47 percent) of young physicians (up to age forty-five) – were immigrants who had reached the country after 1989.

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<sup>10</sup> See Social Survey in this volume.



In Israel the proportion of practicing physicians – more than three per thousand of population – is one of the highest among the OECD countries. The basic problem with the Israeli system, then, is their geographic distribution.<sup>11</sup> Several studies have examined whether the disparities between the southern region and the rest of the country have narrowed and found that from most standpoints, even after the State Health Insurance Law went into effect, they have not.<sup>12</sup> Data on the southern region indicate that despite the increase in medical personnel during the 1990s, including the period after the law went into effect, the ratios of personnel to population remain less than those in the central districts.<sup>13</sup> and the disparities have not narrowed. The

<sup>11</sup> Chernichovsky et al., 2003.

<sup>12</sup> Nirel et al., 2001; Chernichovsky et al., 2003.

<sup>13</sup> The data from here to the end of the paragraph are based on Nirel et al., 2001.

relatively low availability of personnel in peripheral areas, along with greater needs in these areas than in others, is reflected in relative demand or pressure on physicians. Thus, physicians in the southern and northern regions have heavier caseloads than those in central areas and physicians in the south see more patients than those in the center and the north. A similar picture comes to light in the number of inpatient beds. The central districts (those around major cities such as Jerusalem, Tel Aviv, and Haifa) have higher ratios of general beds to thousand of population than “weaker” areas such as the southern and northern regions. Throughout the 1990s, the data pointed to the relative disadvantage of the southern region in this regard.

***b) The Inpatient System***

Over the years, there has been a perceptible downward trend in the average number of **general and mental health care** beds per thousand population. In contrast, the number of beds for **long-term illness and rehabilitation** per thousand population and, more importantly, per thousand population aged 65+, has been rising.

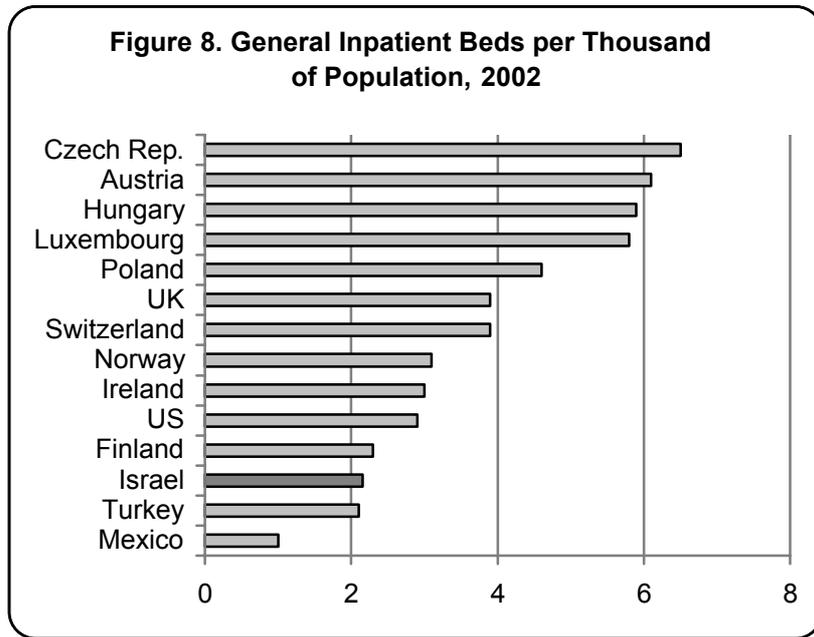
The differential trends in the proportions of beds, shown in Table 2, reflect the many changes that have occurred in each of these fields of inpatient care. In geriatric care (long-term illness), the increase in the proportion of beds compensated for a shortage since the 1970s. It also reflects the rise in business sector activity in the field. In mental health care, the average ratio of beds per capita has fallen by more than 50 percent during the past two decades. This decrease is definitely not the result of a corresponding decline in the incidence of mental illness. Instead, it can be traced to the policy reform aiming to shift care from hospitals to the community. As for general beds, the decrease originates in a decline in the proportion of beds in large wards – internal medicine (down 13 percent since the 1980s), general surgery (–40 percent), maternity (–33 percent), and pediatrics (–52 percent).

**Table 2. Share of Inpatient Beds, by Type**

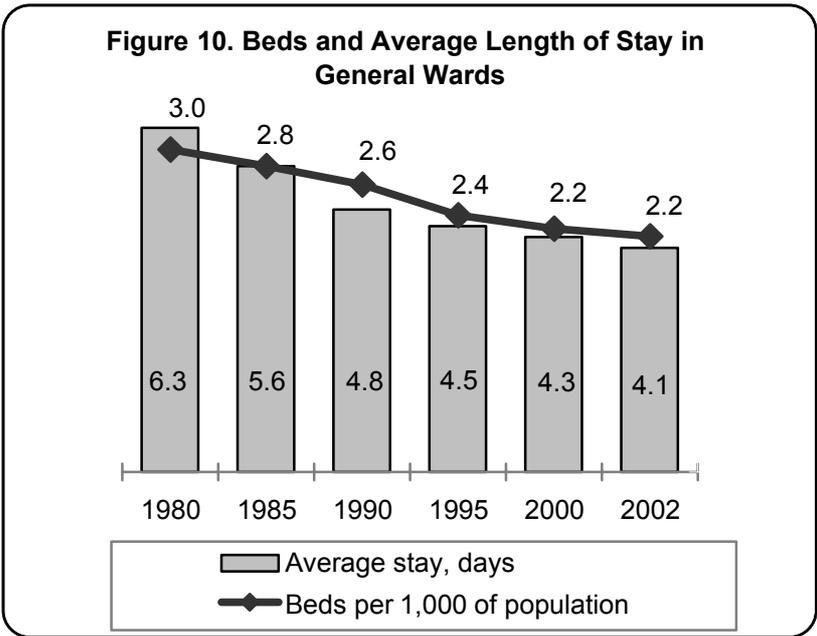
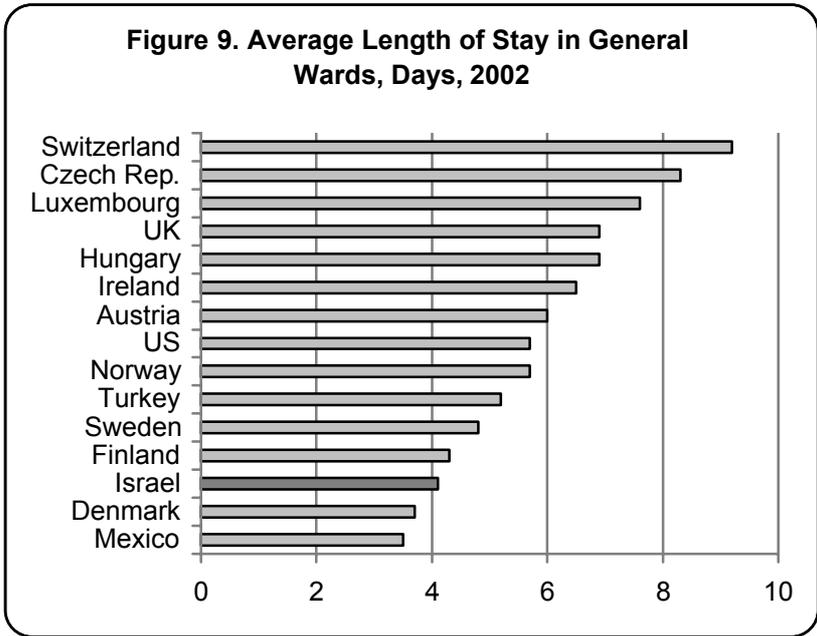
|      | <b>Total</b>               | <b>General</b> | <b>Mental health</b> | <b>Long-term<br/>and<br/>rehabilitation</b> |
|------|----------------------------|----------------|----------------------|---|
|      | Per thousand in population |                |                      | Per thousand<br>aged 65+                    |
| 1980 | 6.7                        | 3.0            | 2.2                  | 18.4  |
| 1985 | 6.5                        | 2.8            | 1.8                  | 20.3  |
| 1990 | 6.0                        | 2.6            | 1.5                  | 22.0  |
| 1995 | 5.9                        | 2.4            | 1.2                  | 24.8  |
| 2000 | 6.1                        | 2.2            | 0.9                  | 30.2  |
| 2003 | 6.1                        | 2.1            | 0.8                  | 32.1  |

Israel ranks rather low among the OECD countries in its ratio of general inpatient beds to thousand of population. However, in making this in itself problematic comparison, one must take account of differences in the age composition of the population. “Older” countries obviously need larger inpatient care systems to meet the health needs of their older populations.

The reduction in the number of beds for general inpatient care and the mentally ill during the past two decades coincides with a decline in the length of **average stay**. In long-term and rehabilitation wards, in contrast, the stay has lengthened (as the number of beds has increased). The average inpatient stay in Israel in 2003 was 4.2 days in general inpatient wards, 100.6 days in mental health care, 171.2 days in long-term illness, and 44.6 days in rehabilitation. Israel is among the countries that have the shortest average inpatient stays in general wards. Notably, in most countries the average stay in general wards has declined in the past decade. The greatest change occurred in Switzerland and the Czech Republic, where the average inpatient stay has fallen since 1990 by 4.2 days and 3.7 days, respectively, but still remains very long. In Israel, the reduction was 0.7 days.



The fall in the length of average inpatient stay may be explained at two levels, medical and economic. At the medical level, recent changes have definitely affected the duration of inpatient stay. First, medical technology has improved, making care more effective. Second, community based health care services have become more effective, as reflected in early diagnosis (which also enhances the effectiveness of inpatient care), the availability of alternatives to hospitalization, relatively early discharge of inpatients, and expansion of ambulatory hospital facilities.



At the economic level, the shortening of average stay can be explained by increased monitoring by Sick Funds and by methods that reimburse hospitals for some hospitalizations on the basis of treatment category (e.g., paying for heart-bypass surgery at a fixed unit rate). This method of reimbursement (DRG) does not take into account the actual length of patients' stay. An additional factor is a shortage of beds in some wards, which may prompt hospitals to try to shorten patients' stay in these wards in order to vacate beds for new patients. Thus, occupancy rates in 2003 were 106 percent in internal medicine wards, 118 percent in dermatology wards, 114 percent in maternity wards, and 102 percent in special neonatal wards. The highest occupancy rate was found in observation wards (190 percent). Generally speaking, the trends point to greater efficiency and responsiveness in the inpatient system, along with technological changes.

#### **4. Satisfaction with the Health Care System**

On the whole, the Israeli public is satisfied with its health care system. In the annual Taub Center Social Survey, half of the respondents considered the health care system to be good or very good and another third found it reasonable. The survey findings and Health Ministry data indicate, however, that public satisfaction with the health care system has fallen slightly in recent years (Figure 11).

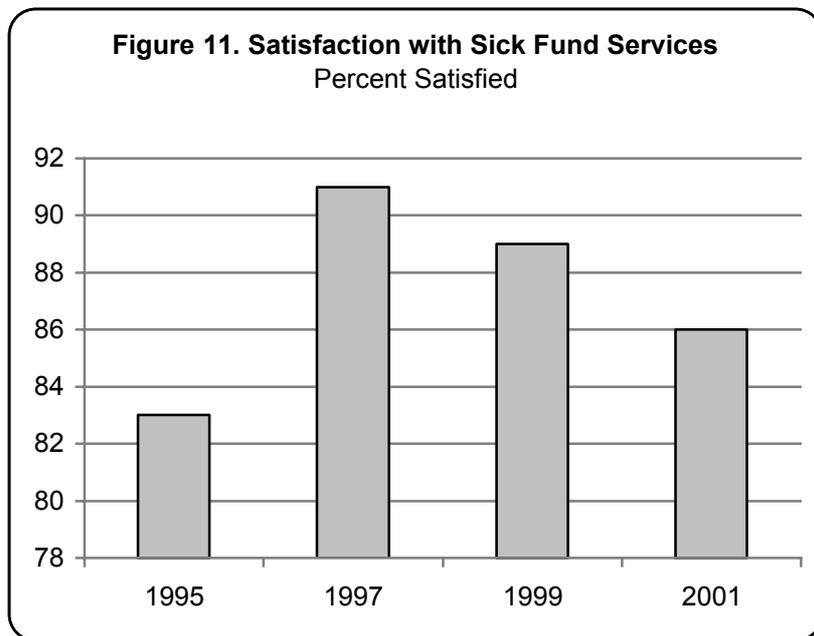
Israelis are highly satisfied with their health care system and highly dissatisfied with their education system.<sup>14</sup> The results of the 2003 European Social Survey, conducted in twenty-two countries in September–December 2002, confirm this.<sup>15</sup>

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<sup>14</sup> Barr, Oren, and Levin-Epstein, 2003.

<sup>15</sup> The European Social Survey (ESS) is the result of an initiative of a research group in Europe (including Israel) that receives funding and encouragement from the European Foundation for Science and the

Interviewees in all countries were asked to express their opinion about the education system and the state of health care services. Their responses were ranked on a 0–10 scale, 10 denoting “very good” and 0 denoting “very bad.” The range of average scores was wide – 3.9–7.8 for education systems and 3.4–6.6 for health care systems. Thus, the education and health systems of some countries are highly regarded and those of other countries are believed to be in “not good” or even “bad” condition. Generally speaking, in all countries except for Israel and Spain, education systems received higher average scores than health systems.



European Union. Israel takes part in the survey due to an initiative of the Israel National Academy of the Sciences and Humanities, which also provides funding. The fieldwork in Israel and the preparations for it were performed by the B.I. Cohen Institute for Public Opinion Research at Tel Aviv University, under the guidance of a steering committee on which various universities and disciplines were represented.

To examine the extent of correspondence between satisfaction with the education system and satisfaction with the health care system, a distinction was made on the basis of level of satisfaction (high or low, based on the midpoint of the scale). The countries were profiled at four levels:

1. Strong satisfaction with health care and education systems (Scandinavia, Switzerland, and Netherlands);
2. Poor satisfaction with the health care system and strong satisfaction with the education system (UK, Ireland, Czech Republic, Hungary, Slovenia);
3. Strong satisfaction with the health care system and poor satisfaction with the education system (Israel and Spain);
4. Poor satisfaction with both systems (Portugal, Greece, Poland).

## **B. Basic Problems of Israel's Health Care System**

### **1. The Capitation Formula in the State Health Insurance Law<sup>16</sup>**

The question of adjusting and updating the formula used to allocate national health insurance resources has accompanied the health care system almost from the day the law was implemented and has been debated at length by the Knesset Labor and Social Affairs Committee (until the late 1990s) and the Commission for Examining the Israeli Health Care System and the Status of Its Physicians.<sup>17</sup>

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<sup>16</sup> This section was prepared by Gabi Bennun, Deputy Director General for Research, Ministry of Health. The contents reflect the views of the Taub Center health team.

<sup>17</sup> The Amorai Commission, 2002. See Zmora, Chernichovsky, and Shmueli, "The Capitation Mechanism and Public Allocation for Health Services in Israel," Taub Center for Social Policy Studies in Israel, 2003.

Section 17 of the State Health Insurance Law details the methods for allocating resources for the Sick Funds beginning in January 1995. From that year on, the allocation has been based on a formula that divides the insured in each Sick Fund into nine age groups and assigns each group a differential weight to reflect use costs by age. The formula is meant to apportion national health insurance resources among the Sick Funds on the basis of user needs in order to make the apportionment more efficient and equitable. It should be noted that prior to this method, resource allocation was based largely on the level of income of each fund's members. The formula set forth in the law had an additional goal: to remove the incentive for the Sick Fund to discriminate in member selection or by trying to reserve the "good" members for themselves.

The weights were determined when the State Health Insurance Law went into effect, as stated, and were first modified in January 1997, when responsibility for the funding of maternity inpatient care was transferred from the Sick Funds to the National Insurance Institute. The change in 1997 also included an adjustment of the database (pattern of health care services consumption, expenditure patterns, and age distribution) to the most recent data available at the time, those of 1995.

In addition to the allocation of resources by age, the allocation method gave special consideration for patients with the following serious illnesses: kidney failure requiring dialysis, Gaucher's disease, thalassemia, hemophilia, and, since 1999, AIDS. The calculations are performed at a fixed rate on the basis of the number of each fund's members with these illnesses. The funds are given separate compensation for patients with these serious illnesses because they entail expensive and long-term care and because morbidity in these cases is not necessarily related to the patient's age. Budgeting for these illnesses accounts for about 5 percent of total resources under the health

insurance law; the remaining 95 percent is apportioned on the basis of membership in terms of age-standardized persons.

The table below shows the effect of the allocation formula on the relative distribution of resources among the Sick Funds at the end of 2002:

|                                     | <b>Total</b> | <b>Clalit</b> | <b>Leumit</b> | <b>Maccabi</b> | <b>Meuhedet</b> |
|-------------------------------------|--------------|---------------|---------------|----------------|-----------------|
| Percent distribution:               |              |               |               |                |                 |
| Insured                             | 100.0        | 55.5          | 10.0          | 23.5           | 11.0            |
| National health insurance resources | 100.0        | 61.1          | 9.2           | 20.6           | 9.2             |

Over the years, it has been argued that the weights established for each age group need adjustment due to changes in the patterns of health care service consumption (inpatient and community based), patterns of Sick Fund expenditure, and the proportions of the age groups in the population. The Ministry of Health examined the matter and found that the database of the current allocation formula should be adjusted immediately on the basis of the 2002 data.

Apart from the demand for an update of the database of the allocation formula, various proposals have been raised over the years for the inclusion of additional variables in the formula (i.e., other than age) so that the formula would better reflect the differential needs of persons insured with each fund. One set of proposals advocated the inclusion of variables that affect demand for health care services, such as state of health (morbidity) and socioeconomic situation (employment). Another group of proposals recommended the inclusion of variables that affect service supply, such as differences in the geographic distribution of services, economies of scale, and differences in input prices.

In 2002, the Amoraï Commission recommended the continued allocation of resources under the Insurance Law on the basis of age groups and serious illnesses. However, it also

recommended an update of the database used to determine the age group weights and the splitting and widening of the age groups at the extremes (dividing the 0-4 groups into 0 and 1-4 subgroups and the 75+ group into subgroups of 75-84 and 85+).

In 2003, Clalit Health Services petitioned the High Court of Justice to amend the capitation formula immediately. In November 2003, pursuant to the court's discussion of the matter, the Minister of Health appointed a team representing the ministries of Health and Finance to examine the method of allocating national health insurance resources. The team has not yet presented its recommendations.

In sum, it is important to note that the capitation based allocation formula determines the division of resources among the Sick Funds. If the formula is modified in any way, each fund's share of the resources will change (since more for one fund means less for another). This does much to explain the failure of all attempts to adjust and/or amend the formula since 1997.

## **2. Incorporation of Hospitals<sup>18</sup>**

The methods of ownership and management of government hospitals has been on the public agenda for more than two decades. During the past fifteen years, three public commissions with various powers have taken up the matter and several important conferences on social and economic issues have chosen it as their main theme.<sup>19</sup>

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<sup>18</sup> This section was written by Professor Shlomo Mor-Yosef, Director General of Hadassah Medical Organization. The contents reflect the views of the Taub Center health team.

<sup>19</sup> Such as the Caesarea Conference, sponsored by the Israel Democracy Institute, and the Dead Sea Conference of the Israel National Institute for Health Policy and Health Services Research.

“Incorporating the hospitals” sounds simple. The Ministry of Health runs all government owned hospitals. The Ministry is also in charge of setting policy and overseeing implementation. In this capacity, the ministry is also responsible for hospital supervision. This duality of functions creates an obvious conflict of interest for the ministry in its activity *vis-à-vis* hospitals and *vis-à-vis* Sick Funds. The funds are, on the other hand, under the supervision of the Ministry of Health and on the one hand, they enter into negotiations with it as a customer service provider basis. This is the crux of the problem when looking at the Ministry of Health. As for the hospitals, another problem arises: despite differences in size, nature, and geographical location, they are all run subject to the same set of management rules.

Solutions to these two problems have to take into account economic and labor relations issues. Most importantly, however, they must emphasize the continued overarching responsibility of the state for the availability of adequate medical care, in both qualitative and quantitative terms, in all parts of the country. In other words, the final test concerns neither economic nor operating efficiency. Thus, also in the framework of incorporation or privatization, the state must take responsibility for hospitals that don't succeed in balancing their budgets, if their continued existence is important. The state must insure the continuation of Israel's currently high level of medical care by supporting and encouraging the university medical centers that set the country's medical standards and induce the system at large to rise to the highest levels of medical care.

One of the committees that left their imprint on the country's health care system, and the one that was most responsible for the passing of the State Health Insurance Law, was the State Judicial Commission on the Functioning and Efficiency of the Health System, chaired by Justice Shoshana Netanyahu, which issued its recommendations in 1990. In regard to incorporating the hospitals, the commission spoke unequivocally: “...The

commission recommends the transfer of these hospitals to autonomous management, in accordance with principles to be detailed below.”<sup>20</sup>

Twelve years later, in 2002, the Commission for Examining the Israeli Public Health Care System and the Status of Its Physicians, chaired by Adi Amorai, published its conclusions on the topic. Recommendation 7 stated, “Hospitals that are owned by the government and by Clalit Health Services should be transferred to the status of autonomous not-for-profit corporations.” Two years later, in May 2004, a committee under Moshe Leon for the examination of the operation, management, budgeting, and ownership of government hospitals released its recommendations. Its main conclusion was that action should be taken to disengage the hospitals from direct operation by the state. The transformation of all general hospitals (government and Sick Fund-owned) into public hospitals operating as public not-for-profit corporations was again proposed.

Beyond these three esteemed commissions, in which the country's finest experts in health care system management and health economics took part, the State Comptroller also called attention to the matter. In the Comptroller's opinion, the imperfect nature of the health care market makes government supervision more important than it would be in a perfect market, but as long as the supervisory authority – the Ministry of Health – also owns the government hospitals, the question of its ability to perform its supervisory function remains moot.<sup>21</sup>

As the issues were being debated by these various committees and in academic forums, the Israel Medical Association (IMA) worked out its position on the matter. This stance accepts, to some extent, the definition of the problem in

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<sup>20</sup> *Netanyahu Commission Report*, 1990, Vol. I, “Majority Opinion,” p. 128 (Hebrew).

<sup>21</sup> State Comptroller, 2004, *Annual Report 54b for 2003*, “Cost of Health Care Services in General Hospitals” (Hebrew), p. 468.

principle, as well as the proposed solution. In a document presented to the Amorai Commission (Section 7, “Incorporation of Hospitals”), the IMA affirmed its belief that “[S]ome transfer of responsibility and authority from the government to the managements of the hospitals may be useful.” The IMA also addressed itself to the conclusions of the Leon Committee in a lengthy document that juxtaposed the advantages of incorporating the hospitals to its price on the national and employee levels.

In contrast to the near unanimity about separating the hospitals from the Health Ministry and turning them into corporations, the Finance Ministry adopted a “minority view.”<sup>22</sup> “The main purpose of incorporating the hospitals,” the ministry believes, “is to get the government out of the business of running and managing hospitals.” Thus, the Finance Ministry perceives the dual function of the Ministry of Health as problematic. However, it offers a different solution: placing the Sick Funds in charge of the hospitals. “Only [thus] will it be possible to subject health care expenditure to true restraint and to impose economic management by the Sick Funds, within a given budget constraint and from an inclusive perspective of the system’s needs.”

The uniformity of the recommendations of the various committees over the years and the consensus in the field about the best way to solve the problem make one ask why the disengagement of the Ministry of Health from the government hospitals has not taken place.

Three main reasons can be cited:

**a. The economic argument.** Implementation of the procedure will be very costly because public hospitals and health care corporations have larger liabilities than government

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<sup>22</sup> The only document the Finance Ministry has released to the public about its stance is “Minority Position on Turning the Hospitals into Government Corporations,” Appendix C-1 to the Leon Commission Report.

hospitals, especially in four main items: employers' tax, medical malpractice insurance, pension contributions for employees, and the direct subsidy that the hospitals currently receive. In the estimation of the Ministry of Health, as presented to the Leon Commission, the increase in cost will be NIS 900 million per year. ("The hospitals were subsidized at this level in 2002, and within the frame of the committee's work, the continued transfer of these flows of resources should be assured, either by ensuring the level of this subsidy in the future or by adjusting prices in the system.") It is important to note that this added cost is largely artificial because much of the subsidy returns to the government by means of taxes or by lowering of the existing liability for pension and malpractice insurance. Furthermore, even today the government spends these funds under other budget items, meaning that they go out of one pocket and return to another. The true cost originates in the need to provide equal conditions on these items for all the other hospitals (the public ones and those of Clalit Health Services). The added expenditure on this account may be estimated at NIS 1 billion per year.

**b. Organization and labor relations.** Many consider this matter extremely complex and problematic to solve and feel that the nuisance of dealing with it deters various players from making the attempt, even though more complex economic moves than this have been performed in Israel. The main problem is trust. Organized labor knows that the government's motive for incorporating the hospitals is economic. When employees observe existing corporations in the health system, such as Hadassah and other public hospitals, they see active owners that have a sense of responsibility for what goes on. In the incorporation process, in contrast, there is a sense of disengagement from the hospital by its owner.

The state will remain committed to inpatient services under any future organizational setting. Therefore, it should

acknowledge this explicitly, clearly, and painstakingly in every forum. Furthermore, the state should make it clear that in the event of economic instability, apart from replacing the management and the board, the state will unfurl a safety net to assure workers' basic rights.

Importantly, the government will determine the hospitals' economic success even after the incorporation process is completed, for two main reasons. First, wage accords – in an industry where wages account for 75 percent of total expenditure – are signed by the government, and labor and management will sign a collective agreement under any form of incorporation. Second, the state sets the rates that hospitals may charge – today and, in all probability, in the future as well. It is important to remember that 90 percent of the corporation's income is from medical service delivery that is tied to these rates. Thus, in the future, too, the overall success of the corporation will be determined by the government's agreements with representatives of labor, on the one hand, and in setting rate policy, on the other.

**c. Lack of an appropriate political environment.** To begin a process as complex as this, the leaders of the system – those at the professional level in the ministries of Finance and Health, and those at the political level – must treat it as a matter of the utmost importance. For this purpose, they must marshal not only the state's financial resources but also the time needed to elevate the issue to the top of the national health agenda.

In sum, to promote the cause of incorporating the hospitals, it will be necessary to adjust the “rules of the game” and mobilize a professional and political leadership that will, on the one hand, emphasize the state's commitment to inpatient services and, on the other hand, direct the process.

### 3. Private Medical Service (*Sharap*)<sup>23</sup>

The question of offering private medical services (*Sharap*) in government and Clalit Health Services hospitals is complex and includes economic, organizational, and ethical considerations of interested parties at the national level. It has been frequently and heatedly debated since the Netanyahu Commission deliberations fifteen years ago and has not yet found its outlet in the formulation of a clear and definitive policy.

Citizens cover more than 30 percent of national health expenditure (beyond taxes and National Insurance contributions) from their pockets. They earmark some of these resources for private medical service in hospitals, especially in order to choose their surgeons and/or to expedite a procedure. *Sharap* is run officially in the public hospitals in Jerusalem (Hadassah and Shaarei Zedek) and although prohibited in government hospitals, the service is offered under the auspices of the hospitals' "research foundations." This aside, physicians in non-private hospitals are allowed to receive patients in clinics after or before working hours and to perform surgical procedures in private facilities. At Hadassah and Shaarei Zedek, about 10 percent of total surgeries are performed within the *Sharap*, with much variation among types of procedures. Often, supplemental insurance covers some of the expense.

#### **Demand for *Sharap***

One characteristic of medical care is uncertainty about the outcome. In many cases, the danger that may result from substandard care is not severe, but when serious health problems arise and invasive procedures are needed, quality of care becomes crucial and patients wish to maximize the results in

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<sup>23</sup> This section was prepared by Dr. Amir Shmueli of the School of Public Health at the Hebrew University of Jerusalem and the Gertner Institute for Epidemiology and Health Policy Research. The contents reflect the views of the Taub Center health team.

terms of their health and minimize the risk by choosing a surgeon and expediting medical procedures. Since the public health care system cannot offer either option as a service under national health insurance, demand by the consumer for private services is both predictable and legitimate. Recent studies show, however, that this demand is more complex than what one might expect. Furthermore, there is no evidence that patients who undergo surgery through the *Sharap* obtain better health results than similar patients in the public system.

**The proponents of introducing *Sharap* in public hospitals offer several rationales:**

1. The introduction of *Sharap* will create sources of income for the hospitals and ease their current budget distress. Thus *Sharap* patients will indirectly subsidize those who use the insured public services.
2. The introduction of *Sharap* in afternoon and evening hours will improve utilization of the public hospitals' medical infrastructure and reduce the average expenditure per patient per day. The larger the share of fixed expenditure for physical and human infrastructure in total expenditure, the greater the decrease in average expenditure will be.
3. The implementation of *Sharap* in the public hospitals will give senior physicians an incentive to spend most of their time in public hospitals, to the benefit of patients who obtain care through the national health insurance system, as well as to the benefit of interns, society at large, and future generations.
4. The running of *Sharap* will make it possible to introduce a personalized wage scale based on performance and reputation, thereby allowing the public system to retain the finest physicians.
5. *Sharap* is related to the issue of incorporating the government and Clalit Health Services hospitals. After the hospitals become autonomous corporations, they will conclude

contracts of private and competitive nature with medical staff, the Sick Funds, and other insurers. (It will then be hard to justify the prohibition of *Sharap* in these hospitals while traditional *Sharap* is available in Jerusalem's older, incorporated hospitals.)

6. The introduction of *Sharap* in public hospitals will reduce the size of the black and gray markets for services in public hospitals. These markets, which exist due to demand pressure, make a negative contribution to social welfare and sometimes endanger patients' health.

**The opponents of introducing *Sharap* in public hospitals express several rationales of their own:**

1. Many arguments in favor of the introduction of *Sharap* are based on the ineptitude of the current system. Supervision of physicians during hospital working hours and preventing direct (black market) payments to physicians are matters for supervision and enforcement; introducing *Sharap* will not solve them.

2. The introduction of *Sharap* in public hospitals will give physicians an incentive to shift their morning activities to *Sharap*. Thus, *Sharap* activity will crowd out public system activity, resulting in longer waiting time for surgery in the public system. This, in turn, will generate greater demand for *Sharap*, and so on. It would be difficult to control the quantities of surgical procedures under the two systems.

3. If *Sharap* is introduced, surgeons working under *Sharap* will initiate more procedures (apart from shifting them from private hospitals to public ones), causing national health expenditure to rise because some of the surgeries will be medically unnecessary.

4. Public system patients and *Sharap* patients who undergo the same surgical procedure in the same hospital and at

the same time may be treated unequally with the danger of discrimination on basis other than the identity of the surgeon.

5. The introduction of *Sharap* in surgery will inspire leading physicians in other departments and disciplines to apply pressure for the creation of similar arrangements in order to improve their status.

6. In the long run, the shifting of more surgeries to *Sharap* may impair the extent and pace of specialization by young physicians.

7. The introduction of *Sharap* will create an opportunity for the emergence of a private market within a public institution for additional medical products. These products and initiatives should be part of the competition among hospitals for the provision of inpatient services to members of the various Sick Funds under public auspices.

**In sum**, the main reason for the lack of an explicit decision to forbid or permit *Sharap* in public hospitals (as is the case in Canada, for example) is that even the proponents of *Sharap* acknowledge the need for a well developed supervisory mechanism. Both sides agree that the *Sharap* system should be placed under several additional restrictions in order to insure that activities in the public setting are not harmed, e.g., separating private accounting from public accounting and forbidding expediting medical or surgical procedures for non-medical reasons.

The *Sharap* issue is certainly fraught with economic and social considerations. The decision on how to resolve it will have a major effect on shaping the image of Israel's inpatient and health care system in the future. Although the rationales in favor of introducing *Sharap* in public hospitals seem solid, the restrictions that aim to assure the continued performance of the public setting alongside the private one are critical and have created difficulties that, for the time being, are insurmountable.

The solution to this matter may be inseparable from the question of incorporating the public hospitals. The introduction of *Sharap* in public hospitals or those owned by Clalit Health Services will be much less problematic after these institutions become autonomous corporations. Once this happens, too, it will be impossible to forbid them to undertake a practice that has been accepted for years in the older Jerusalem corporations. As autonomous corporations, the public hospitals will conclude contracts with their physicians regarding the extent and nature of their work, and with the Sick Funds and other insurers regarding the extent and types of service that they will purchase, on the basis of pertinent and competitive negotiations.

## Sources

### *Hebrew Sources*

- Barr, K.; Oren, A.; and Levin-Epstein, N. (2003) "Israel in Europe: Closer to the East of the Continent than to the West," *De'ot Ba'am* 9, December.
- Central Bureau of Statistics (2004a), "One Percent Decrease in Per-Capita National Health Expenditure in 2003," press release, July 13.
- , (2004b), "Welfare of the Population in Israel: Initial Findings from the 2003 Social Survey," press release, August 9.
- Chernichovsky, D.; Elkana, Y.; Anson, J.; and Shemesh, A. (2003), "Equity and the Israeli Health Care System: Relative Poverty as a Health Risk Factor," Center for Social Policy Studies in Israel, Jerusalem.
- Gross, R.; and Brammli-Greenberg, S (2001), "Supplemental Health Insurance: Changes in Policy and in Consumer Behavior," *Social Security* 61, pp. 154–171.
- Habusha, Z., and Schiff, R. (2002), *Comparative Report on Activity of the Sick Funds for 2002*, Ministry of Health, Jerusalem.
- Horev, T. (2004), "The Judicial System's Influence in Shaping Health Policy," Taub Center for Social Policy Studies in Israel, Jerusalem (July).
- Israel National Institute for Health Policy and Health Services Research, and JDC-Brookdale Institute (1999), *Supplemental Health Insurance: Issues in Policy and in Market Behavior*.
- . (2003), "Supplemental Insurance," *Report of the Fourth Dead Sea Conference on Disparities and Inequality in the Health System in Israel*.
- Nirel, N.; Pilpel, D.; Rosen, B.; Zmora, I.; Greenstein, M.; and Salzberg, S. (2001), "Access to and Availability of Health Care Services in the South: Has the State Health Insurance Law Eliminated the Disparities to the Disadvantage of the

South Relative to Other Districts?" *Social Security* 59, pp. 76–95.

Report of the Commission for Examining the Israeli Public Health Care System and the Status of Its Physicians (the Amorai Commission) (2002), State of Israel, Jerusalem.

Report of the Committee for Examination of the Operation, Management, Budgeting, and Ownership of Government Hospitals (the Leon Committee) (2004), Tel Aviv, May.

Report of the State Judicial Commission on the Functioning and Efficiency of the Health System (the Netanyahu Commission), Majority Opinion (1990), Government Printing Office, The Knesset, Jerusalem.

State Comptroller (2004), "Cost of Health Care Services in General Hospitals," *Annual Report 54b for 2003*, p. 468.

State Health Insurance Law, 5754-1994.

State of Israel, Ministry of Health (2004), *Personnel in Health Occupations 2003*, Jerusalem.

--. (2004), Statistical Data on the State Health Insurance Law, 1995–2002, Jerusalem.

Zmora, I.; Chernichovsky, D.; and Shmueli, A. (2003), "The Capitation Mechanism and the Public Allocation to Health Services in Israel," Center for Social Policy Studies in Israel, Jerusalem (November).

### ***English Sources***

Central Bureau of Statistics (CBS) *Statistical Abstract of Israel*, various years.

Gross, R., and Brammli-Greenberg, S. (2004), "Evaluating the Effect of Regulatory Prohibitions against Risk Selection by Status on Supplemental Insurance Ownership in Israel," *Social Science and Medicine*, 58, pp. 1609–1622.

OECD, *Health Data 2004*, 2<sup>nd</sup> edition.

WHO (2004), *The World Health Report*, Statistical Annex.