The Health System

This chapter surveys various developments in the health system. As an introduction to the survey, we present the state of health of the Israeli population as determined by several indicators and compare it with the situation in other developed countries. We then examine national expenditure on health and the funding of the health system. Developments in the hospitals and health funds gives a picture of overall changes in health care, and the degree to which the health system meets users expectations and needs is also explored. The remaining sections of the survey deal with specific sectors of the health system, with emphasis on developments in the past year. In addition, we will devote a separate discussion to trends in the use and regulation of medicines, dental health care, and mental health care.

1. Health in Israel: Comparisons with Developed Countries

According to the World Health Organization (WHO), improvement in the health of the populace, combined with a reduction in the inequality of the health status of different population groups, is an important test of any health system.[1] In this section of the survey, we focus on the health of Israelis in different social strata, as measured by infant mortality, general mortality rates, and life expectancy.

Infant mortality. The infant mortality rate, a common indicator used to gauge the health of the populace, was 5.4 per thousand live births in Israel in 2000. This number is another milestone in the decline in infant mortality in Israel, in the past

[1] WHO 2000.

two decades. The improvement in this indicator is mainly due to technological progress relating to healthy pregnancies and childbirth and improved preventive and support services in the community. For many years (see Fig. 1), infant mortality in Israel has been below the average for OECD countries. Nevertheless, the average among the non-Jewish population – though also declining – is higher than in OECD countries. Furthermore, the relative disparity in infant mortality rates between Jews and non-Jews has not changed over the years. The health of the population is affected by many factors, including lifestyle, diet, level of education, and income. Infant mortality as an indicator is especially sensitive to the effects of public health services. There is a clear connection between the socioeconomic level of a locality and infant mortality: infant mortality per thousand live births in Herzliya and Kefar Sava – towns with a relatively high socioeconomic status – is between 1.8 and 2.5, as opposed to 6.4 and 6.9 in Afula and Safed, which have a relatively low socioeconomic status.

Life expectancy and mortality rates. In 1998, life expectancy in Israel was 76.1 for men and 80.3 for women (Table 1). The average life expectancy in OECD countries that year was 73.5 and 79.7, respectively. Based on the combined calculation of life expectancy at birth for women and men, Israel ranks twenty-third out of 191 countries.[2] The men rank higher than the women: in Israel the life expectancies of men and women are only 4.2 years apart – due to the relatively long life expectancy of men – compared to an average difference of 6.2 in OECD countries. The disparity in life expectancy between Jews and non-Jews remained constant over time; in 1998 there was a difference of 2.2 years between Jewish and non-Jewish men (with the higher rate for Jewish men) and a three-year difference among women.

[2] WHO 2000.

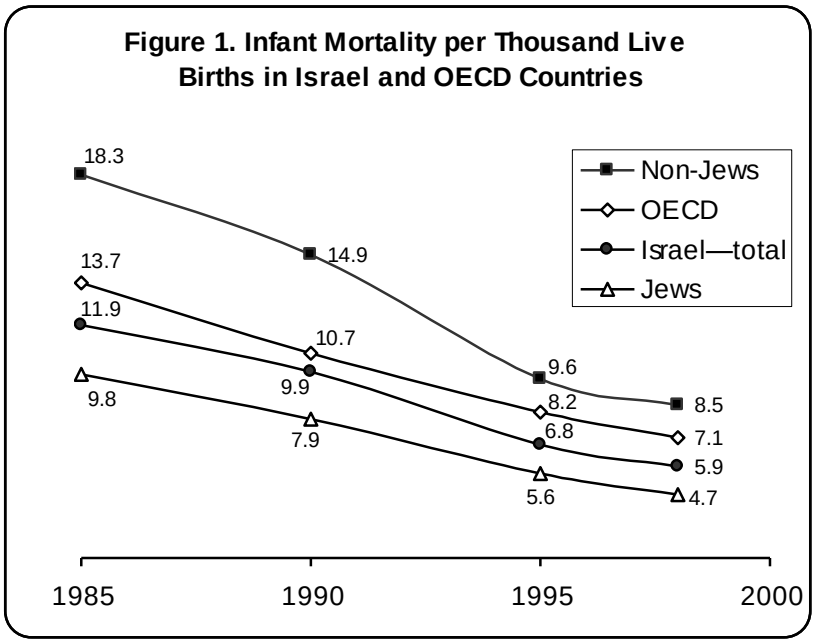


Table 1. Life Expectancy in Israel and OECD Countries

	Women				Men			
	OECD	Israel			OECD	Israel		
		Total	Jews	Arabs		Total	Jews	Arabs
1980	73.4	75.7	76.2	73.4	69.5	72.1	72.5	70.0
1990	78.3	78.4	78.9	75.9	71.8	74.9	75.3	73.3
1998	79.7	80.3	80.7	77.7	73.5	76.1	76.5	74.3

Overall, life expectancy in Israel is continuing to increase, and this trend applies to different age and population groups. It should be kept in mind, however, that these averages do not reflect the differences between population groups and the potential for improving the health of the populace, at least as measured by the indicators mentioned above. These data show that the average state of health can be enhanced by improving the health of the weaker population groups, which are heavily concentrated in the non-Jewish sector. Such an improvement depends first and foremost on better socioeconomic conditions, especially the level of education, and an increased allocation of resources to the health system within the weaker populations.

2. National Expenditure on Health and Funding Methods

In Israel, as in other welfare states, the health budget is determined primarily by the government. The government's strategy has an immediate and significant impact on the availability of and access to health care among different population groups and the social well-being achieved by means of health care. The government accomplishes this through control of national health expenditure by determining the health budget, the level of the health tax, co-payment arrangements, and supplemental insurance plans.

In 2000, national health expenditure totaled NIS 40.1 billion in current prices.[3] This includes spending on all health services provided in clinics and hospitals, the services of private doctors and dentists, household expenditure on medicine and medical instruments, expenditures on research and governmental administration in the health field, and investments in buildings and equipment for health-related institutions. In 2000, national

[3] CBS 2001.

health expenditure rose by 5 percent in constant prices, following similar increases in 1998–1999; previously there had been stability in 1997 and rises of 6 percent in 1996 and 8 percent in 1995. National health expenditure in Israel totaled 8.3 percent of GDP in 1999, similar to figures in Italy, Denmark, and Greece but less than in Germany, Canada, France, Norway, and the Netherlands, where the figure was between 8.5 and 10.5 percent; and, of course, lower than in the United States (13.7 percent). The lowest rate of expenditure among OECD countries was in Ireland: 6.1 percent. In Israel, as in the world as a whole, spending on health as a percentage of GDP has been increasing, although in recent years it has stabilized somewhat.

Figure 2. National Expenditure on Health as a Percentage of GDP: International Comparison, 1999

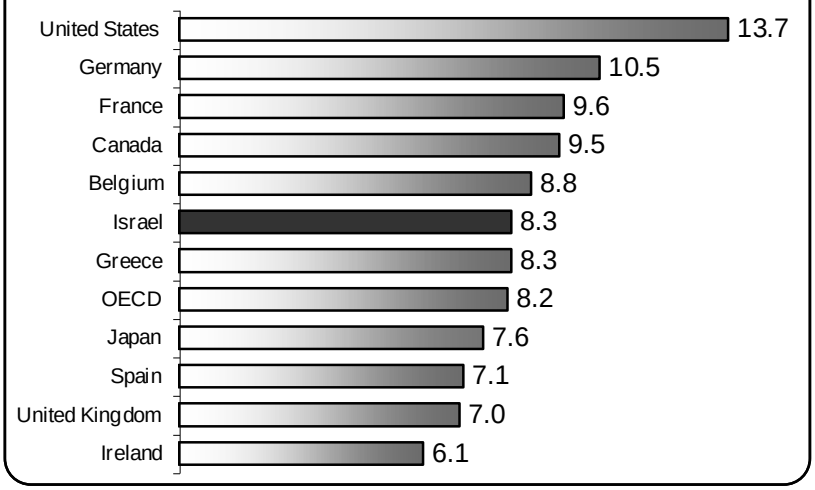


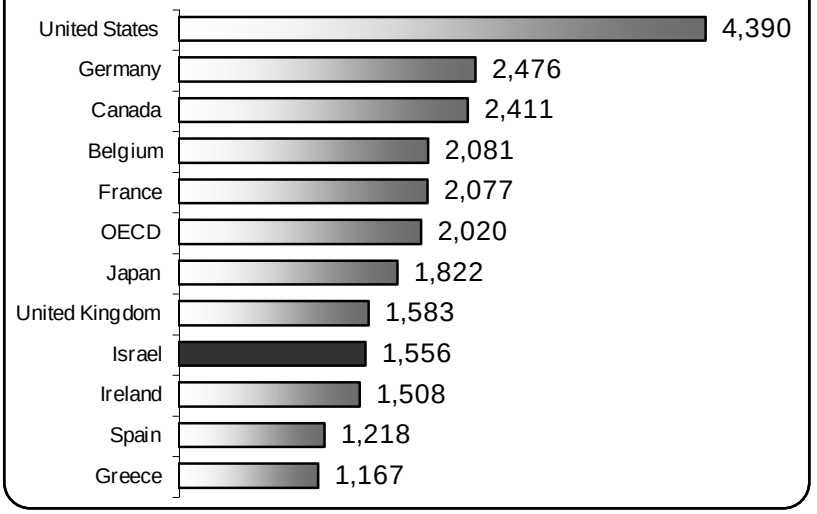
Table 2. National Expenditure on Health as a Percentage of GDP in Israel and OECD Countries

	1960	1970	1980	1985	1990	1995	1998	1999
Israel	5.7	5.6	6.8	6.6	7.7	8.1	8.2	8.3
OECD	4.0	5.5	6.8	6.9	7.2	7.8	7.9	8.2

National health expenditure per capita. In 1999 national health expenditure per capita in Israel totaled $1,556, similar to the figure in countries such as England and Ireland in terms of purchasing power parity. In that same year, spending in OECD countries averaged $2,020. In Germany, Denmark, Canada, Belgium, France, the Netherlands, and Japan, expenditure came to $1,800–$2,500, and in Portugal, Spain, and Greece, it was $1,100–$1,300. In the United States – primarily due to the extensive use of private medicine – per-capita health expenditure is the greatest, at $4,390. It should be noted that the calculation in terms of purchasing power of GDP takes into account differences in product costs in the different countries. A possible objection to the comparison presented above is that it disregards differences in the health-care price index between countries. Furthermore, it does not standardize average national health expenditure per capita by country; i.e., it does not take into account the age distribution of the population of each country. Due to the younger age structure of the Israeli population relative to most OECD countries, Israel may be in better shape than is indicated by these statistics.

Figure 3. National Health Expenditure per Capita: International Comparison

U.S. dollars, in terms of purchasing power parity, 1999



An entirely different picture emerges when comparing the relative development of real average spending on health care per capita in Israel over the past few years. Before the State Health Insurance Law went into effect, average expenditure per capita in Israel was fairly similar to average expenditure in OECD countries. Since 1995, however, per-capita expenditure in those countries has risen by 33 percent, whereas in Israel it has risen by only 11 percent.

In 1999 and 2000, the state budget funded 46 percent of total national expenditure on health, and the health tax funded 25 percent.[4] Payments by households for medicine and medical services, including dental and private medical care, covered 29 percent, an increase of 2 percentage points over 1995, the first year of the State Health Insurance Law. In the European

[4] CBS 2001.

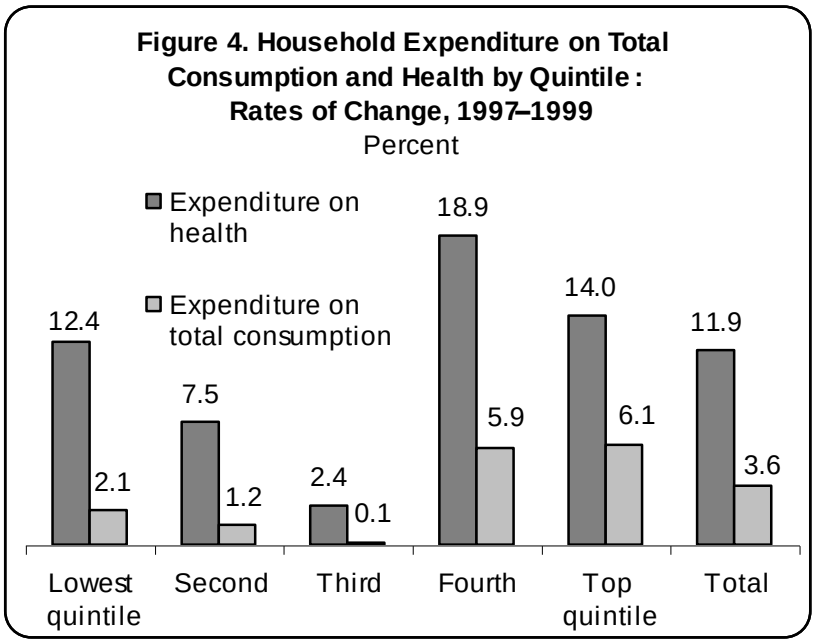
countries that Israel strives to resemble, public spending as a percentage of national expenditure is higher than in Israel. The fact that households cover such a large portion of national health expenditure means that the socioeconomic disparities in Israel, including access to health care, are increasing, since household funding of health care is fundamentally regressive. This assertion is supported by a comparison of the data on health expenditure against total consumer spending. Household expenditure on health care rose by an average of 12 percent between 1997 and 1999, while consumer spending overall rose by 4 percent. Figure 4 shows that the *relative* burden of expenditure on health care increased especially in the three lowest quintiles. Furthermore, according to a survey on the subjective health of Israelisperceived health improved somewhat between 1995 and 1997, but between 1997 and 1999 relative satisfaction in the lowest quintile with aspects of the health funds declined, resulting in a disparity between this quintile and the others.[5] This may be connected to the deficits in the health fund budgets in these years, which necessitated cutbacks in services. Various studies have shown that the growing inequality in health, according to both objective and subjective indices, corresponds to increasing disparities in income distribution in Israel and adverse developments in income inequality.[6]

Further inequities in the financing of the public health system in Israel are caused by the increasing prevalence of supplemental insurance plans and spending on them. In 1999, 51 percent of the adult population had purchased supplemental insurance policies from the health funds, and 24 percent had purchased commercial policies. (The two categories overlap somewhat, since some people had both commercial policies and Figure 4. Household Expenditure on Total Consumption and supplemental healthfund policies.) In 1997 these figures were 38

[5] Gross and Brammli-Greenberg 2001.
[6] Shmueli and Gross 2001.

and 16 percent, respectively.[7] The premiums for these supplemental insurance policies are based not on income but on standard prices (in the health funds) and actuarial risk (in commercial policies). Therefore, the cost of supplemental insurance policies is fundamentally regressive and contributes to widening the gaps between socioeconomic groups.

Figure 4. Household Expenditure on Total Consumption and Health by Quintile: Rates of Change, 1997–1999



[7] Gross and Brammli-Greenberg 2001.

Although the State Health Insurance Law stabilized the funding of the health system in 1995, in later years – including 2000 – the health funds accumulated budget deficits. These deficits were covered only in part by recovery plans or balancing arrangements concluded each year between the Finance Ministry and the health funds. It is widely agreed that the instability in sources of funding has led and will continue to lead to financial crises in the public-health system. According to the Witkowsky-Nevo report on healthfund activities, the funds' deficit was NIS 1.5 billion in 1997 but then dropped to NIS 800 million in 1998 and NIS 200 million in 1999. It is estimated that in 2000 the deficit in the health funds' budgets went back up to NIS 650 million. In 2001, these budgets are expected to have a larger deficit than in 2000. Due to the financial instability and underfunding of the public health system, the private sector is expanding, black- and gray-market medicine is spreading, and illegal private medical services are being offered in several government hospitals. Furthermore, the health funds have taken measures to economize and improve their efficiency, including cutbacks in services. The Finance Ministry's policy throughout has been to reduce the funds' deficits by increasing co-payments for medicine, charging a fee for visits to specialists, and levying additional fees for the use of health services. As a result of this policy, the burden of co-payments by healthfund members almost doubled between 1995 and 2000, as manifested in the increase in the funds' income from these payments – from an average of NIS 136 per (standard) person in 1995 to NIS 256 in 2000 (in constant 1999 prices).[8] Later we will discuss one of the adverse effects of this policy: a tendency among the weaker population groups not to buy medicine prescribed by a doctor due to its cost.

The financial crisis in the health funds and public hospitals, caused by failure to adjust the cost of the "basket" of healthcare

[8] Witkowsky and Nevo 2000.

services covered, is discussed at length in a report by a parliamentary commission of inquiry into the implementation and funding of the State Health Insurance Law (the Tal Commission), submitted to Knesset members in late February 2000. The commission found that the value of the individual annual healthcare "basket" received declined by about NIS 200 between 1995 and 2000 (in real 2000 values). The commission recommended legislating a mechanism for adjusting the cost of the "basket" of health-fund services. This mechanism would include a demographic coefficient adjusting the cost to the size and age of the population; a technological coefficient; and a coefficient for the healthcosts index, which would be adjusted to the cost of the health funds' actual inputs including a factor not currently part of the index: the cost of a hospitalization-day. Despite the commission's recommendations, the government decided not to introduce such legislation and instead is continuing the present policy of setting the cost of the "basket" each year "in keeping with budgetary priorities."

3. Health Services

a. Hospitals

Of 14,165 general hospital beds in the year 2000, 46 percent were governmentowned, 30 percent were owned by Clalit Health Services, 16 percent were owned by some other public entity, and 8 percent were privately owned. The occupancy of beds in general hospitals declined slightly that year (to 93.1 percent), while the average hospital stay (4.3 days) did not change and turnover in utilization of beds in general hospitals decreased.

One salient feature of hospitalization in recent years has been the establishment of specialized care units in general hospitals. The establishment of specialized units is a means of giving substantial pay increases to senior physicians, since each new

specialized unit increases the on-call shifts of the doctors in charge of it. Furthermore, the opening of a new specialized unit results in the hiring of additional workers and the purchase of new equipment. In 1981 there were 76 specialized units in government hospitals, most of them with hospital beds. Another 54 specialized units were added in 1981–1989 and another 199 in 1989–1999, most of them with no hospital beds (according to data from the Finance Ministry Budget Division). The addition of specialized units apparently has an impact on the demand for the health services provided by those units.

As a example of this, the number of transplant units in general hospitals in Israel is much larger, relative to the population, than in OECD countries. In 1998, according to Health Ministry data, 26 heart transplants, 16 lung transplants, and 51 liver transplants were performed in Israel in nine transplant centers. In terms of the need to carry out a minimum number of transplants in order to achieve a reasonable level of professional expertise, as well as from the standpoint of economic efficiency, it would be better to have one or two national centers to perform all transplants. The proliferation of transplant units beyond what is required by the population size necessarily leads to a reduction in the number of transplant operations performed by each surgeon and a decrease in each surgeon's experience and professional skill, and as a result may have a detrimental effect on the health of transplant patients. Many countries use regulatory measures to keep the number of transplant units down. For example, in the US any hospital that wishes to perform transplant surgery using public funds must perform a minimum number of transplants of each type. In the Netherlands, with a population of 18 million, there are two transplant units for livers and hearts.

The matter of reorganizing hospitals belonging to the government and to Clalit Health Services as corporations is still on the agenda of Israel's health policymakers. The incorporation

of the hospitals was supposed to produce an internal "market" within the hospital system and to free the Health Ministry from having to act as the overall administrator of dozens of hospitals. As a result, the Health Ministry would be able to focus on its ministerial functions, including setting health policy, monitoring the health service providers, and setting rules for the behavior of these entities, including the health funds and hospitals.

A CSPS position paper concerning procedures for the incorporation of government hospitals explains why the process has failed and suggests alternatives for the future.[9] The alternatives include the continuation and completion of the process of incorporation, the establishment of a centralized hospital authority, and the formation of a hospital authority through which each hospital would receive the status of a quasi-corporation. The situation that has now developed is one of the matters examined in the position paper. The paper found it to be extremely problematic, since the incorporation process is plodding ahead without the setting of clear stages of progress and, more importantly, without the demarcation of goals and the setting of clear rules of conduct for government hospitals that are in the midst of this process. For example, private medical care has spread within government hospitals.

The rules of conduct should include several components, the first being a new method of remunerating hospitals. The present method has undesirable ramifications, as described in the position paper. It is based on predetermined rates for a hospitalization-day and some thirty hospital activities. Among the undesirable effects of the present method of remuneration is the emergence of specialized medical care in hospital outpatient clinics, which results in problems of duplication with the parallel development of these services in the community. The rules of conduct for incorporated hospitals should also address the form and essence of the competition between them. It is known from

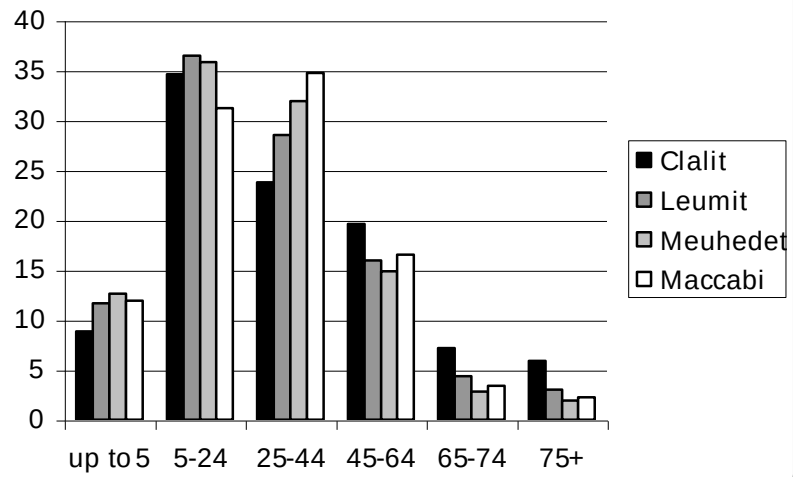
[9] Shirom et al. 1997.

the international literature that such competition is often associated with the development of "worthwhile" hospital services such as private medical care of various kinds in hospitals.

b. Health Funds

According to the State Health Insurance Law, every resident of Israel must be registered with one of four health funds in order to receive the "basket" of health services guaranteed under the law. The four health funds in Israel, in order of size, are Clalit Health Services, Maccabi Health Services, the Meuhedet Health Fund, and the Leumit Health Fund. Each fund receives its share of the healthcare budget from the National Insurance Institute (NII) based not on the actual number of people it insures but on a weighted number of insured persons; the weighting is done according to the age structure of each fund's membership. With the exception of the youngest group, as the age of the insured person rises, the allocation that the fund receives increases; a senior member – over age 75 – is equivalent to more than three members of average age. As an illustration of this capitation principle, we present the case of Clalit Health Services, which insures more than two-thirds of the elderly but only 57 percent of the total population (in 2000). At the beginning of 2001, Clalit insured 3,642,000 people, but its weighted number of members, computed according to the capitation formula, was around 4,169,000. This difference takes into account the highly unbalanced age structure of the Clalit membership.

Figure 5. Distribution of Health Fund Membership by Age, 1999



NII figures for January 2001 show that Clalit's share of the weighted number of insured persons declined in 2000. Since the State Health Insurance Law went into effect in January 1995, Clalit's share of the weighted number of insured persons has fallen by 7.1 percent to 61.3 percent in January 2001. According to NII data for 1999, the percentage of members aged 25–44 is the lowest in Clalit – 24 percent, versus 35 percent in Maccabi, 32 percent in Meuhedet, and 28 percent in Leumit. This substantial difference in the age structure of the funds has not changed much in the past few years. Assuming that no major change occurs in this age structure in the coming years, Clalit's share can be expected to decline further, while the other funds increase their share. Consequently, Clalit Health Services will have to devise a strategy for the gradual decrease of its share of the Israeli population and Maccabi and Meuhedet will have to devise a strategy for the gradual increase of the percentage of people they insure.

We have already noted that more than two-thirds of elderly persons in Israel are insured by Clalit – much more than in the other age groups. Moreover, people aged 65 and over, among whom the proportion of low-income people is greater than in the general population, constitute 12.9 percent of Clalit members, compared with 5.5 percent in Maccabi, 4.5 percent in Meuhedet, and 7.1 percent in Leumit. According to a Health Ministry report on the health funds' activity in 1999, weighted per-capita expenditure in Clalit Health Services in 1999 was NIS 2,686 per year, similar to that in Meuhedet (NIS 2,692). Weighted per-capita expenditure that year was higher in Leumit (NIS 2,733) and highest of all in Maccabi (NIS 2,810).[10]

4. Satisfaction with and Responsiveness of the Health System

The health system's responsiveness to the legitimate demands of citizens and a reduction in the inequality of this responsiveness between different socioeconomic groups are paramount goals of any country's health system. It is one of three goals: the other two are improvement in the state of the health of the populace, along with a reduction in the inequality in the health status between different socioeconomic groups; and fair funding of health care. These goals reflect basic criteria according to which the effectiveness of every health system is measured. The WHO uses the term "responsiveness" for indices such as consumer dissatisfaction, availability and access to health services from the consumer's perspective, and the consumer's freedom of choice and autonomy.

In recent years the CSPS has conducted public-opinion surveys of a representative sample of consumers examining a variety of aspects of social policy in Israel, including an

[10] Witkowsky and Nevo 2000.

assessment of the improvement in health services. The surveys all asked an identical question: Compared to the situation one or two years ago, is the level of health care better? Those surveyed were asked to choose one of the following options: much better, somewhat better, no change, somewhat worse, or much worse. In 2000, 10.6 percent of respondents reported that the level of health care in Israel was somewhat or much worse. In 2001, in comparison, this figure was 10.2 percent. An analysis of the responses by background variables – including sex, age, country of origin, year of immigration, level of education, religiosity, occupation, and income level – indicates that affluent native Israelis aged 50–64 of European or American origin and whose income was self-described as well above average are the group in which a relatively high proportion perceived a worsening in health care. In 2001, for example, 23.2 of those with above-average earnings expressed this feeling.

How satisfied are Israelis with the health services that they receive from their health fund? According to the survey conducted by the CSPS in September 2001, 89 percent of respondents assessed the level of service that they received from their health fund as good. In 2000 a comparablesized sample of residents was asked a similar question: How satisfied are you with the services that you receive from your health fund? A total of 83.5 percent replied that they are satisfied or very satisfied. However, because it is a guiding principle in health systems to strive for constant improvement in the quality of service, we will focus on the group of respondents who were dissatisfied with and did not have a high opinion of the service that they receive from their health fund.

A caveat should be attached to these findings, as well as to the results of similar publicopinion polls conducted by other organizations in recent years. None of these polls took into account the state of health of the people in the sample, and no data were collected on the prevalence of chronic illnesses and

the actual utilization of health services of those surveryed. The people included in the samples, it may be assumed, use only a small variety of health services and to a limited extent. Thus, public-opinion surveys of this sort do not reflect the opinions of those users for whom the quality of health care received from their health fund is especially critical, i.e., the chronically ill.

The group of respondents in the public-opinion survey for 2001 who did not view their health fund's services positively – close to 11 percent assessed the level of service that they received from their health fund as not good or not so good – was analyzed demographically. It was found that the people dissatisfied with their health funds included a disproportionately high number of people aged 64 and above, retired people, and people with belowaverage incomes. Among immigrants from the Soviet Union who came to Israel before 1989, i.e., those who have been in Israel for a relatively long time, about 21 percent had an unfavorable view of their health fund's services, almost twice the average for insured persons overall. About two-thirds of the people in this group are insured by Clalit Health Services. It should be emphasized that only a minority – one-third – of the immigrants from the former Soviet Union who came to Israel after 1989 joined Clalit. This group showed a marked preference for the other three funds.

A comparison of the satisfaction of members of the different health funds in 1995, 1997, and 1999 – based on surveys by Gross and Brammli-Greenberg – shows an increase in satisfaction levels between 1995 and 1997.[11] The percentage of members who were "satisfied" or "very satisfied" rose, with the biggest change in Clalit, whose satisfied membership increased from 80 to 90 percent. Between 1997 and 1999 there was a drop in the number of satisfied members in Clalit and Leumit. Meuhedet members remained as they were, with 95 percent satisfied or very satisfied. Only in Maccabi did satisfaction

[11] Gross and Brammli-Greenberg 2001.

improve – from 94 to 96 percent. Based on a comparison of the 1997 and 1999 surveys, Clalit is growing worse, or at least not improving, in terms of satisfaction and the level of service as perceived by those surveyed (a representative sample of adult Israelis aged 22 and over). The survey data from the three years are presented below in detail.

Table 3. Satisfaction with Health Funds, 1995, 1997, and 1999, by Fund (*Percent satisfied or very satisfied)*

	Total	Leumit	Meuhedet	Maccabi	Clalit
1995	83	85	91	91	80
1997	91	91	95	94	90
1999	89	85	95	96	86

Source: Gross and Brammli-Greenberg 2001.

The same report by Gross and Brammli-Greenberg includes data, arranged by health fund, on the percentage of people in the 1999 sample who are dissatisfied with each of eleven different services. Of the eleven services, two clear sources of dissatisfaction are the selection of medications and the ease with which medicine can be obtained in the fund. Of those insured by Clalit Health Services, about one-third were dissatisfied with the selection of medicines in the fund (compared with one-fourth in Meuhedet and Leumit and 15 percent in Maccabi), and one-third were dissatisfied with the ease of obtaining medication (compared with 17 percent in Meuhedet and only 7 percent in Maccabi and Leumit). These data are important in part because of the number of chronic patients in Clalit who need medicine on a regular basis: in 2000, 16.3 percent of Clalit members were defined as chronically ill with high blood pressure, diabetes, heart disease, asthma, and malignant diseases.

5. Other Health Issues

a. Trends in the Use and Regulation of Medication

The CSPS report for 1999 presents comparative data on the share of medication in national health expenditure in developed countries. According to a publication of the Central Bureau of Statistics on national health expenditure in Israel, the share of medicine and medical instruments purchased by households (excluding the purchase of medication by hospitals and health funds) in national health expenditure rose from 5 to 6 percent between 1996 and 1997 (the last year covered by the publication). The annual changes since the State Health Insurance Law went into effect in 1995 have been substantial: the figure rose 20 percent per year in 1995 and 1996 and another 4 percent in 1997.

In the ten years from 1989 to 1998, household expenditures on medicine rose substantially. These expenses pose a major financial burden for households in the lowest income decile, i.e., those with the lowest income. The availability and selection of medicine through the health funds are sources of dissatisfaction, especially for members of Clalit Health Services, as indicatedin the previous section.. Data from the Witkowsky-Nevo report (2000) indicate that the health funds spent an annual average of NIS 536 per member on medication (1999). There was a major difference between health funds: NIS 479 in Clalit, versus NIS 565 to NIS 673 in the other funds. In Clalit Health Services, co-payments cover 43 percent of the fund's medication expenditure, compared with only 30 percent in the other funds. The Arrangements Law for 1998, which increased medicine co-payments by members of health funds, set a monthly ceiling for payments by chronic patients. Therefore, the differences in the percentage of chronic patients insured by each fund cannot explain this disparity between medicine co-payments by members of Clalit and the other funds. The differences

apparently have to do with the way the co-payments are computed. Even before 1995, Clalit calculated co-payments per "dose" of the medication; the size of this dose was determined by the fund itself. In contrast, the other funds compute the co-payment on the basis of the full retail price of the medication, with the minimum co-payment currently NIS 17. Frequently, the full retail price of the medication bears no relation to the price that the fund actually paid the supplier. The Health Ministry is aware of this problem, but so far the present method has not been changed. Co-payments rose in 1999 and again in July 2001. On average for all the health funds, consumers pay 14–16 percent of the price of medication in co-payments.

Another aspect of medicine co-payments is that they sometimes prevent those in the lower socioeconomic groups from purchasing prescribed medications. According to the survey of satisfaction mentioned above, 11 percent of the people interviewed reported that in the previous year (the survey was conducted in 1999) they had refrained from buying medicine prescribed by a doctor because of the price. A study conducted by Ben-Gurion University examined the impact of co-payments on the use of prescription medicine for children with acute infections during the six weeks of the study.[12] The study was carried out in a pediatric clinic in Qiryat Gat, a city rife with unemployment at the time. It was found that about one-fifth of the prescriptions were not filled or only partially filled. The researchers interviewed the parents to find out the reason they had not obtained the medications prescribed for their child. Approximately one-third of those questioned responded that they did not fill the prescription because of the co-payment; this third is characterized by low-income and high housing density. The researchers concluded that the co-payment policy is having an adverse effect on the health of low-income population

[12] Reuveni et al. 2001.

groups. This effect runs counter to the principles of justice and equality which is the basis of the State Health Insurance Law.

The medicine sector is one of the few sectors of public health care in which a reform was implemented and further reform is planned. In the first stage, price controls were lifted from non-prescription medicines in order to boost competition and lower the prices of non-prescription drugs. In fact, the prices of these medications increased by about 40 percent. In this context, the second stage of the reform was implemented in an attempt to reduce the prices of non-prescription medicine: the Arrangements Law for 2002 includes a clause permitting the sale of non-prescription medicine outside pharmacies – for example, in supermarkets.

The Finance Ministry claims that these price increases were due in part to inadequate access to these medications and to the fact that their sale was restricted to pharmacies. The Arrangements Bill is intended to make the situation in Israel similar to that in many countries in Europe (e.g., the Netherlands and England) and North America, where non-prescription medicine is sold in retail storesas well as automatic vending machines in public places. The bill has yet to be passed by the Knesset; if it is, it will substantially change the Israeli consumer landscape. Another change included in the Arrangements Bill for the coming year will shorten the lengthy, expensive process of licensing medicine in Israel by stipulating that any medication already approved by the US Food and Drug Administration (FDA) or its equivalent in the EU (EMEA) will be eligible for licensing in Israel in an abridged process.

b. Dental Health Care

Studies on dental health conducted in Israel indicate that this is one of the most problematic areas of the health system.[13] Dental

[13] See, for example, Horev and Chernichovsky 1999.

health care is an example of what happens to an important area of health care when it is entrusted to private-market mechanisms. In the fifty years since the establishment of the State of Israel, and even prior to that, dentistry in Israel has been based on the principles of a free market and competition, with minimal involvement and regulation by the Health Ministry. The State Health Insurance Law of 1995 did not change this situation, since, with the exception of certain examinations (preventive dental exams for children), dental health care is not included among the health services covered by the law.

In most developed countries, direct payment by the recipient is a fairly limited component of health system financing. In the past two years, there has been a rise to 29 percent in the share per household in financing national health expenditure. A substantial portion of these payments are to dentists, who are paid directly by the recipient of the service. About 90 percent of expenditure on dental health care is paid directly by Israeli households.[14] Ostensibly, the present system of dentistry in Israel resembles that in the United States, except that there most adults (57 percent) have dental health insurance, whereas in Israel only 8 percent do.[15] In terms of social solidarity and fair funding of the health system, the latter of which, according to the WHO, is a major goal of health systems around the world, this form of healthcare funding is customarily viewed as regressive, posing a burden on weak population groups.

There is clear evidence that the market mechanism has failed to ensure a reasonable supply and equity of dental health care in Israel. Instead, it has caused a tremendous flow of resources to dentistry, financed directly by Israeli consumers. This money flow is reflected, inter alia, in a large number of dentists relative to the population and a greater percentage of national health expenditure on dental health than in other developed countries.

[14] Berg, Rosen, Sgan-Cohen, and Horev 1996.
[15] Berg, Zusman, and Horev 2001.

According to various approaches to evaluating the effectiveness of health services, the result of this state of affairs is that Israel ranks around the bottom of the Western scale in every indicator of dental health, including dental morbidity of various kinds. The Israeli dental health system is inferior to the United States, too, where dental health care is also private. This is because dental health care in Israel is predominantly treatment as opposed to preventive care. Moreover, fluoridation of drinking water in Israel is still only partial.

The survey conducted by the CSPS in September 2001 included the following question: "In your opinion, should dental health services be included in the healthcare basket, even if it means raising citizens' premiums for national health insurance?" Of those sampled, 73 percent replied that it would be "desirable" or "highly desirable," and another 9 percent indicated that they were indifferent. A vast majority of the subjects in the CSPS sample are in favor of the proposal to include dentistry in the healthcare basket that the health funds provide, even if this entails higher premiums for national health insurance. The rate of support for including dentistry in the healthcare basket did not vary greatly by age, sex, education, or occupational level. Nor were differences found between the religious and the secular or between immigrants from different countries. This sweeping support reinforces a clear recommendation that the CSPS included in its previous reports to make dental health care for those up to age 18, as well as all preventive dental health services, part of the healthcare basket. This recommendation is based both on considerations of social solidarity and equality in access and availability of health services as well as on economic considerations, since this change would reduce national health expenditure.

c. Mental Health Care

One of the topics dealt with at length in the most recent annual report of the WHO is mental health care. According to the

report, one of every four people is expected to suffer from mental illness at some point in his or her life, but neglect, the stigma of mental illness, and a desperate shortage of resources prevents most of these people from receiving help. Psychiatric and neurological illnesses now account for about one-third of total morbidity in the world. The burden of mental illness is the greatest in industrialized countries, because their populations are older. The WHO projects that, in 2020, clinical depression will be the secondleading cause of morbidity in the world. The WHO's main recommendation to governments around the world is to combine treatment of mental illness with communitybased primary health care, and to assist in this by providing guidance and assistance to primarycare physicians, nurses, and other health professionals in the community. The report recommends a shift from institutional treatment of psychiatric patients to communitybased treatment with the aid of new medications that make this possible. The report includes a series of alternatives for implementing and funding the shift from hospitals to the community.

Mental health care in Israel, as in other countries, still suffers from an "apartheid" policy, i.e., separate hospitals, community-based treatment not covered by the health funds, and severe discrimination against the mentally ill in supplemental insurance plans. For the sake of comparison, the US Senate is about to pass a bill that has already been approved by the House of Representatives, requiring complete parity between mental patients and other patients with respect to eligibility for healthinsurance benefits. In 2001 a policy decision was made in Israel that would make the Health Ministry responsible for psychiatric hospitalizations, in diametrical opposition to the WHO recommendations in this regard, which, as stated, call for the integration of mental health care with community services. So far, the legal situation regarding responsibility for communitybased treatment of mental patients remains vague

and highly problematic. In practice, the Health Ministry treats some of the patients in community mental health clinics, and Clalit Health Services operates its own system of communitybased treatment. The other funds do not have any significant system of communitybased mental health treatment. A reform of mental health care planned since 1995 (or even prior to that) would put the health funds in charge of providing these services, including hospitalization. This reform complies with the principles set forth by the WHO. So far the planned reform has not been implemented due to disputes over suitable infrastructure budgets for communitybased alternatives to hospitalization and a disagreement between the health funds and the Health Ministry regarding the redirection of budgets for mental hospitals to the rehabilitation of these patients in the community.

The severe neglect from which the mentally ill suffer in Israel can be described in budgetary terms. The Health Ministry's budget for mental health care in 2001 was NIS 949.4 million, about 7 percent of its total budget and 5 percent less than in the 2000 budget. A position paper published by the CSPS on this subject emphasizes that, of the estimated 70,000 chronic mentally ill in Israel, only about 6,300 are in mental hospitals.[16] Nevertheless, most of the Health Ministry's budget for mental health care – 81 percent – goes to hospitals. The budgeting method practiced in the mental hospitals for the mentally ill, based on an allocation per occupied hospital bed, precludes administrative flexibility and the diversion of resources to rehabilitation activities in the community. Operating psychiatric hospitals as general mental health centers and as part of a communitybased treatment system, with community services available and accessible for continuous treatment, might permit integration of the communitybased and hospitalization services, while allowing for flexibility of resources and transferring the

[16] Aviram 1997.

emphasis to communitybased preventive treatment, in line with the WHO recommendations.

Every year, approximately 4,000 new patients are admitted to psychiatric facilities. Most of them are discharged within less than a year. For many of those who are discharged, there is no suitable rehabilitative solution in the community. The Health Ministry continues to fund the hospitalization costs of hundreds of mentally ill patients with no medical justification, simply because there is no suitable setting for them in the community. These data, which are included in the 1998 State Comptroller's Report,[17] demonstrate the urgent need to allocate the funding required for the creation of community based alternatives to psychiatric hospitalization and to have the health funds take responsibility for them. The present state of affairs in mental health care is described in the State Comptroller's Report as a moral and professional failure. The vast majority of the mentally ill live in the community, but only a few thousand receive rehabilitative and preventive therapy from voluntary organizations such as *Enosh*, *Hitmodedut*, and *Benafshenu*. The situation is even graver with respect to mental health care for children and teenagers. According to a survey by the Brookdale Institute, about 7 percent of children aged 14 and under suffer from physical or mental disabilities or behavioral problems.[18] Fewer than 20 percent of the children who require psychological intervention – including those with drug and alcohol addictions – reach professionals. The shortage of funds and professional staff positions for communitybased mental health care is causing an increase in unnecessary hospitalizations and greater reliance (among those who can afford it) on private treatments.

In 2001, there was some change for the better with respect to the rehabilitation of the mentally ill in the community. At the

[17] State Comptroller 1999.
[18] Naon 2000.

beginning of the year the Community Rehabilitation of Mental Patients Law, sponsored by MK Tamar Gozansky, went into effect. The new law calls for setting up regional rehabilitation boards to examine the eligibility of each chronic mentally ill patient in the community for a rehabilitation program. Various rehabilitation services are to be offered to the mentally ill in the community, including assistance with employment, housing, education, dental care, and support groups for mentally ill patients and their families. In expectation of when the law would take effect, the Health Ministry prepared to grant a package of community rehabilitation services to approximately one thousand chronic mentally ill patients, in addition to those already in rehabilitation programs; the plan would cost an additional NIS 100 million, only part of which had been approved by the middle of the fiscal year.

Sources

Aviram, U. 1997. "Mental-Health Services at a Crossroads: Prospects and Risks in View of the State Health Insurance Law." In Y. Kop (ed.), *Israel's Social Services 1997.* Jerusalem: Center for Social Policy Studies in Israel (Hebrew).

Bendlak, Z. 2000. *Health Fund Membership*. Jerusalem: National Insurance Institute. Periodic survey no. 168 (Hebrew).

Berg, A., B. Rosen, H. Sgan-Cohen, and T. Horev. 1996. *Household Expenditure on Dental Medicine*. Jerusalem: Brookdale Institute. Research report 255-96 (Hebrew).

Berg, A., S. Zusman, and T. Horev. 2001. *Social and Economic Aspects of Dentistry in Israel in the Age of National Health Insurance*. Jerusalem: Brookdale Institute. Research report DM-359-01 (Hebrew).

Central Bureau of Statistics. 2000. *National Expenditure on Health in 1962–1999.* Jerusalem.

Central Bureau of Statistics. 2001. *National Expenditure on Health in the Year 2000.* Jerusalem, publication 173/2001.

Gross, R., and S. Brammli-Greenberg. 2001. *Public Opinion on the Level of Service and Functioning of the Health System in 1995, 1997, 1999.* Jerusalem: Brookdale Institute (Hebrew).

Horev, T., and D. Chernichovsky. 1999. "An Optimum Model for Israel's Dental Care System." In Y. Kop (ed.), *Israel's Social Services 1999.* Jerusalem: Center for Social Policy Studies in Israel (Hebrew).

Naon, D., B. Morginstin, M. Schimmel, and G. Rivlis. 2000. *Special-Needs Children: Assessment of Needs and Their Coverage by the Services.* Jerusalem: Brookdale Institute (Hebrew).

Office of the State Comptroller. 1999. *Report on 1998.* Jerusalem (Hebrew).

Parliamentary Commission of Inquiry into the Implementation and Funding of the State Health Insurance Law. 2000. Jerusalem: The Knesset.

Reuveni, H., B. Sheizaf, A. Elhayani, M. Sherf, Y. Limoni, S. Scharff, and R. Peled. 2001. "The Effects of Co-payment Policy on the Purchase of Prescription Medication for Children in the Community with Acute Infections." Unpublished manuscript, Ben-Gurion University, Faculty of Health Sciences, Department of Health Policy and Management.

Shirom, A., N. Egoz, G. Ben-Nun, H. Doron, D. Michaeli, J. Michel, and D. Chernichovsky. 1997. "Incorporation of Public Hospitals in Israel. Assessment of Developments and Policy Alternatives." In Y. Kop (ed.), *Israel's Social Services 1997*. Jerusalem: Center for Social Policy Studies in Israel (Hebrew).

Shmueli, A., and R. Gross. 2001. "Income-Related Inequality in Health in Israel in the 1990s." *Social Security* 59.

Witkowsky, Y., and Y. Nevo. 2000. *Report on the Health Funds' Activity in 1999*. Jerusalem: Health Ministry, Unit for Monitoring of the Health Funds (Hebrew).

World Health Organization. 2000. *World Health Report 2000: Health Systems – Improving Performance*. Geneva.

World Health Organization. 2001. *World Health Report 2001: New Understanding*. Geneva. Accessible at www.who.int/whr.