

# POLICY BRIEF

## Hot Issues in Israel's Healthcare System

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### Introduction

The Israeli healthcare system has long produced good comparative healthcare outcomes on a range of indicators – low infant mortality, high life expectancy, effective chronic disease management, and good primary care quality. These results are consistent with the country's longstanding history of developing and supporting community and primary care with a strong public health orientation.

The National Health Insurance Law, enacted on January 1, 1995, ensures universal healthcare coverage for Israeli citizens and permanent residents. In recent years, however, there has been a greater shift away from public financing and an increase in private insurance coverage, which has led to concerns about Israel's full commitment to publicly-financed, universal healthcare. There has also been a longstanding discussion about the dual role of the Ministry of Health: serving both as regulator, responsible for licensing, planning and regulating healthcare facilities, professionals and medical technology, and care provider and hospital owner – two roles that could conflict with each other.

Due to various concerns about public hospital care in Israel, Minister of Health Yael German commissioned a 13-member "Committee to Strengthen the Public Health System" in June 2013 to recommend policy and operational changes to the healthcare system. The key discussion issues include: 1) The public-private mix in healthcare expenditures and *Sharap* (*Sherutei Refuah Prati'im*), privately paid care in hospitals that provide publicly-entitled care; 2) private insurance including commercial plans and supplementary insurance plans sold by Israel's public health plans. The supplementary plans are considered semi-public due to their organizational structure and governing regulations requiring, for example, that all members within an age group pay the same rate; 3) the dual role of the Ministry of Health as service provider and regulator; and 4) medical tourism. This brief provides a short context on healthcare system issues relevant to the German Committee discussions.

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**This brief provides background and context on major healthcare issues currently under discussion in Israel, including the provision of private healthcare services in public hospitals, growth in private insurance and government hospital ownership**

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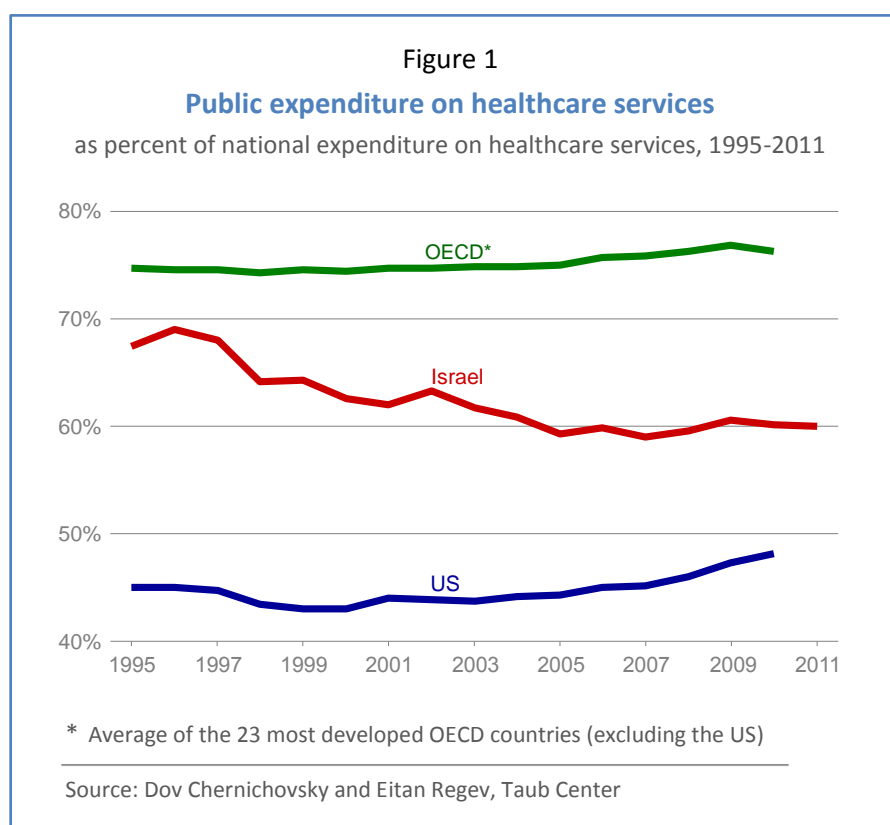


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## Healthcare Financing

- Healthcare spending, at 7.7% of Israel's 2011 GDP, is the fourth lowest relative to 23 other OECD countries that average 9.7% of GDP. After adjusting for population age, Israel's 7.9% of 2011 GDP spent on healthcare places it ninth lowest relative to the 24 OECD countries examined. The average spending of the other 23 countries is 8.1% of GDP (OECD data, 2011, analysis by Eitan Regev).
- In the other 23 OECD countries, the average share of national healthcare spending that is publicly financed has remained steady over the last 15 years, and is currently at 76%. In contrast, Israel's public financing share has declined almost 10 percentage points over the same period (Figure 1) and stands at about 60% (Chernichovsky and Regev, 2013). Israel's lower share of public financing is partly due to the fact that in Israel, in contrast to other OECD countries, there is substantially less government funding for long-term care for older seniors.
- As stated, 60% of healthcare spending in Israel is financed by the public and paid for via a combination of general and health taxes. The 40% share of private healthcare spending is distributed as follows: 26% for direct purchase of private services, 12% for semi-public supplementary and commercial insurance premiums, and 3% for co-payments on publicly-covered services) (Chernichovsky and Regev, 2012, analysis by Liora Bowers).



### Healthcare Coverage

- Four competing non-profit health plans (Clalit, Maccabi, Leumit, and Meuhedet) provide insurance for Israel's population, covering the basic basket of health benefits guaranteed to Israelis under the National Health Insurance Law.
- The government has increased the health basket by about 1% annually over the last decade to include new technologies or pharmaceuticals. In 2007, public debate about the adequacy of the basket led to a temporary approximately 1.8% increase in the healthcare basket for the following three years (Rosen and Samuel, 2009). These increases are in addition to regular annual adjustments for demographic changes and increases in medical prices.
- There is concern that funding for the health basket is insufficient to cover the services guaranteed under the National Health Insurance Law. The four health plans had a deficit of 3.6% of their total budget in 2011, which required government support to reduce the deficit to 2.3% in 2012 (for a total NIS 861 million 2012 deficit). These ongoing deficits have led the plans to take out bank loans and delay payments to providers (Ministry of Health, 2013).
- Services such as psychological counseling, choice of doctors or nurses in acute care settings, and dental care are often paid for directly by households or private insurance, although there are some ongoing coverage reforms in mental health and dental care.
- Over a 12-year period (1999-2011), the percent of Israelis with semi-public supplementary insurance has grown from 46% to 73%, and the percent with commercial insurance has grown from 24% to 41% (Bin Nun, 2013) (Table 1).

### Healthcare Delivery

- Over the past decade, health plans have prioritized primary care reforms, including sizable investments in electronic medical records, a national program for quality measurement in chronic disease management, and development of multi-specialty care clinics.
- Government budget constraints and attempts by the Ministry of Finance to contain overall healthcare spending has led to declining hospital infrastructure – including facilities, capacity and technologies.
- Israel has among the lowest number of acute care hospital beds from the OECD countries and capacity increases have been negligible over the last decade. In 2011, Israel had 1.9 beds per 1,000 people, compared to an average of 3.0 beds among 23 of the most developed OECD countries (Chernichovsky and Regev, 2013).
- Hospital occupancy rates in Israel are the highest in the OECD – at 96% – as compared to the 76% average of 25 OECD countries. Israel's occupancy rates are also much higher than the 85% target that is considered the safe limit in the UK, Australia and Ireland (OECD, 2012).

### Hospital Wait Times

A 2009 State Comptroller Report highlighted that neither the Ministry of Health nor the Health Plans maintain reliable information on wait times, as waiting lists are dispersed among various hospital departments. It also noted that the Ministry of Health has not issued standards regarding wait times and that its regulatory procedures requiring hospitals to supervise wait times and establish relevant metrics have not been followed.

Even with minimal data available, the Report did suggest that wait times for certain elective surgeries were long due to several factors:

1. Lack of sufficient supply of anesthesiologists (30% fewer than the recommended standard) and operating room nurses;
2. Lack of sufficient reimbursement to entice physicians to perform certain surgeries in the afternoons; and
3. Surgeons moving to private or community work in the afternoons, among others.

The Report also indicated that because physicians often have multiple employers, it is difficult to obtain good estimates on physician take-home salaries.

Building on these concerns, there is a need to decide on systems that will effectively collect and monitor waiting times for elective procedures in hospitals.

**Table 1. A comparison of basic, supplemental and commercial insurance plans in Israel**

	National Health Insurance (NHI) - basic health plan	"Semi-public" Supplementary insurance	Commercial insurance
<b>% population coverage (1999)</b>	All citizens and permanent residents	46%	24%
<b>% population coverage (2011)</b>	All citizens and permanent residents	73%	41%; most also have supplementary insurance
<b>Insurer</b>	Four non-profit plans (Clalit, Maccabi, Leumit, Meuhedet)	Sold by the four basic health plans	Private insurance companies (e.g., Harel, Phoenix, Clal)
<b>Enrollment</b>	Individuals select and enroll in one of four health plans	Individuals purchase from health plan	About 45% of the insured are covered individually; 55% via employers/unions
<b>Issue, underwriting and coverage policies</b>	<ul style="list-style-type: none"> <li>Must be offered to all citizens and permanent residents, regardless of health status</li> <li>Services covered, known as the "health basket", are dictated by law</li> </ul>	<ul style="list-style-type: none"> <li>Highly regulated</li> <li>Must offer to all health plan members regardless of health status</li> <li>Cannot offer "life-saving medications" not in health basket, nor grant easier access to treatment abroad than does the basic health basket</li> </ul>	<ul style="list-style-type: none"> <li>Insurers allowed to reject applicants</li> <li>Great flexibility in services allowed to cover</li> <li>Insurers can require enrollees to seek reimbursement via the supplementary insurances first</li> </ul>
<b>Premiums &amp; health plan financial performance</b>	<ul style="list-style-type: none"> <li>Health plans receive a fixed payment for each member from the government (estimated at about NIS 4,100 in 2012), which varies only based on age, gender and geography</li> <li>Government pays the premiums, which are financed via a progressive employee health tax and general taxes</li> <li>Not premium payments but co-pays for some services</li> <li>Total cost of health basket services was NIS 34.7bn (2012)</li> <li>Operating deficits exist across all four health funds, totaling NIS 861mn (2012)</li> </ul>	<ul style="list-style-type: none"> <li>Premiums depend on program selected (each health plan offers two options)</li> <li>Premiums vary only by age (up to about double for a 65 versus 25 year-old)</li> <li>2012 average per-member annual premium: Range from NIS 595 for Meuhedet to 622 NIS for Maccabi</li> <li>NIS 3.5bn total revenue from supplementary insurance (2012)</li> <li>The health plans spent 82% of revenue from supplementary insurance, or 2.9bn, on medical expenses in 2012. The remaining revenue covers marketing, administration, profit, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Premiums based on various factors, including age, gender, health status and plan type</li> <li>Estimated 2010 average annual premium: NIS 1,375 for an individual policy; NIS 846 for a group policy</li> <li>2bn NIS total revenue to the insurance companies (2010)</li> <li>In 2010, insurers earned a profit of 19% on individual plans and 5% on group plans</li> <li>Medical loss ratio (share of premiums spent on healthcare services): 39% for individual policies; 81% for group policies (2010)</li> </ul>
<b>Services covered</b>	<p>Israeli law specifies a list of services that must be covered by health plans:</p> <ul style="list-style-type: none"> <li>Diagnosis</li> <li>Medical consultation, lab work and treatment</li> <li>Hospitalization</li> <li>Rehabilitation</li> <li>Treatment abroad (select cases)</li> <li>Select accessories, medical supplies, technology and pharmaceuticals</li> </ul> <p>The following are provided by the Ministry of Health directly: maternal/child health; nursing care; mental health (transition to health plans in process)</p>	<p>Design their own coverage, including:</p> <ul style="list-style-type: none"> <li><i>Sharap</i> (private services in public hospitals) / care in private facilities</li> <li>Preventative services (tests, vaccinations, home-monitoring equipment, sports rehabilitation orthopedic shoes)</li> <li>Curative (second opinions, transplants, chronic condition procedures)</li> <li>Medical (dental, orthodontic, fertility, diagnostics)</li> <li>Other (prenatal, dietary, lifestyle, etc.)</li> </ul>	<p>The companies offer a wide range of policies, with services such as the following:</p> <ul style="list-style-type: none"> <li>Transplants and surgeries abroad</li> <li>Co-pays not covered by supplementary insurance</li> <li>Life-saving medications not in health basket</li> <li>Faster diagnostic services</li> <li>Personal doctors/nurses to accompany patients through hospital stay</li> </ul>
<b>Regulatory oversight</b>	Ministry of Health	Ministry of Health	Ministry of Finance's Insurance Commissioner
<b>% of covered persons using benefit in last 2 years (2013)</b>	Not Available	73%	21%

Source: Liora Bowers, Taub Center for Social Policy Studies in Israel; Data: Various (see references)

- OECD data indicates a strong correlation between low hospital bed capacity and long wait times for medical care, and a slightly weaker correlation between overall health spending and long wait times. In line with these findings, the OECD categorizes Israel as having problems with waiting times in both inpatient and outpatient care (Siciliani, et al. 2013).
- 96% of hospital beds are located in public hospitals. Hospital bed ownership is distributed as follows: government (46%); Clalit Health Plan (30%); non-profit (e.g., Hadassah) (20%); private (e.g., Assuta) (4%) (Rosen and Samuel, 2009).
- Patients can generally visit any public hospital of their choice, although health plans increasingly steer patients to hospitals with favorable contracts. Within public hospitals, patients cannot select their treating physician.

### *Hospital Financials*

- Public hospitals have little control over the roughly 70% of their budgets spent on labor costs (Chinitz and Israeli, 2011). Almost all public hospitals in Israel have operating deficits; thus a pattern of “putting out fires” inhibits efforts at longer-term planning and infrastructure investment.
- Public hospitals use independent funds (special legal entities that they manage), which represent about 10% of their budgets, to entice top physicians with higher pay. Revenue to these funds comes from selling “after hours” public services to the basic health plans (Rosen and Samuel, 2009).
- Public hospitals are not permitted to accept private insurance at their facilities (*Sharap*). However, due to historic precedent, Jerusalem non-profit hospitals (Hadassah and Sharei Tzedek) are exempt from this prohibition.
- Medical tourism in Israel is still relatively small in terms of size and the number of hospitals involved, but is growing very quickly. While data is limited, it is estimated that public acute care hospitals received about NIS 470 million in 2012 revenue from medical tourism (or about 3% of their total income) (Linder-Ganz and Central Bureau of Statistics data, 2013, analysis by Eitan Regev). Government, Clalit and Hadassah hospitals each earned about 291 million, 70 million and 108 million shekels, respectively, from medical tourism in 2012. Sheba and Ichilov hospitals together represent almost 80% of medical tourism income revenue to government hospitals (Linder-Ganz, 2013).

### *Healthcare Workforce*

- Israel’s physician to population ratio was roughly 10% higher than the OECD average in 2009, largely due to the influx of doctors from the former Soviet Union in the 1990s (OECD, 2011; Rosen and Samuel, 2009).
- However, Israel has current shortages in anesthesiology and geriatrics, and faces potential future shortages in general surgery, internal medicine and pediatrics, among others (Israel Medical Association, 2011).

- With a small number of very competitive medical school enrollment slots, Israel had the lowest relative number of medical school graduates among 23 OECD countries in 2009 (Chernichovsky and Regev, 2013). However, a major expansion initiative by the state has doubled medical school capacity over the last several years and is expected to have a positive impact on supply in 6-8 years.
- Israel has a low supply of practicing nurses, and a very low number of nursing graduates (Chernichovsky and Regev, 2013).

### Physician Pay

- Public hospital physician contracts are negotiated through collective bargaining between the Israeli Medical Association (the physician's union) and hospital owners, including the government, Clalit Health Plan and Hadassah Medical Organization. The Ministry of Finance has regularly pushed back against increases in physician wages, due to concern this will have a spillover effect on wages of other public-sector workers (Rosen and Samuel, 2009).
- Public hospital specialists often work in private hospitals or community settings to supplement their income from the hospital. A 2001 Myers-JDC-Brookdale Institute study of six specialties (ophthalmology, dermatology, ear-nose-throat, gynecology, general surgery, cardiology) showed that 84% of physicians held more than one job, more than 40% had three or more workplaces, and that the surveyed physicians worked an average of 63 hours per week (Nirel et al., 2003).
- Physician strikes due to salary issues are commonplace in Israel. The most recent strike took place in 2011 and was resolved via a nine-year agreement, whose success is still greatly debated among physicians (for more details, see side bar).

### Conclusion

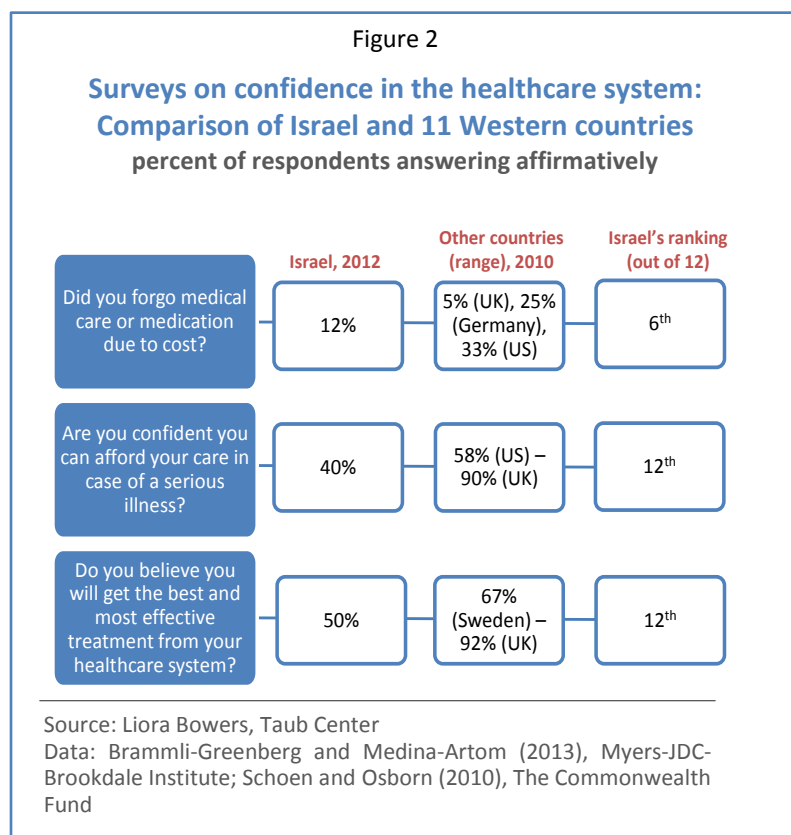
This brief provides a general overview of some primary aspects of Israel's healthcare system such as financing, budgets, and stakeholder relations – issues related to the current German Committee's focus. When considering the strength of the healthcare system, it is important to keep in mind public perception and confidence in the system. According to a 2012 survey by the Myers-JDC-Brookdale Institute, most Israelis – around 90% – express high levels of satisfaction with both their primary care physicians and their basic health plans. For the most part, Israelis are able to afford the medical care and medications they need (Figure 2). Nonetheless, when it comes to more acute healthcare needs that would require hospital care or complex treatment, there is much less faith in the system. Specifically, Israelis express very low levels of confidence that they will obtain the best treatment or that they could afford their care in case of serious illness. These anxieties have likely spurred the uptake of supplementary and commercial insurance and illuminate the importance of the issues under discussion by the German Committee.

There is great debate among the physician groups (the Israeli Medical Association (IMA), the hospital-employed physicians group and the medical residents organization), about the outcome of the 2011 physician strike.

The IMA's position is that the strike resulted in notable increases in physician wages, reduced workload, significant pay increases for understaffed specialties and for the periphery, limits on extended work shifts for residents and support for continuing education.

In contrast, hospital physicians and medical residents' organizations believe the 2011 physicians' strike settlement was insufficient. They believe the agreement did not do enough to raise overall physician wages, reduce hospital physician workload, adequately address workforce shortages, counter the move to the private market or address the gap between the higher salaries of community physicians as compared to hospital-based physicians (Chernichovsky and Regev, 2012).





As the German Committee and the country engage in this public discussion, below are some key issues for policymakers and the general public to consider:

- The lagging hospital infrastructure and large deficits of the basic health plans and public hospitals, alongside the growing private financing of care, may indicate that public spending on healthcare is insufficient in Israel. Nonetheless, any additional healthcare spending must be allocated in a manner that promotes continued system efficiency and efficacy, and be undertaken in consideration of other national priorities such as housing and education.
- Given the large growth in private health plan enrollment over the last decade, new policies to address Israelis' risk aversion in case of serious illness should be considered and access to certain services made universal. Such services should include options for obtaining a second opinion and some choice in selection of one's surgeon, as well as provision of care coordinators for complex medical cases. Such services can be added to the health basket directly, or made available through expanding supplemental insurance to cover the entire population, via subsidies where necessary.

- Given Israel's very low number of hospital beds, and the weak national data collection and monitoring of wait times for medical care, it is likely that lengthy wait times are a major problem. This likely contributes to Israelis' concerns about their healthcare and uptake of private insurance. Israel should consider adopting a national strategy to reduce waiting times, as many other OECD countries such as Canada, Australia and Denmark have done. Israel should also consider adopting some of the following policies, which have been shown to reduce wait times in OECD countries: Hospital payment systems that promote productivity (rather than admissions or long hospital stays); better management of waiting lists; guidelines to prioritize patients based on clinical need; sanctions on providers failing to meet waiting time guarantees; and, increased provider choice for patients (Siciliani, 2013).
- With only a fifth of enrollees using their commercial plan benefits in the last two years, many Israelis are likely "over-insured" or unnecessarily purchasing duplicate coverage. More can be done to help Israelis better understand their rights and benefits under their health plans.
- While debate continues about the success of the 2011 physician strike settlement, the underlying motivations for privatization remain. The relatively low wages and high workload of public hospital physicians must be addressed, albeit with a recognition that some pressure towards privatization and further remuneration for physicians will likely always exist.
- There is concern that *Sharap* and medical tourism exacerbate shortages in hospital beds and nursing, reduce access to the most experienced doctors, and increase waiting times for Israelis in the public system. However, private financing can also help improve care quality, keep top physicians committed to and practicing in public hospitals via higher pay, and provide additional revenue to improve overall hospital services. As such, Israel should consider ways to better regulate medical tourism and private care in order to both take advantage of the potential benefits while supporting the public system.
- The Ministry of Health's ownership of public hospitals leads to questions about its ability to objectively regulate hospitals and engage in effective long-term national planning as well as the impact on operational flexibility and customer service within the hospitals. Potential solutions range from simply providing more operational maneuverability to government hospitals, transitioning them to become non-profits or selling them to the health plans.

The issues under consideration by the German Committee are part of a much larger strategic discussion on the type, size and direction of Israel's healthcare system. Israel is in an excellent position to capitalize on technology and telecommunication advancements that are changing the nature of modern healthcare and shifting healthcare delivery outside of clinics and hospitals. Nonetheless, the pressing insurance and hospital system issues must be addressed, and done so alongside advancement of and coordination with home-based, primary and community care. The strong legacy of population health and community care is the foundation of Israel's healthcare system and a key contributor to the country's impressive achievements in healthcare outcomes.



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