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Current Developments in the Healthcare System

Dov Chernichovsky

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Center address: 15 Ha'ari Street, Jerusalem, Israel
Telephone: 02 5671818 Fax: 02 5671919
Email: info@taubcenter.org.il Website: www.taubcenter.org.il

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Introduction

The first part of this introductory chapter is about developments in financing of Israel's healthcare system. The second part discusses several of the stated goals for improving the system, as they are outlined in the Ministry of Health Plan for 2016 (Ministry of Health, 2016b):

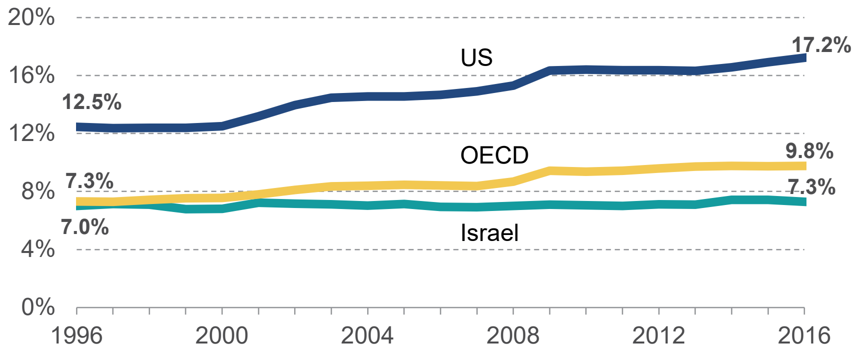
- Increasing access to services and choice in the public system (Goal 1.1 in the plan)
- Preparing the healthcare system for the aging of the population (Goal 4.1 in the plan)
- Adjusting the healthcare system to changes in the characteristics of the population due to chronic illness (Goal 4.3 in the plan)

1. Financing the system

In 2016, expenditure on healthcare in Israel was 7.3 percent of the GDP. That is 2.5 percentage points lower than the average in the developed countries in the OECD, and 10 percentage points lower than in the US (Figure 1). In contrast to the trend of rising healthcare spending as a share of GDP in other developed countries, spending in Israel has remained fairly stable over the 20 years between 1996 and 2016 (about 7 percent of the GDP). At the beginning of 2013, there was a slight increase in spending, but that trend has reversed over the past few years.

* Prof. Dov Chernichovsky, Principal Researcher and Chair, Health Policy Program, Taub Center. I wish to thank Aviv Brill for his invaluable help gathering data and creating the figures for this chapter.

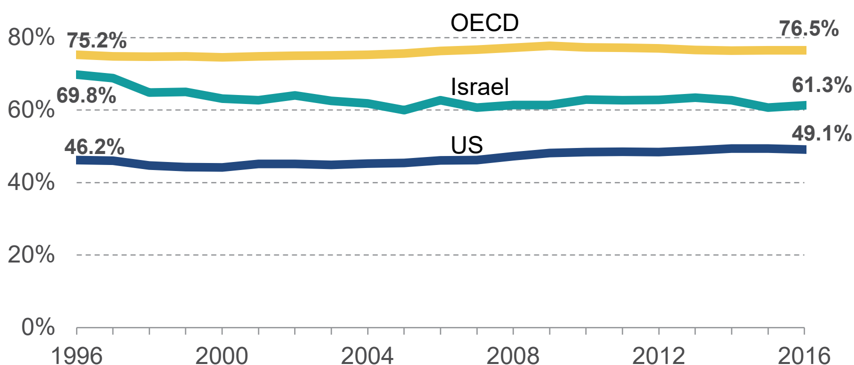
Figure 1. National expenditure on health as a percent of GDP



Notes: The OECD figure is an average of the 21 most developed OECD countries.
Source: Dov Chernichovsky, Taub Center | Data: OECD, Health spending indicator, 2017

The share of public funding out of the total national expenditure on health dropped from about 70 percent to about 60 percent between the mid-1990s and 2005, and has remained quite stable since then: ranging between 60 and 65 percent (Figure 2). Consequently, the share of public funding in 2016 was 15 percentage points lower than the average in the developed OECD countries that have universal health insurance like Israel, and 12 percentage points higher than in the US, which does not have universal insurance.

Figure 2. Percent of public expenditure out of national expenditure on health



Notes: The OECD figure is an average of the 21 most developed OECD countries.
Source: Dov Chernichovsky, Taub Center | Data: OECD, Health spending indicator, 2017

The drop in the share of public funding over the years is associated with an increase in private expenditure on healthcare out of total household expenses: from 4.6 percent, in 2000, to 5.7 percent, in 2015 (Figure 3). This rise comes mainly from increased spending on private insurance (Figure 4). While insurance used to represent 18 percent of private health spending in 2000, that figure increased to 37 percent by 2015.

Figure 3. Share of healthcare expenditure out of total household expenditure

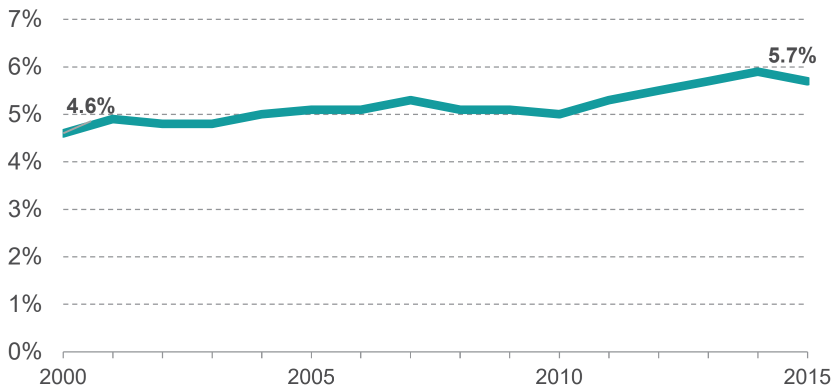
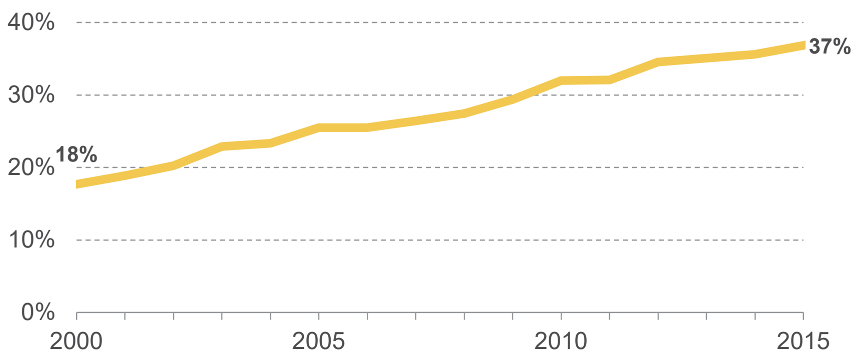


Figure 4. Expenditure on private insurance out of total household expenditure on healthcare



Source for both figures: Dov Chernichovsky, Taub Center | Data for both figures: CBS, *Household Expenditure Survey*

These data on healthcare funding — indicating stability in healthcare spending as a share of GDP along with a drop in the overall share of public funding — should be examined in light of some broader developments:

- Demand for medical care has increased in the last decade due to the rapidly aging Israeli population (Chernichovsky, Kaplan, Regev, and Stessman, 2017), as well as a rise of about 2 percent a year in overall per capita income.

- At the same time, there has been a drop in the supply of medical personnel in the system, at least in the public sector: the number of physicians under age 65 dropped from 3.43 per 1,000 population at the beginning of the 2000's to 3.08 in 2015, and the number of nurses under age 65 dropped from 6.4 to 5.7 nurses per 1,000. However, this may be a short-term issue only, as the number of medical students, licensed medical personnel and those beginning specialty training shows an upward trend (Ministry of Health, 2016a).

- The health insurance market and the healthcare services market are increasingly exposed to market imperfections and failures, mainly due to the monopoly power of the service providers. The failures are heightened by the health funds' supplementary insurance system, which requires those wishing to use their insurance to do so only in privately-owned facilities, mostly staffed by the same physicians who work in the public system.

Rising demand alongside falling supply, particularly in the public sector, are reflected in a rise in the price of healthcare. That is, given that the share of healthcare spending out of GDP remains stable while there has been a drop in the share of public spending, it can be deduced that the quantity of care available to each resident has diminished over time.

The healthcare financing situation is shown by the indices presented in Figure 5. Since the implementation of the National Health Insurance Law in 1995, spending on health rose at a similar rate as the GDP; that is, by about 40 percent (note the stability in the share of national expenditure out of GDP in Figure 1). These data do not take into account two factors: demographic adjustment to the needs of the population, and developments in the price of medical care.

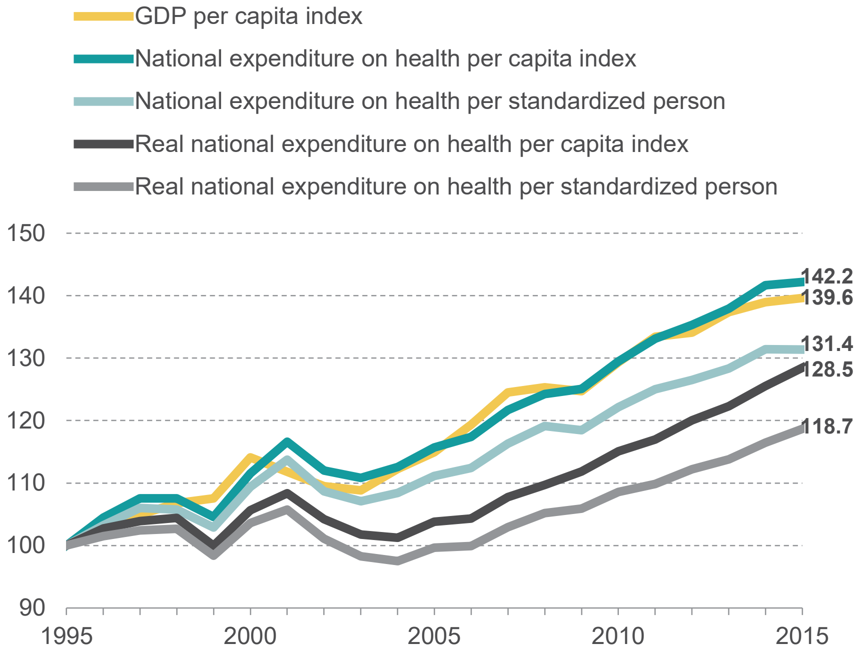
Demographic adjustment: Looking at the size of the population in terms of standardized persons — using the capitation method[1] that accounts for the influence of the population's changing needs like the aging population — the result is that spending per age-standardized person has eroded by 10 percentage points between 1995 and 2015.

Developments in the price of medicine: In addition to the erosion in spending that arises from an aging population, spending on healthcare has eroded by another 10 percent as a result of the relative rise in the price of medical care.

Thus, the rise in real spending on health — i.e., care available to the public, calculated by standardized person — has been about 20 percent since 1995 (compared to a 40 percent rise in spending when these factors are not accounted for). The situation is not as bleak as it might appear, though, since, at the same time, technological advances in medicine have led to more effective treatment with greater potential benefits, although these effects are difficult to quantify. Looking forward, the state can ameliorate the situation by financing more job positions in the public system for the growing number of medical personnel in the medium to long term.

1 The capitation formula is used to allocate budgets to the health funds. The allocation per resident is based on the age and gender of the insurance holder, relative to a standardized person, and includes a supplement for those living in the periphery. As such, the size of the population can be expressed in terms of standardized persons.

Figure 5. Expenditure index for healthcare out of GDP per capita
Index year: 1995=100



Notes: Standardized person according to the capitation formula that accounts for gender and age. Real expenditures are adjusted for inflation in the cost of medical care.

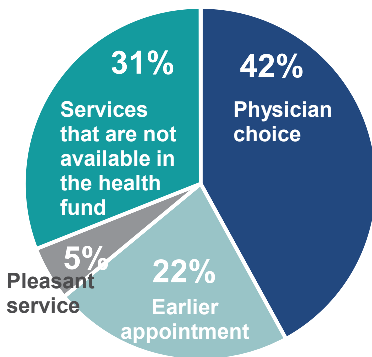
Source: Dov Chernichovsky, Taub Center | Data: CBS, *Statistical Abstract of Israel 2016*

2. Increasing access to services and choice in the public system

Waiting times for medical treatments, in particular hospitalization for elective surgery, are longer in the public system than in the private system. As shown in a previous Taub Center study on the subject (Bowers and Chernichovsky, 2016), waiting times for elective hospitalization in Israel show an inverse relationship to the availability of hospital beds in different parts of the country (thus, waiting times in the periphery are longer). These data reflect the growing gap between supply and demand in the public system, referred to previously.

In contrast to the private system, the public system does not always allow patients to select their treating physician. As can be seen in Figure 6, of the households that report use of private medicine, 42 percent said they did so in order to select the physician of their choice. Another 22 percent turned to private medicine in order to get an earlier appointment rather than wait for their turn in the public system. The two reasons are interrelated, as appointments with specific physicians in the private system (including through the use of supplementary insurance) are oftentimes more readily available with shorter waiting times than those with the same physician in the public system.

Figure 6. Reasons for using private medical services, 2015



Source: Dov Chernichovsky, Taub Center
Data: CBS, *The Social Survey*

A related issue concerns the acquisition of clinics that perform surgical procedures by commercial health insurance companies, and the full or partial acquisition of private medical facilities by health funds that oversee the provision of entitled care. These developments require deeper examination than is possible here, but even a cursory glance raises a number of concerns that require the state's attention. There is clear indication of a muddled, uncontrolled public-private mix in the healthcare system that indicates an absence of clear policy and suitable regulation. Not only might this situation both undermine the public's ability to make informed choices and the ability of service providers and the system to monitor outcomes, it might also undermine the quality of public health.

The purchase of medical care facilities, and particularly surgical centers, by commercial insurance companies encourages demand in two ways: by increasing both demand for commercial insurance and demand for medical procedures of questionable necessity. Inevitably, insurance companies will channel patients to the service providers they own, thereby compromising the public's freedom of informed choice.

There is a similar concern regarding the purchase of private service providers by the health funds, which could create a conflict of interest between the two functions of the funds (care managers and insurers on the

one hand, and service providers on the other). In the end, this also reduces patients' freedom of choice between service providers. In this context, it is worth noting that in the US and Europe such acquisitions are not common, and in certain countries (for example, Germany) medical insurers, including health funds, are forbidden from doubling as service providers.

In November 2017, the press reported that physicians were paid large amounts of money by certain health funds to transfer between the funds and bring their patients with them. This affair led to a draft regulation with a number of rules:

1. Physicians may not move to a different health fund within 30 km of their present place of work.

2. Clients will no longer be able to transfer between health funds Online.

3. Clients can transfer between health funds at most four times a year (it was previously six times a year).

4. Solicitation by telemarketers, sales agents or public relations personnel on behalf of the health funds will be prohibited.

5. The health funds will be prohibited from offering auxiliary health activities such as classes, gyms and sports lessons.

6. Directors of the health funds will be held criminally liable should the laws be broken.

While rules 4 and 5 are understandable, since they are meant to prevent the use of public funding for uses other than medical purposes, the other sections are problematic. Rule 1 undermines physicians' freedom of occupation, and, in fact, led to a two-hour warning protest by hospital physicians (Israel Medical Association, 2017). Likewise, that prohibition, as well as rules 2 and 3, undermine competition between the health funds. Prohibiting transfers between health funds via the Internet only increases the ability of health funds to engage in "cream skimming" or selection of clients. This rule would increase the likelihood of face-to-face contact and thus create opportunities for health funds to discourage clients with pre-existing medical conditions from joining. (Although discrimination based on pre-existing conditions is illegal, it behooves the health fund to have a healthier population.)

The data show the importance that the public gives to selecting their treating physician, and the attempt by the health funds to meet this demand. Unfortunately, the funds' actions are having the opposite effect leading to reduced competition and freedom of choice between service providers.

Considering how the healthcare services look today, it is worth revisiting the need for health funds in Israel. There does not appear to be real competition between the funds: the number of funds in Israel is the lowest in the developed world by all criteria, and only 2 percent of the population switches funds in a given year (as compared to the Netherlands, for example, with a population that is double the size of Israel's, wherein 7 percent of the population transfers among 24 health funds annually). At the same time, the funds are losing their public character; their resemblance to commercial insurers is growing, and their not-for-profit character is losing its meaning.

In light of this, Israel might consider introducing a British-style public health service (similar to a single health fund), which purchases services from competing providers without competition between funds over physicians and clients. This model is very common and would not require extensive changes to implement. It is also cheaper to operate than the health fund model, because there is a single funding mechanism rather than four such mechanisms as is currently the case. Another alternative could be to convert private insurers into health funds, with appropriate regulation as defined by the National Health Insurance Law. This option could create real managed competition between the funds and the insurers, as is the case in Germany, Switzerland and the Netherlands.

3. Preparing for an aging population

The latest State Comptroller's Report asserted that "the quality of home care provided to elderly nursing patients is defective, sometimes to the point of neglect. Not only does this violate the right of the elderly to age with dignity at home, but it also might worsen their physical and mental health status [...]" (State Comptroller, 2017).

The issue of long-term care and insurance became even more urgent following an announcement by the insurance commissioner that at the beginning of 2018, the group insurance of about 1 million people insured through their workplaces would expire. Following the public uproar in reaction to that announcement, the government outlined a number of measures at the cost of about NIS 1 billion:

- Raising the maximum elderly allowance for nursing care to NIS 5,000
- Canceling the means test imposed on the elderly's children in order to determine the subsidy level of long-term institutional care
- Making transfers to long-term care insurance sold by the health funds available to those currently holding group insurance policies from their workplaces, without a period of eligibility and underwriting

These measures, along with the decision to provide free dental treatment to the elderly from age 75 and up, will undoubtedly contribute to improving long-term care in Israel, which is inferior relative to countries in Western Europe, Australia, Canada, and Japan, for example (Chernichovsky, Kaplan, Regev, and Stessman, 2017). Furthermore, despite the moral hazard involved, canceling the means test for children of elderly long-term patients contributes to the universality of the long-term care system.

From a financing perspective, however, and for the sake of a more equal system (at least as compared to the norms of the aforementioned countries), it is necessary to substitute considerable amounts of money from private sources with public funding. Today, NIS 14-15 billion are invested in the long-term care system, about half from public sources and half from private sources. An expenditure on the scale of NIS 3 billion would be needed in order to adequately increase the share of public funding. Any step towards increasing the share of public funding must also make arrangements for the 3 million Israelis who are underinsured for long-term care. According to a Bank of Israel study, some of these 3 million are elderly and currently do not own long-term care insurance to supplement state-provided services due to high premium costs (Cohen Kovacs, Ramot-Nyska, and Haran Rosen, 2017).

Likewise, the measures recently proposed by the government do not solve the problem of fragmentation of services and the lack of service integration under a single agency. This fragmentation causes considerable challenges for the elderly and their families and poses a central problem within the system (Chernichovsky, Kaplan, Regev, and Stessman, 2017). In general, it appears that Israel has been postponing the implementation of a comprehensive solution to the problem of long-term care and its funding, as exists in other countries with universal healthcare systems.

4. Adjusting the healthcare system to adapt to changes in chronic illness

A previous Taub Center study points to an increase in the risks of obesity and diabetes in Israel, beyond the average in European countries (Bowers and Chernichovsky, 2017). These findings stand against the backdrop of another study (Azarieva et al., 2017) indicating that households belonging to the lowest income quintile in Israel cannot afford to purchase what is defined as a "healthy food basket."

If the government wants to address these problems effectively, it should consider establishing an inter-ministerial national program since the challenge expands beyond health into the areas of education, food prices and their regulation. The need for this is highlighted by the efforts of the Ministry of Health to remove unhealthy beverages and foods from educational institutions, and to clearly mark products according to the nutritional risks they carry.

Conclusion

The long-term trends and funding data from recent years indicate that access to medical care, both in quantity and quality (waiting times and physician choice), depends increasingly on private funding — which imposes a growing burden on household budgets. Stagnation in resources available to the public system limits both the Ministry of Health and the government's ability to operate in the health arena. That said, in the last several years the government has made efforts to improve the system in a number of areas: adding MRI machines to the system; allocating NIS 900 million towards a national plan to shorten waiting times for medical care; expanding full-time specialist doctors who only work via public funding in the hospitals; and prohibiting doctors from referring their public system patients to their private practice. There is still room for reforms in other areas, including: establishing mechanisms that would allow for patient choice of physician in the public hospital system; expanding the number of job positions in the public system — a necessary measure to prepare for increased numbers of medical school students, licensed practitioners and the increased job supply; and reallocating the revenue spent on supplementary insurance purchases to underwriting medical care in the publicly-funded hospital system.

Furthermore, the government's efforts to shorten waiting times and increase physician choice in public hospitals are an attempt to square the circle, considering the incentive system inherent in the current supplementary insurance arrangements. These arrangements, which

enable the use of supplementary insurance funds only in privately-owned institutions, incentivize health funds and the commercial insurance companies to acquire medical facilities — actions that increase the expenditure on health even as their impact on health outcomes are questionable. Commercial insurance companies providing medical care and the acquisition of facilities that provide private medical services by the health funds reduce competition between service providers raising questions regarding the efficacy of the current health fund model in Israel.

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