

Needs and Funding in Israel's Healthcare System: General Trends

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The Israeli healthcare system has many achievements to its credit, at least regarding its relative contribution to Israel's high life expectancies and low infant mortality rates. In 2014, the life expectancy for Israeli women was 84.1 years; for men it was 80.3 years. These are some of the highest figures in the world: Israeli men rank 3rd globally, while Israeli women rank 11th.¹ Israel's infant mortality rate is one of the world's lowest — 3.1 per 1,000 live births (2014 data), and is a major factor behind the country's high life expectancy.

There can be no doubt that the share of public funding in Israel's healthcare system, manifested in universal, high-quality insurance coverage, is a significant contributor to these achievements. However, both the coverage and its quality are constantly eroding, as reflected in a declining share of public funding and a reduction in real funding available to the system, at a time when needs have dramatically increased.

Relative to other developed countries, Israel's 65 and over age group accounts for a small share of the population: 10.6 percent (in 2013), compared with 15.9 percent in the OECD countries (OECD, 2016). However, this group's rate of growth is high relative to its counterparts in other developed countries. Israel's population forecasts through the year 2035 indicate continued and intensified population aging (Figure 1). The number of those aged 70 and over is expected to grow by 103 percent, compared with a 31 percent increase for the rest of the population (this figure does not appear in the graph). That is, the population aged 70 and over is expected to double within two decades, from today's figure of 610,000 to 1.24 million in 2035. The demographic process will feature a 43 percent rise in the incidence

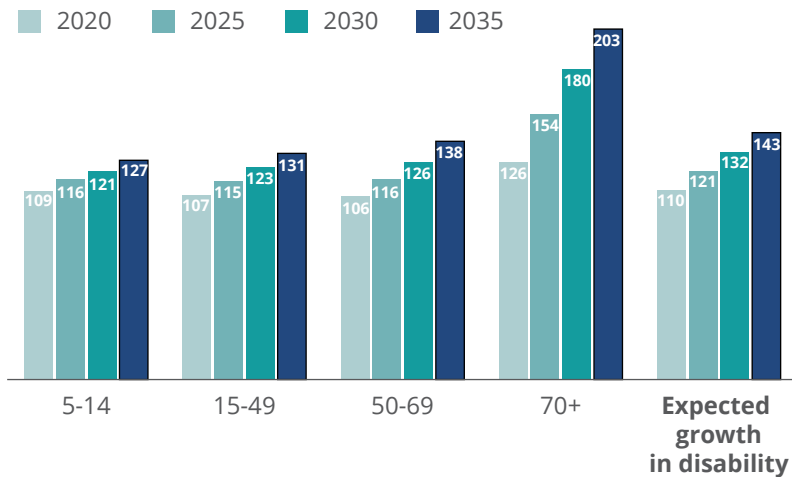
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1 Except where otherwise indicated, the source of the data in this introduction is the Central Bureau of Statistics (2016).

of disability, which is part of the disease burden.² Based on the data in Figure 2, the elderly population's contribution to disability will rise from 16 percent in 2015 to 23 percent in 2035. As such, a basic feature of Israeli society and of the Israeli economy over the next 20 years will be a projected annual population increase of 1.5 percent, and an annual 1.8 percent increase in disability. In other words, the rate of increase in disability – and in long-term care and medical needs – is 16 percent higher than the population growth rate. Although the population growth is a welcome development that reflects longer life expectancies, it nevertheless entails preparation on the part of the long-term care and healthcare systems.

Figure 1. Rate of expected growth relative to 2015 in years of disability

By age group, Index year: 2015=100



Source: Dov Chernichovsky and Haim Bleikh, Taub Center.

Data: Central Bureau of Statistics, *Projections of Population in Israel to 2035*, Table 10.

² To estimate disease burden caused by disability, the disability-adjusted life years (DALYs) metric is used. For more on this topic, see Chernichovsky and Bowers (2014).

Share of public funding sources relative to consumption

Taub Center reports of the past decade have devoted considerable attention to a number of specific trends. One trend that has been discernible in recent years is stability in healthcare as a share of GDP — 7.5 percent in Israel versus a median expenditure of 9.4 percent of GDP in OECD countries. In contrast to the trend in Israel, the OECD's relatively high median expenditure share is the result of a steady rise in spending in these countries.³

A second notable trend is a decline in the share of public funding: in 2014, private funding represented 38 percent of total healthcare funding in Israel — the OECD's highest after the United States. This situation reflects the ongoing emergence of a gap between the share of healthcare expenditure that is publicly financed in Israel and in the OECD on average (Taub Center, 2016). While the share of government expenditure on healthcare out of total public spending rose to some degree, there has been no rise in the government's contribution to healthcare as a share of total GDP. This was due to an overall drop in the state budget's share of GDP. (It should be noted that a spending decrease also means a decline in the tax burden.)

Given the rise in demand and the need that is not being met through increased public funding, private spending is escalating. This increase exceeds the public expenditure increase that would have been needed to meet the same objectives. The private spending increase is subject to market failures; had the same amount of money been spent publicly rather than privately, the return would have been greater, as will be shown below.

A third trend that has garnered attention in Taub Center publications has to do with a continuous decline in the real resources available to the healthcare system: hospital beds, physicians and nursing manpower per capita.⁴

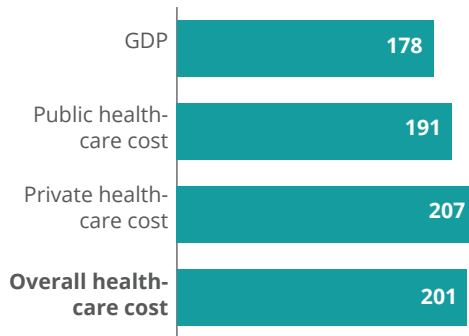
Changes in the healthcare price index, which encompasses both private and public medicine, reflect the change in the private-public mix and the implications of this change to the healthcare system's changing needs and demand for care, and real sources or supply of care. Between 1995 and 2014, healthcare prices increased more than the GDP price index (Figure 2). While the GDP price index rose 78 percent during the period in question, the

3 For current data see the Central Bureau of Statistics (2016).

4 See the in-depth discussion of the aging of Israel's physician population in Chernichovsky and Regev (2014).

Figure 2. Changes in indices of healthcare cost

2014 versus 1995, Index year: 1995=100



Source: Dov Chernichovsky and Haim Bleikh, Taub Center.
Data: Central Bureau of Statistics, *Statistical Abstract of Israel* 2015.

healthcare price index rose 101 percent, or 23 percentage points more than the GDP price index.⁵

The private healthcare price index rose by 107 percent between 1995 and 2014, compared with a 91 percent rise in public healthcare prices. That is, the price index of private care, reflecting the rising demands for private care, spearheaded the relative healthcare price hike in Israel. Since there is no reason why technological developments in healthcare should be more expensive

than technological developments overall, the rise in prices appears mainly to reflect a real increase in labor costs. This is the result of a relative decline in manpower supply and aging in the labor intensive sector, as well as “duplicate payments” for treatments that are covered by the public system and provided at privately-run clinics.⁶

Taking a long-term view of the consequences of these developments, Israel’s national per capita healthcare expenditure rose at the rate parallel to that of the GDP per capita increase — 1.7 percent per year, on average — for a total of 38 percent between 1995 and 2013 (Figure 3). The closeness of the two measures is reflected in the relatively stable share of healthcare expenditure in GDP, which, as noted, is on the order of 7.5 percent. However, this picture does not take into account the trends noted above: growth in demand and needs due to rapidly changing demographic conditions in Israel, as well as a rise in healthcare prices relative to the GDP price index.

Taking population aging into account through an age-weighted analysis, the rise in per capita — not need or age-weighted — healthcare expenditure

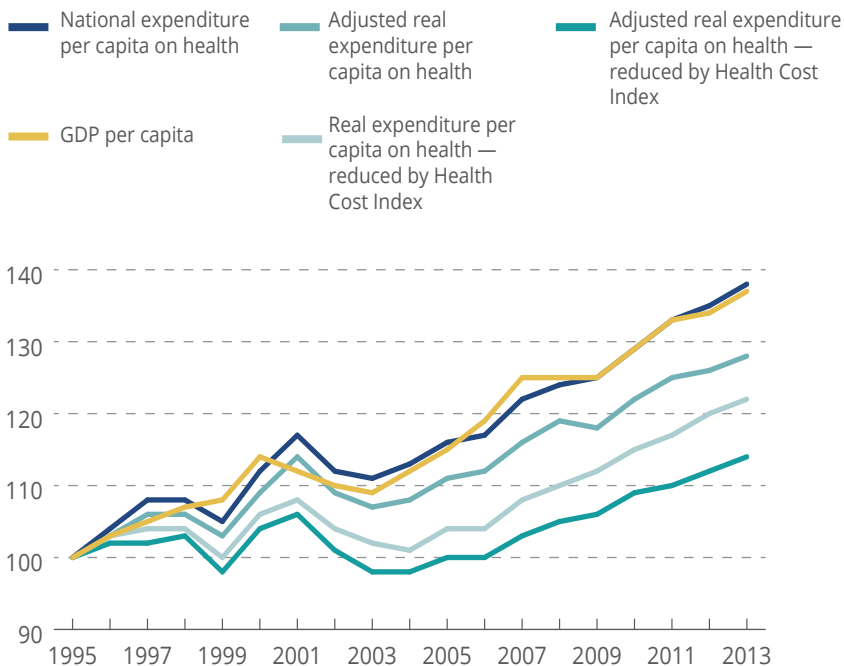
5 The combined healthcare CPI is a weighted average of private healthcare prices (CBS) and public healthcare prices (Plotnik and Keidar, 2015). The weights are the share of private expenditure and the share of public expenditure in total healthcare spending (respectively).

6 For more on this topic see Chernichovsky, Navon and Gamzu (2011).

in GDP prices amounts to a 22 percent increase, or an annual average increase of 1.0 percent. When both variables are taken into account — population aging and healthcare prices relative to GDP prices — the real increase in per capita healthcare spending (needs-weighted) is just 14 percent, rather than 38 percent, or a mean annual increase of only 0.6 percent, rather than 1.7 percent, over two decades.

Figure 3. Indices of healthcare expenditure and per capita GDP

Index year: 1995=100



According to Capitation index.

Source: Dov Chernichovsky and Haim Bleikh, Taub Center.

Data: Central Bureau of Statistics, *Statistical Abstract of Israel 2015*.

To conclude, since Israel's National Health Insurance Law was implemented in 1995, there has been a trend toward continual improvement in the average level of healthcare available to Israeli residents. However, the improvement level is lower — on the order of two-thirds — than what would be expected given the overall rise in standard of living during the period

in question. That is, as a result of the quickly aging population combined with public policy that eroded the share of public resources and did not plan adequately for declining healthcare manpower, Israel's healthcare system has not fully benefited from growth in the country's economy.

Earlier efforts to address the decline in resources available to the system, especially the issue of physician aging, as well as preparation for population aging and the adoption of funding policies designed to reduce healthcare price inflation – especially in the supplemental insurance sphere – would have resulted in better and more equitable healthcare today, supported by Israeli economic capability. To ensure improved conditions in the future, the Israeli government must take corrective action at once.

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