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ISRAEL'S HEALTHCARE SYSTEM

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Israel's Healthcare System

Dov Chernichovsky and Eitan Regev*

Abstract

The recently resolved labor dispute between Israeli physicians and the state cast a shadow on the Israeli healthcare system's achievements of the past two years: the dental care reform, the reduced copayment burden, and other easing of the financial burden, e.g., the elimination of the Tipat Halav fee. Manpower increases were recently authorized for the system, and access to healthcare in Israel's periphery is expanding. Some of these measures represent promises to the public which, hopefully, the government will be able to keep. These changes do not, however, have the power to bring about structural change in terms of financing, organizing or managing the system. The recent wage agreements may conceivably increase the share of public funding in Israel's national health expenditure; but such a development would merely reflect a lack of long-term government policy. The public system is eroding and administered from crisis to crisis. An analysis of household healthcare expenditure indicates that those who need and are able to leave the public system do so. Decades of achievement in the realm of equity and efficiency are eroding, and public health may ultimately suffer. Within the overall context of worthwhile initiatives and long-term policy with far-reaching consequences for Israel's social services system, an assessment should be made of the reform proposed for long-term care insurance in Israel – a sphere that by default, rather than by a process of careful consideration, is regarded as a healthcare system issue.

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Within Israel's healthcare system one can still detect the impact of a lengthy physicians' strike that had unprecedented consequences, most notably a loss of physician unity around the issue of Israeli medicine's future. The strike and its repercussions undermined, to a certain degree, several outstanding achievements of the healthcare system of the past two years. The dental care reform that took effect in 2010 and continued into 2011 ensured public entitlement to free dental care for children up to age ten – a trend that is set to expand. In 2011, a reduction in the private funding burden was approved, and copayments for generic drugs were lowered from 15 to 10 percent. Additional financial relief was instituted in several service areas, including a repeal of the *Tipat Halav* Mother-Infant Care Center fee. Additional hospital beds and job positions were also recently approved, as well as increased physician training quotas – including continued development of the new medical school in northern Israel and quotas for nursing staff. Healthcare access in the periphery has been expanded through a program aimed at creating emergency centers, recruiting nurses and increasing the number of MRI machines in the system. Some of these measures represent promises to the public, which it is to be hoped the government will be able to keep. In addition, at this time, efforts were being made to incorporate mental health care into the general healthcare framework and to expand the circle of those eligible for continuing care. Notwithstanding reservations regarding the Health Ministry's approach to the issue of continuing care (to be discussed in greater detail later in this chapter), these initiatives are welcome ones.

It should be noted, however, that these changes – including the outcomes of the strike – are insufficient to bring about fundamental structural changes – changes in whose absence the various achievements of the system may be erased over time. For example, achievements in dental health efficiency and equity will be reversed if system-wide efficiency is lost, and this in turn might harm those households that currently enjoy publicly-subsidized dental care. Although, in the wake of the new wage agreements, the share of public funding in Israel's national

health expenditure is likely to rise, this change reflects an absence of long-term governmental policy vis-à-vis the system. The budget that the Ministry of Finance has been allocating to the healthcare system for the past decade and a half is a savings-oriented one that reflects a lack of long-term thinking. Up until now the system has been administered from crisis to crisis, with intervals of gradual erosion of resources until a breaking point, when public outcry generally erupts. When this happens the government is forced to increase the healthcare budget and to temporarily correct the erosion that has occurred, in a patchwork manner. Last year's physicians' strike constituted one of these breaking points. Governmental intervention is characterized by point-specific measures that are not part of any long-term strategy.

The diversion of voluntary insurance funds – intended to ensure comprehensive healthcare for policyholders – to private treatment frameworks continues to create distortions within the system, and it is doubtful whether the workplace time-clock instituted for physicians will be able to solve these fundamental problems. Israel is witnessing the emergence of separate healthcare systems for the poor and for the rich, as indicated by family expenditure surveys. More and more highly-educated and high-income people, including families with children, are choosing to pay privately for the same services available publicly. One outcome of this situation has been a continual and steep rise in prices within the private healthcare market, which significantly offsets rising public expenditure on these services.

This chapter contains four sections. Section 1 offers a comparative look at Israel's healthcare system relative to other countries over time. Section 2 deals with the prolonged physicians' strike, against the background of the healthcare manpower crisis. Section 3 discusses private healthcare expenditure as an expression of the system's functional status, and the way in which such expenditure contributes to disparities and poverty. Section 4 focuses on long-term care funding in Israel and on associated problems, in a context of international comparison.

1. Achievements of the System

The achievements of Israel's healthcare system are measured in terms of two main perspectives: the population's health, and its satisfaction with health services. Several secondary parameters that impact the main parameters are measured as well: equity, cost containment, economic efficiency, and freedom of choice.

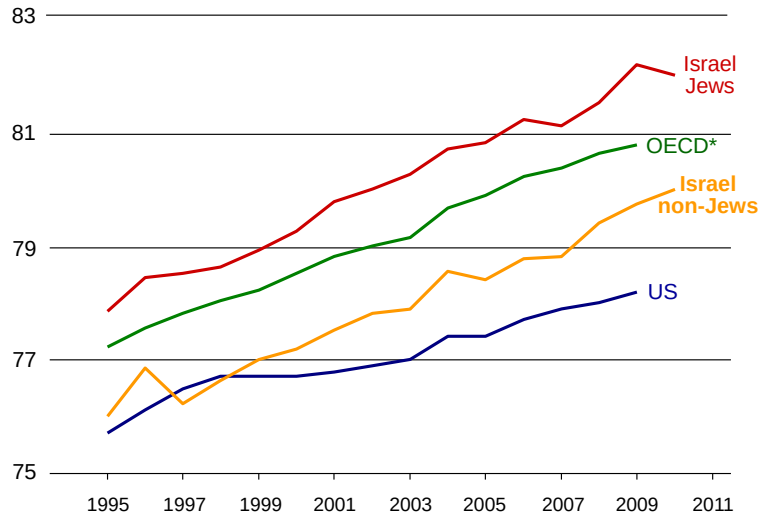
The Population's Health Status – Life Expectancy and Infant Mortality

In general, Israel continues to witness a consistent rise in the life expectancy of its population. The life expectancy of Israel's non-Jewish population improved, rising from 79.8 in 2009 to 80 in 2010. By contrast, the Jewish population's life expectancy has been trending downward: from 82.2 in 2009 to 82.1 in 2010. This decline has been attributed to changing figures for Jewish women, while the life expectancy values for Jewish males have remained stable.

Despite the slight decline in life expectancy recorded for Israel's Jewish population, the life expectancy continues to exceed that of the populations of most developed countries; Israel's non-Jewish population is also closing the gap relative to the OECD states (whose average life expectancy is 80.8), and Israel's Jewish population (Figure 1).

Figure 1

Life expectancy at birth, 1995-2010



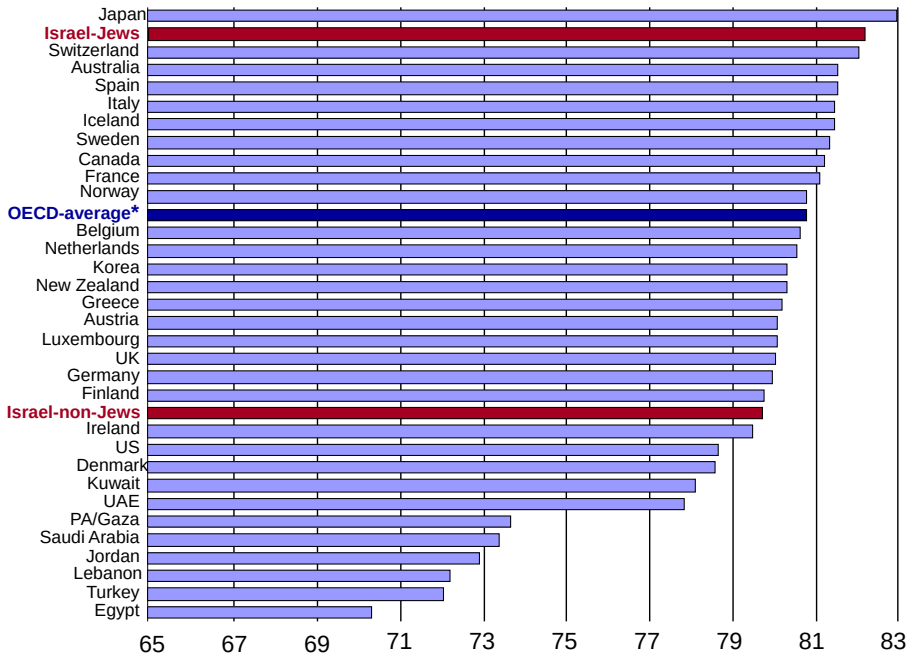
* Average of the 22 most developed OECD countries (excluding the US).

Source: Taub Center for Social Policy Studies in Israel.
Data: Central Bureau of Statistics, OECD.

The life expectancy of non-Jewish Israelis is high compared with that of Arab and Muslim countries, at least those in Israel's proximity (Figure 2). However, it is still lower than that of Jewish Israelis and compared with most Western countries.

Figure 2

Life expectancy at birth, 2009



* Average of the 22 most developed OECD countries (excluding the US).

Source: Taub Center for Social Policy Studies in Israel.

Data: Central Bureau of Statistics, OECD.

Regarding infant mortality, the trend toward improvement among the Jewish population continued, while no significant improvement was found for the non-Jewish population. Closing the gaps in this area between Jewish and non-Jewish Israelis (Figures 3 and 4) is one of the main challenges facing the healthcare system.

Figure 3

Infant mortality over time*, 1995-2010

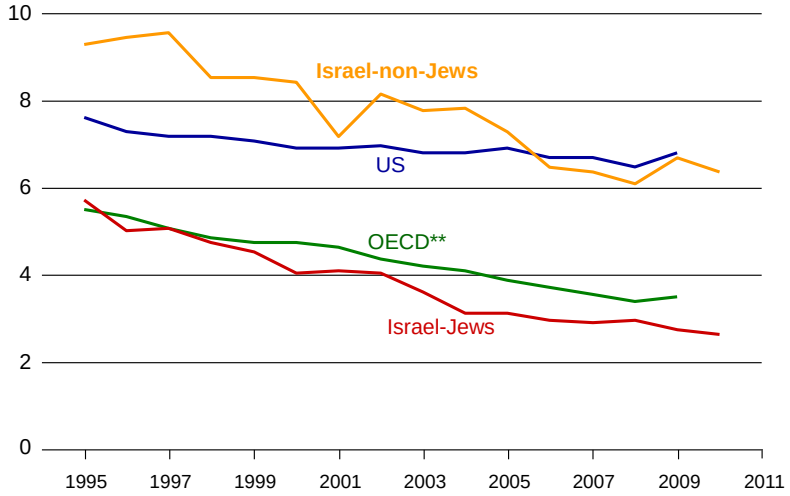
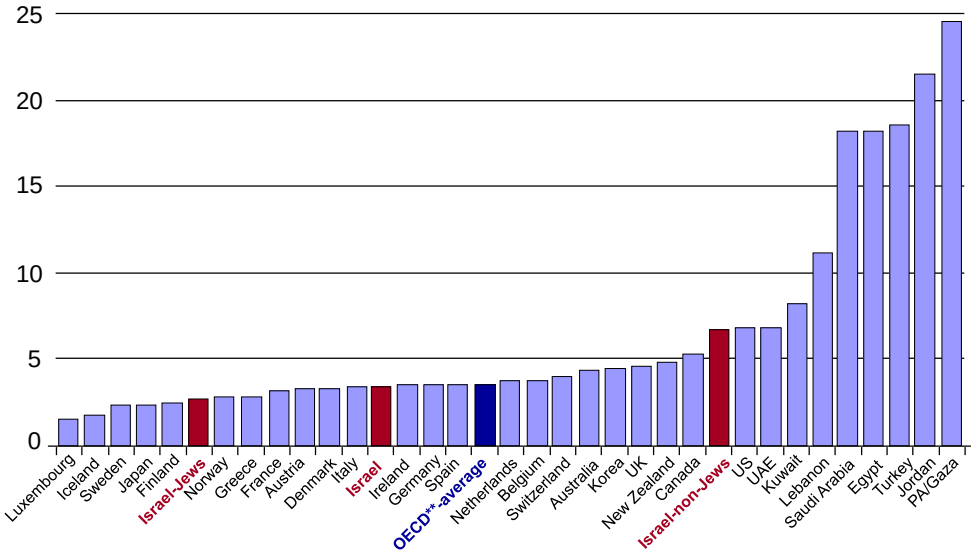


Figure 4

Infant mortality across countries*, 2009



* Infant mortality up until age 1 per 1,000 live births.

** Average of the 22 most developed OECD countries (excluding the US).

Source for both figures: Taub Center for Social Policy Studies in Israel.

Data for both figures: Central Bureau of Statistics, OECD, World Bank.

The Healthcare System's Medium-Term Socioeconomic Objectives

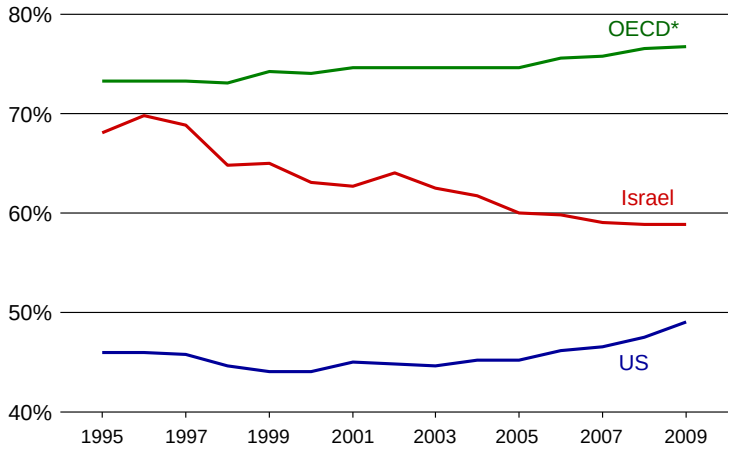
The system's medium-term objectives relate to greater equity, cost containment, service-provision efficiency, and freedom of choice. On the one hand, these socioeconomic factors are beneficial to healthcare consumers and to society as a whole, while on the other hand they also serve the system and contribute to its performance. In addition to their practical aspects, these objectives also have intrinsic value, particularly with regard to equity and freedom of choice.

Equity. Equity relates to two issues: the progressivity of healthcare financing and the relationship between income levels and access to healthcare. The share of public funding in Israel's total national health expenditure continues to trend downward: in 2009 public funding accounted for 58.9 percent of all health spending, versus 68.2 percent when the healthcare system reform was instituted in 1995, 76.7 percent in the OECD countries and 49 percent in the US. In comparison with the US and other OECD countries, the trend in recent years in all of these countries, including the US, has been opposite to that of Israel; they have shown a rise in the share of public funding as a percentage of the national health expenditure (Figure 5).

Figure 5

Public expenditure on healthcare services

as percent of national expenditure on healthcare services, 1995-2009



* Average of the 22 most developed OECD countries (excluding the US).

Source: Taub Center for Social Policy Studies in Israel.

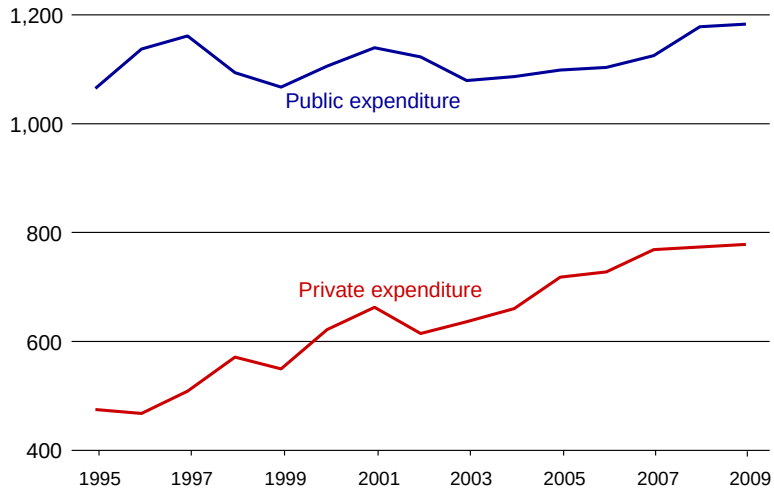
Data: Central Bureau of Statistics, OECD.

In terms of health expenditure per capita, during the period 1995-2009 Israel's public health expenditure grew by just 11 percent, from $1,066 to $1,182 at purchasing power parity per capita (2000 prices), and was characterized by a high degree of fluctuation – point-specific budgetary increases followed by long periods of gradual erosion. Major budgetary increases were authorized only once every few years, usually in response to crises arising from these periods of budgetary erosion. At the same time, private per capita expenditure grew steadily during the same period, for a total of 64 percent: from $474 to $778 at PPP per capita (Figure 6).

Figure 6

Per capita expenditure on healthcare services – public vs. private

in PPP dollars, 2000 prices, 1995-2009



Source: Taub Center for Social Policy Studies in Israel.
Data: OECD.

As will be seen in greater detail in Section 2, the regressive nature of Israeli healthcare financing is reflected in household budgets: the increase in private funding of healthcare translates into a worsening income-distribution situation and deeper poverty among sectors that were already poor. It also results in less accessibility to services among these groups, due both to a decline in their ability to pay the rising prices, and to a lack of availability of healthcare services.

Cost containment. Israel's national healthcare expenditure in 2010 was NIS 61.2 billion, accounting for 7.5 percent of GDP. This is a relatively low percentage compared with other Western countries, and places Israel, for the first time, below the average of the OECD's 22 most developed

countries (7.7 percent) – excepting the US, which continues to deviate from this picture with its high rate of health expenditure as a percentage of GDP: 14.6 percent (Figure 7A).

The decline in Israel's national healthcare expenditure is continuing despite a rise in the rate of private expenditure. Hence, there has been a significant erosion of public financing, which did not expand relative to the rise in GDP (Figure 7B). This means that Israel's publicly financed system and those dependent on it are not enjoying the fruits of Israel's economic growth. This is true of the population as a whole, in light of the fact that, in GDP terms, the rise in private funding did not fully compensate for the erosion of public funding, and also in view of the inflation that affected private healthcare prices.[1]

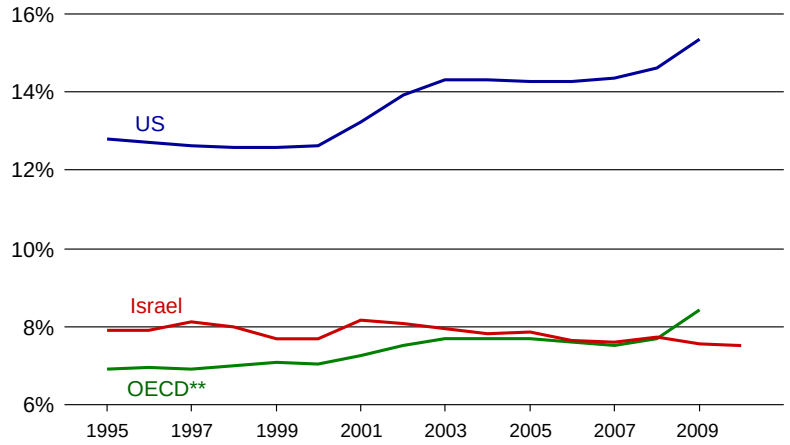
[1] It should be noted that healthcare expenditure as a percentage of GDP is also related to GDP growth rate relative to healthcare expenditure. Given the long-term downward trend in Israel's expenditure rate, the low rate of expenditure compared with other countries should not be attributed to inter-country GDP growth-rate differences.

Figure 7

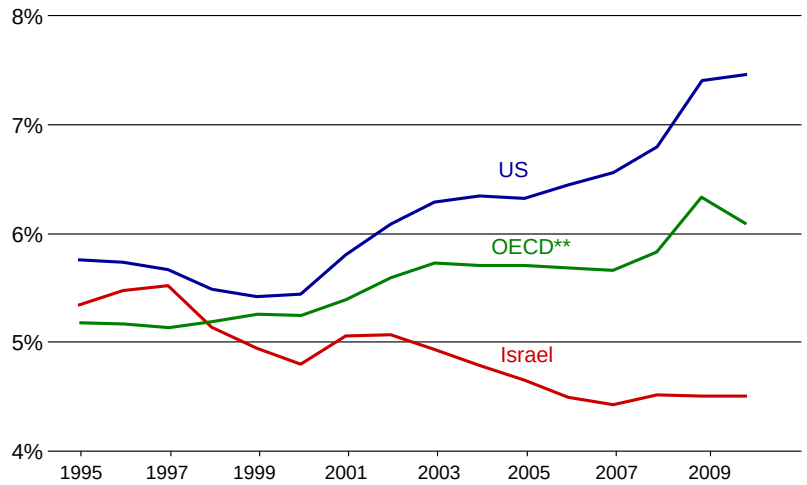
Expenditure on healthcare services

as percent of GDP*, 1995-2010

A. National expenditure



B. Public expenditure



* Adjusted for standardized person in Israeli risk adjustment terms (old capitation method) as percent of regular GDP.

** Average of 22 most developed OECD countries (excluding the US).

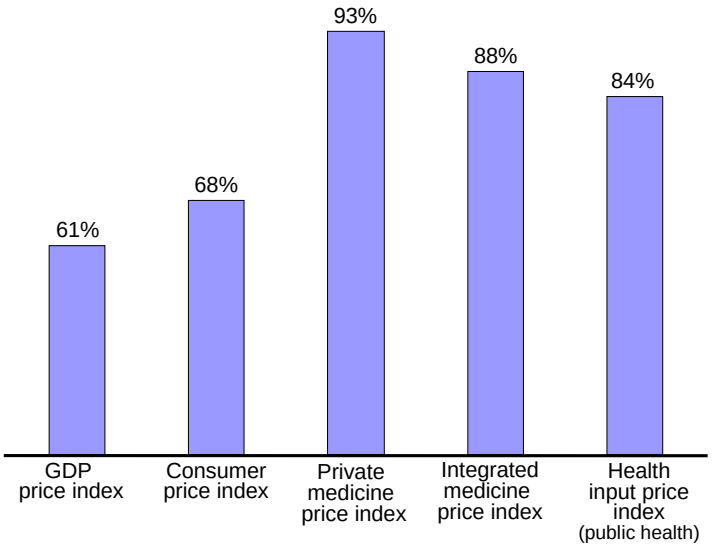
Source: Taub Center for Social Policy Studies in Israel.

Data: Central Bureau of Statistics, OECD.

In Israel's healthcare system, cost containment is not reflected in a curbing of service-price inflation. There has been, in effect, a loss of expenditure control within the system. In terms of their expenditures, the private and public systems are not keeping pace with price increases in the healthcare system. As may be seen in Figure 8, the composite healthcare price index rose by 88 percent and the private healthcare price index by 93 percent between 1995 and 2010, while the GDP deflator rose by just 61 percent. What this means, particularly in the context of the previous discussion, is that in terms of real services, the share of healthcare services in the GDP declined more than would be expected based on the percentages in the graph.

Figure 8

Changes in price indices, 1995-2010



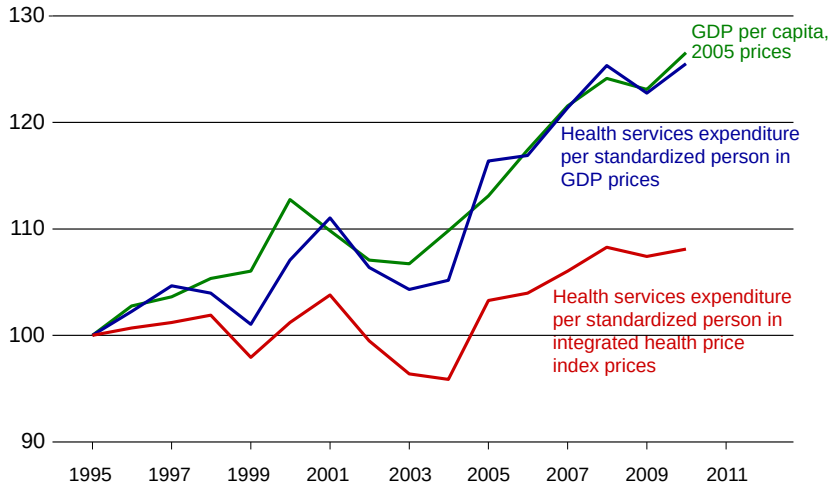
Source: Taub Center for Social Policy Studies in Israel.
Data: Central Bureau of Statistics, Ministry of Health.

The meaning of the rise in prices may be seen in Figure 9: since 1995 there has been a real (actual) increase of only 8 percent in per capita healthcare purchasing power per standardized person in Israel – despite the fact that the real per capita GDP rose by 26.6 percent during the same period. The situation is even worse taking into account that the share of private expenditure out of total national healthcare expenditure has increased over the years, and that private services have become more expensive.

Figure 9

Healthcare expenditures per standardized person, 1995-2010

Index: 1995=100



* Adjusted for standardized person in Israeli risk adjustment terms (capitation formula) through 2010.

Source: Taub Center for Social Policy Studies in Israel.

Data: Central Bureau of Statistics.

Freedom of choice. Data are not available regarding the degree to which the healthcare system is characterized by choice. However, in the context of the discussion of structural changes undergone by the system, and of major issues on the Israeli public agenda – particularly that of privately paid medical services (*SHARAP*) – it is important to emphasize that, in contrast to normal practice in the various healthcare services available in the community, Israelis have no freedom of choice with regard to physicians in publicly-funded hospital settings (hereinafter: "public hospitals"), despite the fact that hospitalization is frequently essential to ensure survival and well-being (exceptions to this lack of choice are the publicly-funded Hadassah and Sha'arei Zedek Medical Centers in Jerusalem, where choice is possible via *SHARAP*).

2. The Physicians' Strike

The physicians' strike lasted from March to August 2011, at which time an agreement was signed between the Israeli Medical Association and the government (the Ministry of Finance). Labor relations returned to normal only in late 2011, after an agreement was reached with the medical residents.

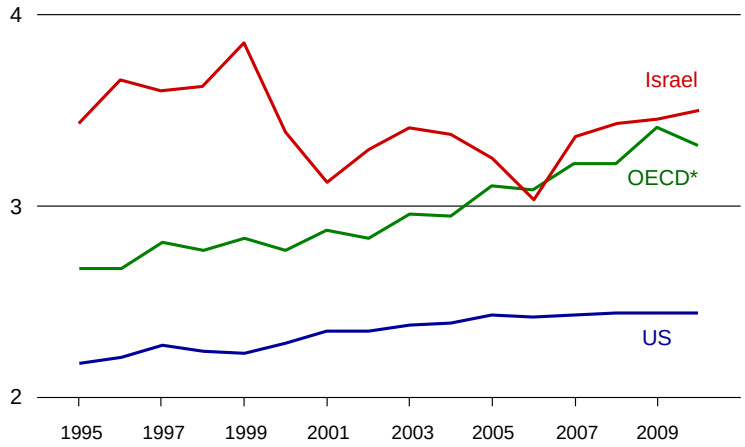
Despite its status as one of Israel's most prolonged labor disputes, it is highly doubtful whether the strike helped resolve any structural issues within the system, or whether it indeed saved Israeli public medicine, as the strike's organizers originally intended. This section will look at the basic factors behind the crisis, and at the strike's outcomes as perceived by some of its participants.

Signs of the Crisis – A Reduction in the Supply of Physicians and a Decline in the Number of Hospital Beds

Over the years, Israel has enjoyed a high physician-to-population ratio compared with other developed countries and compared with the US (Figure 10). A significant increase in this ratio was registered during the early 1990s due to the large number of physicians who came to Israel in the great wave of immigration from the former Soviet Union. However, by the late 1990s a downward trend could already be discerned in Israel's physician-to-population ratio, and the disparities narrowed between Israel and the OECD countries (per thousand people).

Figure 10

Physicians per 1,000 people, 1995-2010



* Average of the 22 most developed OECD countries (excluding the US).

Source: Taub Center for Social Policy Studies in Israel.
Data: Central Bureau of Statistics, OECD.

Over the last few years Israel has witnessed a moderate rise in this index; as of 2010, the Israeli physician to population ratio was still high compared with all other developed healthcare systems, and especially compared with the US. The number of physicians per thousand people in Israel is 3.5, versus 3.1 in the OECD countries, and 2.4 in the US. In this context it is important to note a lack of age-adjusted population data; when Israel's high proportion of young people compared with the OECD states (Section 4) is taken into account, Israel's situation is even better than that indicated by the figures.

The data do not, of course, reflect relative shortages in specific medical specialties or in the numerical distribution of Israeli doctors between public and private healthcare or between Israel's geographic center and the periphery. The serious problem for which no reliable data exist is that of the siphoning of physician manpower, particularly specialists, out of the public system and into the private market, and a consequent worsening of the relative shortage of physicians (especially specialists) in the public system. As noted, at the core of the process lies the replacement of public funding with supplemental insurance, which creates ever-greater demand outside of the public system.

Hospital beds. When Israel joined the OECD, the resulting uniformity of definitions enabled better international comparisons of hospital bed numbers. Figure 11 presents up-to-date figures recently published by the OECD regarding general inpatient beds. It shows that the ratio of hospital beds per thousand people in Israel has continued to decline, and is significantly lower than the ratios of the other developed countries included in the comparison, as well as the US: just 1.93 beds per thousand people, versus 2.66 in the US and 3.44 in the OECD states.

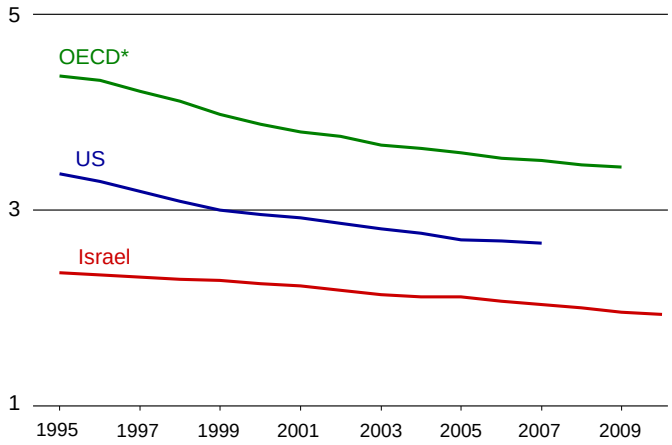
It is important to note that this disparity is obscured when one looks at Israel's total inpatient-bed data, which include emergency room, long-term care and psychiatric beds. Nevertheless, the data for 2010 confirm the medical community's contention that Israel is suffering from an overall inpatient bed shortage.

The downward trend of recent decades in general inpatient bed numbers, observed in the US and the OECD as well, appears mainly to reflect technological developments that have led to a relative decline in the need for general inpatient care. However, because Israel's starting point was lower than that of the other developed countries, the decline in inpatient bed numbers per capita may be problematic.[2]

Figure 11

General hospital beds

per 1,000 population, 1995-2010



* Average of the 22 most developed OECD countries (excluding the US).

Source: Taub Center for Social Policy Studies in Israel.
Data: Central Bureau of Statistics, OECD.

[2] It is important to remember, in this context, the relative youth of Israel's population.

In the Wake of the Physicians' Strike

The Israeli Medical Association (*IMA*) went to battle to "save Israeli public medicine." However, the agreement reached did not enjoy the support of the entire physician community – a situation that deepened rifts within the *IMA*. The Hospital-Employed Physicians Organization (known by its Hebrew acronym, *Arbel*) undertook to advance the cause of those doctors who choose to devote all of their work hours to serving the public in Israel's public hospitals, while *Mirsham* (Medical Residents Working to Improve Israeli Medicine) sought to represent Israel's younger, resident physicians who, it was claimed, were paying the price of the public system's inadequacies.

Each of these organizations stood its ground regarding the physicians' strike and its outcomes. The following *Spotlights* summarize the organizations' positions on the strike's achievements (or lack thereof), on the healthcare system's deficiencies, and on the issues needing in-depth systemic attention.

Spotlight A: The IMA's Position

Zeev Feldman*

Prior to the collective bargaining process aimed at reaching a new collective agreement, the IMA undertook a comprehensive preparatory initiative in which it appealed to all Israeli physicians and to the heads of all 180 professional associations included within the IMA. The initiative featured an effort to understand and define existing needs and issues relating to standards, hospital work conditions and understaffed specialties, and to address them in its demands at the negotiation table. Never before had so transparent a preparatory process been set in motion, or followed by, so transparent a collective bargaining process; updates on the progress of the negotiations and on the difficulties encountered were posted continuously on the IMA website.

Agreement provisions addressing disparities in the quality of healthcare provided to Israel's periphery and the impossible medical staff workloads resulting from decades of neglect, as well as ensuring IMA participation in overseeing the agreement's implementation over the coming years – all of these things constitute a major achievement of the State of Israel's longest-running physicians' strike. The agreement reached contains numerous sections and clauses and addresses the majority of the objectives that were defined at the outset of the process. One thing is clear: doctors who invest more of their time in public medicine will earn more.

The IMA team that spearheaded the struggle set major objectives regarding physicians' wage and work conditions, and formulated demands regarding the operation and future of Israel's healthcare system, including: a 50 percent wage increase; future safeguarding of real physician wages; improved physician pension arrangements; a solution to the physician shortage and an increase in the number of job positions; solutions for understaffed specialties; improved work conditions for the medical residents who account for 22 percent of all Israeli physicians; and the advancement of medicine in the periphery.

* Dr. Zeev Feldman, Director, Pediatric Neurosurgery Unit, Safra Children's Hospital, Tel Hashomer, and member of the IMA secretariat.

Achievements of the Struggle

Physician wages. Based on the agreement, Israeli doctors will be receiving over three billion shekels a year more in wages.

Reduced workload. The agreement calls for a reduction in the workload of young physicians. A thousand job positions were added to the system, half of them aimed at easing the shift burden on the residents to no more than six per month; options were also provided for the possibility of specialist shifts, to ensure professional backup during the afternoon, evening and nighttime hours.

Weekly day of rest. The agreement ensures a weekly day of rest for those working weekend shifts, and allows for mechanisms to ensure that residents are able to go home after their shifts.

Strengthening of understaffed specialties. The agreement provides for wage raises and individual bonuses for those working in the understaffed specialties that employ 50 percent of physicians in central Israel. Those working in these specialties will be entitled to significant increases in the daily salary rate, and to a higher rate of compensation for their heavier work load; physicians who choose to join understaffed specialties will receive grants in the amount of NIS 300,000.

Strengthening the periphery. The agreement proposes wage increases and individual bonuses for physicians in the periphery. For example, a doctor in the periphery will earn 20 percent more than a colleague in the center of the country while a physician who moves to the periphery for work will receive a bonus of NIS 300,000.

Encouraging in-service training and professional advancement. The agreement encourages in-service training days and even stipulates a compensatory mechanism for such days and for the shared funding of conferences for residents, as well as overtime pay for residents and the creation of paths to physician advancement.

Specialist compensation. The agreement provides for the appropriate compensation of subspecialists consulted outside of scheduled on-call hours (up until the present agreement there was no compensation in these instances).

Much of the frustration of Israeli physicians in the wake of the agreement stems from unrealistic expectations that the agreement would include high enough wage increases so as to bring public healthcare system wages in line with those of private frameworks and thereby enable doctors to forego their non-hospital jobs. Those opposed to the agreement must, however, understand that any blow to the IMA's status or power will be disastrous for Israeli physicians, and that unity is crucial to the continued advancement of Israeli medicine and its physicians.

Future Objectives

The idea that the voice of the physician community was silenced when the present agreement was signed is entirely mistaken. Over the coming years there will be a need to advance the cause of numerous issues crucial to the improvement of Israel's healthcare system, among them:

1. The declining share of public expenditure in the healthcare system. At the time that the National Health Insurance Law came into effect in 1995, the state bore some 70 percent of Israel's healthcare expenditure, but over the years it has been shirking its obligations and reducing its share in healthcare financing. The public healthcare expenditure has declined in recent years to just 55 percent, compared with an average of 73 percent in the OECD countries to whose level of service Israel aspires.

2. A lack of long-term planning that is based on the healthcare system's needs. The current situation stems from a combination of faulty planning and a failure to allocate necessary resources. The national priorities, as reflected in the share of healthcare expenditure as a percentage of GDP, has kept the public healthcare system's share frozen at a level of 7.8 percent for many years, despite population growth, population aging, a complex morbidity situation, new technologies, and the high-level therapeutic capabilities offered by modern medicine. Recently, in 2010, another decline in the state's share of the national healthcare expenditure was registered, to just 7.5 percent. In light of Israeli population-aging forecasts calling for a rise in the percentage of the elderly from 9.4 percent to over 13 percent within less than 20 years, there will have to be a change in resource allocation to the healthcare

system. The system must stay current and reflect these changes if Israeli citizens are to receive optimal healthcare.

3. The public hospitals are not benefiting from the growth in general healthcare services. The public hospital system currently has no way of improving its status by providing services to holders of supplemental insurance in the public health funds. According to the law, the health funds are currently selling their members coverage packages that expand the basic basket of services that they are required to provide. This system generates four billion shekels per year, but the public hospitals have no access to these funds.

Spotlight B: Arbel's Position

Amnon Mosek*

The medical profession in unique in several ways. Physician training is lengthy and entails an uncompromising investment in study and in the training period, followed by a commitment to work around the clock and to be available at all times and in any situation. The compensation for this commitment is not always financial; the doctor's ability to sacrifice for the good of the patient, and to help others, brings with it a high degree of satisfaction. That being said, doctors should be compensated at a reasonable level; physician salaries should enable those who choose medicine as their vocation to devote all of their time to it without being concerned for their livelihood.

Hospitals lie at the heart of the medical world. They serve the most seriously ill patients, they are the training ground in which students become doctors, and they are the venue for most medical research. But while the population has grown and aged, the state has not made any corresponding increase to the number of inpatient beds or to the number of hospital physician positions. The workload borne by the doctors and the hospital departments is overwhelming. The state has transferred the responsibility for building and upgrading hospitals to private donors. Not only that, but over the years the state has opposed wage and pension increases for physicians in Israeli hospitals, meaning that their income has remained very low.

Reality indicates that the problem with Israel's healthcare system is not one of insufficient financial resources, given that the state enables private medical frameworks to thrive using the same public funds, and is creating a situation in which physicians earn much less in public hospitals than in non-hospital frameworks. The current state of affairs is such that doctors cannot work solely in hospitals; they are forced to find non-hospital frameworks in which they can supplement their income. The Israeli public is also aware of the discrepancy between the hospital workload and the hospital physician's earning potential. Moreover, many fine physicians are seeking their futures abroad. The overall

* Dr. Amnon Mosek, Neurology specialist, Tel-Aviv Sourasky Medical Center (Ichilov); representative of Arbel.

picture is grim and poses a threat to equity within the system and to the system's ability to provide healthcare services to all citizens.

Outcomes of the Strike

When the strike began, there was unequivocal unity among the participating doctors. However, major rifts erupted along the way between the younger physicians and the Israeli Medical Association (IMA) leadership. After a prolonged legal battle the IMA signed the agreement, despite opposition on the part of some medical residents. In Arbel's view, the agreement reached by the IMA fails to address the roots of the problem:

Physician wages. The overall physician wage has changed by only a few percentage points per hour and does not amount to a significant increase, meaning that hospital doctors will still have to seek additional sources of income in order to make a living.

Shortage of job positions. The thousand job positions that are going to be added to the system will barely cover the shortage that has developed up to now; it will not suffice for the workload anticipated over the coming nine years.

Overtime budget. The future of overtime budgeting beyond the coming year is obscure; it does not appear that doctors will be compensated for extra work on the hospitals' behalf.

In addition to these unresolved issues, the agreement introduced new problems into the public health system, particularly regarding morale. Firstly, a nine-year agreement precludes any possibility of change in the foreseeable future. Secondly, the outcomes of the strike and the split with which it culminated have deepened disparities within the healthcare system and polarized the physician population. The bottom line is that the public healthcare system gained nothing from the strike, and may have even been harmed by it.

Spotlight C: Mirsham's Position

Yona Vaisbuch*

Achievements of the Strike

The residents' agreement will improve the situation regarding two main issues:

Additional supervisory and enforcement mechanisms. The mechanisms stipulated by the agreement ensure, for the first time, the exercise of important medical-resident rights: no more than six shifts per month, and a weekly day of rest.

Third shifts and on-call bonuses. Shifts and bonuses are the only areas in which the agreement stipulates an increase beyond what already exists. These are attractive new work modes intended to compensate doctors for their work in the public system during the afternoon and evening hours. The shifts and overtime bonuses have created, for the first time, a mechanism that resembles a true full-time job in a public hospital, and that enables shift doctors to add a few thousand shekels to their NIS 4,800 salary.

Weaknesses of the Agreement

Failure to address the problem of service and quality of care. The agreement between the IMA and the state, most of whose budget is earmarked for wages, does not significantly change existing work methods or the quality of service that the public healthcare system provides to citizens. Indeed, it freezes the current situation for nine years, thereby discouraging physicians working in the system.

Lack of relevance to the physician population as a whole. The agreement deals with two main issues: improving service to the periphery and addressing the needs of understaffed specialties. The doctors belonging to these two sectors account for fewer than half of all of the physicians in the system, and the agreement is useless to the other

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half. Moreover, Mirsham estimates that the medical-resident profile in the periphery will not change significantly.

Failure to address the flight to the private market. The agreement does not address one of the main problems of medicine in Israel today: the flight of physicians from hospital-based public medicine to private medicine, and the even more dangerous migration to biotech and work abroad. Compensation for salaried health fund employees (without overtime like on-call or shift work) is double or even triple that of hospital employees. This situation makes it hard for hospital-based physicians to survive, and forces them to choose between the following alternatives: working in two or three different places, including hospitals, for 16-18 hours a day, or working solely in the community, on a reasonable schedule. This situation damages the morale, the functional ability and the dedication of those doctors who choose to work in the hospitals. If full-time jobs were defined, standardized and appropriately remunerated in the public hospitals, hospital-based physicians would not have to seek additional work in order to supplement their income.

No change in the nature of the work. A large share of the physician's time is spent on paramedical tasks (taking blood samples, inserting catheters, signing admission and discharge forms, and arranging tests) that could be performed by medical secretaries or physician's assistants. A change of this kind would likely increase physician satisfaction, professionalism and the amount of time devoted to direct patient care.

Inadequate resolution of the job position problem. The agreement's main achievement was the addition of a thousand job positions over the course of nine years. However, the IMA estimates that this addition will account for only a third of the positions currently needed by the system.

The problem of medical-residents. Apart from the added job positions, there was no real change in the work conditions for resident doctors, nor were limits imposed on the number of hours they could work – limits that would prevent exploitation, ensure learning and improve training.

One of the main lessons that was learned from the recent physicians' strike was that the system has a great many flaws, and that any future struggle will have to focus on achieving a single goal, and on ensuring peace in the industry for that specific goal for a short period of time (not more than three years). Experience from the past and present, and the fact that Israel currently has no Minister of Health, compel one clear and distinct conclusion: strengthening Israel's public medical system has not been a priority of the Israeli government during the past three decades.

In summation, despite the agreement's long-term character, it appears mainly to have resolved certain point-specific issues within the system, rather than the fundamental problems: the declining share of public investment in the healthcare system, the lack of a long-term plan, and the private system's growing share at the public system's expense – a situation liable to worsen existing inequities and to impair the public system's effectiveness. To these may be added one particular consequence of the healthcare system – the loss of status suffered by the physician in the public system. Based on the foregoing, it appears that the basic situation of a doctor who wants to devote all of his/her time to public-hospital work has not improved. This being the case, it may be assumed that the public system's physician-shortage problem, and particularly its specialist-shortage problem, is not about to be solved – despite the fact that Israel has no relative shortage of healthcare manpower.

Even given the global decline in general hospital bed numbers, the long-term solutions required for Israel's healthcare system, as noted by a number of relevant parties, are: increasing public medicine's share of the mix relative to the private services, and encouraging technological advances that will save on manpower and inpatient beds. These changes should supplement short-term efforts to increase the supply of manpower.

3. Private Expenditure on Healthcare Services in Israel as an Expression of the Public System's Functional Status and Its Role in Disparities and Poverty

As noted earlier, in Israel the share of public expenditure in the total national health expenditure has declined to the lowest level exhibited by those developed countries that provide their residents with universal health insurance – less than 60 percent in 2010 (see Figure 5). This decline is exposing Israel to situations that other countries are trying to escape: a closer linkage between health status and poverty, and system-wide inefficiency.[3]

The impact exerted by private healthcare expenditure on income distribution and poverty in Israel was assessed through an innovative approach employed in a study by Navon and Chernichovsky (2012). The study, which is based on data from 2009, looked at how private funding is worsening Israel's income-distribution situation and driving a catastrophic rise in poverty. This chapter features updated findings from that study, according to a survey of family expenditure for 2010.

The components of private healthcare expenditure in Israel. Since 1997 there has been an increase in private healthcare expenditure's share of total average household consumption: from 4.1 percent to 5.1 percent. Nearly all Israeli households (93 percent) reported some form of private healthcare expenditure during the survey period (not including private expenditure on nursing care); the average figure arrived at was NIS 646 per month, per household.

[3] Defining the poverty line and determining how it is arrived at are central to this work in two areas: classifying private expenditure on healthcare by economic status, and measuring the impact of this expenditure on poverty. In both cases the research relied on the relative poverty definition used by the National Insurance Institute (for an in-depth discussion see Navon and Chernichovsky 2011 – Appendix 1).

- **Copayments** account for 7 percent of the total private expenditure. Forty-four percent of households reported expenditure of this kind, for a monthly average of NIS 117. Among the respondents, copayments for prescription drugs was the main expenditure, both in terms of percentage of households that made such payments (35 percent) and the average level of expenditure (NIS 289 per month).
- **Supplemental health insurance** (hereinafter: "supplemental insurance") – as defined in the original study (insurance for services not covered by the public basket), also accounts for 7 percent of the total expenditure. Eighty percent of households reported that they spend money on such insurance, and the average monthly expenditure made by these households was NIS 56. Surgical procedures and choice of surgeon are major items within this category – in contrast to dental care, a sphere on which expenditure is low despite its exclusion from the health basket.[4]
- **Out-of-pocket expenditure on supplemental services** is the largest expenditure item among the various out-of-pocket expenditures, both in terms of the average amount of expenditure – NIS 551 per month – and in terms of the number of households that report it (44 percent). This expenditure accounts for 47 percent of private expenditure on healthcare. This item includes dental care, a field whose insurance options are relatively limited (Chernichovsky and Navon 2010). The financial expenditure on surgical procedures, which is included in the expenditure on parallel services, is especially high, but refers to just 1 percent of the population.

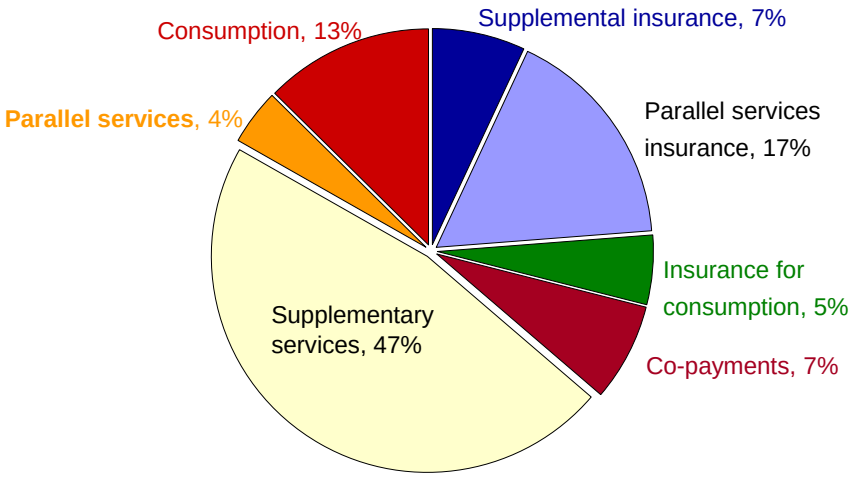
[4] Since 2010 dental care for children has been included in the basket.

According to the study, expenditure on these three items serves as a kind of alternative to taxes, in the sense that it has a basis in necessity, is a matter of public interest, and affects 44 to 80 percent of Israeli households. Expenditures on these items together amount to 61 percent of total private healthcare expenditure (Figure 12).

Figure 12

Distribution of private expenditure for healthcare services

by categories, Israel 2010



Source: Navon and Chernichovsky, 2012 (Taub Center update.)
Data: Central Bureau of Statistics.

In addition to these three items, there are two additional spheres for private healthcare expenditure:

- Parallel services and products (hereinafter: parallel services): services or products that are provided through full or partial public funding.

- Consumption services and products: expenditures that are not specifically healthcare, and which it is not in the public's interest to subsidize in any way.

Private Expenditure on Medicine as an Expression of Efficiency and Equity in the Public System

The study findings yield several important insights regarding the public healthcare system's efficiency and equity:

- Low income is a barrier to access for services that entail copayments and that are in the public interest, and for parallel services, including dental care, that are not in the basket of services.
- Out-of-pocket expenditure on parallel services correlates positively with income, educational level and insurance coverage, as well as with the presence of elderly people and children in the household. That is, groups characterized by more numerous needs than average and which are able to afford it, spend more on these services.
- The positive correlation between high socioeconomic status, including education level, and expenditure on voluntary insurance and out-of-pocket expenditure – over and above the fact that insurance coverage is positively correlated with healthcare service consumption and out-of-pocket expenditure – support the hypothesis that voluntary insurance in Israel may worsen the inequity situation, at least in the short-term. The insurance policies purchased by those with relatively high incomes give them better access to service as well as better protection for the household budget in cases of high expenditure on services not included in the health basket.

- The fact that high-income people in general, and the highly-educated in particular, spend relatively large amounts on parallel services both through insurance and out-of-pocket, supports the hypothesis that the public system is not functioning well – at least in the consumer's view – and that even with regard to the basic basket of services, two parallel systems are developing – a system for the poor and a system for the rich.[5]
- Households that include children or elderly people, two populations that have a need for more health services, spend more (relative to income) on parallel services – another indication of non-optimal system functioning. The positive influence of number of wage earners on insurance, when all other variables are equal, hints that employer expenditure on insurance may play an important role – a role that likely expands as general expenditure on insurance grows.
- Having insurance for parallel services has a large and particularly significant influence on total private healthcare expenditure. This finding is consistent with the hypothesis that insurance for parallel services constitutes an impetus for public-system service providers to encourage demand in the private system.

Private expenditure on healthcare services and income distribution. Private expenditure on the various forms of healthcare, by income quintile, is detailed in Figure 13 and in Table 1. The highest quintile spends three times as much as the lowest quintile – a fact that is

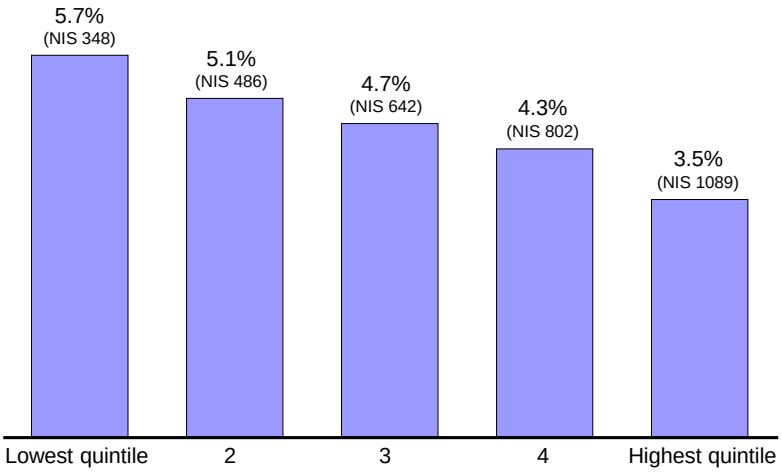
[5] The concept of the public system's functioning is complex and relative, inasmuch as it is subject to the effects of reciprocal relations between the holding of supplemental insurance, purchased within the public system, and the use of that insurance in the private system. Patients whose financial status enables them to use supplemental insurance in the consumption of a relatively large number of healthcare services are referred from the public system to the private one, and therefore suffer less from the public system's erosion in terms of the level of service provided to them – but they spend more out-of-pocket (see Chernichovsky 2011).

consistent with the previous findings. In spite of this, the total healthcare expenditure is regressive: poor households spend a higher percentage of their disposable income on healthcare services – 5.7 percent for the lowest quintile versus 3.6 percent for the highest quintile. Copayments and out-of-pocket payments for supplemental services – primarily dental care – make a special contribution to this situation, and their impact on the average expenditure cancels out the effects of the progressive expenditure on parallel services and on the consumption of, and coverage for, supplemental services – whether out-of-pocket or through insurance. What the findings mean is that, although higher-income Israelis spend a higher percentage of their income on certain areas than do those with lower-income; the lowest quintile, in general, spends a higher percentage of its income on healthcare due to expenditures on copayments and necessary services.

Figure 13

Private expenditure on healthcare services by income quintiles

as percent of disposable income in each quintile, 2010



Source: Navon and Chernichovsky, 2012 (Taub Center update).
Data: Central Bureau of Statistics.

An analysis of the way in which private expenditure affects equity yields the following conclusions:

- In general, the middle-income groups bear a relatively large share of the expenditure on the three expenditure categories in which the public has a direct interest. The higher income quintiles spend a low percentage of their disposable income on these categories, including copayments, as do the lower income quintiles – but the reason in the latter case is non-consumption and lack of access to care, whether directly or due to foregoing insurance for supplemental services. Regarding the impact on health, the findings are even more significant if it is assumed that poor people have a greater need for healthcare than do affluent people.
- The findings support the contention that, in Israel, private insurance worsens the state of the distribution of access to healthcare services, because it affords better access to healthcare services and better protection (in the case of large healthcare expenditures not included in the health basket) to the higher income brackets. That is to say, in Israel the advantages of insurance, including supplemental insurance, are enjoyed mainly by the higher income groups.

Table 1. **Distribution of private expenditure on healthcare services**
by categories of expenditure and income quintiles, 2010

	Insurance			Out-of-pocket expenditures				Total health care
	Supplemental	Parallel	Consumption	Copayment	Supplemental	Parallel	Consumption	
Avg. reported household expenditure (NIS per month)	62	166	53	230	737	347	223	715
Percent of reporting households	80%	81%	82%	27%	53%	10%	47%	94%

Average expenditure per household
as percent of average disposable income

	Insurance			Out-of-pocket expenditures				Total health care
Income quintile	Supplemental	Parallel	Consumption	Copayment	Supplemental	Parallel	Consumption	
1	0.34%	0.76%	0.19%	0.82%	4.35%	0.18%	0.78%	5.72%
2	0.38%	0.93%	0.27%	0.58%	3.26%	0.19%	0.63%	5.06%
3	0.38%	0.95%	0.29%	0.40%	2.96%	0.21%	0.64%	4.68%
4	0.35%	0.94%	0.30%	0.34%	2.56%	0.21%	0.65%	4.30%
5	0.24%	0.76%	0.27%	0.27%	1.63%	0.25%	0.69%	3.55%
Average	0.32%	0.86%	0.28%	0.39%	2.49%	0.22%	0.67%	4.28%
Ratio of expenditure: highest to lowest	3.59	5.05	7.08	1.63	1.88	7.12	4.40	3.11

Source: Navon and Chernichovsky 2012 (Taub Center update).
Data: Central Bureau of Statistics.

The Relationship Between Private Healthcare Expenditure and Poverty

The estimates for 2010 indicate that total private expenditure on healthcare raises the incidence of poverty by 17,840 households[6] (Table 2).

Expenditures in which the public has an interest, as defined in the original study – copayments, insurance premiums and out-of-pocket expenditure on supplemental services – raise the number of Israel's poor households by 2,976, 738 and 8,508, respectively. The greatest contribution to the figures on poverty due to expenditure on supplemental services is actually in households with two wage earners and amongst the Arab Israeli population.

[6] The meaning here is that when one deducts private healthcare expenditure from disposable income, the disposable income of 17,840 additional households falls below half the median disposable income (all data are calculated in terms of standardized persons per household).

Table 2. **The impact of private healthcare expenditure on the incidence of poverty***
by expenditure category and household attributes, 2010

	Arab Israelis	Haredim	Families with elderly members (65+)
Average without influence of expenditures on medical services			
Number of households in group	284,884	85,782	312,106
Number of households at baseline	132,335	32,070	49,156
Percent of the poor at baseline	15.7%	37.4%	46.5%
Impact of total expenditure on medical services			
Percent increase in the poor	1.7%	-0.4%	2.3%
Net number of households added to poor	4,780	-370	7,024
Average change in depth of poverty	14.3%	-1.2%	3.6%
Impact of expenditure on copayment			
Percent increase in the poor	1.4%	-0.6%	0.3%
Net number of households added to the poor	3,878	-475	802
Average change in depth of poverty	2.9%	-1.5%	1.6%

* In contrast to the way the National Insurance Institute calculates the poverty line which is according to net monetary income, the poverty line is calculated here according to net overall income. That is: net monetary income + in-kind income. The population in the sample is the one that was sampled for the 2010 Household Survey (see Navon and Chernichovsky, 2012).

Table 2. (continued)

Families with children (0-18)	No wage earners	One wage earner	Two or more wage earners	Total
986,183	233,132	682,162	922,346	**2,181,736**
242,443	120,355	171,404	40,613	**384,029**
24.6%	51.6%	25.1%	4.4%	**17.6%**
0.1%	2.0%	-0.2%	0.6%	**0.8%**
1,262	4,770	-1,045	5,780	**17,840**
0.5%	4.0%	-0.7%	14.2%	**4.6%**
-0.1%	0.5%	-0.1%	0.0%	**0.1%**
-1,073	1,180	-360	25	**2,976**
-0.4%	1.0%	-0.2%	0.1%	**0.8%**

Table 2. (continued) **The impact of private healthcare expenditure on the incidence of poverty**

by expenditure category and household attributes, 2010

	Arab Israelis	Haredim	Families with elderly members (65+)
Impact of expenditure on supplemental insurance			
Percent increase in the poor	0.0%	0.0%	0.1%
Net number of households added to the poor	—	—	383
Average change in depth of poverty	0.0%	0.0%	0.8%
Impact of out-of-pocket expenditure on supplemental insurance			
Percent increase in the poor	1.6%	-2.1%	0.9%
Net number of households added to the poor	4,542	-1,836	2,805
Average change in depth of poverty	3.4%	-5.7%	5.7%
Impact of expenditure on recipients' insurance			
Percent increase in the poor	0.0%	0.3%	0.1%
Net number of households added to the poor	-90	217	383
Average change in depth of poverty	-0.1%	0.7%	0.8%

Table 2. (continued)

Families with children (0-18)	No wage earners	One wage earner	Two or more wage earners	Total
0.0%	0.1%	0.0%	0.1%	**0.0%**
355	118	-327	564	**738**
0.1%	0.1%	-0.2%	1.4%	**0.2%**
-0.2%	2.0%	-0.5%	0.4%	**0.4%**
-1,633	4,759	-3,714	3,631	**8,508**
-0.7%	4.0%	-2.2%	8.9%	**2.2%**
0.1%	0.4%	0.0%	0.1%	**0.1%**
1,045	989	-234	1,284	**2,423**
0.4%	0.8%	-0.1%	3.2%	**0.6%**

Table 2. **The impact of private healthcare expenditure on the incidence of poverty** (continued)

by expenditure category and household attributes, 2010

	Arab Israelis	Haredim	Families with elderly members (65+)
Impact of expenditure on consumer insurances			
Percent increase in the poor	0.1%	0.3%	0.1%
Net number of households added to the poor	406	217	383
Average change in depth of poverty	0.3%	0.7%	0.8%
Impact of out-of-pocket expenditure on parallel services			
Percent increase in the poor	0.0%	0.0%	-0.1%
Net number of households added to the poor	107	–	-265
Average change in depth of poverty	0.1%	0.0%	-0.5%
Impact of out-of-pocket expenditures on consumption			
Percent increase in the poor	-0.03%	-0.1%	0.0%
Net number of households added to the poor	-743	-44	79
Average change in depth of poverty	-0.6%	-0.1%	0.2%

Table 2. (continued)

Families with children (0-18)	No wage earners	One wage earner	Two or more wage earners	Total
0.0%	0.0%	-0.1%	0.0%	**0.0%**
-3	—	-475	—	**-740**
0.0%	0.0%	-0.3%	0.0%	**-0.2%**
-0.1%	0.1%	-0.3%	0.0%	**0.0%**
-1,325	313	-1,874	147	**1,052**
-0.5%	0.3%	-1.1%	0.4%	**-0.3%**
0.1%	0.3%	0.0%	0.0%	**0.1%**
974	757	—	217	**1,356**
0.4%	0.6%	0.0%	0.5%	**0.4%**

Source: Navon and Chernichovsky, 2012 (Taub Center update).
Data: Central Bureau of Statistics.

In this context, the Navon and Chernichovsky research findings also indicate that:

- Expenditure on parallel services for which public entitlement exists contributes to poverty among families with children and families with two or more wage earners. These findings point to a certain dissatisfaction on the part of working couples with children with the public system, which drives them to spend privately on parallel services, even at the price of falling into poverty. The influence of this expenditure on the deepening of poverty is particularly conspicuous among the Arab Israeli population. By contrast, copayments and out-of-pocket payments for supplemental services contribute to a deepening of poverty among all households. This effect is especially notable regarding out-of-pocket expenditure on supplemental services among households that include elderly people.
- Those with low incomes have a higher chance of falling below the poverty line in all expenditure categories, and particularly in copayments. In this context it should be noted that a positive correlation was found between household size in terms of standardized persons and the probability of falling into poverty. That is, lower income per capita is what raises the likelihood of descent below the poverty line.
- The special impact of income per capita on the likelihood of falling into poverty due to expenditure on services parallel to those included in the health basket is that large, low-income families fall into poverty when they spend money on services that they are supposed to receive through the basic basket of services.
- A larger number of wage earners lowers the chance of falling into poverty, even when accounting for the effects of income per capita. This may be taken to indicate that working people have fewer

healthcare needs, and that they have better access to insurance, especially for services included in the basket.

- Within the parallel services category, the variables that most strongly affect poverty are the number of persons and the dummy variables for the geographic districts (these data are not included in the table). The findings indicate that families with greater needs are relatively more likely to fall into poverty even due to expenditure on services that are included in the health basket. Moreover, people are falling into poverty due to expenditure on parallel services even in districts characterized by abundant service supply. This finding hints that service providers are encouraging demand. Alternatively, the finding may testify to a problem in these districts regarding access to healthcare services included in the health basket.

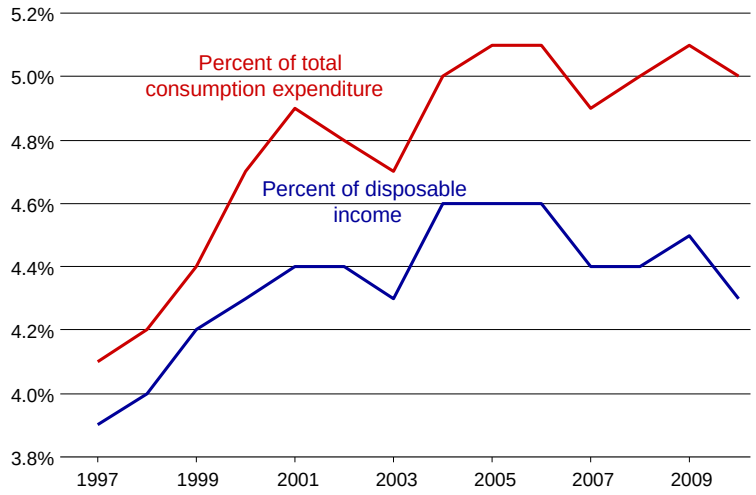
Long-Term Trends

Figure 14 shows a steady rise in private healthcare expenditure as a percentage of household budgets since 1997. One can see that the increase in expenditure as a percentage of total consumption is higher than the increase as a percentage of total disposable income, which means that households are, to a greater and greater degree, foregoing other forms of consumption in favor of healthcare services consumption. The situation is actually worse than these figures would indicate, given that the rise in healthcare service prices exceeds the price rise for the remainder of the household-consumption product basket (Chernichovsky, Gamzu, and Navon 2010).

Figure 14

Private expenditure on healthcare services, 1997-2010

as percent of disposable income and of total consumption expenditure

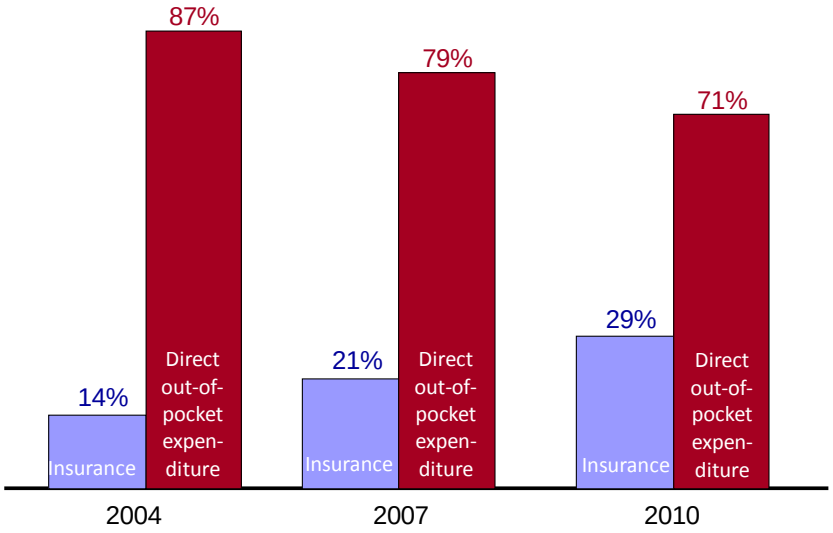


Source: Chernichovsky, Gamzu, and Navon, 2012 (Taub Center update).
Data: Central Bureau of Statistics.

The changes in healthcare expenditure distribution since 2004 are shown in Table 3 and in Figure 15. The share of insurance expenditure is rising, while the share of out-of-pocket expenditure is trending downward. In percentage-point terms, there has been a notable rise in the share of insurance expenditure on parallel services and consumption. Despite a decline in the share of out-of-pocket expenditure, from 87 percent in 2004 to 71 percent in 2010, there has been a rise in direct expenditure on parallel services and consumption – at the expense of the share accounted for by copayment and expenditure on supplemental services.

Figure 15

Distribution of private healthcare expenditures



Source: Navon and Chernichovsky, 2012 (Taub Center update).
Data: Central Bureau of Statistics.

Table 3. **Changes in the distribution of healthcare expenditures in 2004, 2007 and 2010**

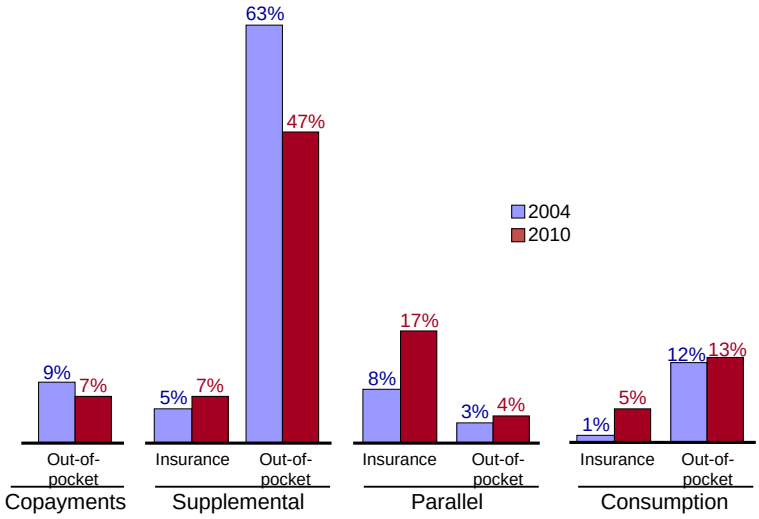
Expenditure		**2010**	**2007**	**2004**
Insurance	Supplemental	7%	5%	5%
	Parallel	17%	12%	8%
	Consumption	5%	4%	1%
	Copayment	7%	8%	9%
Out-of-pocket	Supplemental	47%	55%	63%
	Parallel	4%	5%	3%
	Consumption	13%	11%	12%

Source: Navon and Chernichovsky, 2012 (Taub Center Update).
Data: Central Bureau of Statistics.

Figure 16 summarizes the changes in expenditure, as well as their extent. The data indicate an overall upward trend in the percentage of insured households and in expenditure on insurance, versus a decline in the percentage of households that make direct out-of-pocket expenditures in these areas. The only item for which there has been a slight rise in direct expenditure throughout the period is that of parallel services (from 3-4 percent).

Figure 16

Components of private healthcare expenditure



Source: Navon and Chernichovsky, 2012 (Taub Center update).
Data: Central Bureau of Statistics.

In summary, although the rise in the share of expenditure on insurance – particularly in the form of a rise in copayments – compared with direct out-of-pocket expenditure is on the face of it a welcome development, emerging trends in expenditure distribution may point to a relative worsening of the overall situation. The problem lies in the expenditure that is being made on parallel services. The Israeli public is spending larger portions of its income – whether through private insurance or through direct out-of-pocket payments – for services that are included in the public basket, or that are supposed to be. What this means is that the public system is fulfilling its function vis-à-vis the public to an ever-diminishing degree.

4. Long-Term Nursing Care Funding in Israel

The issue of long-term nursing care (LTNC) and its funding comes up regularly in Israel due to the social and economic challenges that it has long posed to the country as a whole (Chernichovsky et al. 2011; Ministry of Health 2011; Chernichovsky et al. 2010). The topic has become particularly relevant over the last two or three years in light of two apparently contradictory governmental initiatives. One of these initiatives, spearheaded by the Ministry of Finance, seeks – through the health funds – to base long-term care insurance on personal premiums to a greater degree than is currently the case; the other initiative, advocated by the Ministry of Health, wants to make this form of insurance more governmental in nature. The goal of the former initiative is to limit the potential for parallel subsidies, particularly between age and income groups, while the goal of the latter is the opposite.

These issues are addressed in a forthcoming Taub Center policy paper (Chernichovsky, Kaplan, and Stessman 2012) and are also reviewed in this section. The paper complements the publications previously cited by placing the current Israeli situation and the proposals on the agenda in an international and conceptual perspective.

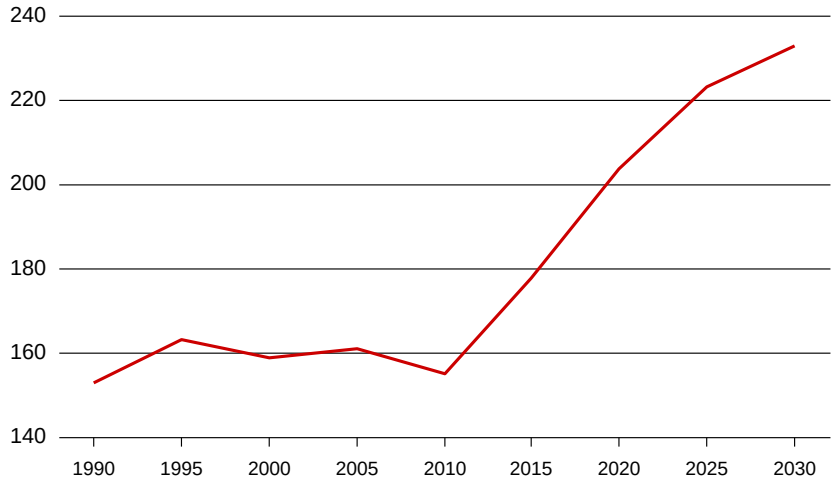
Rising Needs

Forecasts of the Central Bureau of Statistics point to a sharp rise in the total number of people aged 65 and over in the population. By 2030 the number of those aged 65 and over – of whom half will be aged 75 and over – is expected to reach 1,370,000 versus 760,000 aged 65 and over today. The share of the elderly in the population is expected to reach 12 percent in 2020, and nearly 14 percent in 2030, versus 10 percent today. This means that in 2030 there will be 230 elderly people in Israel for every thousand people of working age, compared with 160 elderly per thousand working-age people at present (Figure 17). That is, over the coming two decades (2010-2030) this population group will grow by 80 percent, compared with a general population growth figure of 32 percent (Central Bureau of Statistics, *Forecasts*, 2010).

Figure 17

Elderly dependency ratio*

percent of persons aged 65 and over
per 1,000 working-age adults (ages 25-64)



* Data for 2012-2030 are projections based on current age distribution.

Source: Ben-Moshe, 2011 (Taub Center update).
Data: Ministry of Industry, Trade and Labor.

Compared with the more developed OECD countries, Israel's population is characterized by a relatively low percentage of people aged 65 and over; however the proportion of older seniors within this group (those aged 75 and over) is relatively high, due to Israel's relatively high life expectancy. Moreover, Israel's rate of aging in the population is high compared with that of all other developed countries.

This demographic picture dictates potential for increased long-term care needs. Within the context of this discussion, the issue of old age – particularly with regard to the healthcare of those aged 75 and over – is complicated by multiple diseases per individual, by the changing character and symptoms of disease, by a rise in the prevalence of disease, and by a more lengthy course of illness. Diseases appear at this age that do not characterize younger age groups, and that involve cognitive decline and sensory impairment. The outcomes of morbidity – some of it chronic – among the elderly are manifested in functional decline and in a loss of independence in daily living. These latter phenomena lead to a growing need for hospitalization, facility-based care or constant caregiving in the home (*Report of the Committee on Planning National Geriatric Services* 2011).

Funding Long-Term Care in Israel – Sources and Uses

Table 4 presents the composition and sources of funding for the various forms of long-term care in Israel. The table data themselves, and in international comparison, indicate the existence of questions regarding eligibility and regarding the system's relative efficiency.

Table 4. **Estimates of financing of long-term care in Israel**
by type of care and public funding agent

Public					
Care type	**Primary funder**	**Estimate of those in care**	**Cost estimate** (NIS billion)	**Percent of expenditure for nursing care**	**Notes**
Individual care – community-based	National Insurance Institute	139,419	3.6	32%	Estimate includes those entitled to care only, some nursing patients are entitled to more services
Non-complex institutional care	State (via Min. of Health and Welfare)	16,512	1.68	15%	Calculated on basis of Min. of Health budget for long-term care (services for illness and actual expenditure) + Min. of Welfare expenditure for long-term care
Complex hospitali-zation	State (via health funds)	1,659	0.42	4%	Calculated on the basis of 1,659 complex nursing care patients X 365 days X 700 NIS per hospital day
Total public			**5.7**	**50%**	

Table 4. (continued)

Private					
Care type	**Primary funder**	**Estimate of those in care**	**Cost estimate** (NIS billion)	**Percent of expenditure for nursing care**	**Notes**
Individual care – community-based	House-hold	57,329	2.4	21%	Calculated on the basis of 57,329 work permits in nursing care X $1,000 per month (3.5NIS to the dollar)
Non-complex institutional care	House-hold	29,281	2.5	22%	Calculated on the basis of 29,281 hospital beds X NIS 7,000 per month (average cost)
Net private insurance premiums, after payments for hospitali-zation		No data on number of those insured	0.8	7%	Calculated on the basis of premiums paid for private nursing care insurance (NIS 1,608,431,000) less claims (NIS 790,084,000)
Total private			**5.7**	**50%**	
Total long-term care expenditure			**11.37**	**100%**	

Source: Taub Center for Social Policy Studies in Israel.

Data: National Insurance Institute, Ministry of Finance, Myers-JDC-Brookdale, Knesset Research and Information Center.

Public Funding

Public funding is relevant to three main types of care: personal care in the community, non-complex facility-based care and complex facility-based care.

The National Insurance Institute is the main public funder of personal care in the community. It subsidizes the care of 140,000 elderly people at a cost of NIS 3.6 billion – 63 percent of the total public funding for continuing care. The Ministry of Health and the Ministry of Social Affairs are the public funders of non-complex facility-based care. The cost of this funding is NIS 1.68 billion, constituting 29 percent of the total public funding for long-term care.

The state (the Ministry of Finance and the National Insurance Institute), through the health funds, finances complex long-term care for 1,700 elderly people, at a cost of NIS 420 million – 8 percent of the public funding total. Total public funding for long-term care is NIS 5.7 billion, half of the national expenditure on continuing care.

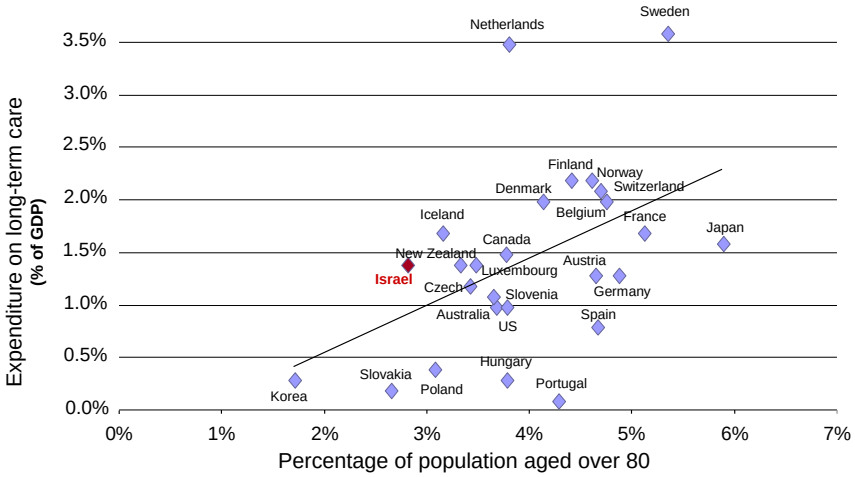
Private Funding

Private funding is used for personal care by means of foreign workers, non-complex facility-based care, and net private insurance premiums (after deducting for insurer payments for insurance-provided facility-based care). Israeli households spend NIS 2.4 billion per year on the employment of foreign workers as personal caregivers to 57,500 elderly people. This expenditure accounts for an estimated 42 percent of all private expenditure on long-term care. Households also spend NIS 2.5 billion per year on non-complex facility-based care for 29,500 elderly people – 44 percent of the total private expenditure on continuing care. The overall cost of net private insurance premiums (after payment for hospitalization) is estimated at NIS 800 million, 14 percent of the total private expenditure on long-term care. Total private funding for long-term care is NIS 5.7 billion – half of the national expenditure on long-term care.

Figure 18

Percentage of aged 80+ and expenditure rate on nursing care*

as percent of total population in OECD countries** including Israel, 2008



* Data include private and public expenditure on long-term nursing care.

** Expenditure data for Austria, Belgium, Canada, Denmark, Hungary, Iceland, Norway, Portugal, Switzerland, and US include actual expenditure on nursing care only and do not include any other national expenditure on long-term care.

Source: Taub Center for Social Policy Studies in Israel.

Data: OECD, Bank of Israel, Ministry of Health.

Israel spends 1.4 percent of its GDP on long-term care.[7] This percentage is similar to the average OECD expenditure (Figure 18). However, when taking into account the relatively low share of those aged 80 and over in the population, Israel spends a high proportion of its GDP on this form of care.

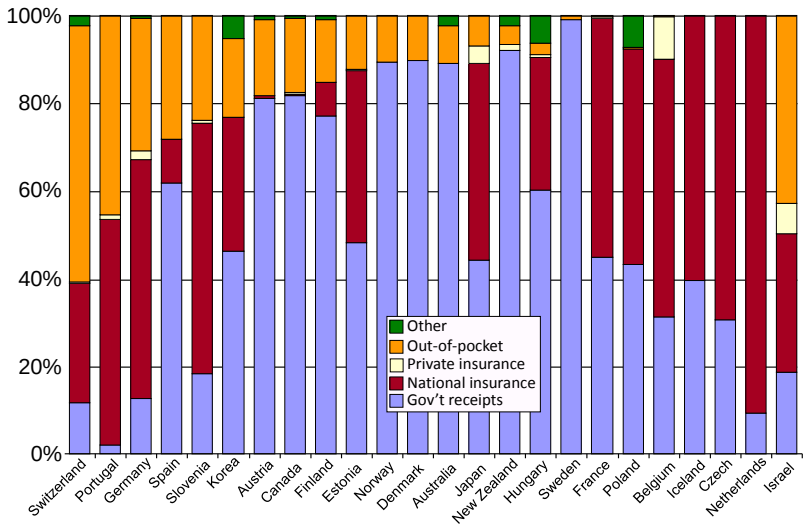
[7] The funding estimates are consistent with those of the Bank of Israel, which places the scope of the expenditure at 1.2 percent of the GDP. The public expenditure estimates given here are identical to those of the Bank of Israel (*Bank of Israel Report 2011*, Chapter 8); by contrast, the Taub Center's private expenditure estimates are higher than those of the Bank.

The most outstanding characteristic of Israeli funding for continuing care is its relatively large share of private funding (Figure 19). Of the countries examined, only Switzerland has a higher share of private funding. The OECD average for private funding share is only 16 percent, meaning that Israel's private funding share for long-term care is three times higher than the OECD average. Israel also stands out for its rate of expenditure on private insurance – exceeded only by that of Belgium. Israel's private LTNC expenditure in terms of per capita GDP is relatively high: 24.10 percent of per capita GDP, versus 17.14 percent for the OECD.

Figure 19

Long-term nursing care expenditures by funding sources*

OECD countries and Israel, 2008



* For some of the countries, the private out-of-pocket expenditure of consumers represent a low estimate. For example, in the Netherlands, participation in long-term nursing care is estimated to be some 8 percent of this expenditure.

Source: Taub Center for Social Policy Studies in Israel.

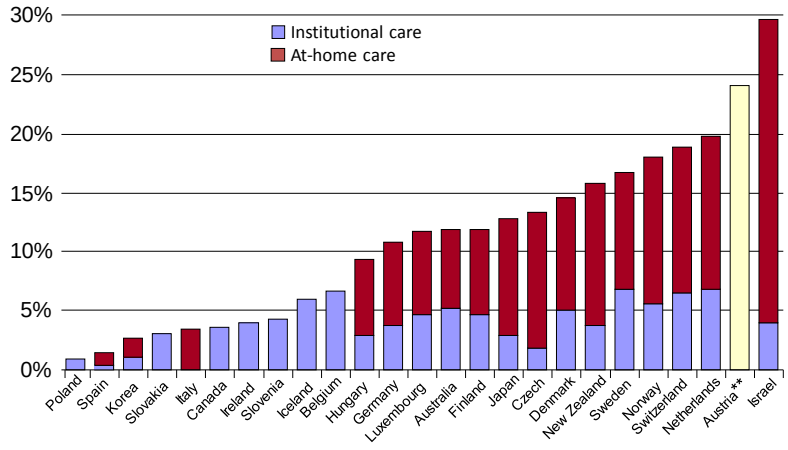
Data: OECD, Bank of Israel, Ministry of Health.

Israel is the leader in the sphere of long-term care for the elderly (Figure 20). Israel's percentage of those cared for in the community and in the household is especially high: 86.5 percent of all Israeli LTNC patients, compared with an OECD average of 50.7 percent.

Figure 20

Consumers of long-term nursing care*

as percent of the population aged 65 and over, OECD countries and Israel, 2008



* Consumers of long-term nursing care aged 65+ – those in institutions and those at home.

** Data for Austria are the percent of those receiving benefits for the purchase of long-term care.

Source: Taub Center for Social Policy Studies in Israel.

Data: OECD, Central Bureau of Statistics, Bank of Israel, Ministry of Health.

An International Perspective on Long-Term Nursing Care Expenditure

On the face of it, Israel's long-term nursing care picture would appear to be a positive one, featuring a high level of coverage at a low cost – a picture testifying to efficiency, high access and relatively low prices. However, this is a partial and misleading picture; a closer look at the data raises questions regarding the system's efficiency, equity and sustainability in the long term.

Israel's relatively low average cost per LTNC patient is derived from the country's high percentage of elderly care-recipients aged 60 to 80 – some of whom are cared for by foreign workers, the cost of whose employment is low relative to the OECD. Thus, when an adjustment for age that also ensures institutional-level comparability is made (Figure 18), the Israeli expenditure turns out to be high compared with the OECD.[8]

Moreover, elderly long-term nursing care recipients are generally obliged to spend larger out-of-pocket sums than those required of elderly people in the OECD. This situation leads to inequity and raises questions regarding the system's efficiency, given the existing insurance frameworks' inability to prevent such a state of affairs.[9]

One particularly serious aspect of the present situation is its unsustainability in the face of anticipated developments: current trends, in Israel as elsewhere, point in the direction of population aging, and specifically an aging of the elderly population (see Figure 17), as well as a relative rise in the wages of foreign workers (a phenomenon stemming from, among other things, a rise in the standard of living of these workers' countries of origin). These trends will likely lead to a decline in private funding capabilities, particularly for the younger generations who

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[8] The figure may reflect a social preference on the part of the very old, as well as Israel's high life expectancy. However, it is unlikely that these factors explain the relatively high cost of care in Israel.

[9] See discussion in forthcoming paper: Chernichovsky, Kaplan, and Stessman, 2012.

will not be eligible, for example, for German reparations and who will perhaps have fewer assets than the current generation has. These developments, along with societal changes, will entail more extensive facility-based care – as in the more developed OECD states – at higher costs and without sufficient arrangements.

Indeed, the reality of the LTNC insurance market and of society's long-term care needs drove the developed countries to choose solutions of a public nature; the way in which selected countries (those closer to Israel on social services funding parameters) implemented these solutions is presented in Table 5.[10]

The comparison provided by Table 5 draws attention to several main points regarding public funding of long-term care in the selected countries:

- Coverage is universal
- Insurance is mandatory for all
- Funding comes from taxes or from social insurance based on the ability to pay (expenditure)
- Compensation is provided to families through in-kind services, cash, or a combination of the two
- Compensation is sometimes conditional on means testing
- Private insurance, mainly in the US but also in Japan and Germany, confers tax credits

Universal mandatory insurance is based on the need for young people's participation in the program, as well as the need to keep them from burdening the public with their parents' care (or with their own care, in the future). The systems are, ultimately, based on the Pay As You Go (PAYG) method, but with accumulating funds.

[10] Countries where LTNC insurance is primarily governmental, such as the Scandinavian states, are not included.

Table 5. **Models for publicly-funded long-term nursing care, selected counties**

	Funding	Compensation	Entitlement	Private insurance
France	General tax	Cash only	Universal, means-test-based private insurance requirement	25% of aged 60 and over
Germany	Salary tax	Service or cash	Universal	Less than 10% optional for those with high salaries
Japan	Salary tax, general taxes, income-based premiums	Service only	Universal for ages 65 and over	None
Netherlands	Income tax participation according to ability	Service or cash	Universal	Mandatory, privately managed
UK	General tax	Service or cash	Means tested	Very limited
Israel	General tax participation according to ability to pay	Service or cash principally for those using foreign workers	Means test, needs test (evaluation of daily living skills)	

Source: Taub Center for Social Policy Studies in Israel.
Data: OECD.

Principles for Reform in Israel

From a financial perspective, international experience clearly indicates that the private insurance market cannot contribute substantially to resolving the issue of long-term care funding; the developed countries have, for all intents and purposes, given up on any private-market based solution to the problem. In Israel, the main way of addressing the issue is that of purchasing long-term care insurance within a framework of private group policies purchased by health funds from private insurance agencies. This solution currently fails to meet the needs of broad portions of the Israeli population, particularly its low-income sectors, nor does it address anticipated developments.

Thus, any approach resembling that which the Ministry of Finance has championed in recent years – one that would turn the health-fund-based "semi-public" insurance into private-premium insurance, albeit in a group framework – would run counter to current international trends. By contrast, the Ministry of Health's approach, one that aspires to ensure universality (if only partial) of long-term care beyond the existing coverage provided by the health funds, is consistent with international trends and with principles of equity and efficiency.

That being said, consideration needs to be given to other options besides that of raising the healthcare tax by half a percent (if at all) as the Ministry has proposed. The basis for this latter option is unclear, both conceptually (the connection between funding long-term care – most of which is not medical but rather social in nature – and the healthcare tax) and in terms of its funding implications. The issue needs to be thoroughly investigated before any far-reaching measures are taken. Instituting mandatory LTNC insurance is an important matter, one with long-term ramifications for Israelis' well-being and social security, and it is important that an initiative of this magnitude be implemented in the best possible way.

The solution in Israel might include the following features and measures:

- A pre-defined basket of continuing care services to be provided in the form of a "nursing care allowance" – cash, in-kind services, or a combination of the two.
- The basket would be funded by pooling all public resources that currently exist within the Ministry of Social Affairs, the National Insurance Institute and the Ministry of Health, through a dedicated account in the National Insurance Institute.
- Mandatory insurance would be administered by a special authority created for the purpose, or within the National Insurance Institute framework.
- Some of the private, health fund based insurance could be converted to mandatory insurance, with the state making up the difference for less-affluent sectors, on a means test basis.
- Health fund based group nursing care insurance policies (some of which, again, would be turned into mandatory insurance) could be arranged in such a way as not to impair mobility between the health funds.
- The definition of a long-term nursing care patient would be that currently used by the private insurance agencies.
- A governmental authority would be established to determine the eligibility of long-term care patients for a "nursing care allowance," and to administer the public budgets, including the mandatory insurance funds, intended for long-term care services.
- The "nursing care allowance" would not be conditional on the patient/family means testing.

- The allowance would be linked to the consumer price index or to another relevant index employed by the Central Bureau of Statistics.
- Future increases in the nursing care allowance would be considered periodically based on LTNC patient needs, and on the state's ability to fund these allowances.

The background for these proposed features is presented in detail in a forthcoming Taub Center policy paper (Chernichovsky, Kaplan, and Stessman).

References

English

Ben-Moshe, Eliahu (2011), *Changes in the Structure and Composition of Israeli Population*, Ministry of Industry, Trade and Labor.

Chernichovsky, Dov (2011), "Israel's Healthcare System," in Dan Ben-David (ed.), *State of the Nation Report: Society, Economy and Policy in Israel 2010*, Taub Center for Social Policy Studies in Israel, pp. 339-395.

Chernichovsky, Dov, Michal Koreh, Sharon Soffer, and Shirley Avrami (2010), "Long-Term Care in Israel Challenges and Reform Options," *Health Policy, 96*, No. 3, pp. 217-225.

OECD, *Help Wanted? Providing and Paying for Long-Term Care*, OECD publication.

oecd.org/els/healthpoliciesanddata/47884942.pdf.

OECD, Online Database.

stats.oecd.org/

World Bank, Online Database, health topic.

data.worldbank.org/topic/health.

Hebrew

Arieli, Daniella, Tuvia Horev, and Nir Keidar, *The National Health Insurance Law: Statistical Database 1995-2011*, Ministry of Health, Economic and Health Insurance Division.

health.gov.il/Download/pages/stat2011_1995.pdf

Bank of Israel (2011), *Bank of Israel Annual Report 2011*, Chapter 8 ("Issues in Welfare Policy"), pp. 293-321.

Central Bureau of Statistics (2011), *Statistical Abstract of Israel, 62*, Table 6.3.

Central Bureau of Statistics (2010a), *Report on Measures of Poverty and Social Gaps*.

Central Bureau of Statistics (2010b), *Health Survey 2009* (Database).

Central Bureau of Statistics (2008a), *Report of the Team for the Development of Additional Measures of Poverty*.

Central Bureau of Statistics (2008b), *National Expenditure on Health 1962-2008*, Special Publication 1408.

Central Bureau of Statistics, *Household Expenditure Survey*, various years.

Chernichovsky, Dov (2007), *Financing of the Healthcare System in Israel 1995-2005: Perspectives on Poverty, Progressivity and Regulation on the Growth of National Expenditure on Health*, Policy Paper, Taub Center for Social Policy Studies in Israel.

Chernichovsky, Dov and Guy Navon (2012), *Private Expenditure for Medical Services, Distribution of Incomes and Poverty in Israel*, Bank of Israel Discussion Paper Series, 2012.01.

Chernichovsky, Dov and Guy Navon (2010), *Dental Health: The Burden on Households*, Taub Center for Social Policy Studies in Israel, Discussion Paper 2010.10.

Chernichovsky, Dov, Ronni Gamzu, and Guy Navon (2010), *A "Malignant Growth" in the Share of Private Expenditure on Healthcare Services and Its Price*, Taub Center for Social Policy Studies in Israel, Policy Paper 2010.12.

Chernichovsky, Dov, Avigdor Kaplan, and Yohanan Stessman (forthcoming 2012), *Directions for Reform in the Financing of Nursing Care in Israel*, Taub Center for Social Policy Studies in Israel.

Committee for the Planning of National Geriatric Services (2011), *Report of the Committee for the Planning of National Geriatric Services – 2010-2020, 2020-2030*, Hadassah Hospital.

Knesset (2009), *Foreign Workers in Israel – Central Issues and the Current Situation*, Knesset, Research and Information Center. Ministry of Finance, Budget Bureau (2011), National Budget 2010.

Ministry of Finance (2009), Capital Markets, Insurance and Savings Division, *Annual Report 2009*, Figures 15-C, 16-C, p. 112.

Ministry of Health, *Public Summary Report on Additional Programs in Healthcare Service of the Health Funds*, various years.

Ministry of Health (2011), *Kotarot*, Quarterly Publication.

health.gov.il/PublicationsFiles/Kotarot_2011_Covers2012k.pdf.

Myers-JDC-Brookdale (2010), *The Elderly in Israel: Annual Statistical Report 2011*, *Mashav*, Table 4.36, p. 217; Table 4.40, p. 321.

National Insurance Institute (2011), *Operating Budget 2009*.