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The Acute Care Hospitalization System in Israel:

From a Vision of Decentralization to a Centralized and Out of Control Reality

Dov Chernichovsky and Roi Kfir

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This paper is one of two that deal with the acute care hospitalization system in Israel:

1. The Acute Care Hospitalization System in Israel: The Current Situation

2. The Acute Care Hospitalization System in Israel: From a Vision of Decentralization to a Centralized and Out-of-Control Reality

These two papers, each complementing the other, discuss a system in crisis reflecting a larger, overall crisis in the healthcare system in Israel. The crisis is the result of two factors: (a) ever increasing gaps between system needs and the public financial resources required to meet those needs; (b) a continued deepening of state involvement in the daily management of the system.

The first paper deals with the physical infrastructure and financing of the system: the structure of the acute care hospitalization market, the number of hospital beds, their allocation among institutions, their geographic distribution and use — all of this over time and in comparison to other countries. This second paper discusses the regulation of the hospitalization system that influences the efficient use of the system's sources and their equal allocation.

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Abstract

The special government program to reduce waiting times expresses the inability of the public hospital system which provides entitled hospitalization to meet the public's needs and expectations in the area of acute care hospitalization. The government's attempt to deal with the challenge has been through a complex and intensive intervention plan which preserves the regulatory frameworks that contributed to lengthy waiting times in the first place. The plan and its regulatory antecedents deviate from the fundamental principles that are meant to provide the foundation for the organization and management of universal coverage in Israel, in general, and the hospitalization system, in particular.

The vision and the reality

In contrast to the vision of the Netanyahu Committee (1990) and the National Health Insurance Law to create a publicly financed internal market, in which competing health funds purchase services from autonomous hospitals, the state finds itself increasingly involved in the daily management to the point of micro-management of the hospital system.[1] The situation places the state far beyond its role to mitigate structural market failures in the system. The result is an ongoing erosion of the economic rationale underlying the activity of the system and the accountability of its administration.

The fundamental flaws in the regulatory framework of the public hospital system make it less worthwhile to invest resources in the expansion of infrastructure (hospital beds) and in operations and purchasing (such as programs to reduce waiting times). Therefore, before resources are invested in the expansion of physical infrastructure, operations and purchasing on a large scale, consideration should be given to reforming the regulatory infrastructure, including ending state ownership and operation of hospitals, a situation that more than anything else reflects the disproportionate involvement of the government in the system.

The "public" nature of hospitals

The state has yet to define clearly the status of a "public" hospital, despite its importance in shaping the relations between the state and hospitals,

1 Health funds are like American HMOs. The National Health Insurance Law of 1995, which mandates all citizens resident in the country to join one of four official health insurance organizations, known as Kupat Holim (קופת חולים — literally meaning "Sick Funds"), which are run as not-for-profit organizations and are prohibited by law from denying any Israeli resident membership.

whether directly or indirectly through the health funds. As part of the vision of the Israeli health system, as outlined in the recommendations of the Netanyahu Committee and the National Health Insurance Law, and based on a review of the state's activities in this area in recent years, a definition is hereby proposed for a public hospital based on the following three criteria:

- **The normative criterion:** The hospital is obligated to offer entitled services equitably, including elective services, as part of the National Health Insurance Law to all residents in need.

- **The operational criterion:** The hospital operates systems of a public nature, such as urgent care departments, emergency facilities, and teaching and research activities.

- **The economic criterion:** The hospital's main revenues are from the supply of entitled services for national entitled healthcare, i.e., from the sale of services to the health funds.

Accordingly, the economic discussion is not about hospital financing and its deficits, but rather the financing of entitled care provided by the hospital as part of the overall configuration for financing the entitled healthcare under Israeli universal coverage.

Hospitalization prices: The Cap mechanism

In contrast to the spirit of the Law, and as an over-reaction to the structural market failures in the healthcare system, including the hospitalization system, the state has created a complex mechanism for regulation of acute care hospital prices and quantities in the internal market in which the health funds and the hospitals operate. This essentially involves the central planning of a large number of processes in a complex and dynamic system.

The original purpose of the regulatory mechanism, which is known as cap or capping, was to deter the hospital from inducing demand by oversupplying services, and was accomplished by setting reduced prices for services (about one-third of regular prices) beyond a limit set for each hospital vis à vis any health fund. Instead of the reduced prices operating only on the margins and temporarily, they became the norm for the hospital system.

The Cap mechanism led to a number of distortions in the system:

A. A weakening almost to the point of elimination of the relative price mechanism (according to average cost) as a system that signals priorities, such as hospital-based services versus home or community-based services, or one particular treatment over another that uses the same infrastructure and manpower.

B. Difficulty in identifying the between hospital deficits that are in part created by below average prices and their causes. This process has led to a weakening of transparency and of accountability in the economic management of hospitals.

C. The artificially low prices for procedures carried out in public hospitals make it difficult for them to pay for medical staff and thereby to compete with private hospitals or clinics for the services of specialists in the afternoon hours. This supported the expansion of the demand and supply for carrying out procedures in the private health system financed by supplementary and commercial insurance.

D. Health fund budgets, and in particular those of small health funds, became dependent on the cap prices which became the main mechanism for government financing of entitled care. This was in place of providing health funds with a realistic budget to finance entitled care, including hospitalization services, according to average cost and as required by the law. The government became accustomed to financing part of the healthcare entitled care budget with artificially low prices for hospitalization services and their full or partial financing of hospital system deficits from the state budget external to the entitled care budget.

In the choice between financing the deficit of the health funds if they were paying actual hospitalization prices, and financing hospital deficits that result from artificially reduced prices, the government chooses to consistently increase acute care hospital deficits financing. This way, the government has greater flexibility in budget allocation than it has in the control of the health funds' budget. This is apparently due to a lack of transparency and the fuzziness in the definition of relations between the state and public hospitals (see the discussion in the section on public hospitals). According

to the basic principles of the Netanyahu Committee and the National Health Insurance Law, though, the function of the state is not to become involved in deficit financing of entitled care.

The Cap mechanism or the reduced hospitalization prices have apparently also contributed to the under-utilization of public hospital infrastructures, and an expansion of the privately financed supply of services by non-public institutions, where the mechanism does not apply. Since the only effective constraint facing public hospital administration in the expansion of service on the margins is the availability of manpower, the reduced prices on the margins have limited their ability to pay physicians for additional hours during the afternoon. This constraint has been partly neutralized by the government deficit finance policy, but mainly by the growing exodus of moonlighting physicians to the private system, which is financed by supplementary and commercial insurance. The problem clearly became even more pronounced in the case of planned (elective) surgical procedures, in which the public system could have shortened waiting times by means of the existing infrastructures, if it was compensated at full cost rather than the reduced cap price. As a result, waiting lines developed in the public hospital system despite the trend in expanding activities of the public hospitals.

The plan to reduce waiting times

The inclusion of the same elective services both in the Cap mechanism, which is meant to reduce the supply of services for entitled care, and in the national plan to reduce waiting times, which is meant to expand those same entitled care services, is a contradiction in the logic of government policy. The government created a budget mechanism separate from the regular financing of entitled care which then required a complex system of reporting and monitoring of purchases made as part of the designated budget framework. This setup serves to further distance the government from the principle of decentralization that underlies the Law and complicates the financing of the system and its management. Moreover, the combination of the need to manage and monitor the purchases carried out as part of the plan with the requirement to reduce defined quantities as part of the health funds' supplementary insurance purchasing[2] has led to a situation in which the large majority of the plan's budget was ultimately channeled to non-public institutions.

2 Supplementary insurance (*shaban*) of this type is provided by the health funds and includes cross-subsidies across insured individuals. For this reason, this type of insurance does not fall under the insurance regulations but under the National Health Insurance Law.

The inefficiency of the system

According to the findings of this study, from 2002 to 2013 (years for which there is complete data), there has been an increase in productivity in hospitalization service production of about 20 percent. One would expect that this addition would have enabled the system to improve the financial performance of hospitals and perhaps also of the health funds. Furthermore, the additional productivity could have improved availability of hospitalization services to the public. Neither of these has occurred. Rather, the deficits of the hospitals and the health funds have grown and service to the public remains lacking, as reflected in the latest plan to reduce waiting times. Therefore, there is at least circumstantial evidence that the regulatory policy — primarily in the form of the Cap mechanism and the public-private mix — has led to systemic inefficiency that adversely affects every aspect of the public system's financing and service.

The general principles for reform

As shown in a previous study, the acute care hospitalization system in Israel suffers from a shortage of resources (Chernichovsky & Kfir, 2019). However, the previously noted fundamental flaws in the regulatory framework of the public hospital system are likely to reduce the effectiveness of any resource investment in the expansion of infrastructure (hospital beds) and in operations and purchasing (such as programs to reduce waiting times).

Therefore, the situation calls for a re-examination of the regulatory tools that the government has used since the enactment of the National Health Insurance Law, with respect to both their costs and benefits and whether they are aligned with the principles underlying the Law. In this context, we propose that the current regulatory policy of Cap mechanisms, deficit financing, and the plan to reduce waiting times be abandoned in favor of an overhauled integrated finance model, which the government has already decided on as part of Paragraph 63 of the Arrangements Law, 2017-2018[3] (which has yet to be implemented).

In the full implementation of the integrative model, direct budgeting of the hospitals by the state serves only as a complementary residual tool to the main financing tool through the entitled healthcare service basket. This model sets default prices for public hospitals so that they reflect the relevant production costs. The special, non-basket, cost components — teaching,

3 The Arrangements Law is a government-sponsored bill presented to the Knesset each year alongside the State Budget Law. It incorporates government bills and legislative amendments that are necessary for the government to fulfill its economic policy.

research, emergency services, and the operation of small hospitals in the periphery as well as excellence centers of a national nature — will be borne by public hospitals through direct state budgeting. This will avoid distortions in the relative prices that public hospitals charge the health funds. Of no less importance is to replace the existing model.

Instead of the Cap mechanism, it is possible to adopt and develop mechanisms such as those widely used in other countries, including Diagnostic Related Grouping (DRG), a cost accounting mechanism used in many countries as a means of spreading risk and regulating quantities. The experience accumulated so far leads to the recognition that the choice of any particular regulatory tool in order to deal with failures in the hospitalization market necessarily involves the creation of some distortions and regulatory costs and that the regulation of the risk of over-supply of hospitalization services in entitled care can be achieved to only a limited degree.

Physician choice in public hospitals

The issue of reducing waiting times relates to the ability to choose a physician in the public acute care system. The public pressure on this issue — which stems from a higher standard of living and a more sophisticated public — has created a significant challenge for the state, which has tried to meet that challenge, at least in part, by the improvised program to reduce waiting times. One way of meeting the challenge is by making the supplementary health services (*shaban* in Hebrew) universal and to "shift" them to the public system. This involves the implementation of a wisely crafted program of choice that is financed by *shaban* revenues and co-payments that will be channeled to the public system. The program, which should not be confused with private medical services (*sharap* in Hebrew), will include those physicians in the public system who today work in the private system during the afternoon hours and it will allow them to work full-time in the public system with appropriate compensation.

Introduction

The recommendations of the Netanyahu Committee *(Report of the Netanyahu Committee*, 1990) and the National Health Insurance Law, 5754-1994 (herein: the Law) which followed those recommendations are based on the assumption that the healthcare system — including hospitalization — is too complex and dynamic for the state to operate efficiently. Therefore, the vision of the Committee and the Law was the decentralization of service provision by granting maximum autonomy to the competing healthcare providers, in an internal market regulated by the state.[4]

According to the Law, the state is to ensure the provision of available and high-quality medical services to its citizens, by means of financing and regulation. The health funds — whose status is defined in the Law — are the "budget holders" or, in other words, they utilize the budget that the government provides in order to manage the consumption of services and their provision under state regulation.[5]

Although the Committee discussed the roles of public hospitals in the context of entitlement and finance, they are not specifically mentioned in the Law and essentially there is no official definition of a public hospital. Accordingly, there is no formal definition of the state's role in the financing and regulation of the provision of hospitalization services as part of the publicly funded entitled care, since such a definition is meant to be regulated based on the Law's principles.

Whether or not a hospital is considered to be public is not determined by its ownership by the state. As will be discussed, the Committee, like others both before and after it, ruled out a situation in which the state, which is meant to finance and regulate the system, would at the same time operate and compete in the hospitalization market.[6] In other words, there was no connection made between the ownership of a hospital and its status as a public institution operating on the basis of the Law.

4 For a discussion of the concepts of an internal market and a system of managed competition, see Chernichovsky (1995, 2002).

5 A budget holder is a term that refers to health funds that are responsible for the utilization of a public budget. In this context, it should be mentioned that the primary function of a health fund is not the direct provision of services but rather the regulation of its provision to the patient as it sees fit, by means of suppliers with which it contracts.

6 This approach formed the foundation for the recommendations of the various committees that examined the issue of incorporating public hospitals and which proposed a model in which a hospital would operate independently from the sale of its services (for further details, see Chernichovsky & Kfir, 2019, Appendix).

The principle of decentralization also dictated the method of financing of hospitalization services in entitled healthcare. Financing was meant to come entirely from health fund payments for services provided to members rather than from other sources, including direct financing from the state budget. In this context, it is important to note that health fund budgets, allocated through a risk-adjusted Cap mechanism, are for entitled care, which, according to the Law, are meant to pay the total cost of providing this care.

In the end, the state must ensure the conditions for sustainable hospitalization services at reasonable levels of availability and efficiency while maintaining conditions of social justice or equity as required by the Law. This is in addition to the financing of the national entitled healthcare. This involves several challenges for the state: (a) dealing with structural market failures that also characterize the internal market created by the Law; (b) ensuring accessibility to hospitalization within a reasonable amount of time and within a reasonable distance from the patient's place of residence; (c) ensuring the existence of an infrastructure whose financing is not part of the ongoing financing of entitled care and which has national importance beyond entitled care, as in the case of emergency services (particularly in view of the country's security situation), infrastructure for the training of medical personnel, and centers for medical research and excellence.

In other words, the main challenge facing the state in relation to the healthcare system in general and the hospitalization system in particular is to ensure a reasonable level of financing for all the functions of acute care and to maintain a fine balance between decentralization and autonomous operations, on the one hand, and the necessary state regulation, on the other hand, in order to sustain the system's activity and to deal with market failures. To this end, the state must avoid regulation that becomes micro-management of the system. All this must be accompanied by systems of appropriate incentives and maximum transparency.

Based on the findings in Chernichovsky and Kfir (2019) that the state has failed in its strategic role to ensure that sufficient resources are available to the system and that the existing resources are used efficiently and equitably, this section relates to the state regulation of the system. This regulation affects the degree of efficiency with which resources are utilized and the equity of their allocation. The discussion does not include the internal management of hospitals but rather the total environment within which they function with a focus on the resources available to the system and their utilization according to the incentives put in place by the state.

The rest of the document is structured as follows. In the next section, the definition of public acute care hospitals in the context of the National Health Insurance Law is discussed. This definition, which is not an official one, is crucial to the proper functioning of the system. In the subsequent two sections, there is a detailed discussion of the incentives created by government regulation, primarily through the determination of acute care hospitalization prices. The price mechanism created by the state dictates to a large extent the character of the system's operations and has contributed to the need for a special program to reduce waiting times for hospital procedures. This program is discussed in the subsequent section. It reveals a basic flaw in the functioning of the system and is the ultimate example of the divergence from the basic decentralization principles that should guide the system as reflected in the recommendations of the Netanyahu Committee.

"Public" hospitals: The lack of a functional definition

"Public hospital" is a key term in the discussion of health policy in Israel. As already noted, the law does not define a public hospital nor the meaning of the term "public." The lack of a formal definition constrains a discussion of the policy for financing and regulating the acute care hospitalization system, particularly in view of the state ownership of a large portion of the hospitals, on the one hand, and its responsibility to finance the entire system and regulate it as directed by law, on the other.[7]

From the state's perspective, the role of a public hospital is expressed in its obligation to ensure the entitled care as set down in the Law to the public. According to this principle, every public hospital in Israel must offer all entitled services produced in its facilities to the health fund members, at all times, without discrimination or preference on the basis of their membership in a particular health fund and independent of the payment for the service.[8] The obligation is similar to that of the health funds according to the National Health Insurance Law, although it applies to a public hospital only, and not to other service providers who provide services on the basis of a commercial contract with the health funds.

7 For further details on the state ownership of hospitals, see Chernichovsky and Kfir (2019).

8 This norm was first spelled out only in 2011 in Medical Administration Bulletin 45/2011 entitled "Rules for the provision of services included in entitled care by the hospitals, under the financing of the health funds." The bulletin specified that a public hospital cannot choose not to produce a service that is included in entitled care or not to offer it to a particular health fund, unless it has received written approval from the head of the Medical Administration in the Ministry of Health.

A hospital that is not owned by the state, which is obligated to provide care by means of its resources and in particular under conditions that are liable to cause it a loss, is essentially required to participate in the financing of the national entitled care from its own sources rather than from the sources specified in the Law. The existing arrangement, in which the state takes on itself the authority over sources that do not belong to it, is problematic and creates a distortion that needs to be resolved.[9]

A significant portion of entitled care is provided by the so-called public hospitals and many of the services are provided only by them. The public hospitals account for a particularly large portion of the hospitalization services provided in the geographic areas in which they operate (for example, Soroka in Beer Sheba and Hadassah in Jerusalem). In the absence of a guarantee of the provision of care by these hospitals, a situation might arise in which some of the local residents would not be able to obtain hospitalization services as specified by the Law or the availability of these services in their area would be lower than in other areas or even relative to residents of that same area who are members of other health funds. Under these circumstances, the state does not fulfill its obligation to provide services with reasonable availability and under equitable conditions, as specified by the Law.

A relationship has developed over the years between the state and the hospitals that provide services according to the Law but are not owned by the state which alternates between two extremes:

- The state is responsible for supervising hospitals and ensuring that they manage their budgets responsibly, based on their own sources.

- The state is responsible for ensuring the provision of entitled care by hospitals according to the standards specified in the National Health Insurance Law, securing their sources as part of the financing of care.

9 The power of the Ministry of Health to provide or withhold a license does not imply that it has the authority to require a non-government entity to bear part of the burden to finance entitled care services as a condition for receiving an operating license. According to the Health of the People Ordinance (1940), the Ministry of Health has the authority to grant a license to establish a hospital, including the various units operating within it, and to supervise its activity. The granting of a license to establish a hospital should be viewed as allocating the right to operate it on behalf of the state. The Clalit Health Fund and Hadassah, for example, established hospitals even before Israel became an independent state and they "granted" the hospitals to the state in order to implement the law. In the historical context, the license regulates the activity of these hospitals once they are established. A license certainly cannot be viewed as a concession with economic value that is granted by the state in exchange for the obligation to participate in the funding of the budget for entitled care.

Until 2014, the attitude of the state towards non-government hospitals tended toward the first approach. The state refrained from direct and explicit support of hospital budgets. It was expected that hospitals would finance their activities, and primarily the provision of entitled care, independently through their own sources (the sale of medical services, donations, and donations from owners). Therefore, in cases where the state saw a need to support the budgets of non-government hospitals, it did so through one or both of the following channels:

- Participation in the financing of construction projects (Clalit Health Fund — various projects; Hadassah 2008 and 2011).

- Support as part of a stabilization agreement (Clalit Health Fund 2006) or a recovery program (Laniardo 2006 and Hadassah 2014).

Some of the support also stems from the unofficial recognition that hospitals fulfill public functions, including the training of physicians, supporting research and sustaining national centers of excellence, as well as emergency preparedness, all of which are not budgeted as part of the National Health Insurance Law.

A "public hospital" was first defined in the 2002 Arrangements Law as follows:[10]

- A hospital owned by the government, a local authority, or a health fund;

- "A hospital that is a public corporation as defined in Paragraph 9 of the Income Tax Ordinance" (a non-profit organization or a public benefit corporation).

According to this functional definition, the first group includes all of the public hospitals that the state sought to include in the Arrangements Law in order to implement the National Health Insurance Law while the second includes private hospitals that were not meant to be included in the

10 The Arrangements Law is a government-sponsored bill presented to the Knesset each year alongside the State Budget Law. It incorporates government bills and legislative amendments that are necessary for the government to fulfill its economic policy.

Arrangements Law. An exception was created with the establishment of the Assuta Ashdod Hospital (see the discussion below).[11]

As part of the 2015-2016 budget proposal, the government decided that from 2015 onward it would submit an annual budget to support the ongoing operations of hospitals defined as public. This decision put an end to the view that non-government hospitals are expected to operate without any public financial support in order to provide health services within the framework of the National Health Insurance Law.

The aforementioned change in perspective was reflected in Paragraph 63 of the Arrangements Law, 2017-2018 (Accounts Settlement Legislation, 2017-2019), which is referred to in the Ministry of Health as the National Budgeting Model. The paragraph authorizes the Minister of Health and the Minister of Finance to reduce the existing budgets for subsidies to government hospitals and support of non-government hospitals, to increase the budget for entitled care, and to instruct the health funds to pass on the amount added to their budgets to hospitals according to a formula specified in a directive. This approach is closer to the spirit of the National Health Insurance Law, according to which the budgets for hospitalization are to be provided by means of the health funds' purchase of this service.

Paragraph 63 is yet to be implemented and apparently will not be in the current legislative period (until the end of 2019). However, it reflects an important development in how the state views the status of public hospitals and their financing. The state, for the first time, clarified that the administrative and legal framework for the various supporting budgets will be through the financing of entitled healthcare including acute hospitalization rather than through deficit financing of hospitals and health funds.

Clearly, this is not to say that special support will be ruled out in situations that obviously involve internal market failures, such as specific support for "overly" small hospitals like Yoseftal in the south and Poriya in the north, where there is a national interest in their operation, in part due to considerations of equity. Similarly, and as part of the integrated financing model that will be described below, the state will directly and transparently finance any activity that is not directly related to the provision of entitled care, such as teaching and research, national emergency services, and the like.

11 This document was written when it became clear that the hospital would have a deficit of NIS 150 million in 2017, its first year of operations. How the government views this deficit constitutes a test of the hospital's "publicness," particularly since it is owned by a health fund that is responsible for providing entitled care and whose activity is liable to be negatively affected in this respect.

In summary, we propose defining a public hospital on the basis of its role vis-à-vis entitled care, regardless of its ownership or its form of incorporation. Accordingly, we propose three basic criteria:

- **The normative criterion:** The hospital is obligated to offer its services, including elective services, as part of the National Health Insurance Law to all residents equally.

- **The functional criterion:** The hospital fulfills publicly oriented functions, such as urgent care, emergency capabilities, teaching, and research.

- **The economic criterion:** The hospital's main source of revenue is from the provision of entitled care, i.e., the sale of services to the health funds.

Therefore, the economic discussion will not deal with the financing of hospitals and their deficits, but rather with the financing of services that the hospitals provide, as part of the financing policy of entitled care.

A hospital that meets these three criteria, regardless of its ownership — such as the Hadassah Medical Center and Assuta Ashdod, which are not owned by the state — is to be considered public, like the Sheba Medical Center, which is state-owned. In contrast, a hospital whose activity primarily involves the sale of services outside the framework of the National Health Insurance Law, such as the Assuta Medical Center in Tel Aviv, is not considered to have a public status.

With respect to private financing in public hospitals as defined above, in the vast majority of cases in other countries, even if the hospital is privately owned but has a public status, such a hospital is not allowed to offer privately funded health services (*sharap*) except by special arrangement.[12] A Supreme Court ruling prohibited state-owned hospitals as a public supplier from selling privately financed services, in order to prevent a situation in which public infrastructure paid for by the taxpayers is used to encourage and subsidize privately financed services.[13] In this context, it is important to mention the special status of the Hadassah and Shaare Zedek medical centers in Jerusalem which are currently permitted to provide privately financed medical services (*sharap*).

12 *Sharap* is the Hebrew acronym for privately funded healthcare services provided in a public hospital.

13 Supreme Court 4253/02, 4325/02, Professor Gabi Barnash v. the State of Israel, March 17, 2009.

Thus, the two main challenges facing the state in this context are the following:

A. The creation of a relationship between the state and hospitals in which the commitment to public financing is not interpreted as a reduction in the budget responsibility of the hospital administrators and as an obligation on the part of the state to cover every operating deficit that is connected to the sale of hospitalization services to the health funds.[14]

B. Minimal harm to the relations between the health funds, as the managers and purchasers of medical care, and the hospitals, as suppliers of services to the health funds within the framework of the Law.

The state's success in dealing with these two challenges, according to the spirit of the Law, will be the test of the system's functioning, as will be discussed below.

14 This issue is currently at the center of the discussion with respect to Assuta Ashdod, which is privately owned from a legal standpoint. The issue is related to the public resources which Maccabi Health Services, a non-profit organization which is almost completely state-financed, used to finance facilities under its ownership.

Spotlight

The hospital in Ashdod

Following a lengthy tender process, it was decided in 2011 that the hospital in Ashdod, whose creation was established in the Hospital in Ashdod Law of 2002, would be built and operated by Assuta Ashdod Ltd. In 2012, the Association for Civil Rights in Israel submitted a petition to the Supreme Court against the permit to operate *sharap* services in the hospital (privately funded healthcare services), which was awarded as part of the tender, and, as a result, the state had to specifically relate to the hospital's status.

According to the practical definition in the Arrangements Law, the hospital planned for Ashdod is not a public hospital. It was planned to operate as a limited company (not owned by the state or the municipality) under Assuta Medical Centers Ltd., which is owned by Maccabi Health Services.

The state claimed in its response to the Supreme Court that the planned Assuta Ashdod Hospital is a public hospital, despite its private, for-profit ownership and incorporation, since the main purpose in its creation and operation is to provide public health services. Later on in its argument, the state explained that the permit to offer *sharap* services in the hospital is a kind of default for public hospitals that have not been prohibited from offering them, such as the public hospitals in Jerusalem.

As part of the proposed Arrangements Law, 2013-2014, the definition of a "general public hospital" was changed in June 2013 (Accounts Settlement Legislation, 2014-2016) and the following criterion was added:

> "A hospital that is not a hospital as mentioned in paragraphs (1) to (4), whose certificate of registration according to the Health of the People Ordinance of 1940 includes facilities for urgent care (emergency room)."

The operation of an emergency room in a hospital is not the only characteristic of its functioning as a public hospital, but the existence of a clear mark of identification in the law and in a hospital's certificate of registration that allows for a simple and clear-cut definition of a public hospital according to its function.

Equal access to hospitalization

Securing equal access to hospitalization, in addition to the determination of prices which will be discussed below, is necessary in view of (a) the unequitable distribution of hospital beds and hospitals in Israel, (b) the special status of hospitals (as regional and national medical centers), and (c) the relatively small number of health funds in the system, alongside their dominance in various areas of the country. These factors provide sellers of hospitalization services or their buyers with exceptional market power as a, at least on the local level.

Every hospital has significant market power in its locale, and it increases as the local population's access to other hospitals decreases (Chernichovsky & Kfir, 2019). Exceptional market power is also the result of the positioning of a hospital as a "national center" or a "super hospital" to create a center of excellence with a high level of specialization and particularly high costs of care.

An example of this exceptional market power in the health system is the Soroka Medical Center in the south, which has no competitors in the surrounding Negev and operates as a kind of regulated monopoly that is required to provide service without discrimination between the health funds in the south and in general. This is in spite of its ownership by Clalit Health Services which competes with other health funds in this region, and who are also dependent on the hospital. In the past, Clalit tried (though unsuccessfully due to appropriate regulation) to use the hospital as a means of competition with other health funds, which in itself was legitimate. Clalit also used the pretext that the prices of hospitalization are not realistic and that it cannot subsidize the other health funds.

As described previously in the discussion of public hospitals, the state requires that hospitals be accessible to the entire population, regardless of their ownership or location and independent of their commercial relations with the health funds. The state established the obligation of the health funds to provide access to hospital services in the National Health Insurance Law and the regulations that followed from it. The Law's Regulations (Arrangements for Choosing a Service Provider), 5765–2005 limits, at least in theory, the freedom of a health fund to prevent access to hospital services with which it does not have a commercial arrangement. Such an arrangement, as noted, obligates the state from a budget perspective to fund hospitalization, potentially not through the health fund.

On the other hand, the health funds possess market power as purchasers of services. It has more than once been claimed in the health system that "Clalit Health Services can dry up any hospital," in view of its dominance in the market, particularly outside of Jerusalem. This is the situation also in other local contexts, such as the relative power of the Meuhedet Health Fund with respect to hospitals in Jerusalem. In these cases, the problem is usually resolved by means of agreements between the dominant purchaser and the dominant seller, which is to the mutual benefit of the two sides and includes, among other things, the use of close proximity and access to hospitalization as a marketing tool for the health funds. The "localness of the arrangement" is one of the reasons for the secrecy surrounding agreements between health funds and the hospitals.[15] Clearly, such agreements are liable to constrain the public's freedom to choose, which is, as mentioned, a marketing factor — though also an economic factor — in the health funds' considerations.

The prices of public hospitalization (the Cap mechanism): The Golem that turned on its master

As previously noted, the state has final responsibility to ensure access to entitled medical services, including hospitalization services, that are efficient and sustainable, within a reasonable distance and time. To this end, it must deal with structural market failures that characterize the internal market created by the Law. This is accomplished by, among other things, measured regulation of hospitalization prices.

The first market failure relates to the asymmetry of information in the encounter between the physician or service provider and the patient with respect to treatments and available alternatives. This situation makes it possible for hospitals to encourage demand for their services, while the health funds, which pay for the hospitalization, have only limited control over the regulation of demand. In other words, a situation may arise of excessive hospitalizations that do not contribute to health, and place an economic

15 According to economic theory, the market solution in a monopoly-monopsony situation is negotiations and a local arrangement between the sides that differs from the unique solution obtained in a market with either a monopoly or monopsony. Since the economic arrangement between a monopoly and a monopsony is local and differs from arrangements between the monopoly and other buyers or between the monopsony and other suppliers, there is a tendency not to bring the details of the local agreement to the public's attention. This fact makes it even more difficult for the state to maintain control over agreements within the system.

burden on the health funds and, ultimately, on the state. Therefore, the state has an interest in regulating the quantity of hospitalization. The basic tool available to the state to accomplish this is regulation of the number of beds and their distribution among the population, by means of the licensing of hospitals according to the Health of the People Ordinance of 1940.[16]

The second market failure follows the hospital's cost structure, which is characterized by a high proportion of fixed costs. In addition to capital and depreciation expenses, which by nature are "invisible" and fixed in the short run, there is a high proportion of salaries within hospital costs in Israel, that are quasi-fixed and are not dependent on the quantity of services provided.[17] The aforementioned structure of production costs, under free market conditions and in a situation of numerous hospitals, can lead to a situation of selling services at marginal costs that entail a loss in the long term. This may translate into a hospital's lack of economic sustainability in the long run since its fixed costs are not covered, a situation that can endanger the healthcare system as a whole. The knowledge that the state will refrain from closing hospitals is liable to encourage this strategy.[18]

The state therefore has an interest in determining prices that are equal to the average service production cost, to protect the economic sustainability of hospitals over time. And, indeed, the services provided by the public hospitals in Israel are regulated on the basis of a price regulation law. In general, there are two types of prices: services that are paid for on a per diem basis, and elective services that are paid for per procedure (primarily surgical), for which a prospective average price is determined according to a system of "differential pricing," practically an Israeli DRG. These activities are generally priced according to average cost and are defined as default prices in accounts settlement between hospitals and health funds. In other words, in the absence of an agreement or some other legal directive, the health funds pay the hospitals according to the regulated prices.

Regulated prices create a system of relative prices that has the power to influence the production decision of hospitals as well as consumption decisions made by health funds. For this reason, the cost fixing of various

16 In this context, it is worth mentioning Roemer's Law, according to which a hospital bed is always occupied.

17 Most of the salary expenses are fixed in the short run. The Interministerial Health Prices Committee uses a conventional breakdown of costs in which the weight of salaries within total production costs is 73 percent. Other costs, such as medical equipment, administration, and security are also fixed in the short run.

18 See the earlier discussion in the section on public hospitals.

services can serve as a tool for the state to signal hospitals regarding preference for the production of one service or another.

It is clear that the determination of average prices at the level of average cost increases economic risks to the health funds. A price higher than marginal cost is likely to encourage longer hospital stays and unnecessary treatments, a situation over which the health funds have limited control. In order to reduce this risk, the state also attempts to limit the quantity of entitled care provided by the public hospitals. The policy of quantitative constraints has been at the heart of the economic regulation of the public hospital system in Israel during the past two decades and is at the center of the discussion in this document.

The policy of quantitative constraint by means of the Cap mechanism

The need for the quantitative constraint of hospitalization by means of a price mechanism is based on two factors. The first is the relatively low compliance with hospital licensing in Israel — regarding the number of beds and other types of physical infrastructure — in determining the level of services provided. The second is, as mentioned, the hospitals' incentive to increase the supply of services to beyond the needs, when the price is equal to the average cost but is higher than the marginal cost.

The idea of reduced prices, or the Cap mechanism, is to set a default price for services provided by the hospital beyond the "optimum quantity" for entitled care; the capped price is lower than the regulated price according to average cost. The cap price is meant to deter hospital administrators from exploiting their power and expanding the supply of services where health funds have limited power to regulate the demand. The setting of cap prices requires that a "quantitative norm" be established for each hospital vis-à-vis a health fund beyond which services will be considered excessive and will be billed at reduced prices.

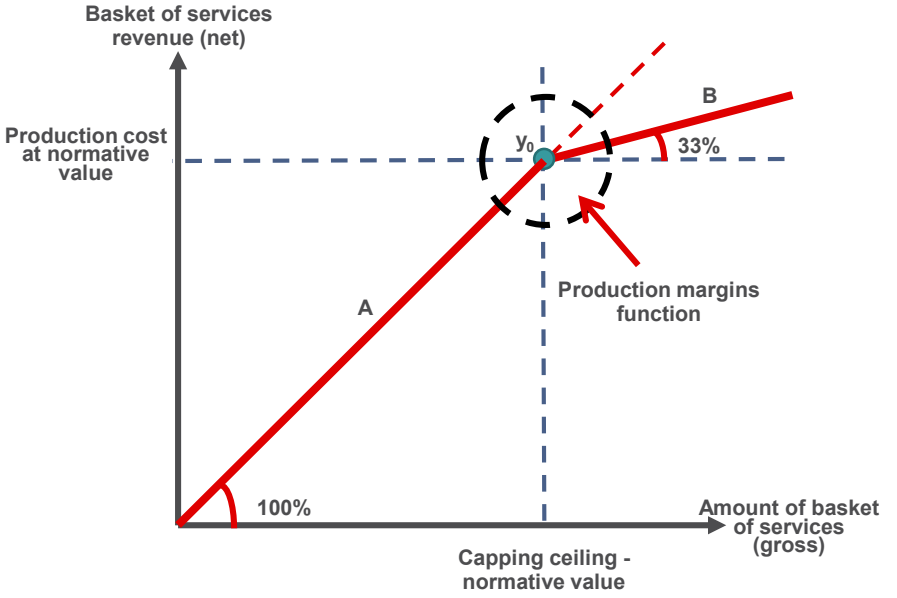
The classic Cap model, which was adopted in the Arrangements Laws from 1997 to 2005, can be described as follows (see Figure 1):

- A production ceiling is set for each hospital with respect to each health fund up to a quantity y_0 which is the normative quantity.

- For consumption of services up to the value of the consumption ceiling, the health fund pays the default prices which are regulated, according to average cost, as described by the slope of Curve A.

- For the "excess" quantity, beyond y_0, the health fund pays a cap price, which is about 33 percent of the full price, as represented by the slope of Curve B.

Figure 1. The Cap mechanism



Source: Dov Chernichovsky and Roi Kfir, Taub Center

The decision to use the Cap mechanism requires the state to deepen its involvement in the negotiations and arrangements between health funds and hospitals, and adopt the role of a kind of "central planner," in violation of the principle of decentralization and autonomy on which the vision of the Israeli model rests. Also, from a theoretical perspective, the use of a Cap mechanism requires the regulator to deal with a number of fundamental problems, which appear to be difficult or even impossible to resolve.

First, the state must determine the optimum quantity to be supplied to the health fund members of each health fund for each hospital and in each year. In other words, it needs to know at any given moment the "optimum quantity" of hospitalization services that the members of each of the four

health funds need to receive at each of the public hospitals (or in other words, the quantitative operations of each hospital multiplied by four health funds multiplied by the number of public hospitals), as well as know the production function and the production costs of each hospital. All this takes place in a highly complex system characterized by rapid changes in production technology, the size and distribution of the population, and more.[19]

Second, the state may have conflicting interests due to the system of incentives in which it operates. Setting the cap ceiling too low will artificially lead to a reduction in expenditure and in savings in the health funds' budgets, which is desirable from the state's perspective. Therefore, there is a built-in risk of exploiting the Cap mechanism in order to achieve savings in the state budget at the expense of hospital budgets rather than achieving the goal of quantitative restraint to mitigate structural market distortions.

To this is added the need for effective budget monitoring of hospitals, and especially state-owned hospitals that know their expenses will be covered regardless of capped prices since their deficits are eventually covered by their owner, namely, the state. Therefore, in the absence of an effective budget constraint, the hospital may expand supply at the cap prices even beyond the norm determined by the regulator.

Meeting these challenges does not appear to be practical, as shown by past experience and as will be described below.

Updating the quantitative norms

The quantitative norms were first introduced into law in 1997 and since then have required an annual update, according to the population growth, the expansion of hospital infrastructure, changes in the geographic distribution of health fund members, changes in health services in the community, and changes in technology and prices. In view of the complexity of the update and the frequency of changes in the various components, the task of updating quantitative norms appears to be nearly impossible, as argued above.

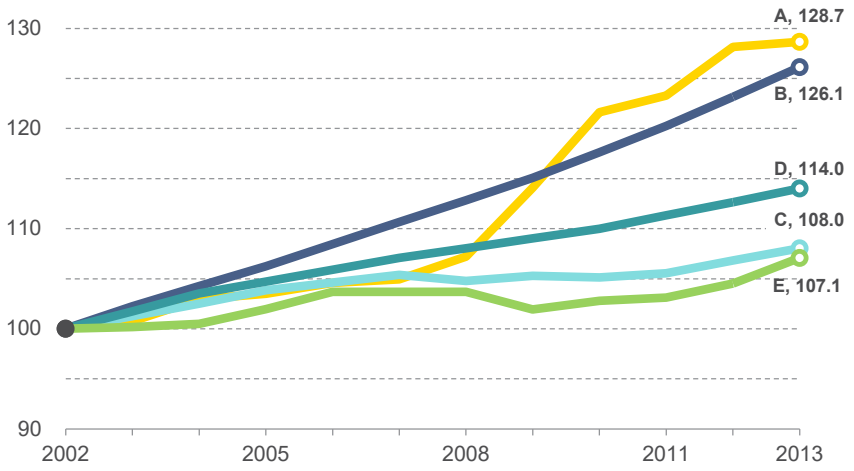
Since 2002, the quantitative norms in the Arrangements Law (Curve C in Figure 2) have been increased at rates that are significantly lower than the rate of population growth (Curve B). The decision to update the quantitative norms has been bundled together with the decision regarding the real updating of the entitled care budget (demographic change;

19 The quantitative activity of each hospital is measured by gross expenditure (prices X activities) in fixed prices.

Curve D) and essentially serves as a tool to achieve budget restraint rather than quantitative restraint.[20]

In retrospect, it appears it was in fact during the years in which the state sought to tighten the restraint on the consumption of hospitalization within entitled care, as part of the overall budget restraint policy since 2002, that the output of the acute care hospitals increased by 28 percent (Curve A), while the quantitative norm set by law grew by only 8 percent (Curve C).

Figure 2: The process of divergence in the implementation of the Cap mechanism



Sources and Data: Dov Chernichovsky and Roi Kfir, Taub Center; Arrangements Law (amendments to achieve the budget targets for 1997), 5756–1996; Arrangements Law (amendments to achieve the budget and economic policy targets for fiscal 2002), 5762–2002; Ministry of Health, 2006, 2008, 2012, 2014 and 2017; Plotnik and Keidar (2015).

20 According to the National Health Insurance Law, the healthcare budget is updated according to the Health Price Index, which represents the prices of inputs, the addition of services and the basket of medicines, as well as a demographic coefficient. The demographic coefficient is meant to capture the growth in demand for health services as a result of the growth in the population. The state has the authority according to the law to set the demographic coefficient each year and this decision is a central component in the state budget decisions in the area of health.

A. Medical services supplied by government-owned hospitals — price weighted amount.[21]

B. Population adjusted to health demand factors according to the Cap formula.[22]

C. Total consumption ceiling, cap decrees, government-owned hospitals.[23]

D. Real demographic index of the national healthcare budget for entitled care.

E. Number of licensed acute care hospital beds.

21 The index of quantity of services is the gross figure appearing in the reports of the Ministry of Health until 2015 in fixed prices. The gross figure is the product of the quantity of each service multiplied by the price of that service according to the Ministry of Health price list. The regulated prices are not market prices that contain information about supply and demand and therefore do not constitute a satisfactory measure of the economic cost or benefit of each service. Nonetheless, an examination of the hundreds of service codes in the price list and the thousands of services that are provided according to those codes indicates that the prices of services are highly correlated with cost and benefit. This is according to the assumption that both the errors in the cost accounting of the Ministry of Health and the excess demand or supply are not correlated with the prices. To this should be added the stability that has characterized the price list over the years, such that apart from the uniform updates in the price list ("Price Index of a Hospitalization Day"), there are relatively few changes in the price list from year to year and most of them are more or less a "zero sum" exercise (in other words, the reduction in the prices of some services is offset by the increase in others with respect to monetary value of the service). Gauging the gross data on activity using the Price of a Hospital Day Index provides a series of service quantities and changes in output over time.

22 The capitation formula is the key according to which the National Insurance Institute distributes the budget for entitled care among the health funds, according to their number of members and their characteristics. The formula weights variables such as age and gender which are used to predict the consumption of health services. Therefore, the change in the size of the standardized population serves as a measure of the changes in demand for the entitled services.

23 The Arrangement Laws define the rate of the "real addition" for all the demand ceilings of the acute care hospitals each year. These also apply to the consumption ceilings by the Maccabi, Meuhedet, and Leumit health funds at the Clalit hospitals and therefore do not reflect the quantitative norm derived from the legislation. In contrast, the consumption ceilings of the government hospitals do not reflect the changes in the quantitative norm either, since in 2010 and 2011 the content of the services in the law was changed. The real standardized coefficient is calculated by multiplying the national coefficient appearing in the law by the change in the proportion of the Clalit hospitals within the total caps.

In other words, from 2002 to 2007, public hospital outputs lagged behind the rate of population growth (the gap between Curve A and Curve B); however, in subsequent years, the gap was closed due to the rapid increase in output during the second half of the decade and the continued growth since then. In particular, it is worth noticing the growth in productivity — the gap between the increase in output and that in factor of production inputs (the gap between Curve A and Curve E).[24] The divergence between outputs and inputs during the second half of the previous decade can be described as a genuine "productivity explosion," with a 4.2 percent annual increase. Since then, as mentioned, there has been a moderate rate of growth (about 1.5 percent per year).

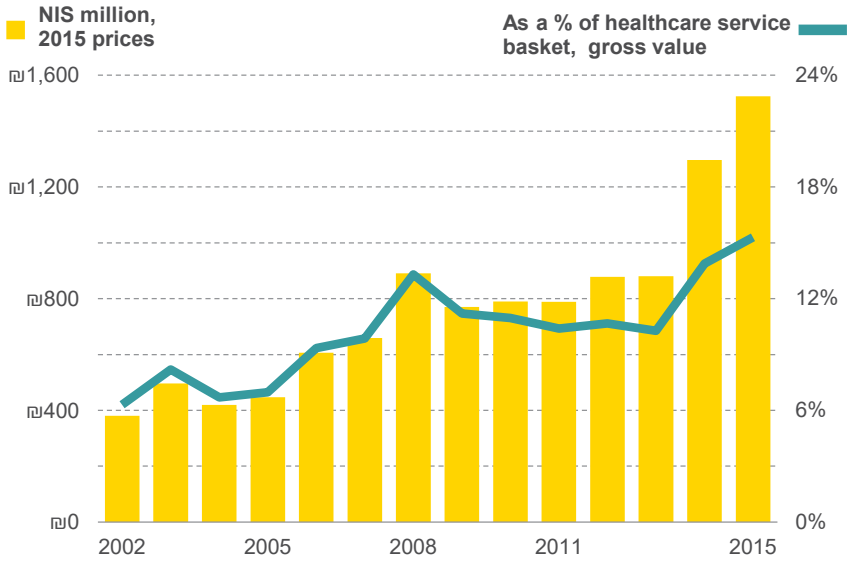
In other words, the fear that central planning will not correctly assess technological progress in hospitalization has been realized. It appears that the updating of the quantitative norm, which represents the optimum quantity of hospital services for entitled care (Curve C), was arbitrarily set and is not based on any factual information on the changes in the quantity of hospitalization services and hospital production costs. Moreover, it appears that the state has not made an effort to monitor the actual quantitative norm, but rather has used the quantitative restraint tool for purposes of budget restraint, which was not the regulation's purpose.

Budget control

As noted, apart from its systemic importance, budget control over public hospitals constitutes an essential component of the regulatory regime of cap pricing. A look at the subsidizing of government hospitals in the survey years shows divergence in the budget that was not the state's intention. During a period in which output and revenues grew faster than inputs, the expectation is that the additional efficiency in production will reduce the deficit in absolute terms. Instead, not only did the deficit not shrink in absolute terms but it actually more than doubled, even relative to the level of activity in the hospitals (Figure 3). In other words, it is possible that, in the end, the increased efficiency did not compensate for the deficits created as a result of the Cap mechanism and other inefficiencies in the system.

24 The number of licensed acute care hospital beds serves as a proxy for factor of production inputs, i.e. capital and labor. Hospital beds are meant to be correlated with manpower inputs by way of the administrative standardization keys and with capital inputs by way of construction and equipment procurement to create new hospital departments.

Figure 3. Budget for revenue balance (covering deficits) for government hospitals



Source and Data: Dov Chernichovsky and Roi Kfir, Taub Center; Ministry of Health, 2006; 2008, 2012, 2014, 2017; Ministry of Finance, State Budget, "Fiscal-Digital" documents, https://mof.gov.il/BudgetSite/statebudget/Pages/tableau.aspx

Budget support is entirely attributed to the financing of entitled care and is presented in the figure as a portion of the total value of the entitled care that is provided. This is based on the assumption — though a weak one — that medical services not included in entitled care (births, health tourism, and others) are balanced or even contribute to a surplus. Thus, all of the budgets provided by the state directly to public hospitals are financing the deficit that is due to the provision of entitled care.

The supplemental budget constitutes an even larger share of the financing of entitled care than that reflected in Figure 3. The figure presents the supplemental budget that is recorded in the government hospitals' operating budget (Paragraph 94 of the Budget Law) which constitutes only part of the support provided to these hospitals from the state budget. Thus, the state supports hospitals by way of additional channels, both in money and in-kind, and that support is recorded in other budget lines, such as budget-financed pensions, computer development and maintenance,

physical development and equipment, financing, insurance, and other administrative overhead. According to the presentation of the Ministry of Health to the National Institute for Hospital Policy Research (NIHP, 2016; p. 12), in 2014, the total support stood at NIS 2.14 billion, which implies about NIS 800 million in indirect support. When this is taken into account, the proportion of financing of entitled care provided directly from the budget in 2015 is estimated to be about 22 percent.

The Golem that turned on its master

The divergence between the formal quantitative norm and the actual quantity, together with an expansion of the discounts in the agreements reached by the hospital administrations and the health funds, has created a situation in which the caps do not apply only on the margins but to wide swaths of activity on an ongoing basis. The process, which includes the direct supplementary budgeting, simply evolved rather being the result of an intentional and transparent process based on a change in approach to the financing of the system. What was meant to be a temporary situation in fact became the norm — backed up by deficit financing from the state — according to which both the hospitals and the health funds operate and make production and consumption decisions in a dominant cap environment. Thus, the Cap mechanism has led to a number of distortions in the system:

- The weakening, and in practice even the elimination, of the relative pricing tool (according to average cost) as a factor that can signal priorities in the system, such as the continued value of a hospital-based service rather than the consumption of the same service in a clinic or in the community or the relative value of one treatment over another using the same infrastructure and manpower.

- Difficulty in identifying the connection between a hospital deficit and its causes. This process has led to an additional weakening of budget control in the system, and of the management accountability of hospitals.

- The artificially low price of procedures in public hospitals has made it difficult for them to compete with private hospitals or clinics for the services of specialists (who come from the public hospitals) in the afternoon hours, which has contributed to the expansion of the supply and demand for procedures in the private system, which are financed mainly by supplementary and commercial insurance.

- The creation of a dependency of the health funds, and in particular the small ones, on the artificially low cap prices, instead of providing a realistic price to the health funds based on their decisions about the provision of entitled care and according to average cost.

The national plan to reduce waiting times: Adding insult to injury

Since 2013, the issue of reducing waiting times has been the top priority of the Ministry of Health, which identified a systemic failure in the waiting times for elective services in the public hospitals. The state viewed the prices of surgical procedures that it sets as the main barrier to expanding output and availability, primarily to beyond the morning hours, in the public hospitals. This is particularly the case in view of the high prices received by specialists — who are employees of the public system — as part of their work in private clinics that is financed by supplementary and commercial insurance.[25]

In 2014, it was decided to allocate a budget to the plan to reduce waiting times and an initial draft of the plan was drawn up. The implementation of the plan finally began in 2017.

Due to the state's desire to preserve the Cap mechanism as a primary tool in the budgeting of the system, it was decided that the reduced prices in the public hospitals would not be canceled and that the budget for expanding the number of surgical procedures in order to reduce waiting times — close to NIS 900 million per year — would be provided as an "earmarked" budget separate from the regular budget for entitled care. The earmarked budget that is provided to the health funds is conditional on a detailed reporting on elective surgical procedures as part of the designated agreements. For each surgical procedure that meets the conditions of the plan, the health fund receives 81.5 percent of the price on the Ministry of Health's supervised list price for that procedure. This price is meant to be higher than the marginal cost or cap and to enable the payment of incentive pay to the staff in order to increase output.

Furthermore, in January 2018, the "cooling-off law" went into effect. It restricts physicians in the public system from referring patients to their private practices for a period of six months. As a result, it was decided that the earmarked budget of the health funds would be made conditional on the health funds' reduction of at least eight surgical procedures financed

25 For further details, see for example Chernichovsky (2018).

by supplementary insurance (*shaban*) for every addition of ten surgical procedures financed by the plan. This mechanism, which is referred to as "shifting," was accompanied by a decision to reduce the membership fees in the supplemental plans.

The plan to reduce waiting times requires that the state and the health funds again manage a particularly complex system of reporting and monitoring of purchasing carried out as part of the earmarked budget. The health funds, in an effort to reduce the bureaucratic burden, used the budget in the *shaban* format. Namely, almost all of the designated purchasing is today channeled to carrying out surgical procedures as a part of a choose-your-physician track in the private clinics and hospitals, within the same mechanism under which *shaban* operates. The result is that the main outcome of the plan is, paradoxically, to replace the source of financing for surgical procedures in the private hospitals and clinics from membership fees and co-payments of *shaban* members to financing from the state budget, or in other words tax revenues. With respect to public hospitals, the result is that even under the new pricing arrangement they are unable to compete with private facilities for the services of those physicians.

In other words, the state is essentially adding another budget arrangement patch to the system, in violation of the spirit of the Law and the principle of decentralization, according to which the entitled care budget is integrative and managed by the health funds at their discretion.

The state therefore finds itself in a vicious circle. At first, it sought to restrain the provision of services in order to ensure the financing of entitled care in a framework of its limited resources. To this end, it established a cap pricing system, which as mentioned required it to deepen its involvement in the planning and management of the provision of entitled care. It then realized that for a large portion of the services there is a shortfall in the quantity provided, rather than an excess, and that it is necessary to encourage production rather than restrain it. However, due to the budget dependency that the state developed as part of the Cap mechanism, the solution proposed did not loosen restraints and thus allow it to reduce its involvement in the public system but rather it led to the allocation of an earmarked budget in a separate purchasing mechanism. This separate mechanism distanced the state even further from the goal of decentralization, in which, for the first time, the state "designates" part of the budget for entitled care and must maintain a centralized and regulation-intensive mechanism of support.

Conclusion

Looking back at the development of the government's regulatory policy during the past two decades reveals a consistent process of deepening involvement in the daily management of the hospital system. This process began with an attempt to deal with the structural market failures in the system and gained momentum with the creation of the health funds' budget dependency and, following that, the dependency of the state on regulatory tools that diverged from their original purpose. The process of divergence led to, among other things, the atrophy of the price system and the erosion of the economic rationalization and accountability of the system's managers. In this context, the designated plan to reduce waiting times constitutes the peak of this process, with the state preferring to adopt a complicated bureaucratic and intervention-intensive mechanism rather than repair the existing regulatory mechanisms, reduce intervention, and strengthen the system's economic rationalization.

The state's special plan to reduce waiting times reflects the lack of a solution to the current problems of the public hospital system, many created by the state's excess involvement in the system. The efforts of the state to deal with the challenge involve a complex and intervention-intensive plan, while preserving the regulatory tools that contributed to the creation of the need for the plan in the first place. Furthermore, the plan deviates from the fundamental decentralization principles on which the public health system and, in particular, the hospital system are meant to be based.

The problematic nature of the system's regulation is especially evident from the main findings of this study. In view of a nearly 20 percent increase in the productivity in the production of hospitalization services, it would have been expected that the system could improve the hospitals' financial performance and perhaps even that of the health funds. Furthermore, the additional output could have been used to improve the availability of hospitalization services to the public. In other words, the gains should have been divided between the producers (the hospitals) and the consumers (the health funds and the public). However, this did not happen. The deficits of the hospitals and the health funds, in fact, grew and service to the public remained lacking, as evidenced by the plan to reduce waiting times. Thus, at least circumstantially, the regulatory policy — and primarily the Cap mechanism and the public-private mix — has created systemic inefficiency that has adversely affected every aspect of the public system, its financing, and its service.

As shown in the previous study, the general hospital system in Israel suffers from a shortage of resources (Chernichovsky & Kfir, 2019). Nonetheless, the fundamental flaws in the regulatory infrastructure of the public hospital system are liable to reduce the value of investing needed resources in expanding infrastructure (hospital beds) and in operations and procurement (such as the plan to reduce waiting times), as long as there is no change in the regulatory system.

Given this situation, an examination of the development of regulation since the passage of the National Health Insurance Law, as well as future reforms that are on the agenda, with respect to these fundamental principles set down by the Netanyahu Committee (1990) and in the Law (1994), which we have called the principles of decentralization. The priority to minimize state intervention in the workings of the internal market of hospitalization services stems from these principles. This applies to both the regulatory mechanism that the state chooses to impose on the autonomous entities operating in the internal market and the need for the state to shed its ownership of hospitals, as was recommended by the Netanyahu Committee and a series of other committees (see Chernichovsky & Kfir, 2019, Appendix).

Guidelines for reform

In view of all of this, it would be worthwhile to re-examine the regulatory tools that have been used by the state since the National Health Insurance Law was enacted, with respect to both their cost and benefit and the usefulness of the principles that underlie the Law, namely the state's responsibility for regulating a decentralized system. In this context, a number of changes should be considered, the main one being a retreat from the existing regulatory policy of the Cap mechanism, deficit financing and plans to reduce waiting times in favor of the integrated financing model, which has already been approved by the government, and the implementation of regulatory and risk management tools widely used in other countries.

In the integrated financing model, the budget framework is fixed and predetermined (instead of retroactive deficit coverage) and is based on the normative cost of services (rather than being specific to each hospital), in a manner similar to the budgeting of the health funds in the National Health Insurance Law. Prospective and normative budgeting is the essential basis for strengthening the budget control and accountability of the hospitals' administration. The model can include a number of components:

- **Integrated financing model:** Completion of the process that began

with the adoption of Paragraph 63 of the Arrangements Law, 2017-2018 (which has not yet been implemented) and transition to an integrated financing model with a high level of transparency. In the full adoption of the model, the direct financing of the hospitals by the state will serve as a complementary tool to the main tool for financing entitled care, namely the sale of hospital services to the health funds.

- **Revision of hospital prices paid for by the health funds:** The integrated financing model will make it possible to redefine hospital prices, so that they reflect the relevant production costs for purposes of planning the provision of the health fund entitled care. These should reflect production costs and should reflect to the health funds the price of hospital-based services relative to the price of community-based services. Overall, it is desirable that the accounts settlement prices include only the cost components that reflect the production costs of services for all producers, including land and capital costs, rather than special publicly oriented components, such as emergency services and teaching.

- **Direct budgeting as a supplementary financing tool to the financing through health funds:** Direct state financing of the public hospitals' special cost components, including teaching, research, emergency services, development of national centers of excellence, and support for small hospitals in the geographic periphery should be considered. The definition of direct budget financing will require clear, defined, and transparent rules for the budgeting of the hospitals.

- **Supervision of prices and management of structural market risks:** Instead of the Cap mechanism, it is possible to adopt and develop mechanisms that are widely used in other countries. The Diagnostic Related Groupings (DRG) system of cost accounting is used in many countries as a tool for distributing risk and regulating quantities and is consistent with a mechanism of differential pricing which the state has already introduced and is developing. The integrated financing model makes it possible to set prices that are lower than average cost in cases of clear market failure in the internal market, alongside maintenance of the framework for normative financing of entitled care. There is no way to avoid recognizing the cost of intervention tools to deal with market failures and the fact that regulation of the risk of oversupply of services to the basket can be achieved only to a limited extent.

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