

Health Services

1. Government Expenditure on Health

Ever since the passage of the State Health Insurance Law, the health system has been mired in deep crisis. Truth to tell, even before the law was enacted the health system suffered from ongoing crises, but this law was intended to solve the system's problems, at least from the financial standpoint, and has not done so. One of the salient parameters of the health system during these years has been the continual and consistent attempts by the government to cut back its budgetary involvement and increase the public's share in the funding of national health expenditure.

In our review this year, the presentation of health expenditures has been modified in order to bring it closer to the changes that have occurred in the past few years in the structure of system funding. One of the main changes was the elimination of health-fund membership dues and their replacement by the health tax. According to the principles of national accounting, there is an essential difference between these two types of levies: the former is voluntary, the latter obligatory. In the course of the changeover, various parameters of course changed, leading to a different incidence of funding. However, to permit a multi-annual comparative survey, the health tax can be presented as the successor of the direct private insurance (membership dues) in effect before the passage of the law. Accordingly, this study does not include National Insurance transfers on account of the health tax as part of government expenditure.

Another major change is the gradual erosion of the “parallel tax” system (the employers’ contribution to the employees’ health insurance) since the mid-1980s and its total elimination in 1997. In the course of the erosion of this tax, the government took over the payments to the health funds that had come from the parallel tax and forwarded them as direct support. To keep the presentation consistent, we have categorized this form of government spending – along with other direct transfer payments to the funds – as “co-payments of medical insurance.” (See Table 1).

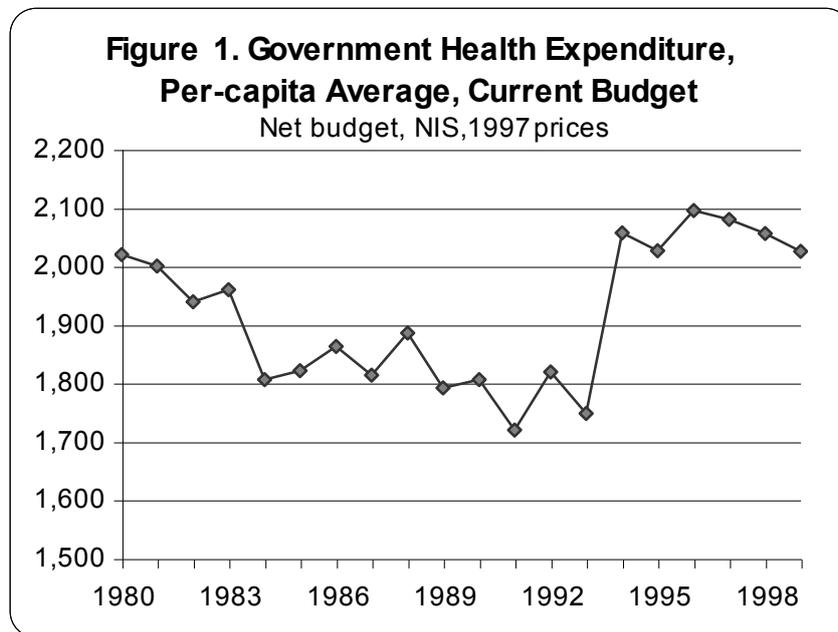


Table 1. Government Health Expenditure, Total and Per-Capita Average Current Budget (1997 prices)

	<u>Total expenditure (NIS millions)</u>			<u>Per-capita expenditure (NIS)</u>		
	Total	Co-payments	Direct expenditure	Total	Co-payments	Direct expenditure
1980	7,833	4,445	3,388	2,020	1,146	874
1990	8,417	5,995	2,422	1,806	1,286	520
1991	8,508	5,938	2,570	1,719	1,200	519
1992	9,320	6,457	2,863	1,819	1,260	559
1993	9,195	6,735	2,460	1,748	1,280	468
1994	11,105	7,860	3,245	2,057	1,456	601
1995	11,235	7,869	3,366	2,027	1,419	607
1996	11,918	8,611	3,307	2,096	1,515	582
1997	12,121	8,732	3,389	2,080	1,499	581
1998	12,286	8,568	3,718	2,059	1,436	623
1999	12,361	8,622	3,739	2,025	1,412	613

The table shows that government expenditure for health has reached NIS 12.4 billion, or 16 percent of total social spending by the government and 3.6 percent of GDP. The table also shows that, on a per-capita basis, the government spent NIS 2,025 (in the current budget) on health – similar to the figure of two decades ago. Between these two points in time, per-capita expenditure fell to a nadir of NIS 1,748 in 1993 before climbing back to its present level. The turnabout in 1994 was due to the health-fund crises that erupted that year and to the passage of the State Health Insurance Law; since then, however, government spending has increased only proportional to population growth. The implications of these findings should be examined in the context of the evolution of the health-care

sector in general, as reflected in data on national health expenditure, which epitomizes the activities of all sectors active in health care – government, other public, and private.

2. National Expenditure

National expenditure essentially reflects the economic side of the activity of the health-care sector. The way it is computed summarizes the totality of the financial activities of every unit of Israel's health-care delivery system. These activities include salary payments to physicians, nurses, and other employees of system facilities, complemented by purchases of the products and materials used by hospitals and clinics. All of these fall under the heading of current outlays, which represent the cost of daily upkeep of the system. Beyond this, the system spends various sums to expand its facilities and acquire durable equipment, such as computerized scanners and x-ray equipment. All outlays in the latter group are investments in capital goods, whose use is neither nonrecurrent nor confined to a single year.

The aggregate financial outlays therefore, represent the extent of activity of the health services in a given period and make it possible to assess the changes that occur over time. In an "environment" free of inflation and price changes, this would indeed suffice to provide the desired real picture. However, the real "environment" in Israel, as elsewhere, is very different. One way to correct for this is to use some other comparative magnitude; the accepted one is the total economic activity of the country as a whole. Juxtaposing health expenditure to the total outlays of the economy provides not only a real indicator of the extent of health-system activity but also represents the relative growth of this sector and measures the burden on GDP of permitting delivery of the services.

In previous decades there was a continual increase in the share of GDP devoted to the health system. This process was not

unique to Israel. It occurred in most countries, and to a certain extent was a source of concern for system planners, because on the one hand there is a wish to improve services as much as possible but on the other hand there are economic constraints that comprehensive planning must take into account. The effort to reconcile these two clashing goals reflects the desire to place health high on the national agenda, without causing excessive harm to other public or private systems. The incessant technological advances have heightened the pressure to devote more economic resources to the health system, while competition by other social and economic objectives have slowed the expansion to some extent.

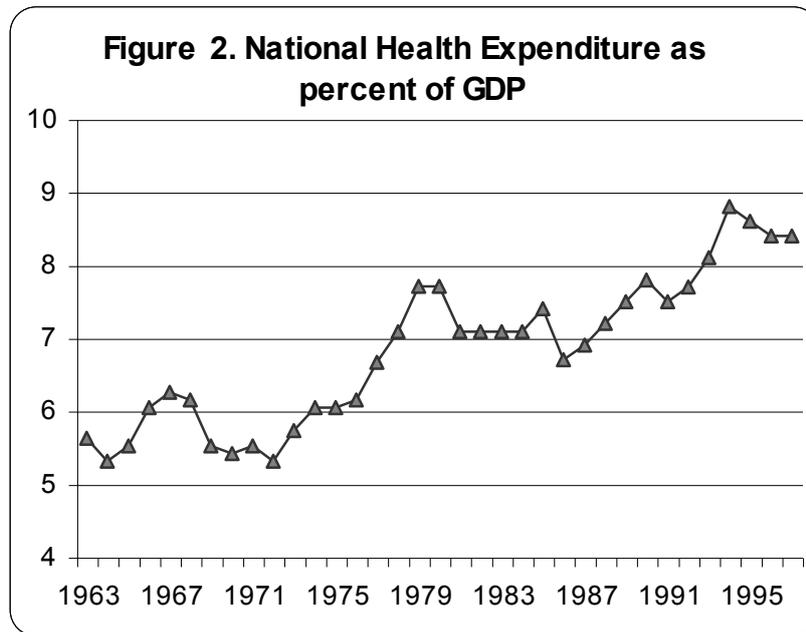
It may be stated empirically that the trend has traced a staircase pattern: from the 1960s until the mid-1970s, health expenditure as a share of GDP was stable at an average of 5.5–6 percent. In the 1980s, the level climbed to the vicinity of 7.5 percent. From the mid-1980s the level crept upward toward 8.5 percent. In practice, this level has prevailed since 1994, with a gentle downtrend in the last three years.

If we focus on the past two decades we find that in the 1980s the burden on GDP rose by 10 percent, from 7 percent to 7.8 percent. To gauge the matter more thoroughly, we should determine what was obtained for the added burden; this, too, can be compared with other uses of the national product. From this standpoint, it turns out that during the years when the burden on GDP grew by 10 percent, there was a vigorous increase in the prices of health services, outpacing the increases in other uses. This implies that each sheqel spent on health services purchased a smaller quantity of services than a sheqel spent on some other field, such as education or private consumption. Indeed, we find that while the burden on GDP rose by 10 percent, the scope of services actually generated was no higher than that generated in other economic sectors.

Table 2. Increase in National Health Expenditure Relative to GDP, (Percent)

	1980–90	1990–94	1994–97
Growth in burden on GDP	9.0	13.7	-3.4
Relative price increase (vs. GDP)	11.3	15.4	-3.9
Real relative increase	-2.0	-1.5	0.4

This process recurred – and perhaps with greater intensity – during the first half of the 1990s. Between 1990 and 1994, the burden of health on GDP grew by 14 percent, but the excess price increase in this sector, relative to others, meant that the actual expansion of service generated was slightly smaller than the real increase that occurred in other sectors of the economy. In the past three years, the trend has reversed direction: the burden on GDP has decreased slightly and the price increase of the sector has become less than that of GDP. The final result is that despite the reduced burden, the scope of service has not declined relative to overall economic activity.



3. System Funding

The health services in Israel have always been overwhelmingly public and only minimally included private services, mostly in dental health. The services are to a large extent provided by four health funds, of which the largest has been and remains Kupat Holim Kelalit (General Health Fund). In recent decades, the Maccabee Health Fund has gained ground on Kelalit. The situation today is no different from that preceding the 1995 reform; the main change has been manifested in the way the funds are financed. In contrast to the past, when the funds charged membership dues to the insured, today collection is by the state (through the National Insurance Institute), which forwards to the funds money commensurate with their

membership, with a slight adjustment made for differences in the members' age composition.

Another change occurred in the component known as "parallel tax." Originally, this was an arrangement between the funds and the organized employers, who participated in funding their workers' health insurance. As time passed, the arrangement was extended to the entire economy and tax was collected by the National Insurance Institute at an obligatory rate, which rose steadily until it reach 4.9 percent of wages. In the economic stabilization plan of 1985, employers were granted relief in the form of a reduced parallel-tax rate; the Finance Ministry compensated the NII for the lost revenue. Eventually, in 1997, the parallel tax was abolished altogether; today the Finance Ministry transfers the sum that would have been due were the tax still levied.

Because of these changes, no simple tracking of funding trends is possible; the various components must be categorized appropriately. The available statistics for this series are presented beginning in 1984 (to be precise, the fiscal year of the time, 1984/85). If we examine the trend over time, we find that in the mid-1980s households funded almost 40 percent of national health expenditure, most of this on private medicine (the largest part of which was for dental care) and the balance as health-fund membership dues. In addition, the "parallel tax" levied on employers produced a sum equivalent to 27 percent of national health expenditure. Finally, government funded about one-third of the total expenditure.

By the early 1990s, the sum paid directly by households as health-fund membership dues had risen to between 19 and 21 percent of total expenditure. As stated, the dues were replaced by a health tax in 1995; in 1997 the tax covered 26 percent of the expenditure. This may be regarded as an increase of one-quarter in the component paid directly by consumers, in the form of an earmarked tax. Offsetting this, the share of direct

government funding decreased to 25 percent of expenditure. (This refers to funding from general government sources as distinct from an earmarked tax. For the purposes of this computation we do not address ourselves to the elimination of the parallel tax in the past year, since in practice the tax had not been collected in full in previous years either).

Table 3. Funding of National Health Expenditure

	Government, total	<i>of which:</i> Parallel tax	Other government funding	Households, total	<i>of which:</i> Fund membership dues	Private services and medicines
1985/86	61	27	34	39	14	25
1989/90	53	27	26	47	19	28
1994	54	22	32	46	21	25
1997	48	22	26	52	26	26

Source: Based on CBS, "National Health Expenditure 1995–1997."

Notes: 1) The "health tax" has been included in the "membership dues" column.

2) The "Other" category in the original table (see: Appendix) has been classified under "other government funding."

If we disregard all the metamorphoses of the various components and address ourselves to the current situation only, we see that in 1997 the government, in various ways, covered about three-quarters of national health expenditure, while households paid for the remaining quarter directly. More than half of households' expenditure went for dental health; the balance was divided roughly equally between spending for private physicians and outlays for medical devices and medications.

In 1998, the health funds also introduced direct collection from patients, whether as a “tax” for visiting a physician or as co-payment for medicines. This solution deviates from the basic philosophy of national health insurance and is regressive. It should be emphasized that it was originally meant to cover the deficits that the health funds had built up. In a national health insurance regime, such a solution is unreasonable. If the funds’ expenses are justified, in the sense that the competent agencies acknowledge that they reflect the real cost of providing services at their existing level, then it follows that the collection and government-funding formula is flawed and needs to be amended to make up the shortfall. This assessment is supported by the fact that the formula for collecting the tax was determined in 1994, on the basis of the national expenditure data available to the planners at that time. These data usually become available at a lag of two years. In view of the aforementioned finding of steep price increases (which became apparent after the fact) in 1990–1994, it stands to reason that the sum needed to provide services at the existing level was underestimated.

The method chosen, which is regressive per se, cannot assure a fundamental solution to the problem. It is especially worth bearing in mind that once the principle of charging for service is entrenched, the way is clear for later increases in the rates and level of co-payment.

4. The Inpatient Care System

A considerable share of the activity of the health system takes place in the various inpatient institutions. It is conventional to classify these institutions according to two criteria – ownership and specialization. According to the first, it is possible to distinguish among five ownership groups: government, Kupat Holim Kelalit, other health funds, other nonprofit organizations, and private. According to the latter, there are four broad

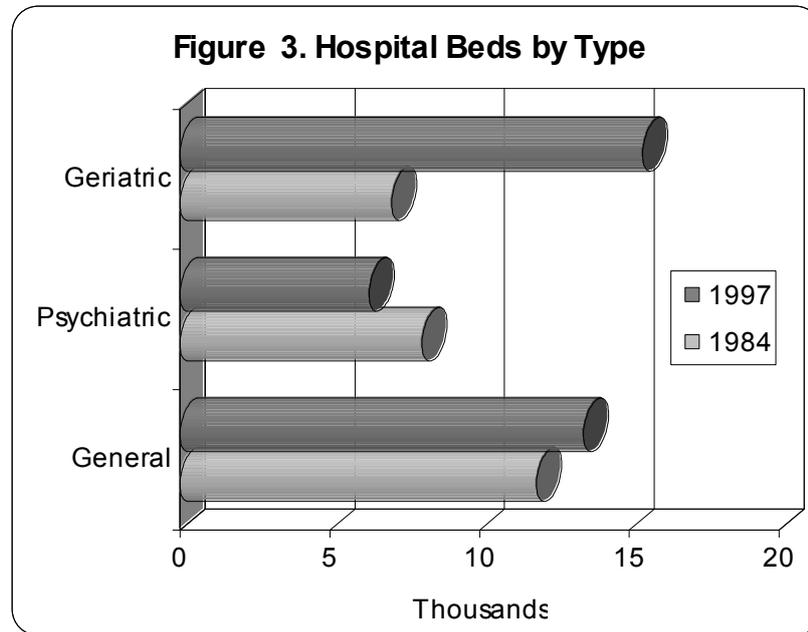
specializations with more detailed subdivisions within them: general, psychiatric, chronic care, and rehabilitation. In most statistical summaries, the two last categories are combined.

In fact, a separate description of the system according to these two criteria may be misleading; it is preferable to examine the matter in a combined fashion, i.e., a cross-categorization by these criteria, taking account of institution size. With regard to ownership, government institutions are a negligible minority: in 1997, the government owned 30 of the 300 inpatient institutions, or one-tenth of the total. However, the picture that integrates all three axes – ownership, specialization, and size (expressed in number of beds) – gives the government institutions a much more respectable place.

General hospitals have 13,500 beds today, about half of them in government-owned facilities. Kelalit owns 30 percent of the beds; most of the remainder belong to other NPOs, such as Hadassah. The share of beds in private institutions has grown vigorously in the past decade but still amounts to a tiny fraction – only four percent of the total.

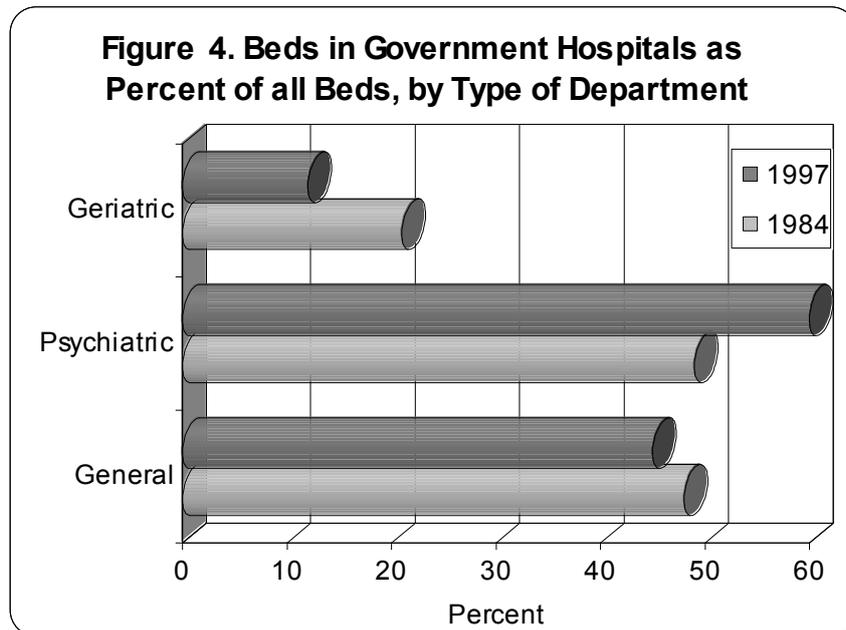
Table 4. Hospital Beds, by Type and Ownership
(Percent)

	General		Psychiatric		Geriatric	
	1984	1997	1984	1997	1984	1997
All	100	100	100	100	100	100
Government	48	45	49	60	21	12
Health funds	31	30	7	6	12	9
Other nonprofit	19	20	3	2	28	38
Private	3	4	41	32	39	40



Historically, the general hospitals accounted for a plurality of the beds: in 1984, there were 12,000 general beds, 8,000 beds in psychiatric institutions, and 7,000 in hospitals for the chronically ill. The balance has changed greatly since then; today hospitals for chronically ill (in fact, geriatric) rank first, with 15,500 beds, followed by general hospitals with 13,500 beds, and psychiatric institutions, with only 6,300 (down from 8,000, as stated, in 1984).

In the geriatric-hospital sector, the government and Kelalit have a very small share – 20 percent for both sectors combined. Most inpatient care is provided in NPO or private institutions – about 40 percent each, for a total of 80 percent of geriatric inpatient beds.



In psychiatric hospitals, the government sector is dominant, with 60 percent of all beds; this represents a perceptible increase at the expense of private institutions, which declined from 41 percent in 1984 to 32 percent today. The other two sectors, Kelalit and other NPOs, play a small and declining role in this field; together they provide only eight percent of the total, down from 10 percent in the previous decade.

As implied by the detailed figures presented above, the growth in the total number of beds has lagged significantly behind population growth. This is manifested in a decrease in the number of beds per capita during the past two decades – from 6.7 beds per thousand to 6.0 in 1997. Here, too, one may discern growing differences among the three types of inpatient care. In general and psychiatric hospitals, the per-capita decrease in the number of beds has been very steep, while it has actually increased in geriatric hospitals.

These distinct numerical trends are not just a “taking of inventory.” Behind them stand many changes in each domain. In geriatric care, there has been a substantial and ongoing correction of the striking shortage that had prevailed in this field for many years. The increase in the number of elderly in the 1970s and the early 1980s, and the rising incidence of senior citizens in need of long-term inpatient care, could not be accommodated by the existing institutions. Only in the late 1980s did vigorous growth occur in this field; as shown above, the number of beds in this field has increased significantly and largely compensated for the continued rise in the number of elderly. It should be borne in mind that the percentage of seniors has hardly grown in the past decade. Even though the emphasis within this cohort shifted to the 75+ age group, the doubling of the total number of beds largely improved the situation in terms of the per-capita average, too.

There has been a steep decrease in the number of beds in psychiatric hospitals, especially in the private sector. One should not make the mistake of thinking that this is part of a philosophy that runs counter to the privatization process; instead, it is the combination of two trends – on one hand, the long-term trend of emphasizing home and community care, and on the other hand, of the effort to shut down private institutions that do not satisfy quality-of-care criteria. Be this as it may, the 50 percent decline in the average number of beds per-capita in population, in the past two decades, is certainly not the product of a corresponding decrease in the incidence of mental illness.

In the third category of institutions – actually the first, in terms of number of patients and other indicators – general hospitals, the number of beds has risen, as stated, but much less than the extent of population growth. For this reason, the number of beds per thousand of population has declined from 3 to 2.3, in a continual and gradual process.

Such a drastic decrease in the number of beds in general hospitals is accompanied – almost as an arithmetic result – by a decline in the average number of admissions or by greater turnover in utilization of beds. There has indeed been a decline over time in the number patients admitted to hospitals, whether as a result of the decrease in morbidity or as a result of a transition to outpatient therapeutic methods. However, the main factor offsetting the decline in the number of beds has been a reduction in the average length of hospital stay. For all general-care admissions, over the past two decades the average patient stay has contracted by one-third, from an average of 6.3 days to 4.3 days per person admitted. Among the larger departments, general surgery is most notable in this regard: the average stay has fallen by 60 percent, from 7.3 to only three days.

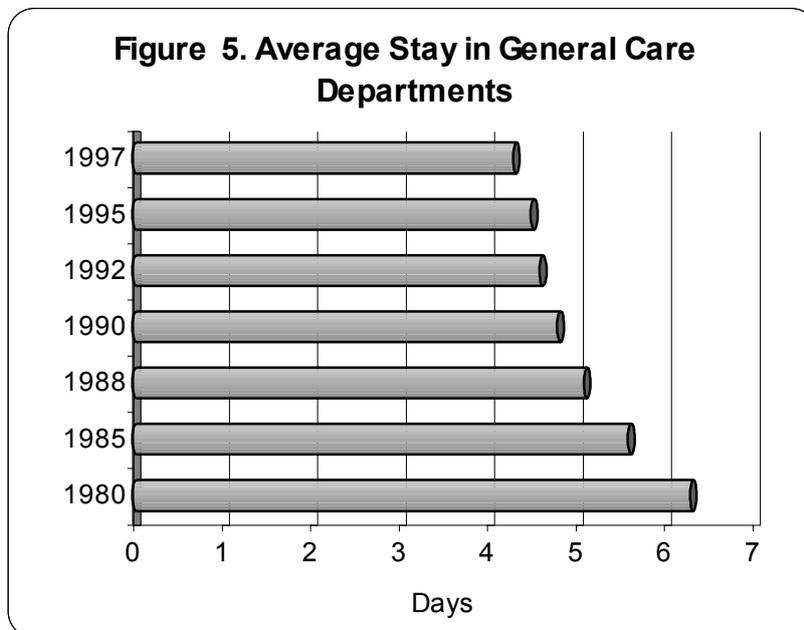
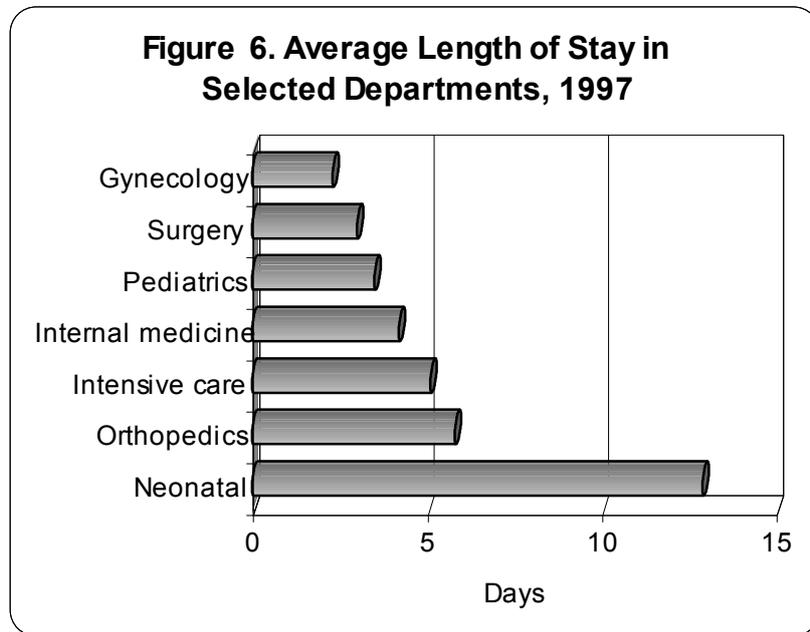
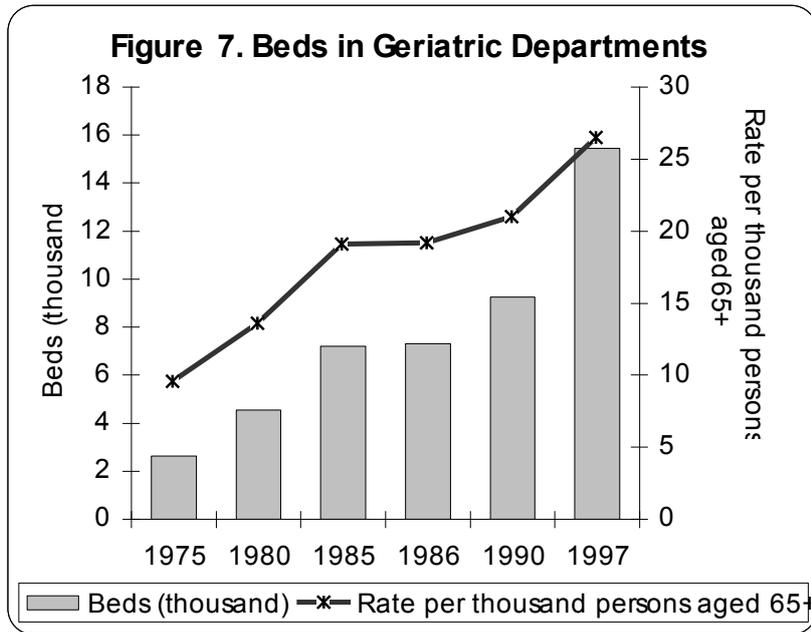
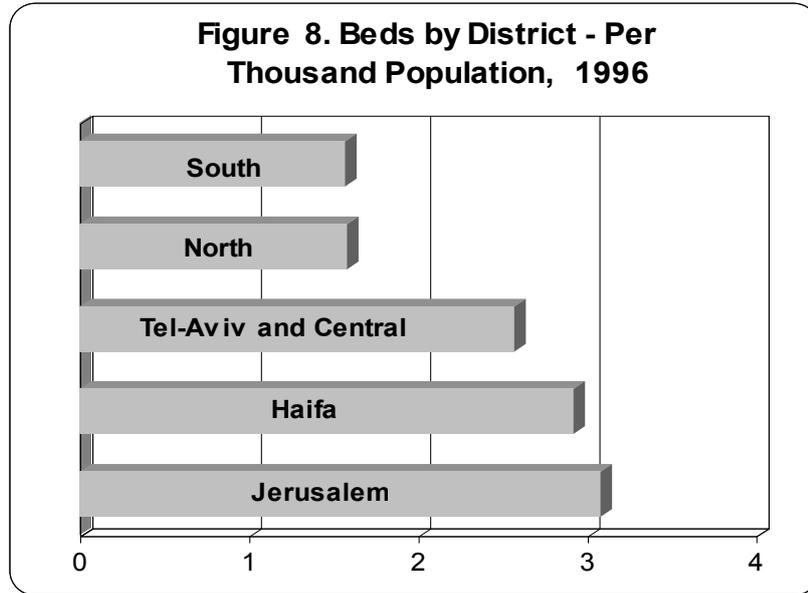


Table 5. Beds by Type (rate per thousand population)

	1980	1985	1990	1995	1997
Total	6.7	6.5	6.0	5.9	6.0
General	3.0	2.8	2.6	2.4	2.3
Psychiatric	2.2	1.8	1.5	1.2	1.1
Geriatric	1.2	1.7	1.9	2.3	2.5
Geriatric per 1,000 aged 65+	13.5	19.0	20.9	23.8	26.4







It is hard to determine the extent to which a process of “streamlining” is taking place here, that is, the introduction of procedures that require shorter hospital stays than previously, and the extent to which it reflects “rationing” in response to a shortage of beds. One indication of the latter may be found in the differences between various parts of the country. Although the available data are not sufficiently detailed, we can infer from them that the number of beds available to residents of the north and south is much smaller than that available to inhabitants of the central area and the major cities. The number of beds in central areas ranges from 2.5 to 3 beds per thousand, whereas in the north and the south the rate is only slightly higher than 1.5 beds per thousand. At the same time, the number of inpatient days in peripheral areas is only half of that in the central areas.

5. Life Expectancy as a Health Indicator

Measuring the health of an entire population requires availability of data comparable both over time and in relation to the situation in other countries. Although the data available are rather scanty, several indicators do point to an improvement in Israelis’ health. For example, mortality from heart disease decreased from 172 cases per 100,000 persons in the early 1980s to 138 cases in the mid-1990s. Nothing can be inferred from such changes as to the efficacy of the health services, but this figure in itself may point to improvements that have been occurring over time.

In the absence of detailed statistics on the health status of the population and the impact of the health services, it is conventional to use life expectancy as a relevant indicator. This is not meant to imply that the absolute level of life expectancy and changes therein are determined by the level of health services. However, there is a general consensus that some correlation exists between advances in health care and changes

in life expectancy. In any case, the prolongation of life with the concomitant improvement in the quality of life is undoubtedly one of the main goals of the health-care system.

Overall, life expectancy in Israel, which ranks among the highest in the world, has been increasing for most of the country's history. For the first few years, the data pertain to the Jewish population only. In Israel's formative years, average life expectancy was 68.5 years. Two decades later, in the early 1970s, this figure had increased to 71.7 – an extra three years on average. From that period we have data for the entire population; the aggregate figure is slightly lower than that for the Jewish sector only.

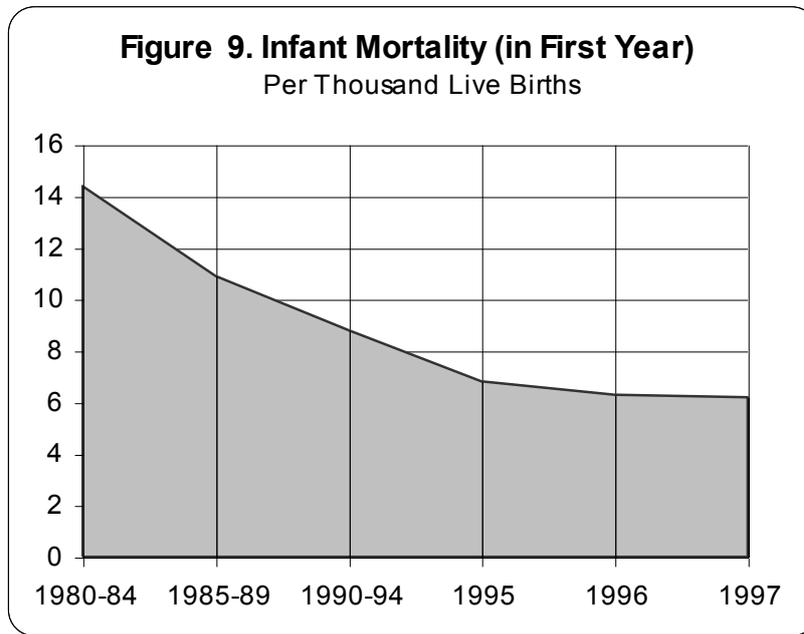
Table 6: Life Expectancy at Birth

	1975– 1979	1980– 1984	1985– 1989	1990– 1994	1995	1996
Total population						
Men	71.2	72.7	73.8	75.1	75.5	76.3
Women	74.7	76.1	77.4	78.8	79.5	79.9
Jews						
Men	71.7	73.1	74.1	75.5	75.9	76.6
Women	75.3	76.5	77.8	79.2	79.8	80.3
Arabs						
Men	69.2	70.8	72.7	73.5	73.8	74.9
Women	72.0	74.0	75.5	76.3	77.3	77.7
Difference between women and men						
Total population	3.5	3.4	3.6	3.7	4.0	3.6
Jews	3.6	3.4	3.7	3.7	3.9	3.7
Arabs	2.8	3.2	2.8	2.8	3.5	2.8

At the start of the fourth decade of independence – that is, in the early 1980s, the average life expectancy of the population at large had climbed to 74.5 years. By the end of the decade it had reached 76.3 years. Today, life expectancy is 78.1 years. If we compare the situation to that of the early years of the state, we find that during the last 50 years average life expectancy has increased by nearly 10 years – a 15 percent improvement.

All of the data mentioned are general, relating to the entire population, irrespective of population group or gender. More detailed data point to substantial disparities that have existed in most years. In the first distinction, population group, we find that life expectancy among Jews is about two years more than among the Arab population, and that this gap has persisted in almost all years.

In the distinction by sex, women's life expectancy exceeds men's; here the gap has actually widened somewhat over time. It should be noted, however, that the disparity between women and men is not as large as in other developed countries. In Israel, it is 3.6 years – meaning that women on average live three-and-a-half years longer than men – whereas in many Western countries the gap is almost twice as large. In fact, Israel owes its high ranking in international comparisons mainly to the longevity of its men – second in the world after Japan (Jewish population only; fourth place for the entire population). Israel's ranking is not so high for women. Up-to-date figures for 1996 show that the longest life expectancy is almost 80.3 years, for Jewish women, followed by 77.7 years for Arab women, Jewish men at 76.6 years, and Arab men at 74.9 years. The gap between the sectors is 2.2 years, while the gender gap is 3.7 years among Jews and 2.8 years among Arabs.



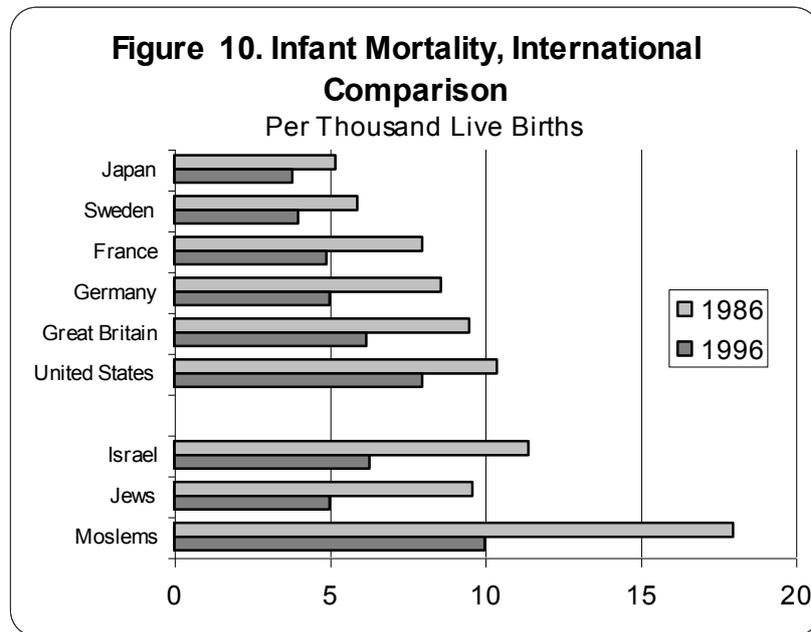


Table 7. Life Expectancy at Birth – International Comparison, 1996

	Men	Women	Difference
Portugal	71.2	78.5	7.3
United States	72.7	79.4	6.7
Germany	73.6	79.9	6.3
Japan	77.0	83.3	6.3
Switzerland	75.7	81.9	6.2
Sweden	76.5	81.5	5.0
Great Britain	74.4	79.3	4.9
Israel	76.3	79.9	3.6

The contribution of the health services to lowering mortality rates is acutely evident with regard to infant mortality. Here Israel does not do as well in international comparison as in mortality rates for the population at large. Be this as it may, much progress has been made in all sectors and all stages of infancy. The overall rate today is eight per thousand births, as against 22 per thousand two decades ago. During this period, infant mortality caused by infectious diseases and pneumonia has almost totally disappeared, the rate plummeting from 4.2 per thousand births in the 1970s to 0.2 per thousand today.

In the field of infant mortality, a sizable gap still remains between the Jewish and Arab sectors, even though vast progress has been made in the latter sector. Although these figures point to an improvement in basic conditions, there is no doubt that the health services play an important role in the advancement of all segments of the Israeli population toward the levels common in developed countries.