The Israeli Healthcare System: from Health Funds Dominance to a National Health Insurance Law

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Health Ideal

A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity

WHO Preamble to its Constitution, 1946
Healthcare Systems

The means by which societies provide support for citizens to maintain their good health
Healthcare Systems Objectives

Effectiveness - Quality
Improving population health

Social Acceptability - Responsiveness
Responding to peoples’ expectations ("needs" and "wants")

Cost
Fair financing of healthcare
Providing financial protection against costs of ill-health
## Factors Influencing Health

<table>
<thead>
<tr>
<th>Fixed</th>
<th>Social &amp; Economic</th>
<th>Environment</th>
<th>Lifestyle</th>
<th>Access to Service</th>
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<tbody>
<tr>
<td>Genes</td>
<td>Poverty</td>
<td>Air quality</td>
<td>Diet</td>
<td>Education</td>
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<td>Sex</td>
<td>Employment</td>
<td>Housing</td>
<td>Physical activity</td>
<td>Social services</td>
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<td>Ageing</td>
<td>Social exclusion</td>
<td>Water quality</td>
<td>Smoking</td>
<td>Transport</td>
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<td>Social environment</td>
<td>Alcohol</td>
<td>Leisure</td>
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<td>Sexual behavior</td>
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<td>Drugs</td>
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<td></td>
<td><strong>Health System</strong></td>
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Source: [Healthcare in the UK: the need for reform](http://example.com), Institute of Directors Policy Paper. February 2000
**Factors Shaping Healthcare Systems**

- Social and family ethics and ethos
  - Social Solidarity
  - Personal Autonomy

- Medical decision-making ethics
  - State Paternalism
  - Patient Autonomy
  - Professional Paternalism

- Political-economical ideology
  - Free Market
  - Social Democracy
  - Collective - Socialist

- Political power centers and decision-making process
  - Providers
  - Consumer
  - Bureaucrats

- Economics (infra)structure
- Technical capability
Healthcare Systems Typology as Determined by Government Involvement

- Freedom of action for workers and employers
  - United States
- Welfare health policy via health funds
  - Germany
- Comprehensive and universal healthcare system
  - Scandinavia
- (Totally) socialized health service
  - Eastern Europe

Healthcare Systems Goals

World Health Organization – “New Universalism”
Delivery to all of high-quality essential care, defined by criteria of:
effectiveness, cost, and social acceptability

United States
Universal access to high-quality, comprehensive, cost-effective healthcare

United Kingdom
Comprehensive, high-quality medical care to all citizens on a basis of meeting professionally judged medical needs and without financial barriers to access
Healthcare Systems Goals

Israel National Health Insurance Law

based on principles of justice, equality and mutual support …

while maintaining dignity, privacy, and medical secrecy …
The Major Israeli Medical Players

Prior to National Health Insurance Law

- KHC – a socialistic healthcare coverage
  - Care based on needs, regardless of income
  - Lack of personal freedom for service options
  - Family premiums based on salary up to ceiling
  - Involuntary membership in JLF

- Other sick funds – “picking the cream”
  - Metropolitan areas, “better” population
  - Use of hospitals and other KHC and government facilities

- Ministry of Health
  - Network of general hospitals
  - Specialized (geriatric, psychiatric, long term care) facilities
  - Services to target groups

- National Insurance Institute of Israel
  - Support of needy handicapped, nursing care, and long term care
Key health provider - **Sick Fund**
- Not for profit HMO belonging to its members

1911 – first sick fund (later known as KHC)
- Organized by socialistic Jewish agricultural day laborers
- Involuntary membership in JLF and KHC
- Equality of service per needs, regardless of income

1921- first Jewish Labor Federation’s sick fund

End 1920s – first proposal for compulsory health insurance law
- Opposition – weaken labor, reduce JLF control over KHC
**Israeli Healthcare System**

**Historical Background II**

- **1930-40s – KHC + private healthcare**
  - KHC – about 50% of population, throughout country
  - European medical providers immigrants
  - Several small sick funds
    - Metropolitan areas
    - Independent providers
    - “Better” population: young, economically well doing members

- **1948-1995 – State of Israel**
  - Same structure, with KHC + 3 sick funds
  - A parallel public (Ministry of Health [MOH]) system and services
  - Minor health insurance market
Political pressures for change

- 1948-1977: KHC superiority – 80% of population
  » Labor in control
  » KHC healthcare provider of new immigrants
  » KHC premiums finance JLF
  » KHC heavily subsidized
  » Decline in JLF & KHC financial position
  » Decline in JLF power and KHC membership
  » Labor voices calling for disengagement of JLF and KHC
- 1994: Labor government ready for National Health Insurance Law
  » Deal between JLF and Ministry of Finance
  » Includes financial saving of the JLF and KHC


1995: National Health Insurance Law
Health-related Israeli Knesset Activity 1984-2001

Law Proposals

Queries
Comparative Performance

**Private – Voluntary System**

**Strengths**
- Choice (responsiveness)
  - Expansive “wants” benefits
- Available to most customers willing to pay an equitable cost for coverage
- Private control of decisions over provision of Healthcare

**Weakness**
- Universal coverage impossible
- Fragmentation of risk pool
  - “Cream Skimming”
  - High sales and administrative costs
- Risk-rated premiums
- Challenge to limit costs

**Public – Mandatory System**

**Strengths**
- Universal coverage
- Direct cost control through government budgets
- No market fragmentation
- Tax – salary based financing (financial fairness)
- Low overhead costs

**Weaknesses**
- Bureaucracy (unresponsiveness)
- Not likely to provide all Healthcare “wants” demanded by public
- Strong public involvement in provision of medical care services (may be considered a strength)
Netanyahu Healthcare System Report
Systematic Concerns

- Unclear entitlement to healthcare service
- Missing policy-making government leadership
- Centralized control
- Politicization
- Unclear financial support by state of sock funds
- Uncontrolled growth of personnel and costs
- Fragmentation of system => inefficiencies
### Netanyahu Healthcare System Report

#### Issues

<table>
<thead>
<tr>
<th>Majority</th>
<th>Minority</th>
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<tbody>
<tr>
<td>MOH failure - dual role as provider and regulator</td>
<td>Flaws are outcomes, since:</td>
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<tr>
<td>Ministry of Finance budget control</td>
<td>– Reasonable health outcomes and costs</td>
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<tr>
<td>Shortage of managerial talent</td>
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<tr>
<td>Oversupply of physicians</td>
<td></td>
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<tr>
<td>Employees unrest</td>
<td>Sources of flaws:</td>
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<tr>
<td>Regressive fees</td>
<td>– Poor functioning of MOH</td>
</tr>
<tr>
<td>Adverse selection by sick funds</td>
<td>– Reduction of public financing</td>
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<tr>
<td>Poor service, queuing</td>
<td>– Inadequate compensation and collective bargaining processes</td>
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<tr>
<td>No “patients bill of rights”</td>
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</table>
Netanyahu Healthcare System Report

Recommendations

Majority
- Revolutionary approach
- National Health Insurance
  - State as health provider
- Private services in not-for-profit hospitals
- Regionalism of sick funds
- Considered as lacking on implementation

Minority
- Evolutionary approach
- Concentrate on “critical change levers”
  - Money
  - Manpower
  - Technology
- Better understood by policy makers
1995 – National Health Insurance Law

- **National Health Insurance**
  - Sick funds as health providers
  - Universal coverage
  - Free selection of sick fund and move between funds
  - Basic package of services
  - From conceive to grave

- Centralized state funding
  - Health tax linked to income
  - Allocation of funding to sick funds by a capitation formula
  - Revoking rights of sick funds to collect fees
  - State responsible to cover deficits

- Managed competition model for the healthcare system
- Does not cover long-term care
The 1995 Law Shortcomings

- Lack mechanisms for
  - Basic package updates
  - Other support services by sick funds
  - Long-term planning
  - Risk management processes

- Ignores funding for
  - Ageing of population
  - Medical advances
  - Health index inflation beyond cost of living
  - Full payment of costly services (e.g., dialysis)
  - Improper initial costs assumptions
  - Infrastructure maintenance and upgrading
Additional Developments

- 1998 Regularization Law
  - Enabled “Complimentary Health Services” by sick funds
    » Collective, non-underwritten, voluntary coverage
    » Expansion of the basic package services and options
    » Complete separation from basic package
  - Prevented sick funds from providing insurance
    » Health or long-term care
  - Requires full information and transparency

- 2000-2001: move to include long-term care
Israel Healthcare Structure Today

- Three coverage levels
  - Basic package per National Health Insurance Law
    » Involuntary, covers all
  - Complimentary services by sick funds
    » Collective coverage for members of funds
  - Individual health insurance by insurers
    » Extensive coverage options

- Strong competition insurers – sick funds

- Poor information infrastructure
  - Pricing and control problems

- Unresolved issues
  - Short and long-term funding
  - Level and equitability of coverage
  - Role and responsibilities of the actors
National Expenditure on Health as Percent of GDP
Health Spending as % of GDP - 1997

Source: WHO
National Expenditure by Financing Sector

Since 1995 Government funding include “health tax”
Hospital Beds – Israel 2000

By type of bed

38,577 beds

By ownership

38,577 beds
Other Statistics

- 6.2% of employed (1996)
- 22 healthcare employees per 1,000 (1996)
- 472 physicians per 100,000 (1997)
- 6 hospital beds per 1,000 (1997)
- Hospitals: 47 generals, 28 psychiatrics, 200 nursing and long-term care (1997)