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

Yair Babad & Tuvia Horev

International Health Seminar – ICA 2002

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

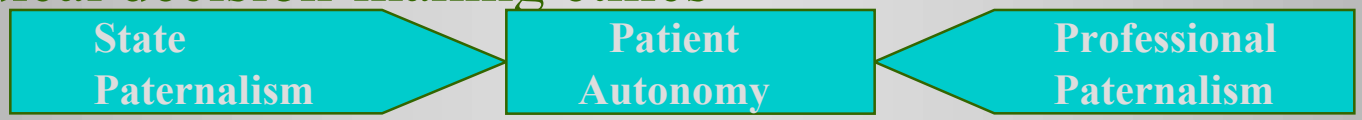
Fixed	Social & Economic	Environment	Lifestyle	Access to Service
Genes Sex Ageing	Poverty Employment Social exclusion	Air quality Housing Water quality Social environment	Diet Physical activity Smoking Alcohol Sexual behavior Drugs	Education Social services Transport Leisure **Health System**

Source: **Healthcare in the UK: the need for reform, Institute of Directors Policy Paper. February 2000**

Factors Shaping Healthcare Systems

- Social and family ethics and ethos

- Medical decision-making ethics



- Political-economical ideology

- Political power centers and decision-making process

- Economics (infra)structure
- Technical capability

Healthcare Systems Typology as Determined by Government Involvement

- Freedom pf 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

Roemer, M.I., "National Health Systems of the World", Oxford University Press, 1991

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

Israeli Healthcare System Historical Background I

- 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

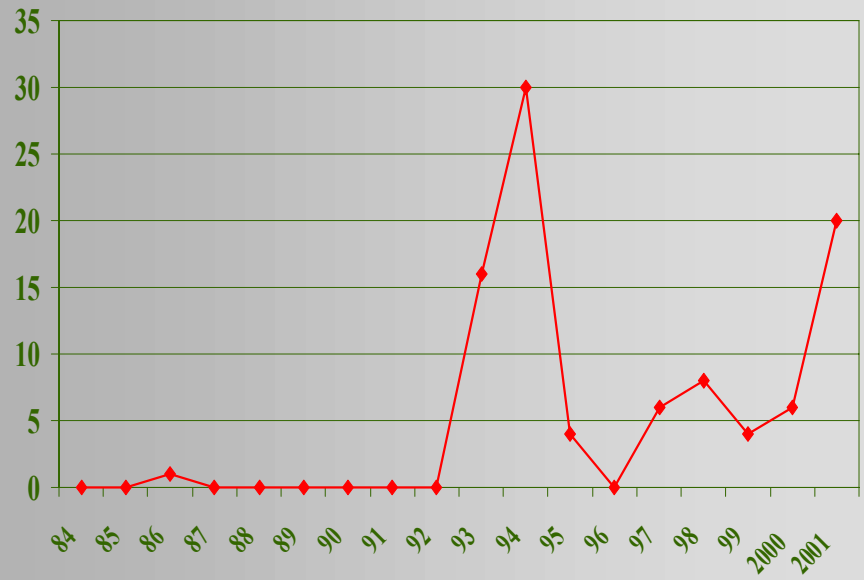
Israeli Healthcare System Historical Background II

- 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

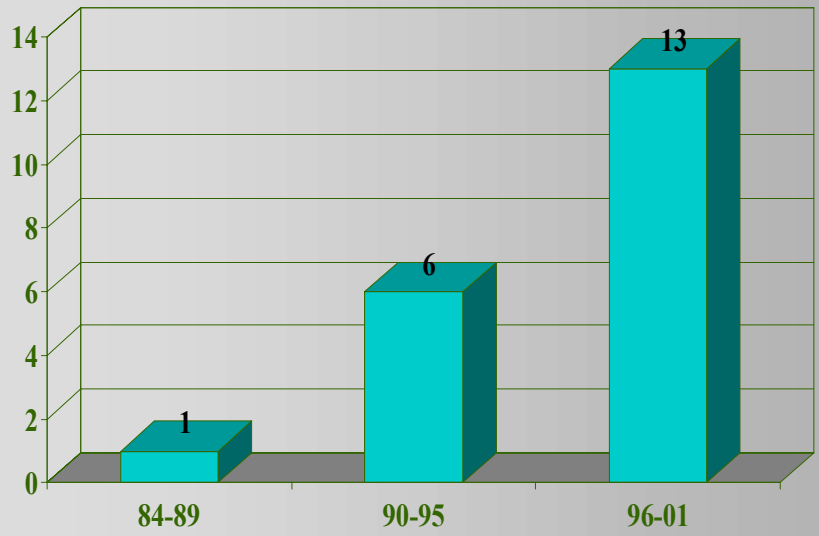
Israeli Healthcare System Historical Background III

- 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
  - 1977-1994: Non-labor government
    - » 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
- 1990: Netanyahu National Investigation Commission – Healthcare System
- 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

Majority

- MOH failure - dual role as provider and regulator
- Ministry of Finance budget control
- Shortage of managerial talent
- Oversupply of physicians
- Employees unrest
- Regressive fees
- Adverse selection by sick funds
- Poor service, queuing
- No “patients bill of rights”

Minority

- Flaws are outcomes, since:
  - Reasonable health outcomes and costs
  - Spectrum of coverages
  - Equitable access to services
- Sources of flaws:
  - Poor functioning of MOH
  - Reduction of public financing
  - Inadequate compensation and collective bargaining processes

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

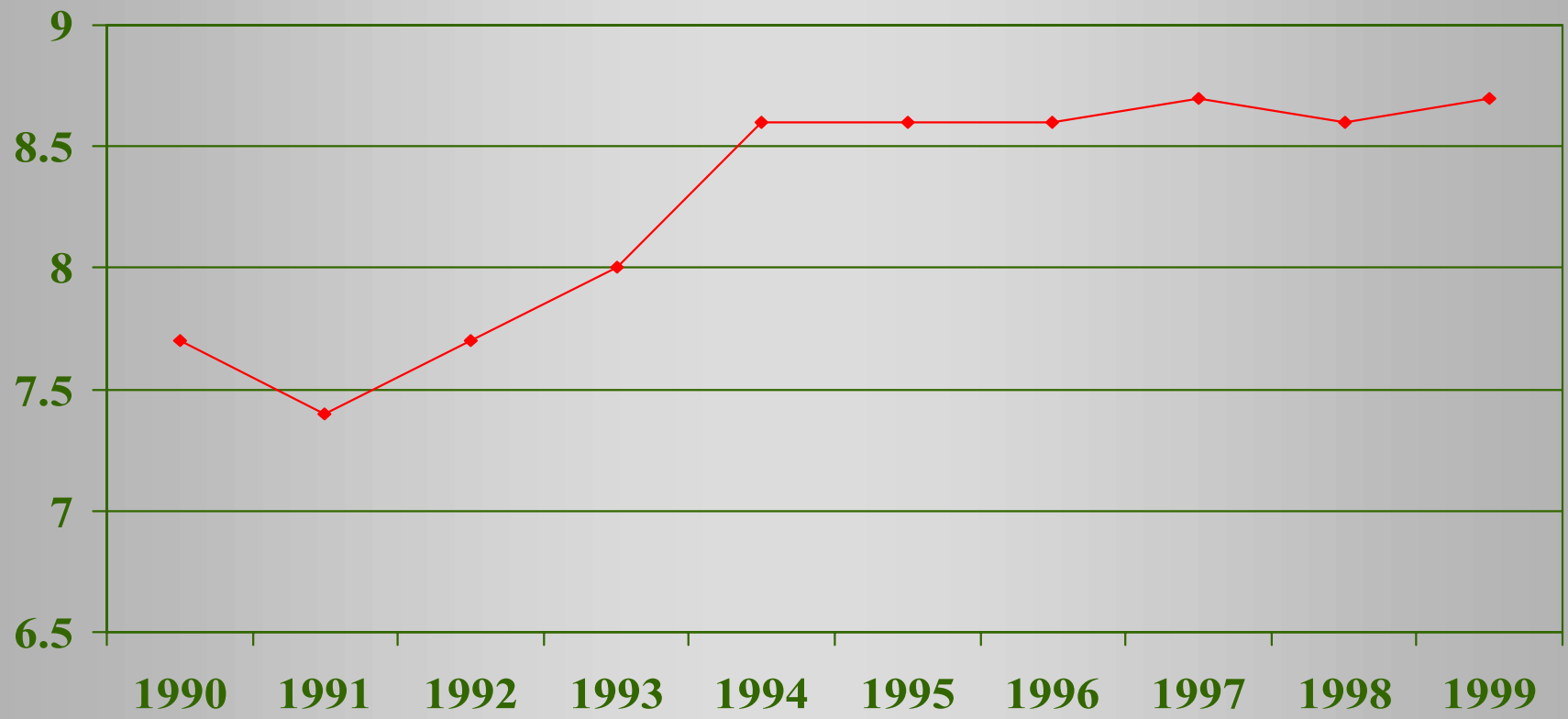
Additional Developments

- 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

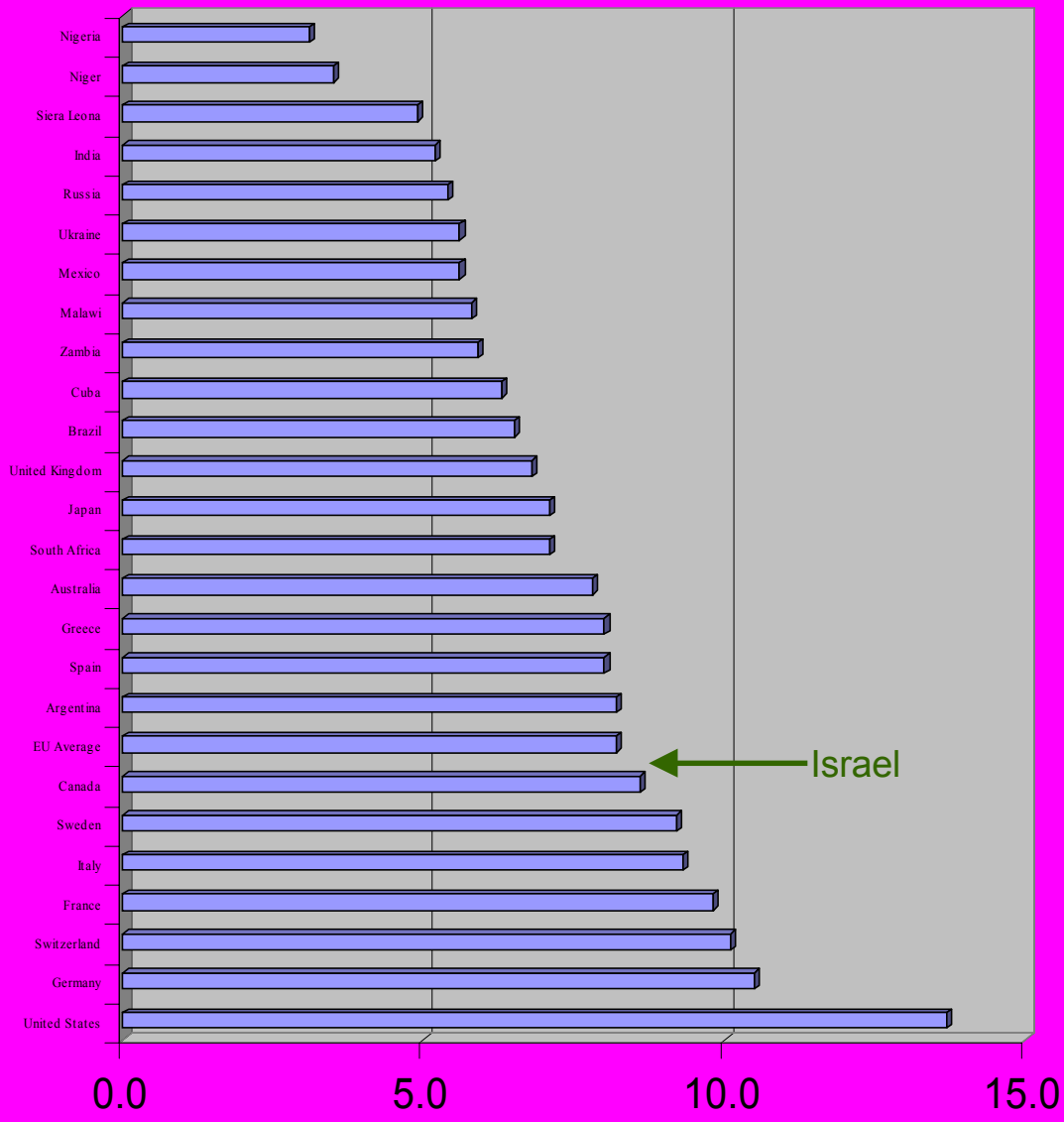
Israel Healthcare Structure Today

- 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

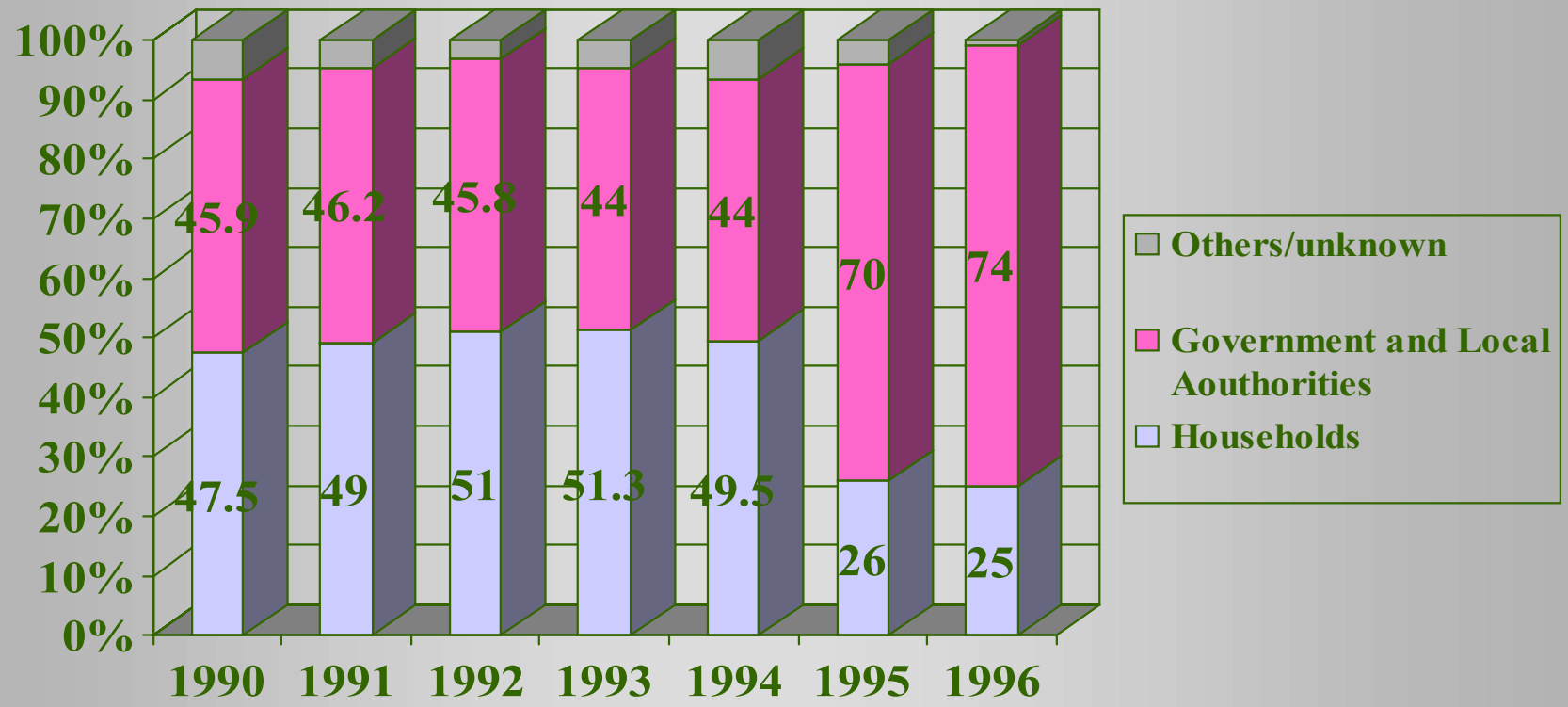


Health Spending as % of GDP - 1997



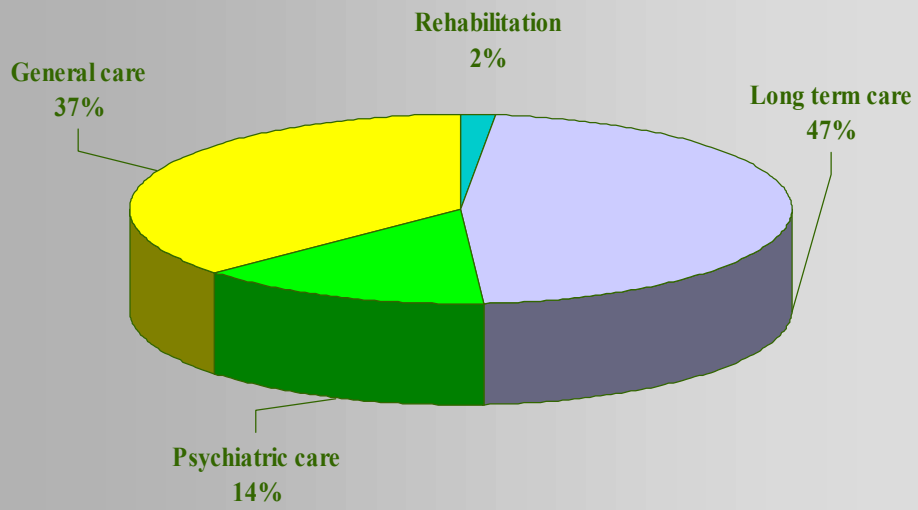
Source: WHO

National Expenditure by Financing Sector

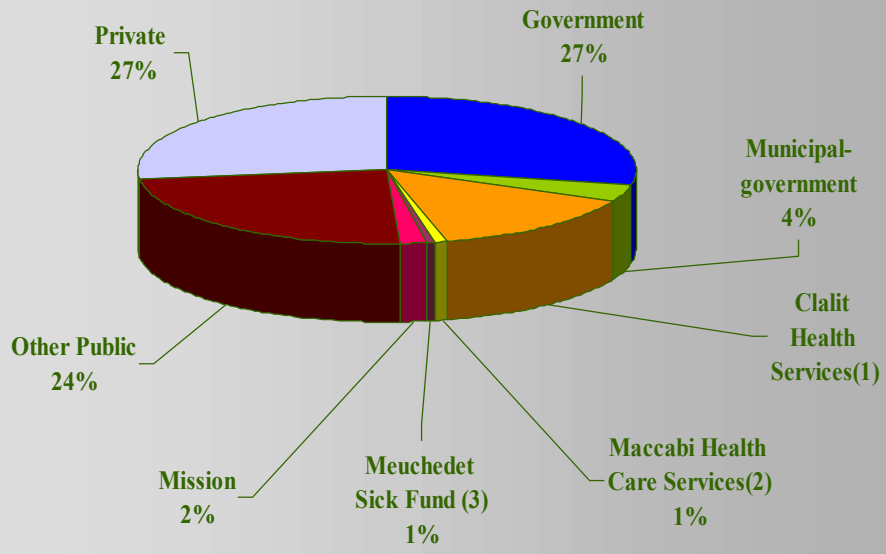


Since 1995 Government funding include “health tax”

Hospital Beds – Israel 2000



By type of bed



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)