



Myers-JDC-Brookdale Institute
Smokler Center for Health Policy Research
Jerusalem



Jewish Healthcare Foundation
Pittsburgh

THE ROLE OF THE GOVERNMENT IN ISRAEL IN CONTAINING COSTS AND PROMOTING BETTER SERVICES AND OUTCOMES OF CARE



Bruce Rosen
Myers-JDC-Brookdale Institute

Prepared at the Request of the Jewish Healthcare Foundation

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This report was prepared within the context of an intensive, multi-staged collaboration between the Myers-JDC-Brookdale Institute in Jerusalem and the Pittsburgh-based Jewish Healthcare Foundation. The goal is to enable policymakers in the US to draw lessons from Israeli healthcare, and vice versa.

In the first stage of the project, two overview documents that provide useful background to the current report were produced:

- ❖ ***Healthcare in the US and Israel: Comparative Overview***
- ❖ ***Healthcare in Israel for US Audiences***

The former may be purchased from the JHF or the MJB Institute and both can be downloaded from the JHF and MJB websites.

The current phase of the project includes four monographs:

- ❖ ***The Role of the Government in Israel in Containing Costs and Promoting Better Services and Outcomes of Care***
- ❖ ***Primary Care in Israel: Accomplishments and Challenges***
- ❖ ***How Health Plans in Israel Manage the Care Provided by their Physicians***
- ❖ ***The Medical Workforce and Government-Supported Medical Education in Israel***

The current report focuses on the role of government.

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TABLE OF CONTENTS

Foreword: Karen Wolk Feinstein, PhD, President and CEO, Jewish Healthcare Foundation	1
Introductory Overview: The Role of Various Governmental Institutions in Israeli Healthcare	2
Monograph Topics	
1. What are the Nature, Extent and Impact of Political Involvement in Israeli Healthcare?	5
2. What are the Processes for Accrediting and Ongoing Cost and Quality Monitoring of Health Funds, Hospitals, Independent For-Profit and Nonprofit Healthcare Providers and Individual Clinicians?	8
3. How is the Overall Budget for Services Provided by the National Health Insurance Law Set?	10
4. What Impact does the Government's Role in Labor Development and Regulation (e.g., Controlling the Supply of Key Physical and Labor Inputs; Influencing Wage Levels) have on Containing Costs and Quality?	11
5. What is the Government's Role in Establishing and Safeguarding Universal Entitlement to Efficient, Equitable and Quality Care?	12
6. How has Israel been able to hold HMOs Accountable for Quality and Costs? (How has Israel avoided the Challenges and Perceived Abuses of HMOS that Virtually Eliminated them in us?) What Role have Incentives Played?	14
7. How does the Government's Role in Direct Service Provision Impact on Costs and Quality?	16
8. What are the Implications of the Process of Prioritizing Resources within the Global Budget (including Allocations to Services, Technologies and Devices and Capital Infrastructure) for Cost Containment and for Quality of Patient Care?	18
9. How is the Appropriate and Cost Effective Use of Pharmaceutical and Technology Vendors Encouraged?	19
10. What is the Influence of Device and Pharmaceutical Manufacturers in the Selection of Covered Drugs and Technologies and how is such Influence Minimized or Managed?	19
11. What is the Role of the Government in Making the Markets Work in the Public Interest (Efficiently and Equitably)?	20
12. Concluding Thoughts and Observations	22
Appendix: Summary of Roundtable Discussion on the Role of Government in Controlling Costs and Promoting Quality in Israeli Healthcare (October 11, 2009)	25
Table 1: Annual Adjustment to the "Cost of the Benefits Package" (%)	10

FOREWORD

In March 2010, the US Congress passed historic healthcare reform legislation. While there is controversy surrounding how that care will be financed, few would question the ethical obligation to extend care to many uncovered Americans and to remove barriers to insurance for persons with previously existing conditions, both of which the new bill ensures. In addition, it restricts payment for waste, error, unnecessary treatment and preventable complications (estimated to account for as much as 40% of US healthcare spending) and recognizes the centrality, and cost effectiveness, of adequate funding for primary care physicians and their prevention activities.

The bill also authorizes a series of ambitious, regional experiments to test new options for transforming healthcare delivery and payment, including: value-based purchasing by Medicare of healthcare services from hospitals, physicians and other providers; partnerships between hospitals and private patient safety organizations; accountable care organizations, through which groups of providers would be jointly and financially responsible for better patient outcomes -- and responsible restraints on overuse; and expanded quality and safety research, with results accessible to patients and physicians.

These experiments have the potential to move the US from a fee-for-service, volume-based system to a value-based system that ties financial rewards to measurable, sustained improvements in patient outcomes and responsible efficiencies. This transformation, should it occur, is also likely to thrust the federal government into a new role – ensuring not only that all Americans have access to healthcare, but ensuring the value of that care as well. In the coming decade, as the US tests approaches to achieving value in healthcare, which will have implications for the role of government, there is much to learn from Israel, where a careful balance between public and private interests has already been forged.

This monograph – the third in a series of six prepared for the Jewish Healthcare Foundation by the Smokler Center for Health Policy Research at the Myers-JDC Brookdale Institute in Jerusalem (an affiliate of the American Jewish Joint Distribution Committee) – details the role of the Israeli government in containing costs, prioritizing resources within budget constraints, and promoting better services and outcomes of care. It considers, especially, the level and importance of stakeholder involvement in the Israeli healthcare system, provides a nuanced look at the budget-setting process, and describes the role government plays in ensuring provider accountability for quality and costs. By concluding with a straightforward assessment of the perceived strengths and weaknesses of government involvement in containing costs and promoting healthcare quality, we hope that it offers guidance to US policymakers, who will be grappling with – and ultimately defining the role of – the US government in ensuring healthcare value in the years ahead.

Karen Wolk Feinstein, PhD
President
Jewish Healthcare Foundation

INTRODUCTORY OVERVIEW: THE ROLE OF VARIOUS GOVERNMENTAL INSTITUTIONS IN ISRAELI HEALTHCARE ¹

The Knesset

Israel is a parliamentary democracy; thus it is the Knesset that ultimately determines laws and budgets. Since the mid-1990s, the Knesset has been very active in health-related legislation, passing such laws as the National Health Insurance (NHI) Law of 1995 and the Patients' Rights Law of 1996. The key Knesset committees relating to health are the Finance Committee, which prepares the annual budget for votes in the plenum, and the Labor, Welfare and Health Committee, which is formally charged with the leading role on health issues.

It is important to note that since the mid-1990s, much use has been made of the annual Budget Arrangements Bill, which accompanies the national budget, to move health and other social policy matters quickly through the Knesset in late December, as part of the annual budgeting process. This Bill is handled by the Finance Committee, rather than by the Labor, Welfare and Health Committee, and its use for substantive issues has come under increasing criticism on the part of Israel's social lobby.²

The Government

Executive power is in the hands of the government. After each round of parliamentary elections, the President (whose role is primarily ceremonial) asks the leader of the largest party to try to assemble a government (cabinet), which must secure and maintain majority support in the Knesset. This is done through the distribution of cabinet portfolios among the various coalition parties. Until the 1990s, the health portfolio was given to one of the smaller, less powerful parties, with the major parties preferring the more visible and powerful portfolios, such as Foreign Affairs, Finance, Defense and Education. The period from 1990 to 1994 was unique, as the Ministry of Health (MOH) was held by major players: first by one of the rising stars of the Likud Party and then by another in the Labor Party. This was a reflection of the growing salience of healthcare issues in Israel. Between 1995 and 2007, there were 11 ministers of health, some from the smaller parties and some second-tier figures from the dominant parties.

The government plays a role in healthcare at several critical junctures. First, while the Knesset ultimately must vote on the annual budget, it is the government that prepares and submits it. The Ministry of Finance (MOF) and its powerful Budget Division play a critical role in drafting the budget. However, the government ultimately determines what is proposed in the budget sent to the Knesset, and the political balance of power as well as the policy priorities of the government as a whole, invariably affect allocations to healthcare.

¹ This section has been excerpted with the permission of the European Observatory on Health Systems and Policies, from Rosen, B. and Samuel, H. 2009. "Israel Health System Review."

² The social lobby is a loose network of Knesset members and nongovernmental organizations, which seeks to advance legislation to promote equality and the well-being of low-income groups.

Similarly, the government plays an important role in the legislative process. While the Knesset will entertain private members' bills, in practice most legislation – and almost all major legislation – is submitted by the government. While the relevant ministry prepares the bill concerned, the government's Ministerial Committee on Legislation plays an important role. For example, in the case of the NHI Law, this was the place where a crucial compromise was reached, whereby the Minister of Finance agreed to support the bill on the condition that the Minister of Health would agree to various measures that would serve to control NHI expenditures.

The Ministry of Health

As in other countries, the MOH has overall responsibility for the health of the population and the effective functioning of the healthcare system. The Ministry is headed by the Minister of Health, who is a member of the government (cabinet) and who appoints a physician as director-general, the Ministry's senior healthcare professional.

Key functions of the MOH include:

- ❖ Planning and determining health priorities
- ❖ Drafting healthcare laws to be put before the Knesset and enacting regulations subsequent to primary legislation
- ❖ Providing adequate resources for the NHI system and other components of the healthcare system; promoting the effective use of resources within the healthcare system, including proposing the Ministry's annual budget for the Ministry of Finance and the government
- ❖ Monitoring and promoting population health
- ❖ Overseeing the operation of the Government's 11 acute care hospitals, 8 psychiatric hospitals and 5 chronic disease hospitals
- ❖ Monitoring and regulating the activities of nongovernmental actors in the healthcare system, including hospitals, health plans,³ various stand-alone diagnostic facilities and so on
- ❖ Regulating the healthcare professions⁴
- ❖ Preparing the healthcare system for various emergency situations, including terrorist attacks or military attacks with both conventional and non-conventional weapons.

In addition to all the usual planning, public health, regulatory and stewardship functions, Israel's Ministry of Health also plays a major role in the direct provision of care. It owns and operates almost half of the nation's acute hospital beds, approximately two-thirds of the psychiatric hospital beds and somewhat less than 10% of the chronic disease beds. In addition, it operates

³ The Ministry of Health is involved in primary care in part through its regulation of the health plans, and in part through a small unit involved in developing policy and strategic initiatives in primary care. However, primary care has not traditionally been a major focus of Ministry attention.

⁴ Part of this function is then delegated to the Scientific Council of the Israel Medical Association (IMA), which works closely with the Ministry on issues surrounding physician licensing and other key matters.

the majority of the nation's mother-and-child preventive health centers. This multiplicity of Ministry roles has long been recognized as one of the problems of the Israeli healthcare system.⁵

The MOH receives important input from various advisory bodies. These include the National Health Council, a statutory body established to advise the Minister of Health on implementation of the NHI Law, and a series of standing national councils on, for example, community medicine, oncology, cardiovascular disease and women's health – appointed to advise the director-general on both long-term goals and pressing issues requiring immediate policy response.

Other Key Government Bodies Involved in Health

- ❖ **The Ministry of Finance:** As noted, this is the agency of the executive branch that prepares the budget for approval by the cabinet and Knesset, and monitors its implementation. Historically, its Budget Division has also been a catalyst for major structural reforms in Israeli healthcare. In addition, the Ministry's Wages and Collective Bargaining Division is the lead government actor in negotiations with the healthcare labor unions. Its Finance and Capital Markets Division plays an important role in regulating the commercial insurance sector. Thus, the MOF has multiple, powerful points of influence over Israeli healthcare. As in other countries, the MOF is the key governmental actor that consistently seeks to limit public spending on healthcare, to constrain the construction of new healthcare facilities, to limit the number of employed physicians, and so on.
- ❖ **The National Insurance Institute (NII):** The NII collects the health tax, which plays a major role in financing the NHI system.
- ❖ **The Israel Defense Forces:** The IDF medical corps directly provides basic and emergency care for military personnel and purchases tertiary services from the civilian sector.

Political Parties

In theory, citizens can influence Israeli health policy through several major channels. The first is the political parties' primary elections and the Knesset elections themselves.⁶ However, throughout the history of the State, domestic issues in general and healthcare in particular have not figured prominently in election campaigns. One important exception was the 1992 general election campaign, in which the introduction of NHI and, to an even greater extent, the eradication of corruption in the Histadrut (the National Federation of Labor) and its separation from Clalit (Israel's largest health plan) constituted central campaign issues for Israel's two largest parties.

⁵ This problem was discussed thoroughly by the Netanyahu Commission, as well as by various other commissions prior to the setup of the Netanyahu Commission. Most senior managers within the government and the health plans concur with this assessment.

⁶ For other methods of citizen participation, see Rosen, B. and Samuel, H. 2009. "Israel Health System Review." Section 2.5 "Patient Empowerment."

It should be noted that the political parties had a substantial impact on health policy even during periods when it was not a central campaign issue.⁷ For many years, the Labor Party resisted efforts to eliminate the health plan system in favor of a unitary, government-run NHI system. They also successfully fought for government subsidies of the Histadrut-affiliated health plan (Clalit). Conversely, for decades the Revisionist parties, predecessors of the current Likud, used their political power to block any NHI legislation that would preserve the dominance of the Histadrut-affiliated health plan. The religious parties used their pivotal role in the political balance of power both to influence NHI legislation and to influence legislation on sensitive issues such as abortion and autopsies.

In recent years, most of the political parties have not sought to advance particular healthcare policies. An interesting exception was the Pensioners Party – a new party that surprised most political pundits by capturing 8 of the 120 seats in the Knesset in the 2006 elections. That party pushed, successfully, for various discounts in co-payments for the elderly. It also pushed, unsuccessfully, for the transfer of responsibility for long-term care from the government to the health plans.



MONOGRAPH TOPICS

1. What are the Nature, Extent and Impact of Political Involvement in Israeli Healthcare?

The main differences among political parties in Israel are in the areas of Arab-Israeli relations, religion-state issues, and to some extent, social/economic orientation. In recent years, it has been rare for the platform of an Israeli political party to take a clear stand on a controversial health policy issue. Exceptions have been when the short-lived Pensioners Party called for a major increase in funding for new medical technologies and when the ultra-orthodox Shas Party called for giving the poor greater relief from co-payments. Still, as Avi Israeli of the Hebrew University (and former director-general of the Ministry of Health) points out, on many of the major issues of healthcare policy, there is agreement among the key political parties, while most other issues in Israeli healthcare do not interest them.

At the same time, some Knesset members have made healthcare issues a focus of their parliamentary activities and sometimes challenge the government on sensitive issues. For example, MKs from the left side of the political spectrum played a major role in stopping the government's efforts to transfer the responsibility of mental health services and preventive mother-and-child health services from the Ministry of Health to the health plans. The Patients'

⁷ Since they are voluntary associations of citizens, political parties' actions can be considered a form of citizen participation.

Rights Law, one of the most important pieces of healthcare legislation in recent decades, began as a private member's bill, rather than as an MOH or government initiative.⁸

Note that in Israel's parliamentary democracy, all cabinet ministers, including the Minister of Health are politicians, almost always members of Knesset, and often also leaders of political parties. In recent years, most potential cabinet members have sought portfolios *other* than the health portfolio. Moreover, in the process of forming coalition governments, the health portfolio has usually been given to minor political parties. The turnover in this portfolio (as with many other portfolios) has been quite high – Israel had 15 different health ministers between 1990 and 2010. These factors are a reflection of the limited power and prestige of the Health Ministry and have adversely affected both further.

This was not always the case. In the early 1990s, two major Israeli political figures from the largest political parties sought positions in the Health Ministry and tried to use them to make major changes in the health system (i.e., the successful effort to pass a National Health Insurance law and the unsuccessful effort to transfer the government hospitals to private nonprofit status). Their tenure in the Ministry of Health constituted important milestones in their careers.

In the past, political parties as such were also more active in health policy. Clalit (then called Kupat Holim Clalit) was a subsidiary of the Histadrut Federation of Labor, which in turn had very close ties to the Labor Party. This, naturally, led the Labor Party to support various policies that favored Clalit and at the same time led to Likud Party opposition to those policies. The ties between Clalit, the Histadrut and Labor were broken in the mid-1990s, in part by the National Health Insurance Law's stipulation that health plans be apolitical and in part because Haim Ramon, then a leading figure in the Labor Party, engineered a split between the Histadrut and the Labor Party in order to increase the Labor Party's appeal among the voters.

The courts also have a significant influence on healthcare through their role in interpreting legislation. For example, the courts ruled that hospitals are required to share the proceedings and findings of internal risk-management processes with patients (usually in the context of medical negligence claims). The courts have also interpreted the laws on informed consent in a very broad manner.

Thus, while the Knesset determines the overall legal framework for the health system's operation and the cabinet determines the annual level of NHI funding, the political parties and the courts also have influence in certain areas. Still, most ongoing governmental decisions about the financing and operation of the health system are left to the senior professionals in the MOH and MOF, with the former having more influence on substantive healthcare issues and the latter having more influence on financial issues.

Sometimes, issues with significant substantive as well as financial dimensions are included in the annual Financial Arrangements Bill, the preparation of which is dominated by the MOF and

⁸ Most of the legislation passed by the Knesset begins as bills submitted by the government. Private members can also submit bills, but they face tougher procedural and political hurdles.

which is expedited by the fiscally-oriented Knesset Finance Committee, rather than the more socially-oriented Committee on Labor, Social Affairs and Health. This bill, which is passed at the end of each calendar year along with the budget, was originally designed to make legal/organizational changes needed to implement the new budget effectively. Most actors in the healthcare system, including the MOH, hospitals and providers, would prefer to see the use of this vehicle restricted to issues of a strictly (or at least predominantly) financial nature, in keeping with the original intent.

We asked several health policy experts for their analysis of the nature of political involvement in the Israeli health system.

David Chinitz, Associate Professor of Health Policy and Management at the Hebrew University, noted that interest groups do play a role in Israel, but believes that their influence on the democratic process seems to be more responsible and limited than in the US. He suggests that in Israel the influence of interest groups has been kept to appropriate levels in part because the governmental decision-making processes are generally seen as legitimate and accountable.

Chinitz also noted that one of Israel's great achievements is that, overall, the public understands and supports the roles that government currently plays in the healthcare system. He attributes this, in part, to the ways in which the policy/public discussions and key processes have been managed. According to Chinitz, another factor may have been a Jewish cultural tendency to define things (expressed in explicit decisions about how much money will be allocated to health, the content of the benefits package, etc.) These factors have perhaps made it possible in Israel to speak comfortably, even in public forums, about the need for budget constraints and prioritization, and to make distinctions between essential and non-essential services. It would be far more difficult to do so in the US.

Another Israeli health policy expert, Dr. Dan Greenberg of Ben-Gurion University, notes that another factor accounting for the greater public support for a major governmental role in Israel compared to the US, may be that a stronger social solidarity underlies Israeli society.

Yitzchak Berlovitz, the director-general of the MOH's Wolfson Hospital, suggests that another factor accounting for public engagement and support in Israel is that the original National Health Insurance Law left certain key policy determinations (such as the extent of the annual increase in financing to reflect demographic changes) open for subsequent decision-making, thereby creating space for ongoing public, policy and political discussions and engagement.

Finally, Sherry Glied, Professor of Health Economics at Columbia University, suggests that various structural factors, such as Israel's reliance on proportional rather than district representation in the legislature, may also play a role.

2. What are the Processes for Accrediting and Ongoing Cost and Quality Monitoring of Health Funds, Hospitals, Independent For-Profit and Nonprofit Healthcare Providers and Individual Clinicians?

2.1 Health Plans

- ❖ To qualify for recognition as a health plan, and thereby be eligible for National Health Insurance capitation payments, an organization must meet a variety of criteria stipulated in the NHI Law. These relate to the size of financial reserves, the number of members, and the availability of services throughout the country.⁹ No new health plans have been recognized since the introduction of NHI.¹⁰
- ❖ The MOH has a special unit to monitor the finances of the health plans. It works closely with several public accounting firms and together they publish annual reports detailing health plan revenues and expenses.
- ❖ All the health plans participate voluntarily in an MOH-sponsored program to monitor health plan quality, which, until recently, was implemented by a team from Ben-Gurion University. While national aggregate data are published, health plan-specific data are not. Moreover, plan-specific data are also not shared with the MOH.
- ❖ Certain types of community-based facilities, such as laboratories, outpatient surgery centers and dialysis centers, require Ministry of Health licenses, which are granted only if the facility meets the Ministry's quality standards.
- ❖ Israel does not have an NGO, similar to the US National Committee for Quality Assurance (NCQA), which accredits health plans, disease management programs, etc.

Note: Commercial insurance companies are regulated by the Commissioner of Insurance within the Ministry of Finance, not the Ministry of Health

2.2 Hospitals

- ❖ A license from the Ministry of Health is required to operate a hospital, irrespective of who owns it and whether it is public or private, and in general, the MOH has full discretion on whether to issue such licenses.¹¹ The license specifies the departments that the hospital is authorized to operate and the number of beds permitted in each department. Any changes require MOH approval.
- ❖ The MOH has numerous quality standards that hospitals must meet in order to receive and renew their licenses.

⁹ The Law also requires the health plans to have articles of incorporation that have been approved by the Minister of Health. To date, no such approvals have been granted, but this has not interfered with the ongoing operation of the health plans.

¹⁰ In recent years, there has been talk of establishing a fifth, privately owned, for-profit plan.

¹¹ A notable exception is that the Knesset passed a special bill requiring the MOH to facilitate the creation of a new hospital in the city of Ashdod, whereas the professionals in the MOH had determined that there was not sufficient need for such a hospital.

- ❖ More and more of Israel's 46 general hospitals are working on voluntary Joint Commission International (JCI) accreditation. Three Clalit hospitals already have JCI accreditation and another three are working with JCI towards accreditation. In early 2010, five MOH hospitals began working towards JCI accreditation.

2.3 Individual Practitioners

- ❖ Licenses are required to practice medicine, nursing and an increasing number of other healthcare professions. The MOH has sole prerogative to grant these licenses.
- ❖ Israel does not have any re-registration or recertification requirements, though there is increasing talk of instituting re-registration.
- ❖ Graduates of Israeli medical schools are granted a medical license upon graduation. Foreign graduates must pass an exam administered by the Ministry of Health and the Scientific Council of the Israel Medical Association (IMA)¹² in order to secure a license, unless they have at least 14 years of work experience abroad.
- ❖ The IMA's Scientific Council, in cooperation with the Ministry of Health and the appropriate specialty societies, handles board certification. Typically, residents take their specialty exams in two stages, with the first stage (a written exam) taken after half the residency has been completed and the second (an oral exam, including a simulation exercise) is taken toward the end of the residency or after its completion.
- ❖ Until 2005, most paramedical professions were regulated solely through a certificate of recognition issued by the Ministry of Health. In 2005, following an appeal to the High Court of Justice, the issuing of such certificates was abolished until and unless the professions become regulated by law.
- ❖ The Knesset recently passed the Regulation of the Practice of Health Professions Law, which stated that all physiotherapists, occupational therapists, speech therapists and dieticians must be licensed in order to practice their professions. The new licensing procedure includes a national exam.
- ❖ Currently, there is a bill in the Knesset Labor, Welfare and Health Committee to expand this law to two additional professions – podiatry and clinical criminology.

¹² While the Scientific Council administers the licensure exam, it is the MOH that has overall responsibility for the exam – its content, structure, grading, etc. In contrast, the Scientific Council has overall responsibility for the specialty certification exams.

3. How is the Overall Budget for Services Provided by the National Health Insurance Law Set?

- ❖ Each year the Government determines the level at which the NHI system will be funded.¹³ The officially determined NHI funding level is financed predominantly from public sources. The remainder comes from private sources, through cost sharing.¹⁴
- ❖ The starting point for government deliberations on the NHI system's funding level for the forthcoming year is the current year's funding level (determined by the government in the prior year). There is an automatic adjustment for changes in healthcare prices (determined by a formula). In addition, the NHI Law mandates annual adjustments to reflect demographic growth, aging, enhanced efficiency and technological advances. However, the size of these adjustments are not determined by a formula, and are instead determined through negotiations between the Ministries of Health and Finance, with the prime minister and other ministers/political parties sometimes getting involved.
- ❖ Ultimately, the budget allocated to health in any given year will be influenced both by the size of the overall government budget and the share of that budget allocated to health. The former will be influenced by Israel's macroeconomic and security situation as well as the government's attitude toward deficit spending. The share of the budget allocated to healthcare will depend on the governmental leadership's perception of the needs in health vs. other areas of government activity and the priority it gives to addressing those competing needs.
- ❖ Note that the government's share in financing Israel's national health expenditure has declined steadily over time, with the role of private financing increasing commensurately. The share of private financing (44%) is still lower than in the US, but the gap is closing.

Table 1: Annual Adjustment to the "Cost of the Benefits Package" (%)

Year	Price adjustment	Demographic adjustment	Technology adjustment	Miscellaneous adjustment
2001	2.1	2.0	1.0	
2002	0.7	1.8	0.7	0.9
2003	-1.9	1.8	0.1	0.2
2004	2.2	1.8	0.2	
2005	1.5	1.1	1.2	-0.4
2006	2.5	1.1	1.9	
2007	1.6	1.1	1.5	-0.6
2008				
2009				

¹³ These monies are then distributed among the health plans according to a capitation formula. It is the health plans' responsibility to provide the full benefits package stipulated by the NHI Law without exceeding their revenues from the capitation and authorized co-payments. In that sense, NHI creates a hard budget cap, not only for the health system as a whole, but for the individual health plans as well.

¹⁴ This is aside from services provided outside the NHI framework completely. Those fully private services are financed through supplemental insurance programs and/or through out-of-pocket payments.

4. What Impact does the Government's Role in Manpower Development and Regulation (e.g., Controlling the Supply of Key Physical and Manpower Inputs; Influencing Wage Levels) have on Containing Costs and Quality?

Physicians

- ❖ Planners and policymakers have a number of tools at their disposal to influence workforce numbers. These include regulation of: the number and size of Israeli medical schools;¹⁵ the amount of assistance given to new immigrants to help them pass licensure examinations; the number and size of residency programs approved; and the provision of financial support for residencies and teaching.
- ❖ In recent years, the MOH has been increasingly active in preparing projections of manpower supply and, to some extent, manpower needs as well. These projections influence how the MOH and other key actors employ the various policy tools listed above.¹⁶
- ❖ If a university wants to establish or expand a medical school, it must receive authorization from the Council of Higher Education (CHE), the public corporation that sets policy for higher education in the country and licenses/accredits all universities and colleges. The Council is independent, but its decisions are influenced by the MOH and the Ministry's perceptions of future needs. In recent years, the MOH has been increasingly active in preparing projections of manpower supply, and, to some extent, manpower needs as well. The MOF also has a major say, as most of higher education is publicly funded.
- ❖ Most residency slots are funded by the hospitals out of their regular operating revenues, although there is sometimes special government funding for a certain number of slots. This occurred in the early/mid-1990s in an effort to encourage employment of large numbers of immigrant physicians, arriving primarily from the former Soviet Union.
- ❖ From 1995–2000, the government provided some funding for family residency training in community settings, but unlike several other developed countries, it provides no such funding today. The financing for these slots comes almost exclusively from the health plans.

Nurses

- ❖ The Ministry of Health sets the required curriculum for all of the training programs for nurses. All the BA programs must also be approved by the CHE.
- ❖ Over the past decade, the MOH has sought to phase out the hospital-based nursing schools that offer diplomas after three years of study, in favor of university-based programs offering BAs after four years of study. Only a few diploma programs remain, but the effort to discontinue them has been put on hold recently, in light of a growing nursing shortage. In

¹⁵ The government recently decided to establish a fifth medical school, to be located in the medically underserved northern region.

¹⁶ Israel historically had a relatively high physician/population ratio, in part due to the immigration of large number of physicians trained abroad. However, it is now facing a projected physician shortage, as the immigration of physicians has tapered off and Israeli medical schools have not expanded commensurately.

addition, the MOH has begun to offer significant tuition assistance to persons with BAs in non-nursing fields who enroll in BA programs to retrain as nurses.

- ❖ The MOH also offers certification of advanced training in particular areas of nursing care.
- ❖ Government also influences the markets for the health professions through legislation and/or administrative directives defining their scope of practice. The MOH recently expanded the scope of nursing practice to enable nurses to prescribe a very wide range of medications and giving them substantial autonomy in the area of palliative care. The scope of this expansion in some areas was scaled back due to opposition from the IMA.

General

- ❖ Yet another way for government to influence the healthcare labor markets is via its influence on wages and working conditions. These are set primarily through collective bargaining agreements between the major employers (the government, Clalit and Hadassah) and the employee unions (such as the IMA and the Israel Nurses Association). The government is represented in these negotiations by the Wages Unit of the Ministry of Finance, which in turn is influenced by both the MOH and the MOF leaderships. It should come as no surprise that the MOH and MOF often do not see eye-to-eye on these matters, with the MOH more willing to grant increases to the healthcare professionals. The MOF's resistance is motivated not only by a desire to constrain healthcare costs, but also out of concern for spillover effects on wages and working conditions in other areas of public service.¹⁷
- ❖ Aside from influencing overall wage levels, the collective bargaining efforts also present an opportunity to use financial incentives to channel professionals into particular, understaffed specialties or geographic areas. Some use has been made of this opportunity (such as special payments for anesthesiologists), but it has not yet become a major tool of public policy.
- ❖ The government has been more lenient with physicians than with other categories of public employees in allowing after-hours work in private settings.

5. What is the Government's Role in Establishing and Safeguarding Universal Entitlement to Efficient, Equitable and Quality Care?

The National Health Insurance Law confers universal entitlement to health insurance and healthcare on all citizens and permanent residents of the State of Israel. They exercise this entitlement by enrolling in any of the four health plans, which are required by the law to provide all their members with access to a wide range of specified health services, and to do so under conditions of reasonable accessibility and timeliness.

¹⁷ For example, the generous wage increase given to the physicians in 1994 was followed by a wave of demands for similar increases from other public sector unions.

This entitlement is backed up with public funding. The government provides each health plan with capitation payments¹⁸ that are supposed to be set at a level that will enable the plans to provide the services included in the benefits package stipulated by the NHI Law. However, some healthcare analysts contend that the level of public financing has eroded over time, making it difficult, if not impossible, for the health plans to meet these obligations.

In addition to stipulating what the health plans are required to do, the government also helps individuals secure their rights vis-à-vis the health plans. One of the major vehicles for doing so is the Ministry of Health's Office for the Supervision of Health Plans, which supervises the health plans' activities in such areas as co-payment levels and supplemental insurance programs, and also monitors their finances.

Another significant vehicle for ensuring health plan compliance with their obligations is the Ministry of Health's Ombudsman for the National Health Insurance Law. Individuals who feel that the health plans are not providing them with services due them under the NHI Law, or who feel that they have faced inappropriate barriers when attempting to switch health plans, can file a complaint with the ombudsman.¹⁹ In 2008, approximately 9,000 such complaints were filed and about a quarter of them were assessed as justified.

The ombudsman's office responds to these complaints at two levels. First, it investigates each complaint per se, collecting relevant information from the individual, the health plan, and sometimes, also from additional parties (such as a hospital involved in the case). If the complaint is deemed justified, the ombudsman can demand that the health plan take remedial action, though often matters are resolved on a voluntary basis. If the plan fails to take the remedial action that the ombudsman has demanded, the ombudsman can provide financial compensation directly to the complainant and then deduct the amount from the government's next capitation payment to the health plan.

In addition to addressing each complaint per se, the ombudsman seeks to identify recurrent issues requiring action that is more systematic. This sometimes takes the form of an MOH administrative directive, while at other times legislation is required. To promote public awareness of these issues and of its work, the ombudsman's office publishes an annual report that contains both statistical analyses of the subjects of the complaints as well as various anonymous case studies. For example, the ombudsman has ruled on the range of indications for which patients are entitled to receive from their health plans prescriptions for certain medications that have been added to the benefits package.

¹⁸ The capitation formula currently includes only an age parameter. There are ongoing discussions about whether to add additional parameters such as location or socioeconomic status, to better reflect differences in risk across individuals and health plans.

¹⁹ In addition, each health plan is required to appoint its own ombudsman. Aggrieved individuals have the choice of addressing their complaints to their health plan's own ombudsman, the MOH's ombudsman, the state comptroller or to the court system.

The courts also play an important role in ensuring that the health plans provide their members with the services to which they are entitled by law. Cases related to NHI are adjudicated in the labor courts, which are relatively accessible to the individual citizen.

Dr. Ran Balicer, Director of Medical Policy at Clalit Health Services, has pointed out that the government contributes to key health system objectives both by intervening when needed, and by not intervening when that is the appropriate course of action. He notes that it is important that government recognize that when things are functioning well and non-governmental actors are acting in the public interest, government intervention can be detrimental. As an example, he cites the major – and voluntary - health plan efforts to improve quality of care, and his concerns that government intervention - such as mandating public reporting - could undermine these efforts.

Dr. Carmel Shalev, of Tel Aviv University, notes that the establishment and growth of co-payments for certain services have eroded access to care, negate the nature of the entitlement, and constitute an issue to which government should respond. She notes that this has been particularly problematic with regard to institutional long-term care services, where there is no general entitlement, but rather a program of means-tested public subsidies.

6. How has Israel been Able to Hold the Health Plans Accountable for Quality and Costs? (How has Israel Avoided the Challenges and Perceived Abuses of Health Plans that Virtually Eliminated them in US?) What Role have Incentives Played?

This section has benefited from insights provided by Tuvia Horev, deputy director-general of the Ministry of Health.

- ❖ Even prior to the introduction of NHI, health plans felt some competitive pressure to control costs, so as not to lose members to competing health plans. However, this pressure was blunted in several ways. First of all, some of the health plans (particularly Clalit) had a long tradition of incurring deficits and then receiving government bailouts. Second, membership in Clalit was bundled in with membership in the Histadrut labor federation and a large portion of the population worked in places where Histadrut membership was a condition of employment; hence, many Clalit members were locked in to that plan. Third, health plans that catered primarily to upper-income persons (i.e., Maccabi and Meuhedet) generally felt that they had significant leeway to pass on increased costs to their members. For many of the members, those increases were small enough, relative to their incomes, that loyalty to a particular physician or to the health plan, combined with inertia, prevented them from switching plans. Those plans also had another way to address cost increases; they could engage in cream skinning to avoid sicker or older patients and could target higher-income patients as members (even prior to NHI higher income persons paid higher premiums).
- ❖ The introduction of NHI increased the competitive pressures on the health plans by removing many of these barriers. The law made it clear that age of bailouts had ended. It broke the link between Clalit membership and Histadrut membership. By replacing the collection of premiums by each health plan with centralized collection of the health tax along with a

capitation formula for distributing those monies, it also broke the link between members' incomes and health plan revenues. In addition, it required all plans to accept all applicants.

- ❖ One way of looking at this is that, prior to NHI, cost containment relied on competition on price in a highly imperfect market. Following implementation of NHI, cost containment relied on global budgets dependent only on the number of members and their ages. Under the new regime, health plans still have an incentive to increase membership (through better service), as marginal revenues somewhat exceed marginal costs, but at the same time, they feel strong pressure to improve efficiency in order to live within the global budget. In the early years of NHI, this was felt particularly strongly in Maccabi and Meuhedet, as the introduction of NHI brought about a major shift of monies from them to Clalit and Leumit (which had older and poorer members). Today, all the plans appear to feel the cost pressures to a similar extent.
- ❖ These enhanced cost pressures led all the plans to seriously review their way of organizing and providing care. Many new models of care were introduced and vendors (such as drug companies) were pressured to reduce prices. Toward this end, one of the most significant steps taken by the plans was making major investments in information systems, largely in order to monitor utilization of the plan as a whole and its organizational subunits. Other important steps included greater decentralization of the health plans, along with the development of mechanisms to monitor the performance of the decentralized units.
- ❖ As noted above, the health plans continued to have a financial incentive to grow, as marginal revenues exceed marginal costs. Sociological and organizational incentives also played a role, as no organization likes to have to downscale and lay off employees. As a result of this incentive to grow, health plans sought to improve service to their members. Member satisfaction is monitored periodically by the Myers-JDC-Brookdale Institute, which shares its survey findings – by health plan – with the general public. When choosing a health plan, individuals can draw on the survey findings along with their own experience and that of their families and friends.
- ❖ All health plans are required to file audited financial reports with the MOH, in a format that facilitates both regulation and inter-plan comparisons. This vehicle has contributed greatly to the government's regulatory efforts and to health plan managers' efforts to increase efficiency.
- ❖ The matter of the impetus to improve clinical quality is more complicated than that of cost and member satisfaction. Here, a number of factors seem to have come together. Two key enabling factors were the development of quality indicators by a group of university-based researchers and the health plans' massive investment in computerization (originally motivated primarily by the utilization management and cost containment pressures). The main motivating factors appear to have been a sincere professional/organizational commitment to improve health and the concern that, at some future stage, comparative data on quality would be shared with the public and would become a factor in the public's choices among health plans.

- ❖ Interestingly, the health plans' efforts to control costs did not run into the backlash that confronted US health plans in the 1990s. There may be several explanations for this. First of all, in Israel everyone is, and always has been, enrolled in managed care and is accustomed to constraints on choice of provider, choice of diagnostic procedure, and choice of treatment. Second, the alignment of incentives between Israeli health plans and their physicians is very strong,²⁰ while in the US this varies among HMOs, depending on the type of plan, its history and culture, and the extent to which physicians work with more than one insurer. Finally, the existence in Israel of a highly visible annual process for adding new monies into the system and expanding the benefits package may soften the sense of capped expenses and a nefarious "them."

7. How Does the Government's Role in Direct Service Provision Impact on Costs and Quality?

This issue arises most frequently and most strongly with regard to the acute care hospitals owned by the government, which account for about half of the bed capacity.

This situation could affect cost and quality in at least three different ways: 1) It could influence the way government sets overall healthcare policy, particularly in areas where the interest of the hospitals differs from that of the health plans; 2) It could influence how government allocates various resources among hospitals; 3) It could affect the manner in which the hospitals are run at the operational level.

At the policy level, some observers believe that because it owns hospitals, the MOH gives more weight to the needs and preferences of their own hospitals than to those of the health plans.²¹ Other observers contend, to the contrary, that due to fear of such accusations, MOH actually bends over backwards to favor health plan concerns. In either case, any such bias could affect decisions on such issues as the fee structure, the extent to which health plans can channel patients to particular hospitals, and the extent to which hospitals are required to share patient care data with the health plans.

Government ownership of hospitals could also influence its decisions about which hospitals are authorized to add beds or new departments, as well as how special funds are distributed for such items as new construction, response to national emergencies, etc. Here, too, there are different views on the extent and direction of the possible bias. Dr. Rachel Nissanholtz, of the Myers-JDC-Brookdale Institute, points out that the publicly transparent nature of many of the relevant processes and Knesset oversight limit the extent to which the decisions can be biased.

At the operational level, some observers have claimed that government ownership makes a hospital less efficient. They point to the civil service regulations and the tender regulations that

²⁰ With most physicians paid on a salaried or capitation basis, they, like the health plans, do not have an interest in encouraging unnecessary utilization.

²¹ For example, the MOH makes direct capital grants for construction and renovation to government hospitals, but not to other hospitals.

limit the flexibility of all government managers, including those running government hospitals. In addition, they claim that because they are part of larger hierarchical organizations, directors of government hospitals cannot make important, on-the-spot decisions on their own, and instead must work through the MOH bureaucracy.

At present, there are no publicly available data for systematically comparing cost or quality across hospitals or hospital ownership groups. It is possible that several years from now the new hospital quality monitoring initiative will generate comparative quality data.

Because of these concerns, over the past two decades there have been repeated attempts to transfer the government hospitals to non-governmental ownership. These have not succeeded, but there has been a steady and significant devolution of authority from the MOH headquarters to the managements of the individual government hospitals.

Another area where issues have arisen with regard to the impact of the government's role on quality and costs concerns well-baby centers.²² Currently 60% of Israeli babies receive preventive healthcare in MOH centers, 20% in centers run by health plans and another 20% in centers run by the municipalities of Tel Aviv and Jerusalem. Several years ago, the Ministry of Finance promoted a policy of transferring the MOH centers to the health plans. Several arguments in favor of the transfer were put forward, including that it would improve links between preventive and curative care. There were also many counter arguments, including the contention that the health plans would not give adequate attention to prevention and the quality of care would suffer. There was also a claim that costs would rise due to duplication – four facilities in each area instead of one. The MOH's public health service (PHS) strongly opposed the proposed transfer, emphasizing a projected deleterious impact on the health of the newborns. Some outside observers contend that the PHS was also motivated by self-interest – to preserve its direct control of this service and the many positions involved, a charge that the PHS leadership of that period vehemently denies.

A third area where the issue has arisen is with regard to community-based mental health services. This was traditionally an area in which governmental directly provided most of the services, although the health plans also developed some service provision capacity (particularly Clalit, which operated a network of community-based multidisciplinary clinics, as well as three major psychiatric hospitals). For many years, both the MOH and the MOF have sought, unsuccessfully, to transfer this responsibility to the health plans. The main arguments in favor are improved integration between physical and mental healthcare and improved efficiency. The main counterargument is that the health plans will not give sufficient attention to the needs of the seriously ill.²³

²² In Israel, preventive well-baby services, such as immunizations and developmental tests, are carried out in nurse-led mother-and-child centers, which operate separately from the health plan pediatricians.

²³ Of course, aside from these sorts of rational, public policy arguments, political factors also play a role. One such major factor is the opposition of certain employee unions to the devolution of service provision from the government to private, nonprofit organizations.

It is noteworthy that in recent years the government budget for both mother-and-child services and mental health services has declined. Many MOH professionals and some outside observers contend that the MOF has deliberately cut government funding for these services, in order to create pressure to transfer them to non-governmental hands. MOF professionals and other observers respond that responsibility lies with the MOH that has substantially autonomy on how to divide its own budget. Another factor may be that all involved were hesitant to invest in the government services (particularly buildings and computers) given the possibility that they might soon be closed down or transferred.

With regard to services for the elderly, a somewhat different issue has been raised. The concern is not so much that government should not be providing care, but that the responsibility for care provision is divided between a large number of governmental and non-governmental entities. This has made it difficult to ensure continuity of care and to ensure that the frail elderly are in the setting most appropriate to their current level of functioning. In some ways, it might be better if all the care were provided by government or, alternatively, if none were provided by government. As the system is unlikely to move to either of those poles in the foreseeable future, there remains the challenge of ensuring continuity across a large number of providers that are from different sectors.

8. What are the Implications of the Process of Prioritizing Resources within the Global Budget (including Allocations to Services, Technologies and Devices and Capital Infrastructure) for Cost Containment and for Quality of Patient Care?

Each year, the government determines how much money will be available for the basic benefits package under NHI and then distributes the monies to the health plans according to a capitation formula. The health plans are obligated to provide all the services in the benefits packaged prescribed by the NHI law. Thus, the government determines for the health plans both what services they must provide and how much money they will have to provide them. It leaves to the plans the task how best to organize the care in order to provide those services as effectively as possible, given the budget constraint. The consensus in Israel is that this has mobilized the health plans to seek out ways to provide care as efficiently as possible. At the same time, because there is competition with other plans over members, they are motivated to provide the services in a manner that inspires loyalty among existing members and that can attract new members.

Each year, the government also determines how much additional money will be allocated to the healthcare system to finance new technologies. The health system then, through a combination of in-depth staff work and a broadly representative public advisory council, prioritizes new technologies and determines which will be funded. The consensus in Israel is that, generally speaking, this has resulted in the channeling of resources to those technologies that are most appropriate in terms of cost effectiveness and societal values and preferences.

Some health system observers are concerned that, while having only one major financial spigot has made it easier to encourage efficiency and prioritization, it has also made it easier for the Ministry of Finance and the cabinet to gradually reduce the share of public financing in healthcare. They contend that this has adversely impacted not only quality of care overall, but

has also contributed to healthcare disparities, as it is more feasible for higher-income persons than others to pursue private alternatives.

9. How is the Appropriate and Cost-Effective Use of Pharmaceutical and Technology Vendors Encouraged?

The main way in which the Israeli government advances these objectives is by creating appropriate incentives for hospitals and health plans, through the use of health plan global budgets and hospital revenue caps. Those organizations then develop their own mechanisms (rules and incentives, supported by information systems) for ensuring that sub-units (hospital departments and health plan regions) and individual healthcare professionals also act accordingly. Additional governmental mechanisms currently in use in Israel include:

- ❖ A well-developed process for determining which new pharmaceuticals and other technologies will be added to the health plan benefits package²⁴ each year, based on considerations of expected benefit and cost.²⁵ (However, full-scale cost-effectiveness analyses are usually not considered, mainly because of lack of data.)
- ❖ An imperfect certificate of need process for determining how many units of very expensive new technologies (such as CTs, MRIs and radiation oncology devices) can be purchased in Israel and who will be authorized to purchase them, as well as who is authorized to establish certain types of very complex or expensive units, such as transplant units
- ❖ Setting the maximum prices at which hospitals can sell specific services
- ❖ Fostering a legal and societal context that supports the use of generic alternatives to high-cost medications.

Note that, despite all the above, there exist significant inter-regional disparities in the availability of expensive diagnostic and therapeutic devices. Further, in some areas, such as genetic testing and medically assisted reproduction, regulation lags behind the dynamic developments in the field.

10. What is the Influence of Device and Pharmaceutical Manufacturers in the Selection of Covered Drugs and Technologies and how is Such Influence Minimized or Managed?

In the process of prioritizing new technologies for inclusion in the benefits package, manufacturers try to promote their products via several mechanisms, including:

- ❖ Submitting highly professional dossiers to the MOH staff unit that reviews the new technology proposals
- ❖ Incorporating into those submissions conservative estimates of the number of potential users of the new technology, and of the future budgetary impact

²⁴ The government does not set a benefits package for the hospitals and each hospital is free to determine its own benefits package, including its own drug formulary.

²⁵ I am indebted to Professor David Chinitz of the Hebrew University for this point.

- ❖ Directly lobbying the members of the Benefits Package Public Commission, (the commission that recommends to the Minister of Health and the government which medications and other new technologies will be added to the NHI benefits package each year)
- ❖ Providing financial support to relevant patient disease associations (advocacy groups) who, in turn, lobby commission members
- ❖ Providing financial support to relevant clinical trials, other research efforts and medical conferences
- ❖ Providing financial support to medical societies or specific doctors preparing expert opinions regard new drugs or devices being considered for addition to the benefits package.

Most experts consulted for this monograph feel that nonetheless, the extent of inappropriate manufacturer influence on commission decisions is limited (as distinguished from appropriate influence via submissions that accurately spell out important new benefits). Contributing factors include:

- ❖ The structure of the public commission, as neither the manufacturers nor the patient disease associations have a seat at the table
- ❖ The strength of the professional staff that supports the commission's work and that can provide independent and high-quality assessments of the claims made in manufacturers' submissions
- ❖ The high degree of public trust that the process has earned over the decade of its existence
- ❖ The relatively small size of the Israeli pharmaceutical market makes it much less of a priority for the large Pharma companies than the huge American market
- ❖ In contrast, the Israeli generics industry is very well developed, and it provides a major counterweight to Pharma interests in Israeli public policy.
- ❖ A legal covenant between the IMA and the Pharma companies,²⁶ which puts limits on the nature of the interactions between the companies and physicians, as well as the health system more generally.

11. What is the Role of the Government in Making the Markets Work in the Public Interest (Efficiently and Equitably)?

11.1 The Health Plan Market

The government has taken a large number of steps to promote equity and efficiency in the health plan market. Some of these steps were part of the 1995 NHI legislation, including:

- ❖ Guaranteeing universal access
- ❖ Setting minimum standards for recognition as a health plan (see section 2.1 above)

²⁶ *The Social Treaty between IMA and Pharmaceutical Companies in Israel*. 2004.
<http://www.ima.org.il/Ima/FormStorage/Type3/emda87.pdf> (Hebrew).

- ❖ Stipulating complete freedom of choice among health plans; requiring that health plans accept all applications, without any exclusions related to pre-existing conditions; making it easy to switch plans by submitting a simple form at any local post office. These actions make it difficult – and, effectively, illegal – to cream skim.
- ❖ Funding the care provided by the health plans via capitation payments that reflect the difference in healthcare utilization among age groups. This reduces the incentive to cream skim.
- ❖ Specifying the benefits package available through NHI, and ensuring that that package is broad and up-to-date
- ❖ Establishing co-payment exemptions, discounts and ceilings for various vulnerable groups
- ❖ Requiring health plans to publicize their arrangements and constraints regarding patient choice among providers.

The government also contributes to effective functioning of the healthcare market by promoting the collection and distribution of information relevant to both consumers and providers. These include providing financial support for the Myers-JDC-Brookdale biennial survey of health plan members and establishing a unit within the MOH to monitor and publicize information on health plan revenues and expenses.

11.2 The Supplemental Insurance Market²⁷

Supplemental insurance is offered by the health plans to consumers on a voluntary basis and is fully funded by premiums paid by the consumers. The government has contributed to the effective and equitable functioning of this market by specifying that here, too, the health plans must accept all applicants without excluding pre-existing conditions or charging higher premiums to those with such conditions. The premium levels may not reflect any risk factor other than age.

The government has also taken various measures to make it easier to switch supplemental insurance programs when switching health plans, such as by reducing/eliminating waiting periods. Essentially, when switching plans, the individual carries with him the eligibility accrued with the prior plan.

The government also regulates which services can be included in the supplemental insurance packages. For example, they are not allowed to cover co-payments for services in the basic package, life-saving drugs or long-term care services. In addition, these packages are not allowed to provide cash indemnities in case of illness, but rather must provide coverage for services actually provided.

²⁷ This section focuses on the supplemental insurance packages offered by the health plans and regulated by the Ministry of Health. The commercial insurance policies offered by the commercial insurance companies are regulated by the Insurance Commissioner in the Ministry of Finance, and there the focus is primarily on financial viability and ensuring that consumers are given fair information to make informed choices; broader health or equity concerns are less emphasized.

11.3 The Hospital Market

The government contributes to the functioning of this market by:

- ❖ Establishing quality standards for hospital licensure
- ❖ Constraining the construction of new hospitals and new beds as well as the purchase of very expensive equipment
- ❖ Setting maximum prices for key hospital services as well as overall hospital revenue caps
- ❖ Monitoring volume purchase contracts between hospitals and health plans and ensuring that they are consistent with the public interest
- ❖ Limiting the extent to which health plans can channel patients to particular hospitals when patients prefer to go to a hospital closer to their home or with which they have an existing relationship.
- ❖ Limiting the extent to which health plans may make use of for-profit hospitals.

11.4 The Market for Physicians

- ❖ Governmental licensure regulations, along with governmental disciplinary procedures, help insure the quality of the physicians.
- ❖ As discussed in Section 4, government plays a role in regulating the quantity of physicians trained in Israel.
- ❖ Government, along with the other large employers, plays a major role in determining the collective bargaining agreement with the IMA, and hence has a significant influence on physician wage levels.

In addition to regulating markets, the government also has a clear role as a direct provider in the Israeli healthcare system. It operates about half of the nation's acute care beds and is also an important provider of psychiatric care, mental healthcare, and well-baby care. Many of these roles are historical and, as mentioned above, there are ongoing discussions about whether and when to transfer some services to the health plans. The government also provides health services to citizens serving in the military.

12. Concluding Thoughts and Observations

Rather than ending with a summary or a single definitive conclusion, we have chosen to end this paper with a series of concluding thoughts and observations. These have been grouped into the following categories:

1. The strengths and weaknesses of the role of government in Israeli healthcare
2. Contextual factors that facilitate or hinder that role
3. Changes over time in the role of government
4. Government's role in promoting regulation and competition.

12.1 The Strengths and Weaknesses of the Role of Government in Israeli Healthcare

In Israel, government is intensively involved in structuring, financing and regulating healthcare. The strengths of that involvement have been in the areas of ensuring universal coverage, cost containment, priority setting, emergency planning and response (as in times of war), and responding to macro-societal needs (such as immigrant absorption). Weaknesses have been evident in the difficulties in implementing major structural changes (aside from NHI), the slow movement toward a national medical record, the decline in public funding for healthcare, and insufficient investment and development in the public health arena.

In Israeli healthcare, there is a consensus that government should be the leader and the final arbiter on many issues, but it should not be, and is not, all-powerful. Power is shared with health plans, hospitals, and others, but not in a way that is debilitating. There are stalemates on some issues, but this is not the general situation.

Some in Israel have argued that the MOH's ability to serve as a planner and regulator have been hampered by its significant role as a provider of services (particularly hospital services). While there is some truth to that, my own reading of the situation is that this has been overstated.

On the other hand, a different tradeoff may be in place. There is a broad consensus in Israel that government has responsibility both for health of the population and the overall functioning of the healthcare system. At least in comparison with the US, Israel appears to be putting more resources into the latter (i.e., stewardship of the healthcare system) and less into the former (public health and population health). The lesser investment in the latter appears to be due more to limited resources (both money and executive attention) than to any principled reservations about an intensive public health role for government.

12.2 Contextual Factors that Facilitate or Hinder that Role

Contextual factors influencing the ability of any government to steer the healthcare system include public attitudes, the size of the country, the system of government and the nature of the healthcare system. We shall consider each of these in turn.

Government involvement in Israeli healthcare (including even the need to ration and prioritize) is facilitated by broad public support for an active governmental role. This stems in part from the long-standing (indeed since the founding of the State) ethos that government has a vital role to play in promoting the well-being of the population, and transcends well beyond healthcare. It has also benefited from the successful effort to communicate to the public why government needs to be involved in healthcare and the fact that its major decisions have been appropriate. The fact that Israel has an integrated, universal system of care financed largely via government also lends legitimacy to government initiatives to shape the care delivery system.

Israel's relatively small size certainly has a major effect on the role of government. On the one hand, it leads to a situation where senior governmental officials have personal relationships with the CEOs of all the health plans, hospitals, professional associations, etc. This undoubtedly facilitates communications and concerted action. On the other hand, small countries and big

countries face the same set of major policy issues, while smaller countries must address them with fewer resources. This leads to a situation where resources for planning and policy development are spread thin.

The overall system of government clearly has implications for how government plays a role in healthcare. In the case of Israel, there is a parliamentary democracy with coalition governments; this sometimes makes it more difficult to reach a consensus within the government, but once such a consensus is reached it is easier to secure legislative endorsement.

The nature of the healthcare system itself also affects government's ability to shape health policy. When the healthcare system is largely integrated (as it is in Israel), rather than fragmented (as is the case in the US), it is more natural to expect government involvement and it is also simpler and easier to implement specific interventions.

12.3 Changes over Time in the Role of Government

The nature and extent of government's role in the Israeli health system are dynamic and change over time. An important watershed was the passage of the NHI Law, which not only gave the government additional specific responsibilities, but also cast it more clearly as have an overall (and fairly open-ended) responsibility for health system functioning.

The level of professionalism in the MOH has improved dramatically over the past twenty years, as reflected in both the training of key staff and the number of highly effective, specialized regulator/planning units. This has led to both improved planning (e.g., manpower planning) and improved regulation (e.g., regulation of health plan finances).

It is important to remember that there was a period, prior to the introduction to NHI, when government involvement in healthcare was viewed as politicized and hence problematic. The NHI Law addressed this politicization by structuring and rationalizing the nature of government involvement.

12.4 Government's Role in Promoting Regulation and Competition

Active regulation on the part of government has not undermined the role of non-governmental providers nor vitiated their energy and initiative. Rather, it has channeled those energies. It has allowed the private providers to develop into their own best selves. Examples include the restrictions on advertising and adverse selection (which focused competitive energies on service and quality improvement), and the development of quality monitoring mechanisms (which gave the health plans additional tools for quality improvement).

Thus, an important part of what government does in Israeli healthcare is to promote competition and ensure the efficient structure and functioning of various markets (particularly the health plan market). Hence, it is not always a choice between reliance on government or on markets; in some ways they can reinforce one another.



APPENDIX: SUMMARY OF ROUNDTABLE DISCUSSION ON THE ROLE OF GOVERNMENT IN CONTROLLING COSTS AND PROMOTING QUALITY IN ISRAELI HEALTHCARE (October 11, 2009)

Participants²⁸

- ❖ Dr. Ran Balicer
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- ❖ Ms. Malke Borrow
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Israel Medical Association
- ❖ Professor David Chinitz
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- ❖ Dr. Tuvia Horev
Deputy Director-General
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- ❖ Professor Avi Israeli
Professor of Health Policy and Management
Hebrew University
- ❖ Professor Gur Ofer
Professor (emeritus) of Economics
Hebrew University
- ❖ Dr. Bruce Rosen
Director, Smokler Center for Health Policy Research
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Introduction and Opening Comments by Participants

Bruce Rosen opened the meeting by providing background on the Pittsburgh-based Jewish Healthcare Foundation, its interest in learning from Israeli healthcare, and the four monographs that it has commissioned from the Brookdale Institute. He then asked all the participants to take five minutes to share their general thoughts on the topic of the roundtable discussion – the role of government in controlling costs and promoting quality in Israeli healthcare.

²⁸ The following were invited, but were unable to attend: Moshe Bar-Siman-Tov (MOF), Gabi Bin Nun (Ben-Gurion University), Revital Gross (Brookdale), Rachelle Kaye (Maccabi), Boaz Lev (MOH), Sigal Regev-Rosenberg (Clalit), Raviv Sobel (MOF).

David Chinitz noted that one of Israel's great achievements is that, overall, the public understands and supports the roles that government currently plays in the healthcare system. He attributed this, in part, to the ways in which the policy/public discussions and key processes have been managed. Another factor may have been a Jewish cultural tendency to define things (expressed in explicit decisions about how much money will be allocated to health, the content of the benefits package, etc.) These factors have made it possible in Israel to speak comfortably, even in public forums, about the need for budget constraints and prioritization, and to make distinctions between essential and non-essential services. It would be far more difficult to do so in the U.S.

Ran Balicer noted that government has contributed to key health system objectives both by intervening when needed, and by not intervening when that was the appropriate course of action. In passing the National Health Insurance Law, government lay the groundwork for an effective and equitable healthcare system and removed various disincentives to appropriate behavior.²⁹ Government continues to play an important role in addressing new problems in a timely fashion. (As an example, he cited the improvements made over the past 5 years in the procedures of the benefits package committee.) At the same time, it is important that government recognize that when things are functioning well, and non-governmental actors are acting in the public interest,³⁰ government intervention can be detrimental. (As an example, he cited the major – and voluntary - health plan efforts to improve quality of care, and his concerns that government intervention – such as mandating public reporting – could undermine the project.)

Gur Ofer listed 4 key factors that have helped Israeli healthcare be cost-conscious and efficient: 1) The National Health Insurance Law and its implementation, which have brought the health plans to the realization that they face real budget constraints;³¹ 2) The existence of four non-profit health plans with a history and culture of public service within each plan (which pre-date NHI by several decades), and a tradition of non-cutthroat ("soft") competition among them; 3) The employment of most physicians on a salaried or capitation basis, rather than FFS;³² 4) Government control of the hospital bed supply.³³ At the same time, he noted that some of these factors, particularly the last, may be adversely affecting quality.

Malke Borrow expanded upon Gur's point that cost-containment measures can sometimes adversely impact quality. In addition to noting the government's constraint on the number of beds, she also noted health plan limitations on physician practices. She also pointed out that

²⁹ Gur Ofer interjected that many key elements of Israeli healthcare were in place even prior to the 1995 passage of the NHI Law.

³⁰ Tuvia Horev interjected that many of the positive actions undertaken by the health plans in recent years should be seen, in part, as indirect effects of NHI.

³¹ Avi Israeli interjected that the health plans have learned that failure to adhere to budget constraints will result in government-mandated limitations on health plan freedom of action (such as the appointment of an external comptroller) and, in extreme cases, replacement of top management.

³² Avi Israeli interjected that many community-based specialists are paid on a FFS basis.

³³ Tuvia Horev interjected that the hospital revenue cap has also been a critical factor.

while Israel has a strong publicly-oriented healthcare system, there has been erosion in recent years, such as the privatization of school health services. She also critiqued two recent changes in how the benefits package committee operates: The reduction in the number of representative of the public and key healthcare professions and the growing involvement of the media.

Avi Israeli took the position that government has a responsibility to play an active role in the monitoring of quality and the sharing of information on quality of care with the public (as takes place in the US and the UK).³⁴ He reviewed the role of the media, physician groups, individual physician leaders, the health plans and the government in the evolution of quality monitoring in Israel. He also noted the eagerness of Israeli hospitals to participate in the accreditation process. With regard to cost containment, he noted that while in Israel it is not possible politically to let a health plan go bankrupt, government has developed an alternative mechanism for ensuring that health plan executives avoid major budget deficits. Recent developments with the Leumit Health Fund established the precedent that the MOH can dismiss CEOs who flaunt budgetary constraints and replace them with other managers.

Tuvia Horev underscored the importance of the budgetary ceilings and constraints imposed in 1994 – at both the national level and the health plan level. While the NHI Law did create mechanisms for the government to expand the NHI budget over time, it did so in a way that ensured that budgetary growth would take place in a controlled fashion, taking into account macro-economic considerations and the extent of pressure on the overall government budget.³⁵ Tuvia expressed the view that the creation of the budgetary ceilings was a major factor in the health plans' increased attention to internal financial monitoring and control, computerization, decentralization, and even quality assurance.

The Role of Politics and Politicization

Bruce Rosen then asked the participants to relate to the JHF's question: "What are the nature, extent and impact of political involvement in Israeli healthcare?"

Gur Ofer responded that there is now a lot less involvement of political parties than there was prior to NHI, when two of the health plans were closely affiliated with particular parties.

Avi Israeli pointed out that on many of the major issues of healthcare policy there is agreement among the key political parties, while most other issues in Israeli healthcare do not interest them.

Tuvia Horev noted that on some issues, such as co-payments, some of the parties (e.g., Shas) have take a clear stand, but he agreed with the other participants that clear and distinct party positions on healthcare issues are the exception rather than the rule.

³⁴ Ran interjected that there is no clear evidence that public reporting actually improves quality, and that the relevance to Israel of the US and UK experiences with this issue may be limited.

³⁵ Avi interjected "...or not".

Many participants noted that while the parties as such are not major players, the Knesset continues to be an active arena for discussions of healthcare issues and, in some cases, it has significantly affected the policy process. Several charismatic Knesset members (generally on the left side of the political spectrum) have made healthcare issues one of their foci and have focused public and political attention effectively.

David Chinitz raised the issue of interest group politics, which is very strong in the US. He noted that interest groups also play a role in Israel, but that their influence on the democratic process seems to be more responsible and limited. He commended the IMA as being involved in a broader set of issues than the AMA and for doing so in a responsible manner. David noted that in Israel the influence of interest groups has been kept to appropriate levels in part because the governmental decision-making processes are seen as legitimate and accountable, as he noted in his opening statement.

Several participants raised the issue of bureaucratic politics and noted the powerful role of the Ministry of Finance (MOF) in shaping health policy.

Ran Balicer and others noted that sometimes elements within the MOH encourage the MOF to push a certain policy, to reduce the extent to which the MOH itself is identified with the policy.

David Chinitz pointed out that sometimes the MOF overplays its hand and that this results in a pushback on the part of professionals and the public.

The Role of Pharmaceutical Companies

Bruce Rosen asked participants to respond to another JHF question: "What is the influence of device and pharmaceutical manufacturers in the selection of covered drugs and technologies, and how is such influence minimized or managed?"

The consensus view was that the companies have relatively little direct influence (compared with the US.) but continue to have limited and indirect influence at several levels:

- ❖ The companies do not have representatives on the benefits package committee. However, they do influence the process by submitting applications to add new technologies/medications and by providing funding for patient/physician NGOs organized around particular diseases.
- ❖ The companies were not at the table when the NHI legislation was developed (in sharp contrast to the current situation in the US).
- ❖ The companies try to influence the prescribing behaviors of individual physicians and department heads (through detailing, sponsoring conferences and research, etc.), but this has been constrained by recent understanding developed between the companies, the IMA and the government.

Wrap-up

Bruce Rosen concluded the meeting by thanking all the participants for their time and insights. He also indicated that he would prepare a summary of the meeting and circulate it for comments.