

UNIVERSAL HEALTH COVERAGE STUDY SERIES No. 32

**Advancing Universal Health Coverage:
What Developing Countries Can Learn
from the Israeli Experience?**

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Abbreviations

EU	European Union
GDP	Gross Domestic Product
HMOs	Health Maintenance Organization
HPs	Health Plans
MICs	Middle-Income Countries
MoF	Ministry of Finance
MoH	Ministry of Health
NHI	National Health Insurance
OECD	Organisation for Economic Co-operation and Development
PCC	Patient-Centered Care
PCP	Primary Care Physician
VHI	Voluntary Health Insurance

Preface to the second round of the Universal Health Coverage Study Series

All over the world countries are implementing pro-poor reforms to advance universal health coverage. The widespread trend to expand coverage resulted in the inclusion of the “achieving universal health coverage by 2030” target in the Sustainable Development Agenda. Progress is monitored through indicators measuring gains in financial risk protection and in access to quality essential health-care services.

The Universal Health Coverage (UHC) Studies Series was launched in 2013 with the objective of sharing knowledge regarding pro-poor reforms advancing UHC in developing countries. The series is aimed at policy-makers and UHC reform implementers in low- and middle-income countries. The Series recognizes that there are many policy paths to achieve UHC and therefore does not endorse a specific path or model.

The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions- used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to provide a detailed understanding of how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding population coverage while ensuring that the poor and vulnerable are not left behind;
- **Strategic Purchasing:** expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers;
- **Raising revenues** to finance health care in fiscally sustainable ways;
- **Improving the availability and quality of health-care providers;** and,
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions.

By 2017, the Series had published 24 country case studies and conducted a systematic literature review on the impact of UHC reforms. In 2018 the Series will publish an additional 15 case studies. A book analyzing and comparing the initial 24 country case studies is also available: *Going Universal: How 24 Developing Countries are Implementing UHC Reforms from the Bottom Up*. Links to the Series and the book are included below.

Daniel Cotlear, D. Phil.
Manager and Editor
Universal Health Coverage Study Series

Links:

<http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>

<http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up>

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About the Author

Bruce Rosen is Director of the Smokler Center for Health Policy Research, a division of the Myers-JDC-Brookdale Institute. The focus of his recent research has included Israeli mental health reform, efforts to monitor and improve the quality of care, health information exchanges, and the cross-national flow of health policy innovations. An important component of his work involves promoting links between research and health policy development. Bruce is the lead author of the European Observatory's country report for Israel and The Commonwealth Fund's profile of the Israeli health care system. He recently co-edited a World Scientific book entitled *Accountability and Responsibility in Health Care: Issues in Addressing an Emerging Global Challenge*, which combined conceptual contributions from leading international scholars with local reports on how the health systems of eight countries are addressing the accountability/responsibility challenge. Bruce is also co-editor of the *Israel Journal of Health Policy Research*, which seeks to promote intensive intellectual interactions between scholars from Israel and their counterparts from around the world. As someone who spent the first half of his life in the United States and the second half in Israel, Bruce has always enjoyed facilitating cross-national learning opportunities between the two countries. In recent years, he has come to see that he can also be helpful in creating bridges with health systems in other countries, as well. He holds a B.A. in economics from Harvard College and a doctorate in health policy from the Harvard School of Public Health.

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Executive Summary

The Israeli health system provides universal coverage of a broad benefits package in a highly efficient manner. Factors contributing to system efficiency include tight government control of the level of public financing, provision of care through competing nonprofit health plans, government constraints on the number and type of hospital beds, a highly-structured process for prioritizing new technologies, various strategies for controlling pharmaceutical expenditures, a well-developed primary care system, an advanced electronic health records system, and rapidly improving systems of transparency and accountability.

At the same time, the Israeli health system faces significant challenges, including lack of universal coverage for long-term care and adult dental care, center-periphery gaps, insufficient care integration, long waiting times for some elective procedures, and a growing private health care sector that poses several threats to the public system, cost containment, and health system equity.

The Israeli health care system has benefited greatly from its capacity to identify relevant innovations in other countries and adapt them to Israel. At the same time, the Israeli experience can be a source of lessons for other countries. Aspects of the Israeli system that might be particularly relevant to middle-income countries include health plan competition in a clear and simple institutional environment, the reliance on health plans such as managed care and patient-centered organizations, the emphasis on primary care, and the investment in e-health. The manner in which Israel is grappling with its growing private sector can be a source of strategies middle-income countries could consider, and a source of strategies they should avoid.

1. Political and Economic Context

Country Snapshot

Israel is a small country located at the juncture of Africa, Asia, and Europe. Its population is just over 8 million, and its population density is among the highest in the western world; in the European Union (EU), only Malta and the Netherlands are higher. The largest population groups are Jews (75 percent) and Muslim Arabs (17 percent). Compared with other high-income countries, Israel's fertility rate is relatively high and its age mix is relatively young. Its fertility rate is also higher than those of many middle-income countries. Israel has one of the highest age dependency ratios among Organisation for Economic Co-operation and Development (OECD) countries, at 63 percent compared with the OECD average of 55 percent and the EU average of 52 percent. It is also higher than upper-middle-income countries (42.6 percent).¹

Israel has a modern market-based economy with a substantial high-technology sector. The 2012 gross domestic product (GDP) per capita was US\$32,567, slightly below the EU average of US\$34,148. At the same time, income inequality in Israel is among the highest in the OECD, within which only four countries (the United States, Turkey, Mexico, and Chile) having more unequal income distributions.

Israel is a democratic state with a parliamentary, multiparty system. It is an active member in many major international organizations, and in 2010, it formally joined the OECD as a full member.

Health status in Israel is similar to that of other high-income countries, even though the share of GDP spent on health is 7.6 percent, compared to the OECD average of 8.9 percent. Life expectancy in Israel is slightly above the average for the EU Member States before 2004 (EU-15) for both men (80.8 years, compared with 79.1 for the EU-15) and women (84.4 years, compared with 84.2 for the EU-15), with life expectancy for Israeli men being among the highest among OECD countries.

Israel's life expectancy for both men and women is also well above the global averages of 69.1 and 73.7 and well above the averages for most World Health Organization regions.² Of course, most of the regions also spend significantly less per capita on health than does Israel, and the share of GDP allocated to health is also usually lower than in Israel.³

As in other countries, Israel's health status has improved significantly in recent decades, even though the share of GDP allocated to health has been stable. Gains have been achieved for all population subgroups, but disparities persist.

Overview of Israeli Health Care

Israel has a national health insurance (NHI) system that provides universal coverage. Every citizen or permanent resident of Israel is free to choose from among four competing, non-

profit-making sickness funds, called health plans (HPs). These HPs must provide their members with access to a legally prescribed benefits package.

The Ministry of Health (MoH) owns and operates about half of the nation's acute care hospital beds, which they operate with considerable autonomy. The largest HP operates another third of the beds (with a relatively high degree of centralized control), and the remainder of the beds are operated through a mix of non-profit-making and profit-making organizations.

The NHI system is financed primarily via a combination of a health-specific payroll tax and general taxation,⁴ with high-income and low-risk individuals subsidizing low-income and high-risk individuals. The government distributes funds among the HPs according to a capitation formula that takes into account the number of members in each plan and their age mix, gender, and place of residence (center/periphery of the country). While public financing remains the primary source of health system resources, the share of private financing has been increasing in recent years, rising from 32 percent of total health expenditure in 1995 to 39 percent in 2012, primarily through a sharp increase in spending on voluntary health insurance (VHI). Israel's 39 percent rate is high compared with 27 percent for the EU, for example, but lower than the 46 percent rate for upper-middle-income countries, the 64 percent rate in lower-middle-income countries, and the 59 percent rate in low-income countries.

Israel's ability to maintain its relatively low level of spending on health is probably in part a reflection of its relatively young age distribution along with various structural features and policies that contribute to cost containment.

Those related to financing include:

1. There are effective mechanisms for risk sharing between the government and the main providers/purchasers of care, through financing of HPs primarily via prospective payments based on a capitation formula with simple and objective risk adjusters; and supplementary HP funding via retrospective payments based on performance and the prevalence of particularly costly diseases.
2. HPs work as managed care organizations with gatekeeping, and some cost sharing from patients for visits to specialists and for medications. Most of the physicians working with HPs are paid via capitation and/or salary arrangements, thereby largely avoiding the cost-promoting effects of fee-for-service reimbursement.
3. HPs purchase inpatient care from hospitals through 50 differential daily fees and activity-based payments based on procedure-related groups. The government publishes maximum-price lists for inpatient care and sets hospital revenue caps to contain hospitals' income increases.⁵ Moreover, due to their dominance, HPs are further able to obtain discounts from hospitals.

Other factors contributing to the efficiency of the Israeli health care system include:

- *Supply constraints:* Israel has deliberately maintained a relatively low bed-to-population ratio. This serves to help restrain overall health expenditures and also affects the division of resources between hospital and community care.
- *Digital health:* Israel has long been a leader in the broad dissemination of electronic health records systems and in the adoption of large-scale health information exchanges that transmit patient-level data between hospitals and community-based providers. These digital health efforts both promote quality and help control costs.
- *Pharmaceuticals:* Israel has relatively low per-capita pharmaceutical spending compared with other OECD countries. Many factors contribute to this, including heavy reliance on generics, bulk purchasing (at discounted prices) by the health plans and the large hospital systems, and health plan encouragement of physicians to prescribe wisely.
- *Health plans as balancers of objectives and integrators of care:* As health plans have overall responsibility for the health of their members and receive prepaid capitation payments from the government to finance that care, they have strong incentives to be cost conscious in their care provision. This is further encouraged by the fact that Israelis rarely switch plans so that, unlike U.S. health plans, the Israeli plans have an incentive to invest in the health of their members to reduce future expenses. The health plans also have an incentive to be responsive and keep their members happy as Israelis have a right to switch plans at any time. Finally, as the budget holders, health plans not only have the incentives to organize care effectively, they also have the capacity to do so.
- *Well-developed and accessible prevention services* (“tipat chalav”) with free-of-charge vaccinations for children, and infant developmental monitoring.
- *Free of charge preventive care for children in schools*, including vaccinations, hearing, vision, and developmental exams.
- *Free-of-charge and accessible primary care services.*

Along with the low and decreasing per capita public expenditure on health, there has been a constant and marked trend of increases in private spending. The VHI market is one of the biggest in OECD countries with about 87 percent of Israel’s adult population covered with VHI, and 53 percent covered with commercial insurance. Household spending on VHI has increased markedly over the last decade. The 26 percent share of health expenditures accounted for by out-of-pocket expenditures are also high relative to many other high-income countries. The comparable figures are an EU average of 21 percent, 14.5 percent in high-income countries, 30 percent in upper-middle-income countries, 56 percent in lower-middle-income countries, and 39 percent in low-income countries. The Israeli rate has also increased somewhat over time. There are large differences in households’ expenditures on health by income quintile, which indicates the existence of inequalities.

On the one hand, the low and stable expenditure on health has been a source of pride for the Israeli health care system. On the other hand, the increasing growth of private expenditure has enhanced concerns about a shortage of resources in the public system and rising inequalities; these, in turn, could pose risks to access to services and the population’s

health. It is not clear whether the Israeli system is an adequately funded system that can provide good care through a very high level of efficiency or whether it has steadily been eroding its resources up to an undesirable point.

Israel's (continuing) Path to Universal Health Care: A Historical Overview

Israel's health plans were founded as voluntary mutual aid societies in the 1920s and 1930s; all of them predated the establishment of the State of Israel in 1948. One plan (Clalit) was established by Israel's main, leftward-leaning labor federation, another (Leumit) by a competing rightward-leaning labor federation, and two (Maccabi and Meuhedet) by independent groups of physicians.

By the 1970s, all the plans were financed through payments from both the members and their employers, with payment levels generally determined as a percentage of income. The two labor federations required all their members to also join the health plans they operated, and (with limited exceptions) that all members of their affiliated health plans join the associated labor federation. Indeed, the membership fees for both the labor federation and the associated health plan were combined into a "joint tax."

The proportion of the population enrolled in a health plan grew gradually over the years. However, every so often, the plan associated with the main labor federation (Clalit) teetered on the verge of bankruptcy. Its recurring financial problems had several sources including managerial inefficiency, the need to split membership fees with the labor federation, and a relatively high concentration of members with low incomes (and hence low membership fees) and of advanced age (and hence higher costs). Until 1977, these financial crises were addressed via bailouts from the government, which until then had always been led by the Labor Party (which in turn was closely connected with the main labor federation). In 1977, the Labor Party lost control of the government to a right-wing party that had no interest in helping Clalit or the main labor federation.

During the first four decades of the State of Israel, there were periodic calls to replace the system of competing voluntary health plans with a single national health care system. The proponents of a change to a unitary system contended that this would reduce duplication and depoliticize the health system; some of those proponents also sought to weaken the Labor Party and its affiliated labor federation. The proponents of preserving the existing competitive system contended that it promotes responsiveness and diversity far better than a unitary system would; some of those proponents also sought to preserve the benefits that the Labor Party and its affiliated labor federation derived from the competitive system.

In the late 1970s and early 1980s, Clalit again amassed major debts. In addition to the three long-standing factors noted above, a fourth exacerbating factor emerged. The two independent health plans increasingly marketed themselves to middle- and upper-income persons, leaving the plans affiliated with the labor federations with fewer members who were paying membership fees at the higher rates.

In 1988, the government established a blue-ribbon panel to examine a growing crisis in the health system that included Clalit's financial problems, a growing inability of all the health plans to pay for new and expensive treatments such as organ transplants, lack of clarity regarding health plans' obligations to their members, a conflict of interest between the government's role as regulator and its role as an operator of hospitals, and frequent strikes in the health care system. The panel recommended a wide range of reforms, of which the most relevant to this case study was the establishment of a national health insurance system. They envisioned a system based on competing independent health plans (that is, without labor federation affiliations) operating within a legally defined and heavily regulated framework.

In late 1994, after several years of intense political wrangling, Israel's parliament (the Knesset) passed a National Health Insurance Law that went into effect in 1995. The law:

- Established health (and health insurance) as a right of all citizens and permanent residents
- Confirmed the role of the health plans as the main building blocks of the health care system
- Required that all health plans be independent of political or other affiliations
- Guaranteed full freedom of choice among health plans
- Spelled out the benefits to which each member is entitled to receive from his or her health plan
- Determined that the system would be financed primarily on the basis of progressive taxation
- Established a mechanism for updating the level at which the overall NHI system would be budgeted
- Established a capitation system for distributing the NHI monies among the health plans.

The change in the financing systems that was introduced in the NHI law has been vital to combining progressive financing and competition in an equity-promoting and sustainable manner. Prior to the law, health plans had a strong incentive to target their market efforts on the young (for whom costs are lower) and those with high incomes (for whom health plan revenues were higher). By breaking the link between member income and health plan revenue, the law greatly reduced the incentive to the health plans to avoid those with lower incomes. By linking health plan revenue with the age of members, the law significantly reduced the incentive to avoid the elderly. Moreover, the financing change also meant that being open to low-income and elderly members would not increase a health plan's likelihood of incurring financial deficits.

Importantly, the main objectives of the NHI law *did not* include expanding the number of citizens with health insurance. By the 1990s, approximately 95 percent of Israelis already had health insurance and many of those without health insurance were moderate-income or high-income people who had foregone health insurance by choice. Nonetheless, Israel's NHI law may have had a major role in preserving broad population coverage, as it replaced a system that was proving to be increasingly unsustainable. If the voluntary-progressive

system had collapsed (rather than being replaced by NHI) then the result might well have been that many low-income, elderly, or seriously ill people would have become uninsured.

The Politics of Keeping Health Expenditures at Less than 8 Percent of GDP

Through their spending on voluntary health insurance and through their responses to surveys, the Israeli public has indicated that they are interested in receiving more health care than is currently provided through the publicly financed health care system. Moreover, the health plans, the hospitals, health care professionals, the MoH, and just about everyone involved in Israeli health care has called for increasing both governmental funding of health care and the total funding of health care.

Accordingly, it is natural to wonder how—politically—the lid has been kept on health care spending as a share of GDP.

There are probably several factors at work, including:

- The widespread sense that, while it would be good if Israeli health care were more available and more responsive, it is already at a reasonable level and that it is certainly nowhere near a catastrophic situation
- Strong competition from other, highly valued, sectors such as defense, education, and transportation
- A strong national and societal commitment to disciplined governmental spending and to maintaining the national debt at manageable levels (in part to avoid a repeat of the Israel's painful 1985 financial crisis)
- The creation of governance structures and processes (such as the powerful Budget Division of the Finance Ministry and the powerful Finance Committee of the Knesset) that help translate into practice the commitment in principle to disciplined governmental spending.

Having said that, it would not be surprising if the health share of GDP increases in the coming years, with the increase mostly likely to come from private financing.

2. Expanding Population Coverage

Population Coverage before NHI Enactment

As mentioned, 95 percent of the population was insured even before the enactment of national health insurance in 1995. The coverage of low-income persons was facilitated by the decisions of all the health plans to voluntarily link premiums to member's income levels, so that the rich were effectively subsidizing the health care costs of the poor. This decision was due in part to the strong social solidarity ethos that characterized Israeli society in its early years. Another factor was the interest of the labor federations in increasing their economic and political power, and their recognition that making it easy to join their affiliated health plans (including for low-income persons) increased their own

economic and political base. Each additional member meant an additional vote for his or her affiliated party, irrespective of the amount of premium revenue generated from that additional member.

How NHI Expanded Population Coverage

NHI expanded coverage to the 5 percent of Israel's population (citizens or permanent residents) that was previously uninsured. Some of the newly insured had previously chosen to forego insurance either because they were rich and preferred to cover their health costs out of pocket or because they were young and were not concerned about health costs. Others were low-income persons, including Arab residents of East Jerusalem, who were unable to access health coverage prior to NHI due to economic barriers and/or limited labor federation activity in East Jerusalem.

The Creation of Special Coverage for Documented Foreign Workers

Persons living in Israel who do not have formal residency status are not covered by Israel's NHI Law. Foreign workers are one such group. It is estimated that at the end of 2014 Israel had approximately 75,000 legal foreign workers (that is, those with valid work visas) and an additional 1,000 foreign workers living in Israel without such visas. The Foreign Workers Law requires employers to provide health care insurance to both these groups. The coverage provided must be the same as that provided by NHI, with the exception of treatment abroad, certain mental health services, and long-term care services. The National Insurance Institute provides coverage for the care of foreign workers injured on the job, just as it does for Israeli workers.

Another significant category consists of those from the Palestinian Authority or Arab countries who are living in Israel in the framework of a law governing family reunification, of which there are about 8,000 people. They are entitled to receive care through the HPs; their benefits package is similar to NHI with the main exception being treatment abroad.

Children living in Israel who lack residency status can be registered with one of the HPs (Meuhedet), with the parents or guardians required to pay the insurance premiums. Approximately half of these children have been registered. The coverage is similar to NHI, with exclusions of treatment abroad and (in the case of children born outside of Israel) treatment for conditions that existed when the child arrived in Israel.

The government makes several services available to all people in Israel irrespective of their legal status. These include emergency care; preventive mother and child health services; and treatment for tuberculosis, HIV/AIDS, and other sexually transmitted infections.

All of the HPs sell health insurance coverage to nonresidents, and those who purchase it receive most of the services in the public health basket.

A special clinic in the Tel Aviv area, run in the context of cooperation among the MoH, the municipality, and several non-profit-making organizations, provides various health care services to nonresidents who lack health insurance.

3. Expanding the Benefits Package

The Annual Process for Expanding the Benefits Package

In 1998, Israel established a formal process for setting priorities for adding new services to the benefits package. Each year, the process begins with “the government” (which is composed of all of Israel’s ministers) deciding how much money it will allocate for these additions. For example, for 2013–16, the government allocated NIS 300 million per year (approximately US\$80 million) and for 2017 it allocated NIS 460 million (approximately US\$130 million).

The key player in determining which new technologies will be funded by this annual allocation is a national public advisory committee appointed by the Minister of Health. This public committee includes senior officials from the Ministries of Health and Finance, the four health plans, and representatives of “the public.” The committee is charged with prioritizing new technologies and developing recommendations that take into account the projected health impacts of the proposed additions to the benefits package, as well as various social, economic, and ethical considerations. To date, the public committee’s recommendations have always been adopted by the Minister of Health and the government.

In parallel with the ministerial process for setting the annual budget for new technologies, the MoH solicits proposals for new technologies/medications (henceforth referred to as technologies) to be considered as candidates for inclusion in the benefits package. Health plans, pharmaceutical companies, the Israel Medical Association, patient organizations, and other groups submit recommendations, along with supporting analytic material.

An MoH staff unit helps the pharmaceutical companies understand the prioritization process and its context (including Israeli health care’s limited resources). As part of this, they help the companies understand that the likelihood that their proposal to add a new drug to the benefits package will succeed in the prioritization process is, in part, dependent on the price at which they are proposing to supply their new drug.

The MoH staff unit also reviews the proposals and prepares various background material for the public committee, with an emphasis on the potential health benefits of the proposed technologies. This is supplemented by the work of an economic subcommittee that provides the full committee with projections of the number of patients to use the new technologies and the cost. The subcommittee includes representatives from the MoH, Ministry of Finance (MoF), and the four health plans.

In their proposals, the companies are required to project how many Israelis will use the drug. Sometimes, a company’s projection is well below the projection developed by the

MoH staff and the economic subcommittee. In those cases, the pharmaceutical company will be encouraged to enter into a risk-sharing agreement with the government and the health plans. In the most common type of risk-sharing agreement, the company commits to covering the cost for all patients beyond the number they had projected.

Interestingly, the health plans' VHI programs are prohibited from covering life-saving drugs (typically for cancer care) that did not make it through the annual prioritization process. This is prohibited partly as a cost-containment measure, partly to promote equity, and partly to encourage public and political support for adequate budgeting of the annual prioritization process. Note, however, that the commercial VHI programs may, and often do, provide such coverage.

In its 15 years of operation, the items approved by the public committee include both preventive and curative services, as well as those intended to extend life along with those intended primarily to improve quality of life. The relative emphases given to these have varied over time.

The overall system of budgeting and prioritizing new technologies has proven to be effective for national decision making, and has earned the support of the public, the relevant government ministries, the courts, and the key health care providers. It has done this through a judicious mix of technical and public considerations and a growing level of transparency.

Expansions of the Benefits Package that go beyond the Usual Annual Process

The annual process outlined above works well for evaluating and adopting new medications and other specific new technologies. The annual budget for new technologies can accommodate the addition of many new items of this sort each year, and both the MoH analytic unit and the public committee have developed the skills and practices needed to handle these sorts of items.

At the same time, there is a recognition that additional processes are needed for considering and funding particularly complex, big-ticket additions to the NHI benefits package. The most striking example was the 2012 decision to add mental health services to the NHI benefits package, which established a right to mental health care and transferred responsibility for mental health provision from the government (subject to significant budget constraints) to the health plans (as a legally defined right of its members). The cost of doing so was well beyond the annual budget for new technologies and, in addition, there was a vigorous debate among professionals about whether transferring the mental health responsibility to the plans would be good for patients. Over a period of 20 years, several attempts had been made to effect this change via legislation. Eventually, proponents despaired of the legislative route and effected the change via an administrative decision of the Israeli cabinet (the most senior forum of Israeli policy makers).

Similarly, when the government decided in 2010 to add dental health services for children to the NHI benefits package it did not do so through the complex analytic unit/committee

annual prioritization process described above. Instead, the Minister of Health transferred some of the monies originally set aside for the annual process to a separate budget line that was used to finance dental care for children.

Supply Expansions to Accommodate Additions to the Benefits Package

Most of the additions to the benefits package that take place through the usual annual process do not pose challenges of ensuring adequate supply. That is because most of these additions involve pharmaceuticals or other manufactured items for which the volume available in the international marketplace is much greater than any increase in demand in Israel.

The situation is significantly different for expansions involving services in which human resources are a vital component, as in the case of mental health services or dental care for children. In both cases, the health plans were already involved in providing relevant services, albeit usually through their supplemental insurance programs (as private but discounted services) rather than through NHI. Moreover, with the inclusion of the service as part of NHI (with little or no copayments) it was clear that demand for services would increase. The challenge has been greatest in the case of child psychiatrists, as Israel has a shortage of such professionals. In contrast, there are relatively large numbers of psychologists, adult psychiatrists, and pediatric dentists working in the private sector. Thus, the health plans faced (and continue to face) the challenge of encouraging sufficient numbers of these professionals to work with the health plans—either instead of their private work or (more commonly) in addition to their private work. There have been some achievements in this regard, but the health plans still have not been able to recruit as many mental health professionals as they would like to hire, and this has led to long waiting times.

4. Financial Resources and Pooling

Description of Tax-Based Financing Sources and their Degree of Progressivity

In 2013, the financing sources for Israel's total health expenditures were as follows:

- 35 percent general government revenue
- 24 percent earmarked health tax
- 13 percent voluntary health insurance
- 27 percent out-of-pocket payments
- 1 percent donations from abroad.

Note that these figures are for total health expenditures, including private expenditures, governmental NHI expenditures channeled through the health plans, and direct government expenditures. The private expenditures include expenditures on services not covered in NHI such as eye care and dental care for adults, copayments for some services provided by HPs such as medications and visits to specialists, and expenditures related to VHI such as

premiums and copayments. Governmental NHI expenditures channeled through the health plans cover a broad range of inpatient and community-based services. Direct government expenditures span such areas as public health, and institutional long-term care.

If attention is restricted to the NHI expenditures channeled through the health plans, 88 percent come from the government based on a capitation formula that takes into account age, gender, and peripheral residence. Another 6 percent comes from the government as payments for persons with certain serious illnesses; only 6 percent of health plan revenues come from copayments. Thus, 94 percent of health plan NHI revenues come from government; these in turn are financed in approximately equal parts by general government revenues and an earmarked health tax.

General government revenues in Israel are composed of direct taxes (primarily income tax) and indirect taxes (including a value-added tax, taxes related to real estate and automobile purchases, and excise taxes on alcohol, tobacco, and gasoline). In 2013, the indirect taxes amounted to 15 percent of GDP, while the direct taxes amounted to 11 percent of GDP. The reliance on indirect taxes is greater in Israel than in most OECD countries. The indirect taxes are regressive, constituting a tax burden in 2011 of 26 percent for the lowest income decile and 13 percent for the highest income decile. In contrast, the direct taxes are progressive, constituting a tax burden in 2011 of 6 percent for the lowest decile and 27 percent for the highest decile. The overall tax burden is U-shaped—31 percent for the lowest decile, 25 percent for the fifth decile, and 36 percent for the highest decile.

The health tax is more progressive than the indirect taxes and less progressive than the income tax. It has two levels of taxation—3.1 percent on income up to NIS 5,800 per month and 5 percent on income between NIS 5,800 and NIS 43,000 per month. There is no health tax on income above NIS 43,000 per month. In contrast, the income tax has no such ceiling and has seven levels of taxation.

Public funding constitutes 60 percent of the total health expenditures, and the remaining 40 percent is funded by households (either through out-of-pocket payments or through voluntary health insurance). This latter share is also non-progressive, as expenditures are not related to income. On the contrary, these private expenditures are related to health status, where the sick (who are usually the poor) spend more than the healthy. Given that these non-progressive household expenditures on health are high, and have been increasing, they raise concern about inequality and access to care.

The Vital Role of the Capitation Formula in Enabling Competition while Preserving Progressivity in Financing

As mentioned, prior to the introduction of NHI, health plans had a strong incentive to target their marketing efforts to the young (for whom costs are lower) and those with high incomes (for whom health plan revenues were higher). This was because even in the pre-NHI voluntary system, premiums were linked progressively to income. By breaking the link between member income and health plan revenue, the NHI law greatly reduced the

incentive to the health plans to avoid those with lower incomes. By linking health plan revenue with the age of members, the law significantly reduced the incentive to avoid the elderly. Moreover, the financing change also meant that being open to low-income and elderly members would not increase a health plan's likelihood of incurring financial deficits.

Policy makers continue to be committed to the objective that the health plans should have an incentive to recruit and provide good care to everyone. Accordingly, the age-weights are refined periodically, as better data become available. In addition, in 2010, separate age-weights were established for males and females and a peripherality parameter was added to encourage greater competition over residents of peripheral regions.

There is evidence that the capitation formula is generous for young ages (zero to 15), and overpays HPs for children enrolled. Whether this is an intentional policy or not, it creates incentives for HPs to attract young families and develop services for children such as nurse-staffed call centers, preventive care, and developmental tests and care.

Simplicity versus Complexity in the Capitation Formula

While Israel has added parameters to its age-based capitation formula in recent years (gender and peripherality), it remains among the simplest of the formulas being used by OECD countries. Many other countries include parameters reflecting health status and socioeconomic status in their formulas.

Israeli policy makers have historically preferred simplicity for at least three reasons:

- It makes it easier for policy makers and health plan managers to understand how the monies are being allocated and the related incentives.
- In Israel, the publicly available data include only limited information on health status and socioeconomic status by health plan.⁶
- While the health plans do have relatively good data on the health status of their members, there is reluctance to base the distribution of billions of dollars of government funds on health plan data. This is due to concerns about definitional consistency across plans as well as perverse incentives for over-diagnosing and/or overreporting.

In contrast to the policy makers' historical position, many health care academics feel that Israel should move forward on introducing health status and socioeconomic status into the capitation formula. They voice concerns that, with the current formula, health plans have an incentive to focus marketing and service efforts on the low risks such as the young and the healthy. They point to evidence that the plans have given particular attention to young families in their marketing and service development efforts.

At the same time, however, the health plans may face a balancing counterincentive. If they were caught explicitly avoiding the old and/or the chronically ill, then they would face

condemnation from both the public and the government. It is not clear whether, in practice, the health plans stint on caring for these groups, deliberately or otherwise.

The debate continues about whether to include additional risk adjusters in the capitation formula such as socioeconomic status, chronic conditions, and disability, to further reduce incentives to HPs to avoid these costly populations. As of February 2016, there are serious discussions about possibly adding health status and health performance parameters for diabetes. Another direction that comes up for consideration from time to time is to give special treatment to outlier cases.

Note that, in addition to the capitation payments, HPs can receive special financial support from the government at the end of each year. The size of these payments is determined primarily by the extent to which the HPs meet various fiscal responsibility and efficiency targets. These targets are set by the MoH every three years, in accordance with key policy objectives. For example, during 2013–14, the objectives included providing preventive care without copayments, preventing hospital readmissions, promoting healthy lifestyles, tackling geographic and social disparities in health, and providing care for chronic obstructive pulmonary disease (COPD).⁷

Copayments and Safety Net Safeguards (copayment limits and discounts)

Within the NHI system, mandatory copayments are set by the government for visits to specialists, allied health professions, medical devices, some diagnostic exams, and medications.

Copayments for visits to specialist physicians in the community are structured as follows. There is a flat-rate charge (about US\$7) for the first visit in any quarter; repeat visits within the quarter to the same specialist are not subject to copayments. Elderly welfare recipients (aged 65 and over) and children receiving disability payments are exempt from copayments for all visits; people afflicted with end-stage renal disease, cancer, HIV/AIDS, Gaucher disease, thalassemia or tuberculosis are exempt from copayments at hospital outpatient departments and dialysis centers.

There is also a quarterly ceiling on total copayments at the household level, which is 50 percent lower for elderly people. Developmental care (for example, speech therapy, occupational therapy, physiotherapy, and mental health care) is exempt from copayments for children whose parents receive income support from the National Insurance Institute. In 2016, the ceiling for households was about US\$60 (the ceiling is not a function of family size) and about US\$88 for individual patients with chronic conditions.⁸

Copayments for allied health professions are paid at each visit. For example, the copayment rates for visits to self-employed psychologists are about US\$38 and for speech therapists or physiotherapists, US\$8.

Coinsurance for pharmaceuticals is 15 percent of the purchase price for patent drugs and 10 percent for generic drugs, subject to a minimum copayment of around US\$5 per item

purchased.⁹ For the chronically ill, there is a quarterly ceiling of approximately US\$260, varying according to HP. Those over age 65 who receive income support benefit from a 50 percent reduction in pharmaceutical coinsurance, while all those older than age 75 benefit from a 10 percent reduction; veterans of the armed forces receive a 75 percent discount, and Holocaust survivors are exempt from coinsurance.¹⁰

User charges cannot be covered by supplemental health insurance programs.

The Complex and Evolving Place of Voluntary Health Insurance

Over and above the NHI, two forms of VHI are available in Israel: supplementary insurance, offered by the HPs to all of their own beneficiaries (HP-VHI), and commercial insurance offered by commercial insurance companies to individuals or groups (C-VHI). Even though the Israeli NHI benefits package is broad compared with those in other OECD countries, Israel's VHI market is still one of the largest. In 2014, 87 percent of Israel's adult population had HP-VHI, and 53 percent had commercial insurance.¹¹ In 2010, this was higher than in all other OECD countries except France and the Netherlands (OECD data for 2010).

The share of the Israeli population covered with VHI has been growing rapidly since the early 2000s, and it is the fastest-growing component of private health care spending. Between 2002 and 2011, household spending on supplemental insurance increased by 70 percent and on commercial insurance by 90 percent.¹² The payments for premiums of both supplemental and commercial health insurance increased by more than 100 percent from 2005 to 2013, compared with an increase of 18 percent in other insurance sectors. The Israeli per capita expenditure on private insurance during 2005–12 skyrocketed by 111 percent, much faster than the average of 39 percent in OECD countries.

One of the possible reasons for the high demand for VHI in Israel is limited confidence in the public health care system's ability to meet their needs in case of serious illnesses. Another reason for the broad VHI coverage is that it is used by insurees to "jump queues," both for elective surgery and for specialist consultation in the community. Insurees can receive faster access to elective surgery in private hospitals and can visit specialists in their private clinics—both financed by their VHI. This is instead of waiting for the public services provided by HPs under the NHI law. Moreover, choice of surgeon in nonprofit hospitals is not allowed under the NHI, and many Israelis buy VHI to be able to choose their surgeon in a private hospital.

5. Strategic Purchasing

How a System of Competing, Nonprofit Health Plans—which are Financed Primarily by Capitation Payments—Contributes to Efficiency and Equity

As discussed, the four health plans have overall responsibility for the health of their members and receive prepaid capitation payments from the government to finance that care. As a result, they have strong incentives to be cost conscious in their care provision. This is further encouraged by the fact that Israelis rarely switch plans so that, unlike U.S. health plans, the Israeli plans have an incentive to invest in the health of their members to reduce future expenses. The health plans also have an incentive to be responsive and keep their members happy as Israelis have a right to switch plans. Finally, as the budget holders, health plans not only have the incentives to organize care effectively, they also have the capacity to do so.

Some of the steps taken by the health plans to constrain expenditures include:

- The development of strong organizational structures going from national to regional to district levels, with clear performance goals, annual work programs, monitoring, and accountability
- The performance of extensive hospital utilization review
- The development of a broad array of community-based services that serve as substitutes for hospital care (for example, an extensive network of community-based specialists, home care services, emergency care centers, call centers, and so forth)
- The creation of electronic health record systems linking all health plan clinicians and diagnostic centers, which contributes to more continuous, coordinated, and cost-effective care
- The development of case management programs for members with multiple chronic illnesses
- Investment in health promotion and disease prevention
- The use of primary care physician as care coordinators and gatekeepers
- The reimbursement of primary care physicians largely on a salaried or capitation basis, to align incentives
- The negotiating of prices with hospitals, pharmaceutical companies, and others, using their large size to secure discounts.

In addition, the two biggest HPs also own hospitals, with Clalit operating a large network of nonprofit hospitals and Maccabi having a wholly owned subsidiary that operates a growing network of for-profit hospitals. This enables them to better organize and control the provision of care as well as providing them with additional market power when purchasing care from other hospitals.

Another key feature of the Israeli situation is the extensive monitoring and publication of findings regarding health care performance in a range of areas. The Myers-JDC-Brookdale

Institute carries out a biannual survey of consumer interactions with their health plans. The MoH monitors and publicizes information on health plan finances. The National Program for Quality Indicators in Community Healthcare in Israel gathers and publicizes information on clinical quality of care. The media summarize and transmit to the public the key findings from these monitoring efforts in a way that the public can understand and then use in choosing a health plan. This information is also used by MoH in its regulatory role.

In 2014, the MoH launched a website that includes independent, open, up-to-date information regarding the services available through NHI and HP-VHI and eligibility for them (that is, information on thousands of services and medical technologies; conditions of eligibility for them; and the process by which eligibility is exercised, copayments set by HP and VHI, and other legal information). The idea is to empower insureds with knowledge and awareness of their rights and eligibility to benefits, so they can demand them from the HPs and/or private insurers; if refused, they can refer the case to the supervisor (the MoH). This policy instrument addresses market failures related to information asymmetry and can potentially improve competition among the HPs and within the VHI market.¹³

Interestingly, the health plans have been active in promoting equity,¹⁴ and there appear to be several factors contributing to this. First, through the capitation formula and other mechanisms, the government has given the health plans financial incentives to develop services in the periphery and improve equity in other ways. In addition, in Israel, having a reputation for investing in equity contributes to a health plan's standing with the regulator, the academic community and perhaps, the general public, as well. Another key factor is the professionalism and values of the health plan leaders and their employees at all levels. In addition, the status of the health plans as nonprofit organizations governed by publicly minded boards of directors, also plays an important role.

Note, however, that despite a broad array of governmental and health plan efforts to reduce disparities, significant gaps remain across regions, income levels, and nationalities with regard to access to high-quality, timely care.

Strategies for Constraining Pharmaceutical Expenditure

Israel's NHI includes a broad pharmaceutical benefit, and pharmaceuticals are provided through the health plans with limited copayments. Nonetheless, its annual purchasing power parity per capita spending on pharmaceuticals (US\$287) is far below the OECD average of US\$527. How does Israel achieve these results?

There are several strategies involved, including the following:

1. *Budget constraint + prioritization.* As noted, each year the government decides how much money it will allocate to fund new additions (primarily pharmaceuticals) to the benefits package, and then has a sophisticated system for prioritizing among the many newly available pharmaceuticals.

2. *Fair and reasonable prices*
The MoH sets maximum prices based on the average prices in a group of reference countries. The health plans then use their market power to negotiate discounts from these maximum prices.
3. *Efficient distribution system.* Most pharmaceuticals are distributed either through the health plans' own networks of pharmacies or through large, independent pharmacy chains.
4. *Effective prescribing behavior.* The health plans strongly encourage their physicians to avoid prescribing expensive medications in cases where lower-cost substitutes (either generic or patented alternatives) are likely to work just as well. This is done through professional meetings and via the health plans' electronic health record systems.
5. *Channeling consumer demand.* Copayments are lower for generic drugs (10 percent) compared to patent drugs (15 percent). In addition, Israel prohibits direct-to-consumer advertising of particular pharmaceuticals. Regulations are being developed to allow advertising of types of medications (in keeping with the public's right to know), subject to various constraints on the nature of the messaging.
6. *Cost-conscious culture and regulatory environment.* Israel's culture and laws promote the availability of generics and competition among patented medications. This is probably due, in part, to Israel being the home of Teva, one of the world's leading manufacturers of generics and the fact that none of the leading manufacturers of patented medications is based in Israel.

6. Supply of Health Care

The Central Role of Primary Care

Israeli health care leaders have long understood the vital role of primary care in promoting an efficient, high-quality health care system. This is reflected in the following:

- Primary care services are accessible throughout the country, with visits to a Primary Care Physician (PCP) rarely requiring more than a short drive and a wait of more than a few days
- Primary care visits are available free of charge (in contrast to visits to specialists, which entail copayments)
- PCPs are well-paid, and often earn more than hospital physicians of the same age
- The health plans allow their members to choose from among all the PCPs who work with the plan¹⁵
- Most Israelis indicate high levels of satisfaction with their PCPs and rarely switch PCPs

- Health plans encourage PCPs to act as care coordinators for their patients and the plans also encourage their members to use their PCPs as such
- The health plans provide their PCPs with extensive logistical support including plan-wide electronic health records systems, call centers, nursing support, and more
- Primary care was the first area for which quality indicators were developed in Israel
- All Israeli medical schools have well-established residency programs for training family physicians
- The OECD has determined that Israel's primary care system is among the most advanced in the world.¹⁶

Nurses play an extensive role in the primary care provided via the HPs in such areas as preventive health care, counselling, triaging of urgent cases, home care, chronic disease management, and the handling of clinical paperwork related to the patients' eligibility for various social benefits.

Israel also has a well-developed system of preventive maternal and child health services, which are staffed primarily by nurses and which are available free of charge. Most Israelis receive these services through clinics operated by the MoH, while others receive them from clinics operated by the health plans or municipalities.

Supply Constraints on High-Cost Services

The MoH periodically develops long-term national and regional plans regarding the supply of hospital beds. In accordance with those plans, it closely regulates the number of hospital beds, along with their distribution in terms of ownership, specialty, and location. The MoH deliberately maintains a tight bed supply—both to control overall costs and to ensure that sufficient resources are available for community-based care. As a result, in 2015 Israel had 1.8 acute care beds per 1,000 population, down from 2.7 in 1998.¹⁷ Israel's bed-to-population ratio has consistently been lower than the OECD average.

There are also seven types of medical equipment the acquisition of which requires MoH approval—irrespective of whether the potential purchaser is a governmental agency, a non-profit-making provider, or a profit-making provider. The devices requiring approval are CT, MRI, and positron emission tomography scanners; gamma cameras; pressure chambers; linear accelerators; and angiography devices. Regulations adopted in 1994, and subsequently amended, set national ceilings for each of these devices, in terms of units per million population. The MoH also decides how to allocate these national quotas among providers (in response to applications for purchase approvals) and (implicitly) among regions. To some extent, the considerations are detailed in the regulations, but there remains ample room for taking into account additional factors.¹⁸

Israel had 9.2 CT scanners per million population in 2012, which is relatively low by international standards. While it is about midway between the rates for the United Kingdom (8.1 per million) and the Netherlands (10.9), it is much lower than the rates for the United States (over 40 per million) and Denmark (approximately 30 per million). The OECD average in 2012 was approximately 20 per million. Note, however, that the CT units in

Israel are used particularly intensively, so that it has about 15,000 scans per year compared with about 7,300 for the OECD countries, on average.

Israel had only 3 MRI devices per million population in 2012, well below the comparable figures for the United States (34.5), the Netherlands (11.8), and even the United Kingdom (6.8). The OECD average is 14. Here, too, utilization in Israel is particularly intensive, with 9,200 scans per year compared with about 5,300 for the OECD countries, on average.

The Vital Role of Electronic Health Records

For over 20 years, all the health plans have provided their physicians with electronic health records systems that enable them to record, retrieve, and share information with other clinicians and diagnostic centers within the health plan. Over the years, these systems have become increasingly sophisticated. They currently provide the clinicians with various decision aids such as alerts about the need to perform certain tests, care suggestions, and notifications about pharmaceutical contraindications. They have clearly played a major role in both improving the quality of care and controlling costs.

In 2014, the MoH launched a national health information exchange for sharing clinical patient data across all of Israel's general hospitals, its four HPs, and additional health care providers. This has provided Israeli clinicians with the world's first national data exchange program, enabling secure authorization-based sharing of clinical data among caregivers. In particular, the system facilitates the flow of information between hospital-based providers and providers based in the community.¹⁹ Citizens can use the "opt-out" feature if they do not wish their data to be accessible.

Additional significant developments over the last few years have been in the mobile and video conference arenas. All the health funds provide extensive mobile applications, striving to emulate what they already offer in a web setting. Services include booking appointments with all clinicians, specialists, dieticians, and therapists; accessing full laboratory results and laboratory history going back 10 years; and ordering recurring prescriptions and medications with their complete history. Patients can view relevant imaging results, request confirmation and pay for procedures carried out at other providers, and check their vaccination history.

Another major improvement has been establishment of secure e-mail connections to PCPs, thereby eliminating unnecessary visits for semi-bureaucratic tasks or to ask a question. In summary, patients can initiate end-to-end health-care-related interaction cycles, both clinical (for example, e-visits and e-prescriptions) and administrative (for example, billing), through a secure, personal health account.

Israel's achievements in health information technology are due in part to its highly-organized system of health care, and in part to its position as an international center for high-technology startups.

Efforts to Reduce Center-Periphery Gaps

As part of a broader, strategic effort to reduce health inequalities,²⁰ the MoH has recently taken several steps to enhance the availability of services and key professionals in the periphery:

1. It has invested substantial financial resources in increasing the periphery's supply of hospital beds, advanced medical devices, specialized hospital units, and freestanding emergency centers.
2. In addition to providing direct funding, the MoH is also using financial incentives to encourage other health system actors to give greater attention to the periphery. For example, a "peripherality" parameter was added to the HP capitation formula in 2010, and the HPs were also offered (and received) special (conditional) payments if they undertook specific initiatives to improve care in the periphery.
3. Major financial incentives were introduced to encourage young physicians to relocate to the periphery.
4. Israel established a new medical school in the Galilee in 2011 as part of an effort to enhance the quantity and quality of physicians in that peripheral region.

Care Integration

The health plans play a major role as care integrators, as they have both the incentives and the capacity to do so. The incentives come from being financed on a prepaid capitation basis (which promotes cost consciousness), having their quality of care monitored (which promotes quality enhancement), and being subject to competition (which promotes responsiveness). The capacity comes from being large, well-run organizations that have been entrusted with organizing the full spectrum of care for their members along with the budgets needed to do so.

The health plans have taken numerous steps to promote care integration, including:

- The creation of electronic health record systems linking all their clinicians and diagnostic centers
- Encouraging the development of the PCPs as care coordinators
- Enhancing the roles of nurses as care coordinators, particularly in the case of patients with multiple chronic illnesses
- Developing care coordinators and facilitators for special population groups such as Arabs and ultra-orthodox Jews.

The government has recognized and appreciated the health plans' abilities in care integration. One of the main reasons that the government recently entrusted the health plans with responsibility for mental health care is the expectation that the plans will be effective in linking physical health care with mental health care. The MoH is also hoping to increase the health plans' involvement in long-term care, to better link up the long-term care system with acute care services. A similar objective was behind past efforts (only partially successful) to transfer the responsibility for various preventive maternal and child health

services from the government to the health plans; the hope was to create more links between prevention and treatment.

Other actors are also playing important roles in promoting care integration. As noted, the MoH is fostering health information exchange between hospitals and the health plans. In addition, a coalition of organizations is working on developing a set of quality indicators for care continuity across providers.

7. Governance and Accountability

The Ongoing Debate about Whether the Ministry of Health should Continue to be a Service Provider and a Regulator

There is an ongoing debate in Israel about whether the MoH should continue to be a service provider in addition to being the system's overall policy maker and planner. The issue arises with regard to several services provided by the MoH, with the most contentious being the provision of acute care hospital services.

The MoH owns and operates about half of the country's acute care hospital beds. It also plays a major role in regulating the hospital system overall, with the areas of regulation including the following:

- Any addition to the hospital bed complement requires MoH approval
- The rates for hospital services, as well as the cap on hospital revenues, are determined by the MoH together with the MoF
- The MoH sets hospital quality standards and monitors performance against those standards
- Those opposed to MoH's continued operation of acute care hospitals make the following arguments:
 - The operation of hospitals distracts the attention of top MoH officials from policy making and planning for the system as a whole.
 - There is a conflict of interest between MoH's regulatory role and its ownership role; the MoH has an incentive to favor its own hospitals in their competition with other hospitals, and to favor hospitals in general in their ongoing tug-of-war with the health plans.²¹
 - All government agencies need to adhere to strict personnel and purchasing regulations, which impede efficient hospital operation.

In the late 1980s, a blue-ribbon panel (The Netanyahu Commission) recommended that the MoH spin off its hospitals as independent trusts. In the early 1990s, the MoH tried to do so, but it was stymied by opposition from the labor unions; the unions were concerned about the impact on job security and working conditions. The independent trust model has continued to be favored by most policy analysts in the decade since, but even those MoH leaders who supported that model have been unable to implement it.

Accordingly, in recent years, alternative models have come into vogue. Several years ago, a Government Hospital Authority was established that was to report to the Minister of Health but not the director-general of the MoH. That proved unsatisfactory, and instead a Government Hospitals Division has been set up that reports to the MoH's director-general. This does not fully remove the potential conflicts of interest, but has allowed most MoH divisions to focus on overall national health policy (including policies relevant to all of Israel's hospitals), while leaving most of the operational issues to the newly created division.

Systems for Promoting Transparency and Accountability

In recent years, the MoH has made transparency one of its main goals. The notion behind this is that insurees/patients/citizens have a right to information about their health, health care, and health care rights, as well as the quality of care provision. The provision of information is viewed as making it easier for consumers to make informed choices and receive better care. Consequently, there is a belief that providing such information is good for the population and for the health system.

This objective has been advanced through a number of initiatives, several of which have been mentioned and which include:

- Establishment of a website with extensive information on consumer rights related to both the NHI system and the supplemental insurance programs²²
- Publication of data from the National Programme for Quality Indicators in Community Healthcare for each HP
- Collection of data on hospital quality, with the intention of publishing the findings by hospital in the near future
- Surveys of patient experiences in general hospitals, with the results published by hospital
- Publication of hospital-specific waiting times.²³

These relatively new initiatives are in addition to several long-standing initiatives to share key data with the public, such as publication of the HPs' financial statements and publication, by HP, of key findings from the MJB Institute's biannual consumer survey on satisfaction with plan services and access to service.²⁴

Health policy development processes are also characterized by transparency and the involvement of a broad range of interested parties. The National Health Council, which is a statutory body charged with advising the Minister of Health on major policy issues, includes representatives of the government, the HPs, the hospitals, professional associations, and the general public. Similarly, the committee that recommends priorities for additions to the NHI benefits package includes representatives of a broad set of institutions and of the general public. The subcommittees dealing with the capitation formula and with hospital pricing include members of the HPs, the MoF, the MoH and (in the latter case) the hospitals, as well. Moreover, proposals for major policy changes, such as extending NHI to include dental care for children, are given substantial time for

consideration and refinement; typically, there are quite a few public forums in which such proposals are presented and debated, along with vigorous commentary in the mass media. In recent years, MoH has increasingly used the web to gather input from the public on key policy issues. When policy changes require legislation, the extent of public discussion—and involvement of elected representatives—is often particularly intense.

Accountability is also given substantial attention in Israeli health care, proceeding along several tracks.²⁵ The MoH plays a major role in ensuring that health care providers meet various quality and financial standards. The public is also involved in promoting market accountability through competition among hospitals and among HPs. The performance of the MoH is also held up to public scrutiny by the media, the Knesset, other health system actors, and independent researchers and analysts. Another key component is the involvement of international organizations, such as the World Health Organization, the European Observatory on Health Systems and Policies, and the OECD; for example, several years ago the MoH commissioned an OECD review of quality in Israeli health care that has been both informative and influential. Finally, every few years the government or the MoH has appointed a blue-ribbon panel of one sort or another to assess the health system's performance and to recommend reforms.

8. Future Challenges

One of the biggest challenges facing Israeli health care is the growth in private financing and private provision. The private share of health care financing has increased from approximately 30 percent when NHI was introduced to approximately 40 percent. The proportion of the population with voluntary (that is, private) health insurance has grown markedly, as has the scope of the private insurance packages. A large and increasing share of elective surgical operations is being carried out in private hospitals.

The growth in private financing and private provision are mutually enforcing. With more privately provided services available, there is a greater incentive to purchase private insurance. As more and more people have private insurance, there is more of an incentive for physicians and business people to develop private services and facilities, which are more profitable than publicly funded services.

The intertwined growth in private financing and private provision poses serious threats to health care equity, access, costs, and effectiveness. They enable high-income persons to obtain more services and to obtain certain services more quickly, with more amenities, and with more personal attention from the physicians (compared with lower-income persons). They increase both the volume of services provided and their prices—first in the private sector and then in the public sector, as well, due to spillover effects. They also threaten to erode quality in the public hospitals, as many surgeons are leaving them in the midafternoon to pursue their private practices in private hospitals. To address these challenges, the government has launched an ambitious program to both strengthen the public system and restrain the growth of the private system.

Another important challenge faced by Israeli health care is that, historically, it has not been particularly patient-centered. In some areas of care, it has not even been particularly patient-sensitive. With health needs pressing, and resources limited, all too often clinicians have focused too narrowly on technically defined results. There is a growing recognition that care must also be sensitive to patient preferences and the patient experience.

Figure 8.1 Government and Compulsory Health Insurance Schemes, Per Capita Expenditure, US\$ Purchasing Power Parities (current prices, current PPPs)

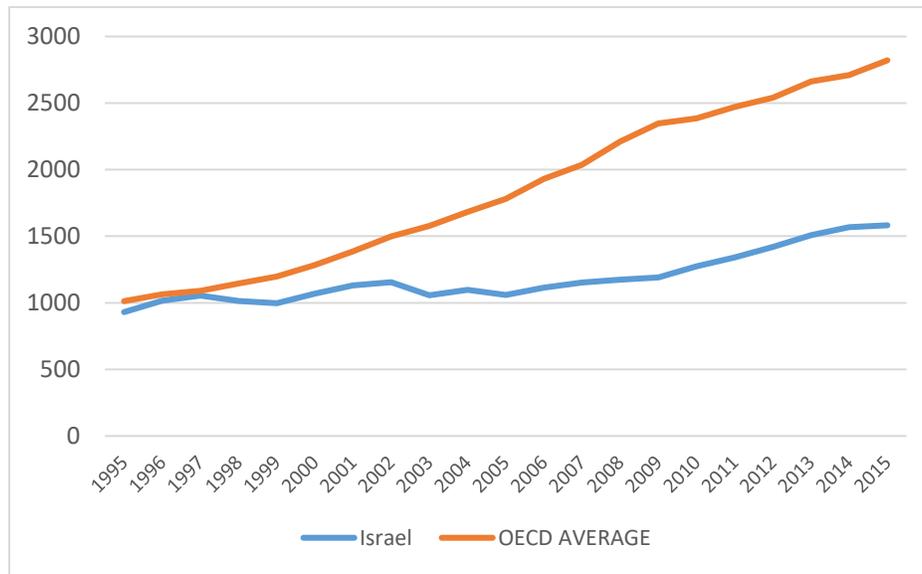
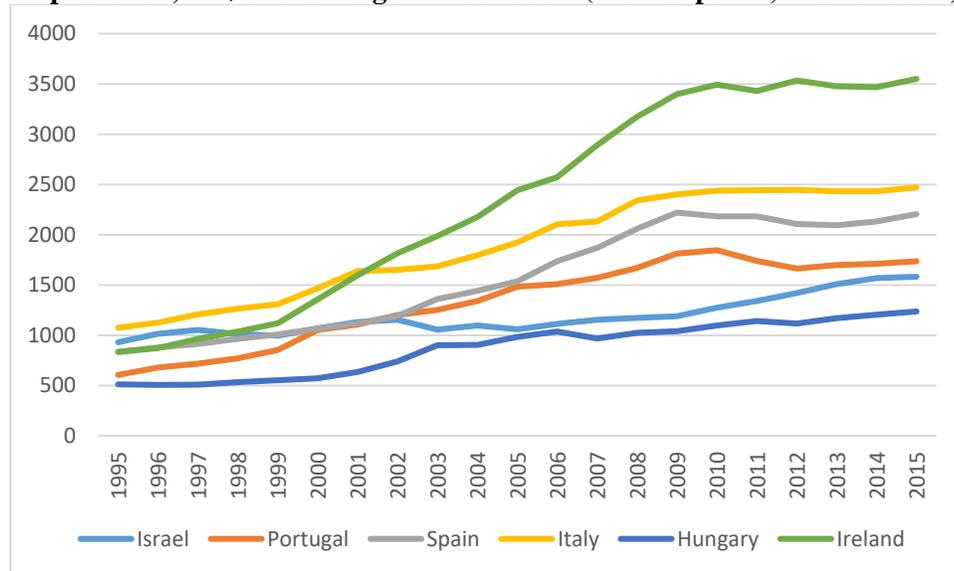


Figure 8.2 Government and Compulsory Health Insurance Schemes, Per Capita Expenditure, US\$ Purchasing Power Parities (current prices, current PPPs)



Source: OECD Health Statistics 2016. Last updated October 12, 2016.

Related developments include a decline in public funding as a share of total health expenditure, Israel's relatively low public expenditure as percent of GDP, and the low and

slow growth of public funding per capita over the years (see figures 8.1 and 8.2). Many Israeli policy analysts and policy makers believe that these developments have contributed to a decline in the accessibility of services and in public confidence in the publicly financed health system, leading to a growth in demand for private services. Others note that per capita government spending on health in Israel has not declined, and they believe that the growth of the private sector is due primarily to other factors—including rising expectations, the availability of low-cost (voluntary) private insurance, and aggressive marketing by the commercial insurers.

In any case, there is a consensus among most policy makers that the fates of the public and private sectors are intertwined and that there is a need to simultaneously strengthen the public sector (including via increased funding) and restrain the growth of the private sector.

9. Israel’s Experience in Drawing Lessons from other Countries

Israeli health care has benefited enormously from lessons learned from other countries. For example, its system of competing health plans and its capitation formula drew heavily on the experience in the Netherlands and several other European countries. Similarly, Israel is increasingly using activity-based payments in its hospital reimbursement system.

In fact, cross-national learning is at the heart of health policy development in Israel. Almost always, when a new policy dilemma arises, policy analysts will explore how it has been addressed in other countries and policy makers eagerly consume that sort of information. Israelis also participate in international conferences and study tours to learn about promising developments in other countries.

When Israelis import innovations from other countries, they of course adapt them to Israel’s unique circumstances. This is not a simple matter of copy and paste. As an illustrative example, Israel’s world-renowned system for monitoring the quality of care in the community²⁶ drew heavily on similar efforts in the United States and the United Kingdom—in terms of both the overall concept and choice of particular indicators. However, those efforts (particularly the U.S. Healthcare Effectiveness Data and Information Set [HEDIS] system) relied heavily on manual data extraction from paper records. Doing so is expensive, and while U.S. health care might have had the necessary funds, Israeli health care clearly did not. Israel did, however, have a resource that was unavailable in the United States: all its primary care physicians had access to standardized electronic health records. As a result, Israel decided to focus its quality monitoring effort on those quality indicators that could be derived from data that could be extracted digitally from the ubiquitous electronic health record (EHR) systems.

As Israel now tries to address the challenge of a growing private sector and the need to be more patient-centered, these two areas have become an important focus in Israel’s cross-national learning efforts. Here, too, the expectation is that we will learn much from other

countries, and at the same time, we will need to adapt what we learn from abroad to Israel's unique circumstances.

10. Potential Lessons from Israel for Middle-Income Countries (MICs)

The Israeli health care system has several strengths that could serve as models for MICs in their efforts to improve their systems and advance universal health care. Israel also faces several challenges, which may be similar to those faced by MICs, and a deeper look at them could shed some light on ways to tackle them.

Strengths of the Israeli Health Care System that might be Relevant to MICs

Health Plan Competition in a Simple and Transparent Environment

HPs in Israel are funded prospectively by the government, and not directly by members; therefore, they do not compete on price, but rather on quality of care for services in the basic package and coverage in the VHI packages. The relatively simple Israeli market is composed of only a few (four) HPs that provide the same services (listed in the health basket), and this makes it easier for individuals to evaluate all the plans and choose the most appropriate one. The simple Israeli market is an advantage compared to countries with many HPs or insurers, who offer many different insurance products (such as Switzerland, for example), where choice may be more challenging.

However, even with a limited number of HPs, in order to make choice and competition efficient, it is essential to provide individuals with transparent and comparative indicators and information to make wise choices. For example, there is a need for transparent information about HPs' performance and quality of care such as waiting times for the different services; public satisfaction with caregivers, services and the HP; and relevant health status indicators. In Israel, a national program funded by the MoH publishes comparative care quality indicators,²⁷ and the MJB Institute publishes public satisfaction by HP as measured in national surveys. In addition, the MoH also publishes comparative data on VHI service coverage and prices.²⁸

Health Plans as Managed-Care and Patient-Centered Care Organizations

The nature of HPs as insurers and providers of health care, and the competitive market also encourages HPs to be cost-conscious and to aim to provide care efficiently. This environment may avoid waste more than other systems. In Israel, HPs actively manage patient care and attempt to promote patient-centered continuous care. For example, in some HPs, primary care physicians are gatekeepers, and may also function as "case managers."

Some HPs develop patient-centered care (PCC) programs for the chronically ill. For example, Clalit's Comprehensive Care for Multimorbid Adults Program (CC-MAP) is based on patient selection according to high risk, and has a dedicated nurse who works

with the primary care physician to create a comprehensive care plan for these patients and coordinates and provides self-management support for these patients with continuous follow-up. Maccabi's PCC program includes care coordinators for discharged complex patients to ensure continuity of care in the community.

HPs have developed PCC services tailored to specific population groups. For example, PCC programs have been developed for the ultra-orthodox Jewish public, with religious "care coordinators" who bridge the relationships between the caregiver/HP and the patient—mainly culturally. There are also services developed for other minorities such as Arabs and immigrants (mainly Russian and Amharic speakers). These include internet and call services in various languages, and care coordinators who speak various languages.

These PCC models could be useful in MICs where populations in different geographic areas or ethnic minorities have different health care needs and/or speak different languages.

Focus on the Development of Community-Based Primary Care

Israel has a well-developed community care system, which has been praised by the OECD,²⁹ and which can be a model for MICs. Israel's primary care is the base of the health care system, with widely available and accessible primary-caregivers who provide preventive and curative care in three different settings:

1. **Primary care physicians in HP-owned or HP-affiliated clinics** who work with a comprehensive e-health records system that facilitates continuity of care. Primary care physicians in Israel can both manage and coordinate care, as they can function both as gatekeepers and case managers. They have access to information on the care provided by specialists, results of exams, and medications prescribed.
2. **Public health clinics** (well-baby clinics, "Tipat chalav"). Nurses at these clinics provide preventive care free of charge, such as vaccinations for children and mothers, and developmental monitoring up to school age. They also orient mothers regarding pregnancy monitoring, lactation, healthy diet, hygiene, dental health, and healthy lifestyles. Physicians are also involved in the development screening of the children.

MICs could use these kinds of public health clinics to provide services similar to those provided in Israel and also to screen and counsel women regarding family planning, abuse, or violence. Children can be screened and treated for physical, sexual, or psychological abuse or neglect. These clinics can be staffed by multidisciplinary teams that combine health and social care, which are often interrelated.

Another idea for health care in MICs is to further develop this model of community clinics and offer care specialized to certain types of patients. For example, some of the clinics could specialize in treating and monitoring specific types of chronically

ill patients such as diabetics, or persons with hypertension, respiratory diseases, or AIDS.

Another option is to develop community clinics for elderly patients, who usually suffer from multi-comorbidities, depression, loneliness, and have specific social needs. For example, these clinics could provide a framework for health, mental, and social care; and a space for them to socialize.

3. **Preventive care for children in schools** free of charge. This includes vaccinations, hearing, vision, and developmental exams, healthy behavior guidance such as healthy nutrition, dental health, and hygiene. Combining formal education with health and hygiene education may be particularly important in MICs.

Investment in E-health Records for Management and Continuity of Care

Israeli HPs have well-developed e-health services for both caregivers and patients. Physicians and nurses have easy access to full medical records, which enables them to manage and coordinate patient care. For patients, there are easy-to-use platforms for digital communication with physicians, and a possibility to request and receive digital prescriptions for drugs and digital referrals to specialists and hospitals. Patients also have full access to their digital personal medical information (results of diagnostic tests, imaging, list of medications, and so forth). In all HPs, it is possible to schedule appointments online.

Other initiatives are patient-centered care dedicated to children such as telemedicine with pediatricians available after work hours. For the elderly or chronically ill there are telemedicine services with nurses and care coordinators who enhance coordinated care. All these services save time and expenditures for providers and patients, and make services more available and accessible for populations in remote areas.

Many MICs have the capacity to implement these platforms. One implementation possibility is through cooperation between government and private insurers and Health Maintenance Organizations (HMOs).

Challenges Facing the Israeli Health Care System which might be Relevant to MICs

A Growing Private Market that Leads to Inequalities in Access and Quality of Care Based on Insurance Type

Despite Israel's NHI and broad health care coverage, private funding and provision of care is still high compared to other high-income countries. About 40 percent of total health expenditures are funded privately either by voluntary health insurance or out-of-pocket payments. VHI in Israel complements, supplements, and duplicates the NHI: it covers services outside the NHI, supplements services in the NHI, but also covers the same services in the NHI with faster access and enhanced choice of provider.³⁰

Over and above the compulsory national health insurance, two forms of VHI are available in Israel: supplementary insurance, offered by the health plans to their own beneficiaries (HP-VHI); and commercial insurance offered by commercial insurance companies to individuals or groups. Nearly 90 percent of the adult population is covered by HP-VHI, 53 percent is covered by commercial VHI, and half the adult population has both HP and commercial VHI.³¹ Given that the NHI is compulsory and individuals cannot opt out, there is a significant amount of dual and multiple health insurance coverage, a situation that creates both a waste of resources and a two-tier health care system.

Similar to Israel, many MICs have “dual” health care systems; often, private funding represents more than half of total health expenditure. In some countries, private health insurance is mandatory for employees, on top of the public health care funding (be it NHS or NHI).³² In MICs, the situation is more severe than in Israel, because the public system is often underfunded and underprovides the services needed, and the private system is broad and provides better care. The private system comprises various commercial insurers and HMOs. As in Israel, VHI duplicates and supplements services provided publicly. Waste may be even worse in MICs where a large parcel of the population pays twice for health care, first to the public system (as general or earmarked taxes), and second to private HMOs and/or commercial insurers. Another disadvantage of relying so much on private funding and provision of care is the lack of continuity of care and care management due to “doctor shopping” and the disconnect between public and private providers. Private funding also exacerbates disparities in access and quality of care.

Israel’s Attempt to Avoid Waste by Tackling Dual Coverage³³

Dual coverage raises concerns that consumers may be paying twice for policies that provide the same or overlapping coverage. Therefore, in September 2015, the Israeli government approved several changes to the regulation of the commercial insurance market to address the multiple coverage issue and protect consumers (MoF 2015a, 2015b, 2015c).³⁴ The changes create more transparent and simpler insurance products to help refine consumer choice and potentially enhance market competition based on quality rather than price. The changes include:

- 1. Creation of a “standard policy” for operations and specialist consultations.** Insurance conditions (including coverage, premium, and copayments) must be the same for all insurers and insured. The premium can vary according to eight age groups and personal risk such as gender and previous medical conditions. Commercial insurance can cover services provided only by physicians who have contracts with the insurer, and providers cannot extra-bill patients. The government is currently considering extending the standard policy to HP-VHI.
- 2. Improving insurance for “severe diseases.”** The MoF (2015) redefined and updated the list of severe diseases, which all commercial insurers are required to cover. This was done to better reflect current epidemiological and technological changes. It defined the diagnosis and symptoms needed for entitlement to compensation. Each

insurer is allowed to add coverage for additional diseases, contingent upon transparent disclosure on its website.

3. Requiring insurers to offer any additional policy packages separately, each with its own price and without mutual dependency of ownership. They are allowed to give discounts to consumers who choose to purchase coverage for more than one service.

Some MICs have several overlapping insurance layers, with some funded by the government, others by employers, and others by households. Consideration could be given to better integration among them, in order to promote more effective universal health care. The Israeli case illustrates one way to do so—by reducing the overlap among layers. But the Israeli approach may not be the best fit for any particular MIC, which might better pursue other forms of integration.

Israel’s Attempt to Limit the Diversion of Patients to the Private Sector³⁵

Israeli residents can opt to visit specialists who are privately funded (that is, paid for either out-of-pocket or through VHI). For example, in exchange for private payment they can choose a surgeon in a private hospital or visit a specialist who has no arrangements with one’s health plan. Choice of physician is also used to shorten waiting times in both the community and in hospitals.

The increasing private health care funding is to some extent crowding out the public sector in the competition for physician time. Prices in the private sector are higher, and physicians in that sector are paid based on a fee-for-service basis. Therefore, physicians have strong incentives to prefer private practice. Many of the best and the more senior physicians have reduced their publicly paid activities, which leads to increasing waiting times in the public sector. Moreover, it increases the gaps in access and quality of care between those who have VHI and those who do not. Those who do not have VHI (the vulnerable population) are the ones who bear and suffer from long waiting times and shortages of resources in the public sector.

A law enacted in December 2015 stipulated that a physician who has started treating a publicly funded patient cannot subsequently provide that patient with a privately funded service during a period of at least four months.³⁶ This law attempts to limit the diversion of patients from the public to the private system. This law, formulated by the MoH and MoF, intends to restrain the growth of private practice and funding as a component of the national effort to strengthen the public health care system.

Like Israel, many MICs also allow physicians based in the public sector to also work in the private sector. The Israeli approach to limiting abuse of this privilege may be relevant to some of these MICs.

Notes

¹ World Bank 2017; <http://data.worldbank.org/indicator/SP.POP.DPND>.

² The regional averages for men are as follows: 58.3 in Africa, 74.0 in the Americas, 67.3 in Southeast Asia, 73 in Europe, 67.3 in the Eastern Mediterranean, and 74.5 in the Western Pacific. The regional averages for women are as follows: 61.8 in Africa, 79.9 in the Americas, 70.7 in Southeast Asia, 80.2 in Europe, 70.3 in the Eastern Mediterranean, and 78.7 in the Western Pacific.

³ The average share of health in GDP is 4.3 percent for Southeast Asia, 14.2 percent for the Americas, 4.8 percent for the Eastern Mediterranean, 7.1 percent for the Western Pacific, 9.5 percent for Europe, and 5.5 percent for Africa.

⁴ Due to the combination of earmarked and general government funding, when there are economic slowdowns and the health tax revenue decreases, the government can increase its share of funding so as not to decrease overall public funding. Another advantage of the two-part funding is that there is always a stable, predictable part of public funding that does not depend on year-to-year government decisions and priority settings.

⁵ The annual revenue caps relate to each health plan-hospital combination. They are adjusted on a yearly base and recalculated every three years. Beyond that, the prices of hospital services are fixed and determined by the MoH and MoF. The main payment mechanism is per diem, but since 2010, the MoH has been adopting a payment method by activity based on procedures (the procedure-related groups, or PRGs). HPs negotiate discounts with each hospital, further lowering the final prices.

⁶ However, there are data on disability status.

⁷ Ministry of Health 2014a.

⁸ Ministry of Health 2016.

⁹ Ministry of Health 2016, 2017.

¹⁰ Ministry of Health 2016.

¹¹ Brammli-Greenberg and Medina-Artom 2015.

¹² Ministry of Finance 2012; Ministry of Health 2012.

¹³ Brammli-Greenberg et al. 2014.

¹⁴ Horev and Avni 2016.

¹⁵ This is subject to the constraint that a physician can declare his or her roster full, and he or she then cannot be assigned (and cannot recruit) additional patients.

¹⁶ OECD 2012.

¹⁷ The total number of acute care beds has increased over time, but not as quickly as the population.

¹⁸ Tal, Sheffer, and Vaknin 2008.

¹⁹ The hospitals make use of digitized information from all the health plans, and two of the four health plans similarly make use of digitized information from the hospitals. The other two plans are holding off on using the digitized information sent to them by the hospitals until the system addresses various concerns about data quality and consistency. In the interim, they use only PDFs of the hospital discharge summaries.

²⁰ Horev and Avni 2016.

²¹ One expression of this “favoritism” is that when MoH hospitals end the year in deficit, they receive subsidies from the MoH to cover the deficit, whereas other hospitals do not receive such subsidies.

²² Brammli-Greenberg et al. 2014.

²³ This has been done twice to date. It has been suspended due to problems with data reliability and comparability. Efforts are underway to address these problems, with the plan to renew publication of comparative data in the future.

²⁴ Almog, Habib, and Rosen 2016

²⁵ Almog, Habib, and Rosen 2016; Rosen, Israeli, and Shortell 2012.

²⁶ Jaffe et al. 2012.

²⁷ The National Program for Quality Indicators in Community Healthcare (QICH) evaluates different types of care—mainly prevention (primary, secondary) and chronic care. It includes mostly process measures, but also intermediate outcome measures (for example Hemoglobin A1C levels). In 2015, the program monitored over 60 quality indicators in 8 domains in community health: Health Promotion, Cancer Prevention, Child and Adolescent Health, Elderly Adults, Respiratory Diseases, Cardiovascular Health, Diabetes, and Antibiotic Treatment.

²⁸ Brammli-Greenberg et al. 2014.

²⁹ OECD 2012.

³⁰ Rosen, Waitzberg, and Merkur 2015.

³¹ Brammli-Greenberg and Medina-Artom 2015.

³² In some Latin American countries, private HMOs employ or contract with physicians and other caregivers, and may also own hospitals. Enrollment of employees in private HMOs is mandatory for employers, on top of the mandatory income tax. It is like having two mandatory health care systems, one public and one private.

³³ HSPM 2015.

³⁴ Ministry of Finance 2015a, 2015b, 2015c.

³⁵ HSPM 2016.

³⁶ Knesset 2015.

References

- Almog, Y., J. Habib, and B. Rosen. 2016. "Accountability and Shared Measurement in Health Care: Examples from Israel." In *Public Accountability and Health Care Governance*, edited by P. Mattei. London: Palgrave MacMillan, pp. 193–215.
- Balicer, R. D., and A. Afek. 2017. "Digital health nation: Israel's global big data innovation hub." *The Lancet*. [http://dx.doi.org/10.1016/S0140-6736\(17\)30876-0](http://dx.doi.org/10.1016/S0140-6736(17)30876-0).
- Brammli-Greenberg, S., and T. Medina-Artom. 2015. *Public Opinion on the Level of Service and Performance of the Healthcare System in 2014 and in Comparison with Previous Years*. Research Report 15-672. Jerusalem: Myers-JDC-Brookdale Institute (in Hebrew).
- Brammli-Greenberg, S., R. Waitzberg, and R. Gross. Forthcoming. "Integrating public and private insurance in the Israeli health system: an attempt to reconcile conflicting values." In *Private health insurance and medical savings accounts: lessons from international experience*, edited by S. Thomson. Cambridge: Cambridge University Press.
- Brammli-Greenberg, S., R. Waitzberg, T. Medina-Artom, and A. Adijes-Toren. 2014. "Low-budget policy tool to empower Israeli insureds to demand their rights in the healthcare system." *Health Policy* 118 (3): 279–284.
- Chernichovsky, D. 2013. "Reforms are needed to increase public funding and curb demand for private care in Israel's health system." *Health Affairs* 32 (4): 724–733.
- Clarfield, A. M., O. Manor, G. Bin Nun, S. Shvarts, Z. S. Azzam, A. Afek, F. Basis F, and A. Israeli. 2017. "Health and health care in Israel: an introduction." *The Lancet*. [http://dx.doi.org/10.1016/S0140-6736\(17\)30636-0](http://dx.doi.org/10.1016/S0140-6736(17)30636-0).
- Cohen, N., and T. Horev. 2017. "Policy entrepreneurship and policy networks in healthcare systems – the case of Israel's pediatric dentistry reform." *Israel Journal of Health Policy Research* 6: 24. <https://ijhpr.biomedcentral.com/articles/10.1186/s13584-017-0146-3>.
- HSPM (Health System and Policy Monitor). 2015. Health System and Policy Monitor (Israel web page). 2015. "Changes to Improve the Commercial VHI Market," November 4. <http://www.hspm.org/countries/israel25062012/countrypage.aspx>.
- . 2016. "Limiting the diversion of patients to the private sector." October 27. <http://www.hspm.org/countries/israel25062012/countrypage.aspx>.
- Horev, T., and S. Avni. 2016. "Strengthening the capacities of a national health authority in the effort to mitigate health inequity—the Israeli model." *Israel Journal of Health Policy Research* 5 (19). <https://ijhpr.biomedcentral.com/articles/10.1186/s13584-016-0077-4>.
- Jaffe, D. H., A. Shmueli, A. Ben-Yehuda, O. Paltiel, R. Calderon, A. D. Cohen, E. Matz, J. K. Rosenblum, R. Wilf-Miron, and O. Manor. 2012. "Community healthcare in Israel: quality indicators 2007–2009." *Israel Journal of Health Policy Research* 1 (3). <https://ijhpr.biomedcentral.com/articles/10.1186/2045-4015-1-3>.

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- Knesset. 2015. Law number 2516 of 25 December 2015 (in Hebrew). http://fs.knesset.gov.il/20/law/20_lsr_318725.pdf.
- Ministry of Finance. 2012. *Annual Report of the Commissioner of the Capital Market, Insurance and Savings* (in Hebrew). <http://www.anet.co.il/anetfiles/files/6199.pdf>.
- . 2015a. Regulation of insurance from 3-8-2015 (in Hebrew). http://www.nevo.co.il/law_html/Law01/501_266.htm.
- . 2015b. Insurance circular 17-1-2015 (in Hebrew). http://www.mof.gov.il/hon/documents/הסדרה-והקיקה/insurance/memos/h_2015-1-17.pdf.
- . 2015c. Insurance circular 20-1-2015 (in Hebrew). http://www.mof.gov.il/hon/documents/הסדרה-והקיקה/insurance/memos/h_2015-1-20.pdf.
- Ministry of Health. 2012. “Issues on policy and regulation of private health insurance” (in Hebrew). http://www.health.gov.il/PublicationsFiles/281112_11122012.pdf.
- . 2014a. “Summary report on HPs activities in 2013.” (In Hebrew). <http://www.health.gov.il/PublicationsFiles/dochHashvaatui2013.pdf>.
- . 2016. “Circular of the Deputy Director General for Supervision of the Health Plans and Supplementary Insurance: Updating payments for health services and medicines for 2016” (in Hebrew). http://www.health.gov.il/hozer/sbn04_2016.pdf
- . 2017. “Call Habriut” (in Hebrew). <http://call.health.gov.il/infocenter/index?page=content&id=GE33>.
- OECD (Organisation for Economic Co-operation and Development). 2012. “OECD Reviews of Health Care Quality: Israel 2012.” Organisation for Economic Co-operation and Development, Paris.
- . 2017. <http://stats.oecd.org>.
- OECD (Organisation for Economic Co-operation and Development) Health Statistics. 2016. <http://www.oecd.org/els/health-systems/health-data.htm>.
- Rosen, B. 2016. “Adaptation of health care innovations from other countries.” Brookdale Briefings – Inside Israel’s Social Challenges. Youtube video clip from Myers-JDC-Brookdale Institute, Jerusalem.
- . 2016. “The Israeli Health Care System.” In *International Health Care System Profiles*. New York: The Commonwealth Fund.
- Rosen, B., A. Israeli, and S. Shortel, eds. 2012. *Accountability and Responsibility in Health Care – Issues in Addressing an Emerging Global Challenge*. Singapore: World Scientific.
- Rosen, B., R. Waitzberg, and S. Merkur. 2015. *Israel: Health System Review*. Health Systems in Transition. Copenhagen: European Observatory of Health Systems and Policies.

Tal, O., N. Sheffer, and S. Vaknin. 2008. “Parameters for Allocation of Expensive Medical Devices (EMD) as a National Regulatory Mechanism” (in Hebrew). *Harefuah* 147: 359–362, 372.

World Bank. 2017. Indicators. <http://data.worldbank.org/indicator/>.

Zwanziger, J., and S. Brammli-Greenberg. 2011. “Strong Government Influence Over The Israeli Health Care System Has Led To Low Rates Of Spending Growth.” *Health Affairs* 30 (9): 1779–1785.

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The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions–used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to portray how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding coverage while ensuring that the poor and vulnerable are not left behind
- **Strategic Purchasing:** expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers
- **Raising revenues** to finance health care in fiscally sustainable ways
- **Improving the availability and quality of health-care providers**
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By 2017, the Series had published 24 country case studies and a book analyzing and comparing the initial 24 case studies. In 2018 the Series will publish 15 additional case studies. Links to the country case studies and the book are included below.

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The Universal Health Coverage Study Series aims to provide UHC policy makers and implementers with knowledge about available and tested tools—policies, instruments and institutions—to expand health coverage in ways that are pro-poor, quality enhancing, provide financial risk protection and are fiscally sustainable.



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