Universal Health Coverage in Israel: Going Beyond the Number Covered

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ABSTRACT: The health indicators of Israel are high, while relative spending on healthcare is low. The enactment of the National Health Insurance Law (NHIL) in 1995 entitled all Israeli residents to free or nearly free health coverage via access to a socially determined "basket" of medical care. However, the NHIL recognizes that universal health coverage (UHC) transcends "the numbers," or shares of population coverage. According to this law, UHC also embodies a series of qualitative attributes.
This paper highlights the UHC attributes achieved in the Israeli healthcare system, beyond population coverage: equitable coverage, progressive contributions, access depending solely on medical need, accountability, and free choice. It also demonstrates particular implementation and continuance challenges: the lack of a firm state commitment to equitable UHC, leading to persistent disparities across Israel.

Introduction

Israel secured universal healthcare coverage (UHC) for its residents upon enacting the National Health Insurance Law (NHIL) in 1995.[1,2]

The law is based on principles of justice, equity and mutual support that aim first and foremost to (a) guarantee every resident free or nearly free access to a socially determined "basket" of medical care, and (b) protect household non-medical consumption from unacceptable spending on such care. In addition to the aforementioned, the law also stipulates a managed competition system to assure quality care and patient satisfaction efficiency and cost controls.

This Israeli legislation aimed to epitomize the full meaning and nature of universal health coverage. Prior to its enactment, Israel already had near-universal (95%) coverage; therefore, the opponents of the law argued that this legislation would be redundant, and that "minor change" was all that was required to make insurance mandatory for the 5% non-insured.

However, the NHIL recognizes that universal health coverage goes beyond "the numbers," or shares of population covered. By this law, UHC also embodies a series of qualitative attributes.

Background

As of 2017, Israel has a population of 8.79 million. Life expectancy at birth is 82.1 years and the infant mortality rate is 3.1 per 1,000 births—these outcomes are higher than for the U.S. and other OECD countries (Table 1).

Simultaneously, Israel spends considerably less per capita and a lower percentage of its gross domestic product (GDP) on healthcare than the U.S. and the OECD average: approximately 7%, as opposed to about 17% and 12%, respectively. Also in contrast

1 The Israeli law makes a distinction between 'citizens' and 'residents'. The NHIL applies to residents, some of whom are not citizens (Chernichovsky, 2009), (Chernichovsky, 2013), (Rosen & Samuel, 2009).

2 There can be entitlement by virtue of other statutes. The latter includes, as key examples, entitlement of those serving in the military, individuals covered by car and other insurance for particular injury requiring medical attention. Regardless of this the principle that every resident is covered for "necessary treatments" is maintained.

to the trend of rising healthcare spending as a share of GDP in other developed countries, spending in Israel has remained fairly stable over the 20 years between 1996 and 2016.

TABLE 1. HEALTH OUTCOMES/SPENDING IN ISRAEL, COMPARED TO THE U.S. AND OECD AVERAGE

Health Outcomes/Spending	Israel	United States	OECD Average
Life expectancy at birth (2015)	82.1 years	78.8 years	80.8 years
Infant mortality rate (2015)	3.1 per 1,000 births	5.8 per 1,000 births	4.2 per 1,000 births
Population above age 65 (%)	11.33%	14.5%	18.05%
Healthcare spending (Per capita)	$2,822 (USD)	$9,892 (USD)	$4,708 (USD)
Healthcare spending (% of GDP)	7.3%	17.2%	12.3%

Source: OECD Data, The World Bank Data

Medical Benefits

Entitled benefits

Israelis have been entitled to maternal, child, obstetric, and mental health care since the State of Israel was established in 1948, and to state-subsidized long-term care in the community and institutions since the mid-1950s. Under the NHIL enacted in 1995, residents of Israel became entitled to additional medical benefits: general preventive, acute, and chronic care delivered in the community and in hospitals, hereinafter referred to as "general care".

Prior to the NHIL, this care was secured by four sickness funds: Klalit Health Services, Maccabi Healthcare Services, Leumit Health Fund, and Meuhedet Health Fund. These funds covered about 95% of the population prior to the law, operating fairly independently from the state. The law then adopted the funds as arms of the state.

Quasi-private and private benefits

Each sickness fund also offers supplemental insurance to its members at community-rated premiums and with no underwriting.[3] Approximately 80% of Israelis hold this supplemental insurance—a dramatic increase from about 20% in 1998.

These funds have been regulated to pay for care and treatment in "private" provider facilities not funded by tax money, and do not monetarily reimburse its members, in contrast to commercial insurance reimbursement.

Israelis also have the option of purchasing wholly commercial insurance; currently, around 30% of Israelis hold this coverage.

In spite of legislation and regulation to the contrary, there is considerable duplication of benefits among all three insurance schemes; however, Israelis purchase voluntary insurance primarily to reduce waiting times and a wider choice of physicians.

3 Some elements of the insurance may stipulate a "waiting period," after which the benefits become effective. This is not underwriting.

The System

The organization of the Israeli system is depicted with the aid of Figure 1 according three functions: funding, fund holding, and care provision.

Funding

In line with the NHIL's principles, universal coverage in Israel is funded by general taxes plus an income-based health tax. The two taxes also replaced mandated employer contributions in 1998. However, these taxes only finance universally-entitled general care originally granted in 1995 (Figure 1 - a). They do not pay for maternity expenses or community long-term care, which are financed through the National Insurance Institute (NII), Israel's social security agency (Figure 1 - b). Nor do they pay for entitlements to maternal and child health, obstetric, or institutional long-term care, which are financed directly through the state budget of the Ministry of Health (Figure 1 - c).

Health tax collection and the share of the state budget allotted to general care are pooled through a special fund managed by the NII. The pooled contributions, about 80% of the public budget allotted to healthcare, are distributed nationally to the four competing sickness funds according to criteria of need, defined by an age-gender risk-adjusted (capitation) mechanism with an adjustment for disparities associated with the "social periphery."

In addition, the cost of five "severe diseases"—Gaucher disease, hemophilia, HIV, Thalassemia, and chronic kidney failure—are paid on a per-treatment basis, according to a Diagnostic Related Groupings method.

The remaining 20% of the public budget finances the healthcare activities overseen by the state and the NII.

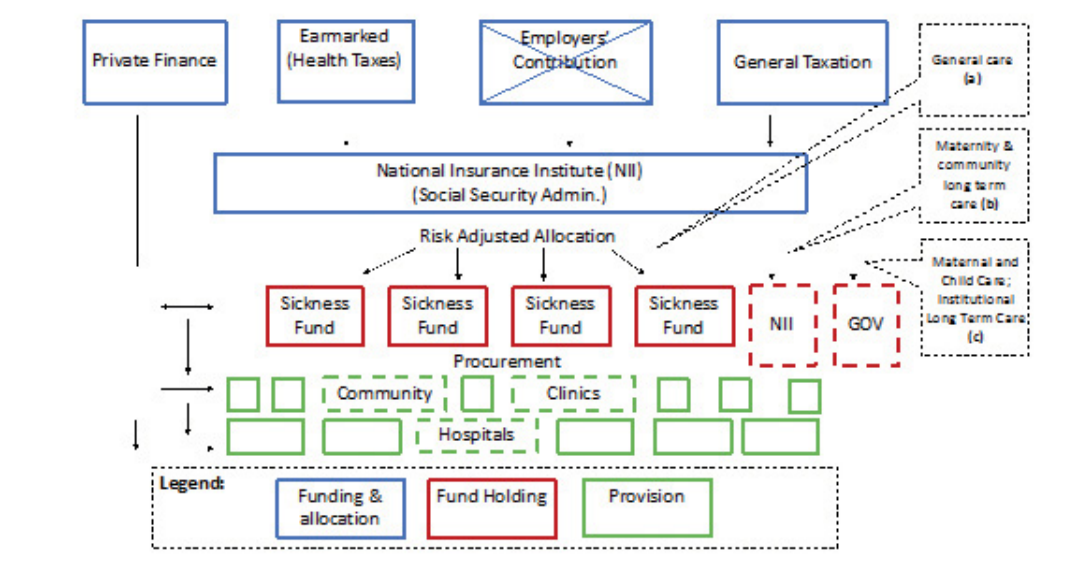
Budget Holding

The four competing sickness funds organize, manage, and procure care for their membership in a variety of ways. The largest fund, Klalit Health Services, is also the largest care provider, owning and operating its own clinics and hospitals. The second-largest fund, Maccabi Health Services, contracts almost all care from private clinics and from hospitals that it does not own (including those owned by Klalit). The two smaller funds, Mehuhedet and Leumit tend to provide primary care in their own clinics and purchase specialized care and hospitalization from institutions they do not own.

Provision of Care

Provider organizations may be public, wholly privately owned, or non-governmental not-for-profit. Public funds can only be used in facilities that do not provide care paid by supplementary or commercial insurance and out-of-pocket pay.

FIGURE 1. THE ORGANIZATION OF THE ISRAELI HEALTH SYSTEM



Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel
Note: This depicts the organization of the Israeli Health System following the enactment of the NHIL in 1995.

The Attributes of Universal Health Coverage in Israel

The right to equitable medical care

The NHIL recognizes access to equitable, basic medical care as a fundamental right to be supported by the public, regardless of one's employment status, place of work, or the level of one's contributions to the system.

Equitable care

The NHIL established a standard "basket" of care financed by taxes that each sickness fund must provide to its members. This standard basket of care was made possible by pooling all income-based tax contributions. Prior to the NHIL, contributions to the sickness funds were already income-based; however, this legislation made them more progressive, thus providing even more protection to household income from "undue" catastrophic medical expenditures.

The allocation of the pooled funds to the sickness funds is done through universal risk-adjusted capitation based on members' expected cost of care or need, and not their tax contributions.

Free choice and accountability

To foster transparency and accountability in the healthcare market, the NHIL granted Israelis the right to switch their sickness fund periodically if they choose—which they could not exercise before 1995—and mandated the sickness funds to maintain open enrollment. According to the NHIL, each sickness fund must accept all applicants who want to join or switch from their current fund, and similarly, participating providers must accept all patients, in accordance with the fund's provisions. These stipulations have increased the sickness funds' and providers' accountability to residents.

Efficiency

To reduce labor costs and boost employment, an employers' tax for funding medical services was abolished in 1988 and was replaced with funding from additional general revenues. This measure also makes contributions more fair and equitable than under the regime with employers' contributions. Additionally, the centralized collection of funds through the tax system significantly reduced financial management cost associated with collection.

While increasing accountability to enrollees, the risk-adjusted allocations forced the sickness funds to improve the efficiency of operations as a means to making them more attractive to enrollees on the managed competition market.

Outstanding and Emerging Challenges

Israel's health reform is incomplete in several major regards, and new challenges to universal coverage as defined here have also emerged. These include: a lack of complete integration of

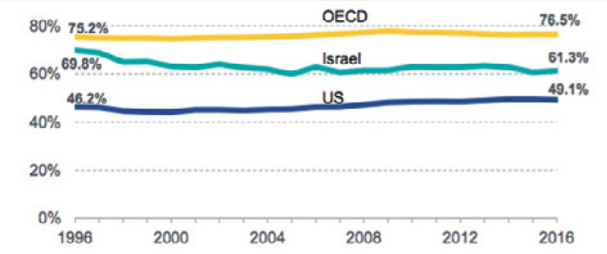
entitlements under sickness funds, uncertain state commitment and funding, an outdated allocation mechanism, and poor regulation of the public/private elements of the health system.

A lack of complete integration

As outlined above, the state oversees entitlement to preventive care, maternal and child care and institutionalized long-term care, while the National Insurance Institute oversees maternity benefits and community long-term care from a separate budget.

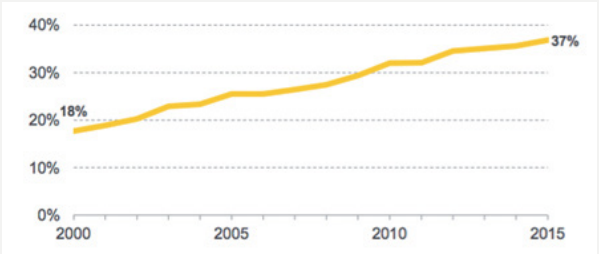
Thus, Israeli policymakers still face the challenge of integrating all entitlements under the institutional umbrella of the sickness funds. This would make the system more efficient, improve quality of care (through integration of treatment), and reduce waiting times, most notably with maternal and child care in the community, as is now the case with mental health.

FIGURE 2. PERCENTAGE OF PUBLIC EXPENDITURE OUT OF NATIONAL EXPENDITURE ON HEALTH



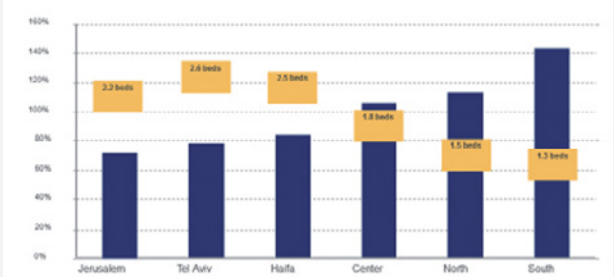
Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel, 2017
Data: OECD, Health spending indicator, 2017

FIGURE 3. EXPENDITURE ON PRIVATE INSURANCE OUT OF TOTAL HOUSEHOLD EXPENDITURE ON HEALTHCARE



Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel, 2017
Data: The Central Bureau of Statistics (Israel), 2015 Household Expenditure Survey

FIGURE 4. REGIONAL AND SOCIOECONOMIC DISPARITIES – WAITING TIMES AND GENERAL BEDS BY REGION (AS PERCENT OF NATIONAL AVERAGE)



Source: Chernichovsky, D., Taub Center for Social Policy Studies in Israel

Declining State Commitment

The commitment to universal health coverage in the state of Israel—mainly by the Ministry of Finance or the Treasury—has been uncertain from the outset. As a result, the negative attitude of the Treasury has prevailed, as evidenced by the 8.5% decline in the share of public health system funding out of total national health expenditure from 1996 to 2016, contrary to relevant international experience (Figure 2). Simultaneously, the share of private finance has increased, mainly in the form of voluntary supplemental and commercial insurance (Figure 3).

An outdated allocation mechanism

The Israeli managed competition model, recommended by the Netanyahu Commission, was to be implemented on a regional basis; the national sickness funds should operate as regional cost centers, assuring that funds intended for a regional population stay with those populations, even if treatment is rendered outside the region of residence (Chernichovsky & Chinitz, 1995). The goal was to ensure equitable regional resource allocation, to prevent public funds from "gravitating toward the center" at the expense of the more remote periphery. However, this recommendation was never legislated, let alone implemented. The risk-adjusted allocation was revised in 2011 to allocate extra funds to the "social periphery," but this change has done little to equalize care across Israel.

Additionally, the risk-adjusted allocation mechanism, based solely on age and gender with an adjustment for the social periphery, leaves excessive room for risk selection against those with chronic conditions. With a fast-growing and aging population, the prevalence of chronic conditions in Israel is rising quickly, highlighting the need for a reformed formula.

Poorly regulated public/private mix

Quasi-public supplemental insurance is regulated to be used only in "private" facilities that do not provide "public" entitled care. This rule also applies for commercial insurance.

However, these "private" facilities are often operated by physicians who also work in "public" facilities. These physicians then refer their patients from the public system to private facilities to augment their own incomes. This referral mechanism also shortens waiting times and increases physician choice for those with supplemental and commercial insurance coverage.

Hence, access to medical care, both in terms of quantity and quality (wait times and physician choice), depends increasingly on private spending, resulting in a growing burden on household budgets.

Persistent Disparities

Increasing system dependence on private funding, a poorly regulated public/private mix, and an outdated allocation mechanism

contribute to persistent and even growing regional disparities in medical infrastructure and access to care in Israel (Figure 4). These also reflect socioeconomic disparities that the NHIL aimed to minimize.

Conclusion

While Israel has equitable and efficient universal health coverage that contributes to the country's positive health indicators at a low cost, disparities in health outcomes and care access prevail. The increasing dependence of access-to-care on private and supplemental insurance in recent years has contributed to growing disparities.

Biographies

Dov Chernichovsky, PhD, is a Professor Emeritus of health economics and policy at Ben-Gurion University of the Negev in Israel. He is also a state-appointed chair of the Israeli National Nutrition Security Council, and leads the Health Policy Program at the Taub Center for Social Policy Studies in Israel. Dov also advises the Israeli parliament on health system issues, and is a consultant for the World Bank.

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