

## **Changes in the financing of health care after the introduction of the National Health Insurance law (NHIL) in Israel**<sup>1</sup>

**Gabi Bin Nun**

There are two main reasons that are continually mentioned as to why health reform is a must in the United States: The huge number of uninsured people (one out of six Americans has no health insurance); and the escalation of health care costs (15.3% of the G.D.P, 6,100\$ per capita – the highest in the world).

The reform of the Israeli health care system that was implemented in 1995 was not driven by the aforementioned considerations, but mainly as a result of the “cream skimming” that had dominated the Israeli health insurance market up to that time. However despite these differences motivating factors between the reforms in the two countries, there is much to be learned from the Israeli experience.

The National Health Insurance Law,(NHIL) which was passed in 1995, granted universal coverage, defined a comprehensive benefit package and ensured freedom of choice between four public health insurance plans called “Kupot Holim” (Sick funds). The law also introduced more progressive collection of funds and created an efficient and fair mechanism for allocating resources towards the funding of the health plans (the capitation formula).

Prior to the initiation of the law, there were four public health plans that covered about 96% of the population<sup>2</sup>. The insurance plans combined service provision with social health insurance.

The health insurance premiums (“member’s tax” or “the uniform tax”) were deducted directly by the health plans or by the labor unions to which they belonged. These taxes were mainly based on the members' income, and on their family status. Members’ taxes were relatively regressive, because of a tax ceiling at a relatively low salary level, and collection of taxes by the health plans was inefficient with high administrative costs. The fact that collection of health insurance fees was carried out directly by the health plans created a link between the income level of the insurees and that of the health plans, and this generated a reverse link with the health needs of its members. This situation

---

<sup>1</sup> .The paper is part of the project "*FRESH-thinking*". This draft is based on an article "the law, health and health system: a decade of implantation the National health insurance law in Israel" written by Gabi Bin Nun and Gur Ofer, published in in a the book : "10 years for the NHIL", 2005.

<sup>2</sup> Two of the health plans were connected to the labor unions that were identified with political parties this linkage contributed to the politicization of the system prior to the NHIL.

encouraged “Cream skimming” of wealthy and healthy insurees in two of the health plans, which were able to do so, and created deep deficits at the two other health plans.

Prior to the passing of the NHIL there was limited freedom of choice between the four health plans. Transitions were limited by creating a binding link between membership and working place. In addition, acceptance of new insurees was contingent on undergoing preliminary medical tests. There were various limitations on the acceptance or eligibility of senior citizen and high risk insurees. The benefits package (the basket of services) to which the insurees were eligible was unclearly defined, and their provision involved different constraints.

Since the early 1980s the level of competition between health plans has risen. This competition largely focused on cream skimming of insurees. The main result of this process was a selective decline in the market share of the biggest health plan ("Clalit") – both in terms of health risk and in terms of the insurees’ income. "Clalit" maintained an increasing share of the low income, large families and a high number of senior citizens and as a result, accumulated a giant deficit that influenced the total health system. The severity of the crisis with which the health system in Israel had to contend prior to initiation of the NHIL could no longer be alleviated by means of a corrective program, as had been performed several times previously. “Surgery” was needed, as well as a basic change in the rules of the game according to which the health plan had operated up to that time. In the wake of this air of crisis, the National Health Insurance Law (NHIL) came into effect in January 1995.

### **The Main Changes in the Breakdown of Insurees between Health Plans prior to Initiation of the Law**

<b>Health Plans (Sick-Funds)</b>	<b>Percentage of insured members</b>		<b>Percentage of Insured aged 65+</b>	
	<b><u>1981</u></b>	<b><u>1994</u></b>	<b><u>1981</u></b>	<b><u>1994</u></b>
<b>Clalit</b>	82.5	65.5	9.4	13.0
<b>Leumit</b>	4.0	8.7	8.7	7.2
<b>Maccabi</b>	9.5	17.6	6.1	4.8
<b>Meuhedet</b>	4.0	8.2	8.3	4.1

Source: 1981 – Survey of use of health services, the Central Bureau of Statistics, publication 717.

Source: 1994 – Parallel tax file of the National Insurance Institute

## **The Main Principles of the National Health Insurance Law (NHIL)**

### **Universal Coverage (Health Insurance for All)**

Prior to passage of the law, health insurance was voluntary. While the extent of insurance coverage was high (96%), there was no obligation to take out insurance. When the law came into effect, in January 1995, health insurance became compulsory. According to the law, every resident over the age of 18 **must** register as a member of the Health Plan of his choice, and also register his minor children.

### **Defining the Benefit Package (Basket of services)**

Prior to passage of the NHIL, the health benefits that were included in the coverage were defined independently by each health plan. Definition of the benefits was unclear, inconsistent and not transparent. The health plans were allowed extensive discretion in determining the content of the basket, as well as in providing various levels of service. Eligibility for the services basket was contingent on payment of member's taxes, and each service provider could make eligibility to the basket conditional on other conditions, such as a preliminary period, age, state of health, reason for requiring service etc.

The NHIL replaced the health plans' arrangements, with an organized system which guaranteed the insuree's eligibility and provided a uniform definition of the benefit package for all health plans. All residents were eligible to receive basic benefits coverage which the health plans must provide at a reasonable standard, and within reasonable distance and time parameters.

### **Freedom of Choice of Health plan**

The NHIL determined that all residents must be accepted by a health plan unconditionally, and ensured freedom of choice between the health plans<sup>3</sup>.

Providing this right changed the previous balance of power between insuree and health plan, from a situation in which each health plan could choose its insurees, to one in which the insuree could choose health plan unconditionally. Freedom of choice between health plans aimed to increase competition and thereby contributed to the system's efficiency. Competition is for accumulation of members – both in maintaining the members already registered with the health plan, and adding new members<sup>4</sup>

---

<sup>3</sup> . The law lay down that insurees may move between the health plans one time during every year.

<sup>4</sup> . As the additional revenue from each new member (per capital allocation) is, on average, greater than the expected additional expense of providing treatment for the new member (due to the advantages of size resulting from the significant fixed costs).

### **Revenue Collection**

Following the NHIL, collection of health insurance fees was transferred from the health plan collection mechanisms to the National Insurance Institute. With this transition the health tax payment (the premium) changed from voluntary to compulsory (4.8% of employees' income). The transition improved the extent of fee collection, and this resulted in an increase in income based on the same tax levels<sup>5</sup>. The transition ended the linkage between the insuree's income and the health plan's revenue. It also greatly reduced the relationship between the health plan and the political parties and workers' unions. Ultimately, transferring collection of fees to the National Insurance Institute, also allowed the raising of the "health tax" progression level.<sup>6</sup>

In addition to the employees' payments, the law maintained payment of a "parallel tax" which was introduced several years earlier – a tax imposed on employers of 4.95% of the salary of each employee.<sup>7</sup>

The sources which, in accordance with the law, were available for health plan included the health tax, parallel tax, co-payments paid by the member and sources from the state budget designed to ensure completion of the funding required for the set basket of services.

### **Fund Pooling – The Capitation Formula**

Prior to the passing of NHIL fees were collected directly by the health plan in from its members. Based on this arrangement, health plans whose members had a higher level of income were "wealthier", and vice versa. This relationship between the health plan revenues and the income of its insurees was a major motive behind the health plan cream skimming behavior. The law ended this relationship by means of collection of the tax by the National Insurance Institute, and allocation of the Total public funds to the health plan on a different basis.

According to the NHIL, allocation of the sources between the health plans is based on weighted capitation. The weighting formula provides a different weighted factor for each age group, which reflects the difference in the expected relative use of health services among the members of the various age groups. According to this allocation method (the capitation formula), around 95% of the public sources of the law are allocated. The remaining 5% of the sources of the law are allocated based on the number of health plan members suffering from one of the five serious ailments (defined in the law).

---

<sup>5</sup>. The revenues increase from shifting the collection of health insurance fees to the National Insurance Institute was estimated to be 14%

<sup>6</sup>. In addition to a change in tax rates at various income levels, there was also an increase in the income ceiling with regard to tax collection – from three times the average salary to four times, and eventually to five time the average salary.

<sup>7</sup>. The "parallel tax" were abolished in 1997 and replaced by general taxation funds.

This allocation formula was designed to divide the financial resources among the plans according to members' needs, generate a more efficient and fair division of the resources, and reduce the incentives for skimming the "good" members..

**The Change in the Sources of Funding and Their Method of Allocation following the NHIL**

Sources of funding	Before the law (1994)		Following the law	
	Allocation basis	Percentage of sources	Allocation basis	Percentage of sources
Health insurance fees	Direct payment to the health plans as % of insurees' salary	43%	Capitation(11 age groups)	44%
Parallel tax <sup>8</sup>	Capitation (3 age groups)	38%	Capitation(11 age groups)	38%
State budget	Negotiation	10%	Capitation(11 age groups)	10%
Co-payments	Direct payment to the health plan	5%	Direct payment to the health plan	6%
Other	Direct payment to the health plan	4%	Direct payment to the health plan	2%
<b>Total</b>		100%		100%

Source: 'Health Systems in Israel, G. Bin Nun, Y. Berlowitz and M. Shani, 2005

During the course of the law's implementation the health plans raised objections, both with regard to the need for periodic updating of the data infrastructure of the formula, but mainly with regard to the need to incorporate in the formula additional variables to the age variable, in order to reflect more accurately the different health requirements of the members in each of the plans. One group of arguments presented the need to include in the formula variables that impact on the needs (demand side) for health services, such as health status and occupation. Another group of arguments presented the need to include variables that impact on the cost of services (Supply side), such as regional differences in the spread of services, advantages of size, differences in the prices of raw materials etc. Allocation based on the insuree's health needs (even if based on the age variable only) was both more fair and more egalitarian than allocation based on the insuree's income, as was the case before the law came into effect. This form of allocation is also more efficient as it guides the resources to the health plans based on their contribution to the population's health. Allocation to the health plans, according to need, makes the plans the principal bearers of the risks of insuring the population and, in effect, turns them into

<sup>8</sup> The parallel tax was cancelled in 1997 this source of funding was replaced by state budget.

insurance companies. The capitation payments are a sort of insurance “premium” calculated according to the expected risks, and their total value comprises the budget constraint placed on the health plan. The plans are not insurance companies in all respects: they cannot set premiums, choose members or decide on the benefits package. These constraints reduced their freedom of action with regard to commercial insurance companies. However, notwithstanding this, they have to contend with most insurance risks, and this is the most important characteristic of insurance companies. This situation generates an important incentive for increasing the efficiency of the plans.

It is important to note that the more the allocation formulae better reflect the risk groups’ needs - the more they act as a better incentive to the health plans to act accordingly. On the other hand, distorted weightings of the allocation formula or the absence of important variables from the formula may encourage the plans to engage in “selection” of insureds or services which may, in turn, generate preference for various groups of insureds. In view of this understanding, and based on accumulated experience in applying allocation formulae around the world, there are grounds to examine the possibility of including additional variables in the formula, in addition to age, as well as establishing a fixed mechanism for ongoing examination of the changes in health costs based on various criteria and on quality data infrastructures.

### **State Responsibility for Funding (Funding the Cost of the Health Basket)**

Throughout all the years of existence of the four health plans the members’ and their employers’ insurance fees payments never covered all the costs, and the state budget was needed to complete their funding, either preplanned or by retroactive covering of the deficits. During these years the extent of state support for the health plan derived from considerations involved in the way the annual state budget was put together, the needs and abilities of the economy, and political considerations. As a result, the extent of state support for the plan was subjected to sharp fluctuations and uncertainty, and this impacted on the stability of the entire health system.

One of the main aims of the NHIL was to ensure stable funding for the health system, in the long term. The law incorporated principles for updating the basket and its cost over time. The law defined “basket cost” which reflects the normative sum of funds available to the health plans for providing the benefits package. According to the law the state is required, each year, to make up the discrepancy between the cost of the basket defined in the law and the other sources of the funding, including health tax, parallel tax and normative self-funding. This principle was designed to ensure, as far as possible, a stable scale of resources, and predefined, over the long term. In addition, definition of the “basket cost” was designed to determine a normative ceiling of expenses – a sort of

budgetary constraint with which the health plans must comply, and any deviation from the budget is not financed by the state.

The application of this principle was discovered to be problematic from the second year of the law's implementation, when the "basket cost" required its first updating, and remains controversial to this day. Maintaining the realistic value of the basket requires a suitable annual updating mechanism, which takes into consideration the rise in prices, population growth and changes in its age structure, the required degree of efficiency enhancement of the system, as well as the need to extend the scope of the basket in view of technological and medical innovations. While the price changes and demographic changes can be accurately measured, the demands for increased efficiency and technological updating needs of the basket cannot be accurately quantified. The law determined partial updating according to price changes, recommended the need for demographic updating and designated (by inference) the remaining updating (in a negative way) for increasing efficiency. The law did not determine the fixed scale of updating for adding new technologies to the basket, and left this amount for annual budget discussions. These two topics remained controversial, and the content of the original law remained as it was, with only minor amendments.

An interim summary of the main principles of the law indicates that the combination of the four main principles: revenue collection based on income tax (designated and general), defining a benefit uniform basket of services, fund pooling based on the weighted capitation, and consumer choice between competing health plans- was supposed to ensure a health system more oriented to fairness, and efficient, compared to the system that existed prior to the law.

### **The First decade of implementation**

Looking back, during the first decade of implementation of the NHIL the health plans were bound by a rigid budget constraint. Complying with budget targets forced the plans to taking greater stock of financial considerations than in the past, and they were obliged to update their management, and control and auditing facilities. The new weighted capitation allocation formula required the health plans to prepare for the new competitive environment which was about to emerge. The government offices (Ministries of Health and Finance) were obliged to prepare accordingly: transfer of responsibility for funding of the system and the direct collection of health taxes imposed additional responsibility on the government and granted it additional authority compared with the previous situation. On the other hand, the allocation to the health plans, based on a predefined formula, was designed to relieve the government of individual involvement in

the plans' budgets by adjusting its supervision and regulation facility. The government could, theoretically, have perceived its new role only as a funding middleman without assuming additional responsibility. However, in practice, it is hard to foresee a situation in which applying responsibility does not follow from control of the funding sources. Opening the health plan to proportional competition imposed on the government responsibility for maintaining the rules of the competitive game; however, it was also designed to relieve the government of a significant share of supervision duties.

### **Basket Cost Updating Mechanisms**

The law determined general rules for annual updating of the cost of the basket in accordance with price changes and changes in the size and composition of the population. However, a discrepancy remained (to the detriment of the health system) between these two indexes. The demographic updating reflected about 70% (and, in recent years, only about two thirds) of the actual demographic change. The shortfalls in updating of prices and demographic changes were attributed to the need to increase the system's efficiency (or decrease quality as some argued).

The questions about the manner and extent of updating the cost of the basket which the system should adopt, compared to the degree of increased efficiency which the system needed to implement, as aforesaid, remains in dispute.

The lack of agreement over the "right" updating mechanism made a decisive contribution to the creation of large deficits in the system between 1996 and 1997. Part of this shortfall was absorbed by the health plan by increased efficiency, another part was reflected in a decline of health service quality and accessibility, and another part was reflected in the search for alternative sources of government funding, - increasing co-payments made by the insureds (see below).

### **How New Technologies should be assessed**

The NHIL does not incorporate an in-built mechanism which ensures the adoption of new technologies every year, and the decision is still subject to annual budget discussions. Until 1998 no funding sources for components were added to the cost of the basket. Following public pressure, the government approved an annual supplement of about 1% of the cost of the basket for technological updates. The amounts made available by the state for this purpose are, as said, determined annually as part of the budget discussions which, naturally, involve political struggles. The decision to use the budgetary supplement rests with "the basket committee" established in 1988 and comprises representatives of the government, the health plans, and the public. Applications for the addition of medicines or technologies to the basket are submitted to the public committee which decides on the technologies that are to be added to the services basket, by law.

There are ongoing discussions in the Israeli health system about the principles of updating the basket, and the correct administrative process to do so. One of the main defects of the current updating process is the large fluctuation and uncertainty regarding the annual budgetary supplement for technological updating. It seems that, after a decade, it is time to assess the process and draw conclusions.

### **Health plan Expenditure**

The health plans ended the first year of the State Health Insurance Law with almost no deficits. However, from 1996, increasing deficits began to develop, peaking in 1997 when the aggregate deficit of the kupot holim totaled NIS 1.5 billion (8.5% of the annual costs). This year's deficit was similar to the deficits of the health system prior to legislation, although uniquely it was divided equally between the health plans while, in the past, the deficit of "Clalit" health plan accounted for most of the total.

From 1998, restructuring programs were agreed to with the health plans which generated financial stability in the system. This stability was achieved by means of three complementary measures: increasing the co-payments, increasing efficiency of the health plans and increasing the Government's subsidies by providing the health plans with a "safety net". These steps reduced the ongoing deficits to a level of 1% of the total costs and reduced the adjusted health plan expenditure per capita.

### **Supplementary Insurance**

The NHIL allows health plans to offer their members an additional health services not included in the basket of services proscribed by the law.

During the first three years of implementation of the law there were numerous discussions about the nature of supplementary insurance, including choosing the party through which it was to be operated and marketed. Ultimately, the rules for operating the supplementary insurance program were left to the health plans, either by themselves or through private health insurance<sup>9</sup>. The number of people joining the supplementary

---

<sup>9</sup> The main principles of operating the program included the following:

- Every member may join the program without conditions or irregular terms, but the health plan will be allowed a reasonable preliminary period.
- The premium will be uniform for all age groups.
- The program is designed to provide health services only and is supposed to only include services not in the basic services basket in the law.
- The program will be financially balanced on an annual basis and entirely financially independent from the budget of the kupot holim.
- The program will not include insurance for nursing facility hospitalization. This was considered to be too weighty for the kupot holim, as well as involving long term risks.

insurance of the health plans rose rapidly from 45% in 1999 to 71% of all insurees in 2005 (4.9 million insurees). The supplementary insurance primarily provides the following services: transplants and operations abroad in life-saving situations, second medical opinions, complementary and alternative medicine, periodic check ups, medical accessories and a number of pharmaceuticals not included in the basket.

The more the basic basket includes important and beneficial services, at a reasonable cost, which are worthy of funding by the public budget, the more the supplementary insurance framework is justified. It is more difficult to justify such a program if it includes essential services over time, and there is certainly no justification for using supplementary insurance as an alternative to the obligatory basket. The supplementary insurance can include those whose efficacy has to be proven, and which will be included in the basket in the future, when proof of efficiency is forthcoming. The law stressed the principle according to which the supplementary must finance it and the health plans income designed for the basket must not be used for supplementary expenses. The siphoning off of resources from the basic basket to complementary insurance was one of the primary concerns which the regulation of supplementary insurance tried – and succeeded – in preventing. However, in recent years, the trend appears to have reversed whereby supplementary insurance sometimes carries the expenses of the services included in the basic basket.

Supplementary insurance, as it is operated in Israel, acts as an interim stage which bridges between the state compulsory insurance and private insurance. The inclusion of various quality components of the services basket, as part of the supplementary insurance programs, and the restriction of eligibility to them to the private sector only, is one of a range of topics relating to the integration of private medicine in the public system. In this area, as in other topics related to supplementary insurance arrangements, there is room to re-examine the principles of operation now that a decade has passed after the law's passage.

### **Different Levels of Competition**

Competition between the health plans was one of the important principles which the NHIL aimed to promote. The rules of play determined by the law allowed complete freedom of choice of health plan by the insuree, and allocation of resources to the plans based on weighted capitation.. The mixture of these two principles was designed to ensure fair competition for insurees while reducing the market failures characteristic of the health insurance sector (failures characterized by skimming, and selection of preferred insurees). The rules of the game laid out by the law generated an incentive for more fair competition, according to which each health plan aims to maintain its registered members and tries to increase the number of members it has as the income “voucher” for each new insuree (the capitation allocation) is, on average, greater than the expected

additional cost of providing them with treatment (due to the benefits of maintaining significant fixed costs).

The incentives which encourage each health plan to maintain a given market share, and even to increase it, were one of the main changes generated in the system after implementation of the law. These incentives changed the balance of power between the insuree and the plan from a situation in which the plan chose the insuree to a situation whereby the insuree chooses the plan, and the plan has an incentive to improve the quality of various aspects of the medical services it provides.

Immediately after implementation of the NHIL the health plans started extensive marketing efforts to recruit new members – both new insurees and members of others plan. All the plans made a special effort to attract groups known to make little use of health services, i.e. less than the value of the insurees' capitation payment voucher. These groups included minorities, the ultra orthodox and, to an extent, residents of outlying areas in general. This effort by the health plans was reflected from the start of the implementation of the law and generated a higher degree of equality in accessibility for the community and provided similar services to these groups. A less positive effect of competition for insurees was the aggressive marketing measures initiated by the plan in the first years of implementation of the law, via the media (television and press), by hiring vote contractors, telemarketing, giving out gifts, establishing registration points at supermarkets and other public locations etc. Part of the marketing efforts even involved means on the fringes of fairness. These marketing efforts continued until 1997 and entailed a significant financial outlay. Against the argument that marketing activities are an organic element of the competitive world encouraged by the law, there were claims of wasting significant resources and the ability to use these sources, alternatively, to improve the standard of services given to insurees. These arguments led to state intervention. Two years after the implementation of the law. A regulation was issued which limited the level of expenditure allowed for marketing by each of the health plans.<sup>10</sup> The integration of these measures led to a drop in the marketing costs of all the plans but discussion of the issue as to the correct level of marketing activity by the plans was not finalized, and it requires re-examination.

*Duplication of services* - Competition between a numbers of suppliers involves a certain degree of service duplication and, as such, additional costs to the system. Part of this service duplication is necessary and comprises the cost of competition, a cost which is more than offset, by the benefits of competition. Nevertheless, ways should be sought to reduce this price. Duplication of services in the health system primarily appeared in outlying areas and small remote places. The competition over penetrating the

---

<sup>10</sup> Another means of moderating the competition and maintaining fairness was achieved by transferring the mechanism of registration and transfer between the health plans from the plans themselves to post offices.

aforementioned places led to the operation of dual community service systems alongside disagreement over cooperation and providing community services for one health plan at facilities belonging to another health plan. This refusal, on occasion, was reflected in charging high prices and creating various administrative obstacles.

The state intervened in cases where it believed the cost of duplication exceeded the benefits of competition, initially by trying to persuade and encourage dialogue between the plans to cooperate with each other. When persuasion did not work regulations (1997 ) were issued which restricted the level of expenditure allowed by each health plan on developing community services, and organized the acquisition of the services between the plans in places where a particular health plan had a monopoly.

Another area in which the phenomenon of service duplication developed was specialist medicine. In this area the health plans developed community clinics which competed against outpatient clinics of hospitals.<sup>11</sup> This duplication, too, required arranging through cooperation, the efficient allocation of work between the clinics and outpatient clinics, and the specialist doctors. Undoubtedly, the lack of organized pricing at outpatient clinics, as well as the absence of a suitable framework of agreements between the health plans and the hospitals, makes it difficult to find a suitable solution in this area.

*Freedom to choose suppliers* - Even before the law was passed the health plans allowed choice of a family doctor, there was a method of referral to specialist doctors, insurees could choose the pharmacy to buy their pharmaceuticals etc. The NHIL clearly determined the insuree's right to freedom of choice of health plan. On the other hand, the law's definitions of freedom of choice of a service provider , were less clear.<sup>12</sup> The main deliberations and differences of opinion in the area relate to the degree of freedom of choice for insurees at hospitals and at the hospitals' outpatient clinics. The law does not allow, and does not fund, choice of doctors at hospitals, for consultation or operations.

Freedom of choice of hospitals increases the competition between suppliers, and thereby can improve the quality of services, and thereby patients' satisfaction. Freedom of choice may also improve the continuity of medical treatment. On the other hand, freedom of choice entails costs for the health plan in that it restricts the possibility of planning, regulation and supervision of use of services, as well as the health plan's room for maneuver to sign services provision contracts with the hospitals and other suppliers. Agreements of allocating the insurance risk between the health plan and the hospitals

---

<sup>11</sup> . The development of duplication at this level resulted, to a large extent, from the overpricing of ambulatory services at the hospitals' outpatient clinics. A significant part of the services offered at specialist clinics, which were developed by the health plans, were cheaper and more accessible to insurees.

<sup>12</sup> . Clause 23 of the law determines that "a member of a health plan may choose a services provider for himself and for his children from among the services provider working with, or on behalf of, the plans"

involve linking the insurees with those hospitals, thereby restricting their freedom of choice. The tightening of the budgetary ring since 1998 led all the health plans to introduce stricter procedures with regard to referrals and choice at the hospitals, as well to specialist doctors outside the clinics.

*Premium competition* - According to the law, the health plans cannot compete over insurance premium rates (health insurance fees) set in the law for all insurees as a percentage of their income. Rejection of the possibility of competing over the premium rates resulted from the argument that the consumer is not highly sensitive to the level of the premium, and his appreciation of how much he gets for what he pays is limited. In addition, there was concern that allowing the health plan to compete over premium rates would allow the plan to exploit this competition for screening insurees (cream skimming).

*Competition for Providing Services beyond the Benefit Package Defined in the Law* – Until 1997 the health plans continued providing services in excess of those determined by the law (the benefit package). The flexibility of the plans in providing these services was primarily impacted by their financial situations and, from 1999, when this situation deteriorated, the plans greatly reduced the provision of services beyond those obliged by the law. Competition over provision of services beyond the basket transferred to the supplementary insurance.

*Movement of Insurees Between Health Plans* – When freedom of choice of health plans, and the previous restrictions on movement were settled, (1995), the expectation was that there would be a significant increase in movement. With hindsight, it appears that the insurees are conservative by nature, and the scale of movement between the health plans was relatively small. Between 1995 and 1997 the process of registration and movement between plans offered a loophole which allowed fictitious movement. This period, as we have seen, also featured much marketing activity by the plans designed to encourage movement. In addition, when reasonable transition became possible one could expect a relatively high initial level of movement. And, in fact, the annual level of transition between the plans accounted for about 4% of insurees each year.

At the beginning of 1998, it was decided that transition between health plans would be carried out at Post Offices. As of that year the volume of movement dropped and has come down over the years. In 2004, only 1% per year changed plans (about 70,000 insurees). It is likely that the drop in transition was impacted by the change in the transition procedure, and the constraints imposed by the state on the advertising and marketing budgets of the health plans. If this is really the case, it possible that the savings of advertising budgets creates a loss, in other words it strangles competition between the plans. Another possibility is that the expansion of supplementary insurance was a restraining factor on movement. The concerns of insurees over possible loss of rights

with plan change possibly come into play here, particularly over having to go through another preliminary period. It is unclear to what extent such concerns can be substantiated, and if more information should be made available in this area. It should be noted that the very existence of the right to transfer between health plans, even if in practice it is not used to a great extent, comprises a constant “threat” to the plan and an important incentive for maintaining an appropriate level of service and competition over insurees, which is not necessarily selective. Moreover, a low national level of movement could “conceal” far higher rates of transition in places where insurees discern large discrepancies in standards of service between clinics and the level of service offered by the various health plans.

### **The NHIL and National Expenditure on Health**

Prior to passing the NHIL national expenditure on health in Israel totaled about 7.9% of GDP (Gross Domestic Product) – a similar level to that of OECD countries. Indeed, in analyzing the problems of the health system in Israel, the level of expenditure was not perceived as excessive. Most of the arguments referred to efficiency of the health insurance market.

The outlay on health as a percentage of GDP has been steadily rising. In the 1960s it totaled about 5% of GDP, compared with over 8% at the start of the third millennium.<sup>13</sup> The passing of the law in 1995 entailed serious concerns that the rise in national expenditure would be accelerated even beyond the acceleration resulting from elements mentioned earlier. The source of this concern stemmed from the assumption that formalizing eligibility to the health benefit package by law, as with extending insurance cover to the entire population (about 95% of residents), may increase demand for health services and, thereby, national expenditure and public funding from the state budget. Due to this concern, and in order to ensure as great as possible control of the level of national expenditure on health, the NHIL included mechanisms for blocking expected demand pressures and constraining public expenditure on health. These mechanisms included setting a “basket cost” ceiling which defined the level of funding by the state budget by law, the demand for a balanced budget from the health plans and providing financial incentives for adhering to this balance, making any expansion of the eligibility basket in the law contingent on the existence of sources for its funding.

Analysis the national expenditure on health prior to, and after, the law was passed indicates that the restraining and blocking mechanisms, which were incorporated in the law, achieved their objective, and the concerns over acceleration of the rise in the level of

---

<sup>13</sup> This rise in the relative share of expenditure on health, out of GDP, is not unique to Israel, and like the rest of the world it is caused by the ageing of the population, technological developments, a rise in the relative price of health services and an increase in demand for health services as a result of a rise in the standard of living

national expenditure on health did not materialize. In the decade before the law (1985-1994) national expenditure on health rose as a percentage of the GDP, from 6.1% to 7.9%. In the same period, national expenditure per capita on health, in fixed prices (2000 prices) rose by about 23%. On the other hand, in the first decade after the law's passage national expenditure on health rose, as a percentage of GDP, only from 7.9% to 8.3%, and per capita expenditure on health in fixed prices rose by only 8%. This moderate increase in national expenditure on health in the decade after the law was introduced is mostly attributable to a rise in private expenditure on health, over which the public system has more limited control. Thus, most of the effectiveness of limiting the rate of increase in national expenditure on health was reflected in limiting public outlay. The funding Table describes the changes in methods of funding national expenditure on health before the law was introduced and during the first decade after its passage.<sup>14</sup>

#### **Funding of National Expenditure on Health before and after the NHIL (%)**

	Before the Law			After the Law		
	1985	1990	1994	1995	2000	2004
Government funding and parallel tax	54	46	49	48	42	42
Member's tax/health insurance fees	14	16	22	22	25	25
Other*	7	7	5	4	5	3
Total public funding	75	71	76	74	72	70
Total private funding	25	29	24	26	28	30
Total	100	100	100	100	100	100

\* Other: including deficits or surpluses of health plan and other NPOs, and funding from unknown sources.

Source: Publications of the Central Bureau of Statistics on national expenditure on health, 1985-2004

The table shows that the share of government funding (including the parallel tax) in funding the system was in decline even before the law, from 54% in 1985 to 49% in 1994. This pattern was counterbalanced by increasing the funding from health insurance fees. After the law was passed the share of public funding in national expenditure on health continued dropped, from about 48% to 42%. The decrease at this time was primarily complemented by an increase in co payment and expenditure on private health insurance. The level of private funding prior to the law was about 25%, and rose in 2004 to around 30%. This level of private funding is relatively high in the western world.

<sup>14</sup> In the interest of maintaining consistency of analysis we have included health insurance fees ("the member's tax") paid to the health plan in the period before the law as part of the contribution of the public sector.

This ongoing pattern of growth in the private share of financing has considerable implications for the aspect of equality in health: the higher the level of private spending the greater the connection between receiving health services and the financial ability of the individual to acquire these services. This finding substantiates the findings of various surveys on the subject<sup>15</sup>.

The lack of equality relating to health deriving from the level of private financing required also depends on the type of services for which private expenditure is required: the impact on inequality will be greater when the services are essential and lower when such services have little or questionable impact on the state of health. The more essential services are included in the public basket, as should be the case, one could assume that private financing on services outside the basket impacts less on equality.

## **Summary**

The passing of the NHIL in 1995 was one of the most important social revolutions since the establishment of the state of Israel (1948). According to the law the entire population of Israel is insured, and there is an extensive benefit package that is backed by legislation. The incentives for screening insurees have declined, and the insuree has complete freedom of choice of health plans. All these greatly contributed to improving accessibility of health services, and to a clear enhancement of the system's efficiency.

This was achieved without inflating public spending on health as a percentage of GDP, or inflating national expenditure on health.

Israel's experience provides an important real-world test case of for countries like the United States that are seeking to reform their health care systems.

The evolution of the Israeli health system after the law's passage illustrated an interesting dynamic between private sector competition and state involvement. Israel has experienced an interesting phenomenon where although the government has provided universal access to a uniform basic basket of health services, it has encouraged competition between the different health plans (Sick Funds). A government mandated coverage plan along with legislated freedom of choice (without limitation) between health plans has created a healthy degree of competition among the Israeli Sick Funds that has led to an increase in the quality of patient services as a tool for attracting new

---

15 . The last cultural survey carried out by the CBS in 2005 offered the following findings: 16% of people who required prescription drugs did not acquire them due to financial difficulties. 45% of people who required dental treatment did not obtain it for the same reason.

members and retaining an existing base. It has also led to a level playing field where the phenomena of “cream skimming”, (a problem among health insurers in the United States) has decreased. These developments are particularly instructive for the United States where the fear of government intervention and health mandates has led to the belief that an active public sector will “strangle” private competition. The Israel case has shown the opposite effect.

Additionally, in cases where the basic basket of services is felt to be restrictive, supplementary insurance plans have been established that provide additional coverage. Again the private sector has adapted to the new model and market forces are working to fill any gaps (real or perceived).

Finally, and perhaps most importantly from the US perspective, the Israeli experience has shown that a government mandated universal health care system with central fair and efficient collection of revenues, central resource allocation mechanism, along with central oversight, does not necessarily lead to greater overall health spending. In regard to its implications for the US in which 1000 insurance companies seeking contracts with millions of employers, perhaps one could suggest that the reduction of duplicative bureaucracies in the collection of fees, the monitoring the overall cost of the health plans (including decrease their numbers), creating a nation wide standard of calculating resource allocation formula<sup>16</sup> - all of that stapes has the ability to reduce a large proportion of the enormous “overhead” that currently plagues the US health care market and that saving can maybe cover the cost of all those uninsured.

---

<sup>16</sup> . Which is much less expensive than a situation in which each insurers have their own calculation