Health Reform And Rationing In Israel

Explicit rationing of health care services in a universal system is easier said than done.

by David Chinitz and Avi Israeli

Rationing of health care services as a means for controlling health spending is receiving increasing attention in most health care systems today. Explicit rationing has become an issue not only in the United States, which spends the highest proportion of gross national product (GNP) on health in the world, but also in countries that traditionally have controlled health spending more successfully. Rapid developments in medical technology and increasing demands deriving from changing tastes and demographic trends strain health care budgets.

Israel, in the context of its recent health system reform, has made rationing explicit by defining a detailed “basic basket of services” to which all citizens would be assured access through a system of universal insurance, and by creating a process for updating the basket. Although experience is still limited, Israel’s experiment provides a unique opportunity to examine how rationing might evolve in the context of structural arrangements under consideration in a number of countries.

What follows is a discussion of the Israeli health care system, the recent reform, and its implementation. We then focus on the evolution of the processes for determining and updating the basic basket of services and provide a case study involving the addition of a new drug to the basket. Next we consider options for the future. We conclude by pointing out how the Israeli experience is relevant for other health care systems that are undergoing structural change.

Israel’s Health Care System

Organization. Even before Israel’s 1995 health system reform, 96 percent of the population of five-and-a-half million was covered by health insurance through four competing sick funds, which functioned more or less like U.S. health maintenance organizations (HMOs). One sick fund dominated the market, with close to 80 percent of the insured population, until three smaller funds began to grow at its expense in the mid-1980s. The large sick fund, the General Sick Fund (GSF), was and continues to be a large staff-model HMO. The smaller funds functioned more like independent practice associations (IPAs). All of the sick funds exercised considerable latitude in design and implementation of benefits packages and in selective enrollment of insureds, although the GSF was obliged to accept any member of Israel’s Histadrut Labor Federation, which owned the sick fund, regardless of age or health status.¹

Sick funds were financed by an earmarked employer tax and income-linked membership dues. Because the GSF was less selective, it had a poorer and older enrolled population, and this contributed to the creation of a large deficit and constant dependence on government bailouts.²

The hospital sector in Israel is dominated

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by the government and the GSF, which together own about 85 percent of general beds. Hospitals are prospectively budgeted, based on per diem rates and differential treatment rates that are determined by the government. The wages of their employees, including physicians, are determined in national salary negotiations.³

■ **Health spending.** Israel’s health spending as a percentage of gross domestic product (GDP), 8 percent in 1993, was comparable to Organization for Economic Cooperation and Development (OECD) averages (not including that of the United States).⁴ However, sick fund (especially the GSF) and hospital budgets were inadequate to meet demand. One indicator of the constraints on access to publicly financed services is the amount of health care services purchased by private insurance and out-of-pocket payments. During the 1980s the proportion of private finance in national health spending grew from less than 25 percent to 29 percent. Under-the-table payments in public health facilities were also becoming a significant factor, which added to public discontent with the health care system.⁵

### The 1995 Reforms

■ **National Health Insurance.** National Health Insurance (NHI) legislation went into effect on 1 January 1995.⁶ The law was intended to centralize financing of health care services while leaving delivery of care in the hands of the sick funds. The law also sought to make access to health care a matter of right. The question was, “Right to what?” Through a process described below, the legislation defined a basic basket of services that the sick funds would be mandated to provide.

Regarding financing of the system, citizens pay an earmarked health tax, which replaces sick fund membership dues. The government is required by NHI law to fill any gap between revenues from the health tax and the cost of the basic basket of benefits. The cost was defined roughly as the expenditure of the sick funds in 1993, updated annually by a health expenditure index.

Citizens may select any of the four sick funds, which must accept without restriction anyone choosing to enroll. The sick funds compete on a quality basis only; no direct payment of premiums (for the basic coverage) to the sick funds is permitted. Sick funds, however, are allowed to market supplemental insurance for services not covered under the basic basket, and private insurers are permitted to offer health insurance coverage for any part of the basic or supplemental basket.

■ **Basket of services.** Those who molded the NHI law sought to be very explicit about the basic benefits package and the process for updating the package. Institutional frameworks for handling these difficult decisions began to evolve during parliamentary hearings and discussions on the draft legislation. A major decision regarding benefits was to adopt as the basic basket the highly detailed service list of the largest of the four sick funds. Since, prior to initiation of the law, this fund was spending the least per member but nevertheless had a reasonably broad benefits basket, this was viewed by most as an acceptable compromise. Several high-visibility and costly procedures were added to the basket in the wake of pressure brought by a number of special disease–interest groups. No prioritization of the services is indicated in the law.

To some extent treatment modalities are also specified. For example, drugs supplied by the largest sick fund as of 1993 are included in the basic basket of services, and access to them requires only a physician’s prescription. Guidelines for some services, such as mammography, are contained in the law. The law thereby limits the discretion of sick funds in providing services. In addition, citizens can sue in the Labor Court, which is somewhat more accessible than the regular court system, if they feel that their rights under the law are being denied.

The bill mandates that the minister of health may recommend additions to the basic basket, but if these require additional resources, he or she must guarantee, together with the minister of finance, their availability.
Any removal of items from the basic basket must be approved by the parliamentary Committee on Labor and Social Welfare.

The legislation also calls for benefits to be further specified, in terms of physical accessibility and timeliness, by a special committee of experts. A related body is a National Health Council, which includes a broad representation of officials from the sick funds, consumers, health policy experts, and government officials and is chaired by the minister of health. The council is intended to monitor implementation of the law and advise the government on various related issues, including the contents of the basic basket and the level of health expenditures.

Finally, additional input into defining the basket of services is offered by several medical councils created by the Ministry of Health (MOH) to deal with medical technology assessments and to make recommendations regarding adoption and diffusion of technology. These councils are primarily made up of leading medical practitioners from selected fields—there is little public participation, although some public-interest groups, such as the Israel Cancer Society, do participate.

The NHI law, especially the provisions regarding the basic basket of services, reflects the trade-off between universal, comprehensive coverage and cost containment. It appears that stakeholders, such as the MOH and the Ministry of Finance (MOF), did not have a clear picture of how the highly explicit process for updating the basket would work. Nevertheless, the institutional mechanisms that were created immediately confronted pressures to add new services to the basket.

**Early Experience**

**“Haves” and “have mores.”** Although not intended as such, Israel’s NHI law accentuates differences between citizens who limit themselves to basic coverage and those who purchase more coverage through supplemental insurance, private insurance, or out-of-pocket payments. Recent data show that since implementation of the NHI law, 16 percent of the GSF population has purchased new supplemental insurance, while well over 50 percent of members of the smaller funds have purchased supplemental insurance or maintained supplemental coverage that they held before the law went into effect. In addition, the proportion of persons who own private medical insurance policies rose from 13 percent in 1991 to almost 17 percent in 1995.

**Financing.** Since implementation of the law, the sick funds and hospitals have been in a chronic state of underfunding. The sick funds and the MOH argue that the situation is exacerbated by health-sector wage and price increases that are determined largely by the government, population changes, and technological development not captured by the health expenditure index.

Despite these pressures, government leaders are loathe to increase tax-financed public outlays for health. Yet the MOH increasingly demands additional funds from the MOF. The latter has responded by proposing a number of measures intended to stretch the public health budget further. At first the MOF sought introduction of increased copayments. This proposal was successfully resisted by the MOH and members of parliament who were ideologically opposed to copayments.

**Cutting the basket.** Most recently, the MOF has recommended carving out “less essential” services from the basic basket, to allow for supplemental and private policies to cover them. This places the question of rationing and priority setting very clearly on the agenda. Unfortunately for the MOF proposals, experience to date indicates that cutting the basket will not be easy.

For example, the special committee charged with detailing benefits in terms of access, which was supposed to report within two years of its creation, has met infrequently, and its future is uncertain. The National Health Council also has functioned sporadically, and its deliberations have been dominated by the MOH. The MOH medical councils have encountered severe resistance from the Israel Medical Association (IMA), al-
though the latter recently signed a “treaty” with the MOH regarding development and implementation of clinical guidelines.10

Thus, the institutional structure to deal with explicit rationing is in place, but its initial steps have been tentative. The following case study describes the functioning of these mechanisms and suggests shifts necessary to enable them to operate as was apparently intended in the NHI law.

A Case Study

A case in point is the arrival on the Israeli medical scene of Betaseron (Interferon-beta), a drug used to treat multiple sclerosis—a disease clearly covered by the NHI law. The best available evidence indicates that Betaseron may have some limited benefit in treating multiple sclerosis and does not appear to be harmful. Several patients requested and were denied access to the drug by their sick funds during 1995. These patients brought a series of suits seeking to require the MOH and the sick funds to supply the drug. In each case the court ruled that the patient should be given Betaseron, with the proviso that should the MOH decide eventually not to include the drug in the basket, the patient would have to return the cost of the drugs given him or her. This appears to imply that the court feels that the MOH must make an explicit decision to exclude a drug and not simply base denial on the fact that currently it is not included.

In January 1996 the MOH decided to include Betaseron in the basket, on the grounds that it could be of some benefit and was of no known harm. Apparently, the MOH presented the MOF with an estimate of twenty million shekels (about $7 million) for the annual cost of introducing Betaseron in Israel. The MOF agreed, as did the Committee on Labor and Social Welfare.

In February 1996 the MOH adopted guidelines (developed in the United States) restricting the use of Betaseron to cases meeting certain requirements. The orders issued by the MOH that were based on these guidelines were not, however, the result of recommendations of any of the special committees mentioned above. They resulted, rather, from routine MOH regulatory processes.

Unfortunately for the MOH, the next court to hear a claim from a plaintiff who did not meet these requirements and was denied Betaseron found that the MOH had not acted according to the law. To paraphrase the words of the court: “The nature of the guidelines issued by the MOH is unclear, it is not known who issued the guidelines, and based on what authority. We have no assurance that the source of the guidelines was the special committee described in the NHI law, and, moreover, we are doubtful that once an item is included in the basic basket that even that committee has the legal authority to bar a patient from receiving the drug.”11 In addition, the court expressed concern that in seeking to limit the use of Betaseron, the MOH was showing concern for “the health budget,” a consideration that is “foul” regarding any service included in the basket. In effect, the court’s position was that cost considerations may be used to keep an item out of the basket completely but not to decide who will receive the service once it is in the basket. Only a prescribing physician can determine the use of a covered service.

The Betaseron case suggests that the decision-making mechanisms created to update the basket might tend to approve additions to the basket and avoid discussions of removing items from coverage. Citizens who find the sick funds and the MOH unresponsive can turn to the Labor Court, and the legal process bars any limitation on entitlement to a service that is explicitly included in the basket. Science, in the form of clinical guidelines, and politics have given way to the courts.
which, it appears, would only uphold the right of sick funds or government to deny a benefit if it were explicitly excluded from the basket.

**Options For The Future**

The Israeli health care system appears to be engaged in a learning-by-doing process regarding the rationing of health care services. One reading of the situation is that there will be an inevitable, if slow, expansion of the basic basket of services, with universal entitlement to any health care service not explicitly excluded from the basket. Alternatively, given the pressure this is likely to place on the health care budget, the decision-making mechanisms created by the NHI law could be relied upon to ration health care services explicitly.

The Betaseron case suggests the possibility of changing the NHI law so that allocation decisions need not be limited solely to the issue of total inclusion or exclusion of services. Rather, the court should be afforded the option of accepting decisions to deny services that were included in the basket if those decisions were made by a recognized and legally sanctioned process, which could be based, in part, on considerations of cost and likelihood of successful treatment outcomes.

Another possibility is to rely more on the sick funds as the mechanism for rationing. The sick funds were noticeably absent from the debates on Betaseron and copayments. Sick funds in Israel are supposed to compete; yet nowhere in the discussion was the possibility raised that one could be covered for Betaseron in one fund but not in another or that the sick funds might decide on their own, taking into account the competitive implications, whether to introduce copayments. This is not surprising, given that the NHI law grants government the authority to decide the contents of the basic basket and whether to introduce copayments. And yet the experience with new entrants to the basket, like Betaseron, may encourage policymakers to avoid specific coverage decisions and try to leave as much as possible up to the sick funds.

Such an approach involves amending the law either by replacing the highly detailed list of treatments, tests, and drugs with a list of more general areas of coverage, or by increasing the discretion of the sick funds and expert committees regarding provision of covered services. Legal recourse would be available in cases where those denied services seek to argue that the decision-making process was unfair or not based on considerations sanctioned by the NHI law.

Implementation of this strategy is made difficult by the fact that it runs counter to the notion—central to the Israeli context—of guaranteed, universal access to a defined but very broad basket of services. On the other hand, the current approach makes cost containment impossible. Policymakers need to identify a process for making coverage decisions that the public can accept as fair and rational. The institutional mechanisms already in place may provide the basis for such a process.

**Conclusion**

Continued developments concerning determination of a basic benefits package in Israel are relevant to many health care systems that are seeking to combine universal coverage and cost containment—especially those that rely on some form of managed competition. While Israel’s NHI law is only in its third year of implementation, some lessons have emerged regarding basic benefits baskets and rationing of health care services.

First, and not surprisingly, explicit rationing of health care services in a universal system is easier said than done. Israel’s NHI law lays down a very clear process for deciding what will be included and excluded from the basic basket. Yet until now, the process has led to the inclusion of one new controversial drug and delays in deciding about a number of others (which may be a quiet way of refusing to include them in the basket).

Second, legislation of universal entitlement to a highly detailed basket of services implies
a potentially central role for courts of law. For the courts to accept denial of services included in an explicit, detailed benefits basket, criteria for such denial must be given legal status. The administrative body making such a decision must be recognized by the court as having the requisite authority, and the process by which the decision is made must be seen by the court as legally sound. Similar arrangements have been suggested to strengthen the position of medical technology assessment in the eyes of U.S. courts, but not in the context of universal, uniform coverage.12

Third, a system of competing sick funds (or, in the U.S. context, managed care organizations) mandated to provide the basic basket of services and to accept all potential enrollees offers the possibility of leaving rationing decisions to the sick funds. The NHI law could be restructured to give some legitimacy to rationing decisions made by sick funds based on considerations such as likelihood of success of treatment and cost. Sick fund policies in this regard could be subject to approval by government agencies, expert committees, and representative bodies such as Israel’s National Health Council, whose authority to develop guidelines for access to health benefits also needs to be given legal legitimacy.

Finally, the Israeli case provides an example of how an institutional structure, created to satisfy various stakeholders at the point of legislation of a basic basket of health services, will evolve with the need to update the basket. Maintaining the balance in Israel between the content of the basket and its cost will require coordinated input from a number of sources, including the MOH, the MOF, parliament, expert committees, and the National Health Council. Although it is too early to tell how this institutional structure will adapt, Israel’s mechanisms for explicit health service rationing should provide important lessons in the future.

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NOTES
3. Ibid.
6. S. Peretz, Compilation of Legislation on Health Insurance (Tel Aviv: Bursi, 1996 [Hebrew]).
8. Ibid., 61.
11. Jerusalem District Labor Court, Decision in the Case of Barazani v the Ministry of Health (Jerusalem, 1996 [Hebrew]).