Reforms Are Needed To Increase Public Funding And Curb Demand For Private Care In Israel's Health System

Dov Chernichovsky

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**ABSTRACT** Historically, the Israeli health care system has been considered a high-performance system, providing universal, affordable, high-quality care to all residents. However, a decline in the ratio of physicians to population that reached a modern low in 2006, an approximate ten-percentage-point decline in the share of publicly financed health care between 1995 and 2009, and legislative mandates that favored private insurance have altered Israel’s health care system for the worse. Many Israelis now purchase private health insurance to supplement the state-sponsored universal care coverage, and they end up spending more out of pocket even for services covered by the entitlement. Additionally, many publicly paid physicians moonlight at private facilities to earn more money. In this article I recommend that Israel increase public funding for health care and adopt reforms to address the rising demand for privately funded care and the problem of publicly paid physicians who moonlight at private facilities.

Banners proclaiming “Rescue the Public Health Care System” flew over work stoppages led by the Israel Medical Association that began in April 2011. Although the labor unrest continued through the end of that year, the work stoppages ended when the government and the medical association reached an accord in August of that year.

The accord primarily addressed the medical association’s demands for better wages and working conditions. It did not involve changes designed to “rescue the public health care system” from problems such as the declining share of government funding dedicated to health care. This decline had been set in motion by the 1998 Arrangements Law for Encouraging Economic Growth and Employment, and for Achieving Budgetary Targets. In 2009 the government’s share of total health care spending in Israel was 58.9 percent, down from 68.4 percent in 1998. The legislation initiated a decrease in the pace of state funding for health care and led to an increase in health care spending through private insurance and patient copayments.

All Israelis are legally entitled to health care. With the decrease in public funding for care, people who can afford privately funded care seek that instead of care that is publicly funded or provided. The result has been inequities in access to care, inefficiencies in providing it, ethical concerns about physicians’ abandoning their publicly paid duties, and the private use of the public medical infrastructure.

I contend that the government has aggravated this situation instead of leading reforms. Such changes would have made prudent use of Israel’s physicians by increasing the demand for publicly paid care, while reducing the demand for privately paid care, which is inefficient and...
The country has approximately 3.5 physicians per thousand people, a ratio about 20 percent higher than the average for the twenty-two countries of the Organization for Economic Cooperation and Development (OECD) that have the highest per capita incomes and that provide universal coverage, not including the United States and Israel.\textsuperscript{3,4} Israel also has a relatively young, and thus relatively healthy, population, with 10 percent of the total in 2009 ages sixty-five and older, compared to an average of 15 percent in other developed countries.\textsuperscript{5} In spite of a ratio of physicians to population that is still relatively high, Israel has to contend with a sharp and continuing decline in this ratio that reduces the supply of physician services in an aging population.

The objective of this article is to examine how the Israeli health care system has changed in terms of its public-private mix of care and to examine the implications of those changes for the performance of the system, in comparison with systems in other developed countries that provide universal coverage.\textsuperscript{6} The article introduces the Israeli health care system, examines the state’s health care policy in the context of long-term developments, and—in view of the outcomes of this policy—concludes with proposals for reform.

The Israeli Health Care System

\textbf{Coverage and Entitlement} The Israeli health care system served 7,836,600 residents in 2011.\textsuperscript{7} Israelis have been entitled to maternal, child, obstetric, and mental health care since Israel became a state in 1948. Israelis have also been entitled to state-subsidized long-term care in the community and institutions since the mid-1950s.

Under the National Health Insurance Law,\textsuperscript{8} which took effect in January 1995, residents of Israel became entitled to additional medical benefits: general preventive, acute, and chronic care delivered in the community and in hospitals, referred to here as “general care.” The effect was to create a universal entitlement to health care in Israel.\textsuperscript{6,8-10} Preventive maternal and child care as well as mental health care are provided mostly in state facilities that are run by civil servants. The state—partly through the National Insurance Institute, which manages Israel’s social security system—also oversees the subsidized long-term care, which is supplied mostly by private providers.

However, the public entitlement to general care granted in 1995 is secured through a managed competition model. Four sickness funds, or plans, compete for members for whom the funds organize and purchase care. It is a fund’s prerogative to decide whether it provides care in its own facilities or purchases care from freestanding providers. The state is also a provider of care. It sells to the sickness funds the use of 40 percent of Israel’s acute care hospital beds, which are owned and operated by the state.

The state plays an ambiguous role in the system. On the one hand, it contracts with the sickness funds to secure publicly entitled care. On the other hand, the funds contract with the state to secure acute hospital care through the state-owned hospital beds. Thus, the state as a provider may compete with other suppliers under managed competition. This situation has long been the subject of reform proposals.\textsuperscript{11,12}

Because of this ambiguity, it is worth clarifying here the interrelated concepts of public provider and public contract in the Israeli health care system. In Israel a “public provider” provides universally entitled care and may in fact be either publicly or privately owned. The provider is thus paid by the public either directly, as in the case of a state agency, or indirectly, as in the case of competing contractors under managed competition. In other words, the public provider has a public contract that may, among other things, prohibit it from providing privately funded care—even though the provider may be a privately owned entity.\textsuperscript{13,14}

Under managed competition, when the state sells care, such as the use of its hospital beds, to sickness funds—as happens in Israel—the state is considered a public provider—not because it owns and operates medical facilities, but because in this case it has a public contract with state-funded sickness funds or plans.

Regardless, in most if not all instances, the state cannot sell care for private money, especially in a system with universal coverage. There are numerous reasons for this prohibition. Key among the reasons is that tax money and public infrastructure might be used to subsidize privately paid care. Indeed, a ruling by the Israeli Supreme Court prohibited state hospitals from selling privately paid care.\textsuperscript{15} Thus, the Israeli state is a public provider, but not all public providers need be state owned and run.

\textbf{Funding} Universal coverage in Israel is funded through taxes, including an income-based health tax that replaced mandated employer contributions in 1998. However, this tax funds only the universally entitled general care that was granted in 1995. It does not pay for entitlements to maternal and child health, obstetric, mental health, or long-term care.

The part of the system’s funding that is public
**PAYMENT & INSURANCE**

**EXHIBIT 1**

Practicing Physicians Per 1,000 Population, Selected Countries, 1995-2010

<table>
<thead>
<tr>
<th>Year</th>
<th>OECD-22</th>
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<tr>
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<tr>
<td>2010</td>
<td>3.50</td>
<td>3.50</td>
<td>3.50</td>
</tr>
</tbody>
</table>

**Source:** Author’s analysis.

**NOTE:** OECD-22 is the twenty-two countries in the Organization for Economic Cooperation and Development that have the highest per capita incomes and that provide universal coverage, excluding the United States and Israel.

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Although demand for health care has grown, the number of practicing physicians per 1,000 people in Israel declined from a high of 3.85 in 1999 to 3.03 in 2006, then rose to 3.50 in 2010 (Exhibit 1). Israel’s physician supply trend contrasts sharply with the steady growth in physician supply in the United States and twenty-two other OECD countries that have the highest per capita incomes and provide universal coverage (the average shown in Exhibit 1 does not include the United States or Israel).3

Israel has traditionally enjoyed a high ratio of physicians to population, compared to other developed nations. Although that ratio is still a relatively high one, its decline is adversely affecting the population’s access to care (Exhibit 1). The dip in the number of physicians and other medical personnel in Israel reflected the end of immigration from the former Soviet Union, which had helped swell the medical labor supply in Israel during the 1990s.

**State Policy** To deal with the decline in the ratio of physicians to population, the state has several main options: It can mitigate the decline, change the ways care is delivered to reduce the demand for physicians’ services, or do both at once. Ways of mitigating the decline include supporting the expansion of medical schools and helping reduce the emigration of Israeli physicians, while encouraging the return of those who have gone abroad. One way to change how care is delivered is to introduce physician assistants, a type of provider that exists in the United States but not in Israel.

The Israeli state chose the first option and decided to expand medical training. The state has helped fund the expansion of the country’s three medical schools and the establishment of a new medical school in the Galilee.16-19 However, these measures came too late and have been inadequate to stop the decline in access and delivery of care. In 2010 Israel had 4.1 medical school graduates per 100,000 population, as opposed to 6.6 in the United States and 10.6 in the twenty-two OECD countries that have the highest per capita incomes and that provide universal coverage, excluding Israel and the United States.3

It is noteworthy, therefore, that the state has not made use of other options to alleviate the situation. That Israel can and should adapt to a lower physician-to-population ratio had been suggested in 1990 by the commission that laid the foundation for the 1995 National Health Insurance Law that secured entitlement to general care.12

Since 1998 the state has consistently resisted meaningful growth in tax funding of care per capita. In constant 2005 dollars, the state per capita contribution to health care increased by 11.7 percent from 1995 to 2010, rising from US$1,091 to US$1,219. Simultaneously, per capita private spending rose by 51.6 percent, from...
US$498 to US$775. The state contribution to health care has been relatively negligible if both population growth and changes in the age distribution are taken into account.

From 1995 to 2010 the Israeli population increased by 37.5 percent. But using the Israeli age-based budgeting mechanism for sickness funds, to account for changes in age distribution, the increase in the population was 44.9 percent. Thus, when the aging of the population is considered, the state’s per capita contribution over this period increased by just 4.3 percent while the private contribution rose by 43.7 percent.7 20

As a result, the Israeli government’s share of health care spending has declined since 1995—just the opposite of what occurred in the United States and in other OECD countries that have the highest per capita incomes and provide universal coverage (Exhibit 2). Israel’s state support for its health care system is now lower than in any of these countries.3

The Israeli state’s funding has thus been almost entirely replaced by private financing in the form of copayments and, particularly, premiums for optional supplemental insurance regulated in the 1998 Arrangements Law for Encouraging Economic Growth and Employment, and for Achieving Budgetary Targets. This insurance is now held by about 83 percent of Israelis, up from about 20 percent at the end of 1998.21 Although originally intended to cover care that is not included in the universal public entitlement, this insurance today also pays for care that is included in the entitlement. However, it cannot pay for any copayments that are required both for entitled care and for care paid by supplemental insurance.

The supplemental insurance is highly regulated. Only the four sickness funds can sell it. They must sell it to everyone who requests it and charge everyone in a particular age group the same amount in community-rated premiums. In other words, the sickness funds cannot discriminate by health status, and they are compelled to insure the cost of treating existing medical conditions.

Moreover, although this insurance is sold by the sickness funds, which are in charge of overseeing the public entitlement, it covers only benefits provided by “private provider” facilities that are not paid for by tax monies. In other words, no “public provider” such as a state hospital can receive payment from supplemental insurance, nor can hospitals or clinics owned by a sickness fund. The sole exceptions are the Hadassah University Medical and Shaare Zedek medical centers in Jerusalem, which have been independent not-for-profit entities since before statehood, and which provide privately paid care as well as publicly paid entitled care.22

Policy Outcomes

The state’s policies regarding the funding of public entitlement and supplemental insurance have fueled demand for care from “private providers.” That demand had already been rising because of the declining per capita supply of physicians. For the most part, the demand for private care has been met by medical personnel who are paid to supply publicly entitled care.

A 2001–02 survey, the latest available, indicated that 98 percent of specialists were paid by the public to provide entitled care, but 48 percent of them also reported some private practice.23 This last percentage has probably increased with the state-induced growth of supplemental insurance, which in turn contributes to the demand for private care.

For example, medical specialists who are paid by the public have been moonlighting at privately funded facilities such as Tel Aviv’s new Assuta Medical Center. They have also moonlighted at flourishing private clinics, as well as at separate organizational units in government-owned hospitals—notably the Sheba and Tel Aviv Sourasky medical centers in the Tel Aviv area.24 These units are selling privately funded care in publicly owned facilities. Because of a lack of effective enforcement, ways have been found to circumvent the Israeli Supreme Court’s ruling barring such activity.15

The specialists occasionally work at the privately funded facilities during the hours when they are supposed to be on public duty.22 And it is alleged that they often treat as public providers patients whom they then refer to themselves as

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**EXHIBIT 2**

Public Funding On Health Care, Selected Countries, 1995–2009

<table>
<thead>
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**Source:** Author’s analysis. **Note:** OECD-22 is the twenty-two countries in the Organization for Economic Cooperation and Development that have the highest per capita incomes and that provide universal coverage, excluding the United States and Israel.
Another result is that staff workloads at public hospitals have been increasing, primarily among residents and specialists in fields that do not attract private providers. The burden on residents has been particularly heavy. Unlike in the United States, for example, in Israel residents perform many tasks of physician assistants and often fill in for absent specialists, especially during night shifts.

In addition, earning gaps have been widening between doctors who work both privately and publicly and those who work only at public facilities. Younger physicians, who carry much of the burden of their seniors—who are abandoning their posts for privately paid practice—lag far behind in wages while they work long and arduous hours treating patients whose care is publicly paid.

Data about the developments in the previous paragraph are not available. The circumstantial evidence is robust, however. Following the agreement between the Israel Medical Association and the government in August 2011, medical residents took to the streets, and many resigned, although temporarily, arguing that their dire situation had not been remedied by the agreement. They also said that they did not see a future in a system in which they need to engage in self-referral and moonlighting to make a decent living.

A growing number of discontented specialists in the Israel Medical Association joined the residents. The specialists claimed that the association had betrayed the goals of the labor dispute. As a result, in November 2011 the state had to sign a secondary agreement with residents that improved their situation by increasing their wages and reducing working hours. Again, as with the August accord, the government did not promise any change in policy.

The relative rise in the prices of medical care compared to other prices reflect the developments discussed above in four ways (Exhibit 3). First, because of the double-dipping of specialists, Israelis who pay privately for care—either through insurance or out of pocket—often pay twice for the same procedure. They pay once through tax-funded wages for absent staff who should have provided the procedure in the first place, and they pay a second time privately, when they obtain it at last.

Second, the decline in the tax-funded physician workforce means that the publicly funded infrastructure is used less and less—for example, labs and imaging or surgical units during the afternoon and evening hours. At the same time, privately funded investment in similar facilities and units is booming. Third, this investment spurs the unchecked adoption of new technology.

And last but not least, patients increasingly appear to pay privately for care that is prompted by providers who engage in self-referral from their public to their private practice. Compared with households that do not have private insurance, those that do spend more out of pocket, even on care included in the public entitlement and even though they do have insurance. This is evident especially in areas where the supply of medical services is high, in Tel Aviv and its surrounding areas.

According to 2009 data, the average Israeli household spends 5.1 percent of its disposable income (after taxes that also pay for entitled care) on privately paid medical care, as opposed to the 3.7 percent the average household spent in 1998. Within spending on care, the largest increases between 2003 and 2009 (years for which data are comparable) were in the shares of spending on insurance as well as out-of-pocket spending to pay privately for care included in the public entitlement.

Israelis pay increasingly more for health care than they do for other goods and services. And one cannot assume that the relative rise in prices of care reflects a technological edge in care vis-à-vis other goods and services. As a result, Israelis get less value for their money than the growth in health care spending might suggest. Namely, overall health care spending grew by 29.9 percent between 1995 and 2010. This growth paralleled the growth in the average income of Israelis.
However, when corrected for the aging of the population as well as for the relative inflation in health care prices (Exhibit 3), actual growth falls to a third of the apparent increase, or 10.6 percent.7

To the extent that data permit comparison, increases in the cost of medical care in Israel appear to be converging with the situation in the United States, in contrast to the experience of Canada and France (Exhibit 4). The data suggest that in Canada and France, prices of care tend to change consistently with other prices. Hence, people in those countries do not face care that is becoming less affordable, and as a result they are not forced to reduce their use of care and possibly their purchasing of other goods and services because the prices of care increased relative to other prices. This is not the case in the United States, and apparently it is ceasing to be the case in Israel.

The data express adverse distributional consequences as well. First, the widening gap between the private care price index and the medical inputs price index (Exhibit 3) reflects the growing compensation gap noted above between personnel engaged in both private and public practice and those employed only in the public sector, whose pay is reflected in the medical inputs price index. The higher percentage change in the medical inputs price index than in the gross domestic product might signify the pressure that compensation for privately paid care puts on compensation for publicly paid care.

The burden of the growth in household private spending on care is greater on low-income households. Low-income Israelis forgo non-medical consumption as well as needed medical care, including the purchase of medications prescribed by their doctors.21 They also wait weeks to receive the publicly paid services of specialists.27 No direct evidence is available on the quality of health care in Israel. However, it is safe to assume that longer waiting times for service, at least in the publicly supported system, have not improved quality. Thus, because of a greater reliance on private funding in the medical system as a result of government policies, the disparities between the well-to-do and the poor have widened, both in the use of medical care and more broadly.21,27

The situation has sociological and geographical ramifications as well. Low-income regions, such as the Negev in the south of Israel and the Galilee in the north, suffer the most because medical personnel in general and specialists in particular prefer to work at more lucrative practices in the central regions. These areas are underserved by medical personnel, especially specialists, and the health status of the population is inferior to that of people in the central areas of Israel, especially Tel Aviv and its vicinity.28

The unfolding situation also has an ethical and moral effect on Israeli life. The work ethic and laws are often disregarded by those who should serve as role models for medical students, interns, and residents. Tension among medical personnel has grown. Transparency and accountability disappear when it comes to the use of public property and money, with the “public” and the “private” becoming blurred. Care becomes less affordable, and low-income groups, mainly in outlying areas, who depend on the shrinking public system, feel increasingly marginalized.20,28

Policy Options
To solve these problems, any reform needs to address the funding of health care, the wages and working conditions of medical personnel, the labor supply, and the public system’s ability to respond to the changes in the supply of and demand for care and hence to patients’ needs.

Funding First, the state needs to increase the share of gross domestic product that it spends on health care from the current 8 percent to 9 percent.7 This increase could be achieved by raising the share of gross domestic product devoted to health by 1.5–2.0 percent for seven to eight years. Simultaneously, and even more important, the state should restore the 1997–98 level of tax-based funding of the health care system. It should increase the share from its current 58.9 percent to 69 percent, the share from 1995, which is more in line with the corresponding percentages in the other high-income OECD countries that provide universal coverage.

### Exhibit 4

**Index Of Health Care Prices, Relative To Gross Domestic Product, Canada, France, Israel, And The United States, 1990–2006**

- **US**
- **Israel**
- **Canada**
- **France**

**Source** Author’s analysis. **Notes** Base (100.0) is 1990.
This new financial arrangement could make the publicly supported system more responsive to changing circumstances by adopting care practices and technology that could alleviate the impact of the declining physician-to-population ratio. Examples include the use of physician assistants, more automated procedures, and—not least—paying physicians in demand in the public system higher wages than those negotiated by the Israel Medical Association. Although every health care system, including that of the United States, strives for the same types of efficiency gains, the situation is more acute in Israel than in the United States. For example, Israel has not introduced the use of physician assistants.

The first step in this direction—a relatively easy one—should be to nationalize the supplemental insurance funds by making contributions mandatory or, even better, part of the progressive health tax. This arrangement would require the state to pay about US$235 million per year for indigent Israelis. Based on 2010 data, this amount would add 1.5 percent to the national health care budget, 0.10 percent to the share of spending on health in the gross domestic product, and 0.50 percent to the share of state funding of the system. All funding, both new and existing, should be reallocated to the publicly funded system for “public providers.”

There would be two immediate gains from this reallocation: The funding would become more equitable, and more resources would be available to public providers, including state-owned hospitals. These changes would come at the expense of private pay to physicians who are already paid by the public, and the investment and use of privately funded infrastructure and technology that are already available in publicly funded facilities.

**Wages and Working Conditions** In a reformed public system, physicians—most of whom are now moonlighting—would become “full-timers,” working only in that system and receiving additional compensation from the now reallocated funds. This compensation would be based on personal contracts rather than the union-negotiated uniform group contracts, or in addition to them.

This arrangement would also give hospital managers the autonomy—and the public funds—they need to manage their physician workforce more effectively than they do now. They would be able to offer contracts and wages according to the demand for the physicians’ services, workforce supply conditions, and technology.

Some measures in this direction are the outcome of the August 2011 accord. For example, the state and the Israel Medical Association have agreed that wages no longer need to be geographically uniform. As a result, physicians in low-income areas have been granted higher wages than those in the center of the country, to make the low-income areas more attractive. But more can be done in the direction of eliminating uniformity in wages, regardless of specialty, need, and so forth.

**Responsiveness** For care under their public entitlement, Israelis can choose any primary care physician or specialist in the community. They do not have a similar choice when they are hospitalized: For their publicly paid inpatient care, Israelis are assigned medical staff by the hospital. As a result, Israelis who want to be treated by a physician of their choice in a hospital have to pay for care in a private facility, where in most cases they are treated by a moonlighting physician.

To rectify the situation, arrangements must be made to allow the public a choice among the specialists who have now become full-timers for extra pay. In other words, the choice that is now available only under private funding arrangements would become available under public arrangements as well.

Managerial autonomy and flexibility in publicly paid hospitals as well as competition in the provision of care could be increased by a reform that has been proposed since 1990.11,12 According to this proposal, the state would stop providing acute hospital care and cease overseeing as well as providing psychiatric care and preventive maternal and child care. State hospitals and those owned by Israeli sickness funds or health plans should be turned over to competing nonprofit hospital corporations or self-standing trusts that are accountable to the public through the sickness funds that coordinate and purchase care. The arrangement of not having the state be a key owner and operator of hospitals is common in most developed nations, including the United States.

An additional rationale for this proposal is that...
Financially, the reforms proposed here for Israel are less dramatic and revolutionary than they might seem.

The state would become an honest broker in the system. It would also be able to allocate more resources to policy making and oversight.11,12

**Labor Supply** The extra pay to physicians proposed above could mitigate the decline in the physician supply, at least in the publicly supported system. The proposed higher wages of specialists in demand could also help reduce the brain drain of physicians from Israel. Even if private-pay options grow, higher wages could still improve the brain drain. Medical doctors have the highest emigration rates among Israeli professionals.29 Numerous Israelis study overseas. Better wages and working conditions could induce more of them to return to Israel than is now the case.

In addition, several ways to expand medical training for Israelis can be reconsidered. First, preference in medical training could be given to Israeli students. Israel accepts about 100 medical students annually, most from the United States.30–32 Some Israelis have hypothesized that these students are subsidized by Israeli taxpayers and that they deprive Israeli students of training opportunities.

Second, specialization and related accreditation arrangements should be transferred from the Israel Medical Association to the state. The association has labor union–type interests in keeping the supply of medical providers low, so that their pay is high. These arrangements should also be reevaluated because some specialization requirements may be excessively lengthy or antiquated.

**Law Enforcement** The August 2011 accord between the Israel Medical Association and the Israeli state stipulates that physicians in hospitals will punch time clocks as a way to assure their publicly funded employers that they are indeed spending their publicly contracted working hours providing entitled care. This requirement may reduce the incentive to moonlight for private pay, especially during working hours paid for by the public, but it will not eliminate the illegal practice of self-referral from publicly supported care to privately paid care. Authorities should devote more resources and attention to law enforcement.

**Conclusion** Israel has had a high-performing health care system and has achieved relatively high health outcomes. Israel’s life expectancy at birth (79.8 years in 2010)3 is one of the highest in the world. This record was achieved while managing medically challenging immigrant and indigenous populations. The health outcomes that have been reached thus far are attributable to a relatively high ratio of very qualified physicians to population, coupled with equitable and efficient funding and operations.

The number of physicians available to respond to the growing population’s health care needs has been declining. Yet by any measure, the country still benefits from a favorable ratio of physicians to population and a relatively young population. The real risks to the system appear to be the relatively unparalleled decline in the share of spending for the system that comes from public sources and the promotion of privately funded care.

Developed countries that offer universal health coverage fairly uniformly spend 9–11 percent of their gross domestic product on health care, and about 70–80 percent of that money is public funding. The Israeli experience suggests that a relatively sharp deviation from these spending shares, at least in the share of public funding, can create great inequities and must be handled with care.

Financially, the reforms proposed here for Israel are less dramatic and revolutionary than they might seem. In essence, the system needs to return to its pre-1998 funding and regulatory arrangements, thus becoming similar once again to other high-income countries that offer their populations universal entitlement. Moreover, the financial reform can support politically challenging and long-awaited structural changes that can, as in other managed competition systems, support managerial flexibility and wider patient choice of publicly paid providers.

The Israeli state needs to resume its leading role in financing health care while relinquishing its relatively sizable roles as a manager and provider of care.
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NOTES


28 Chernichovsky D. Changes in...


32 Tel Aviv University Sackler Faculty of Medicine. New York State/American program [home page on the Internet]. Tel Aviv: The University; [cited 2013 Feb 25]. Available from: http://medicine.tau.ac.il/english/index.php/ny/about

ABOUT THE AUTHOR: DOV CHERNICHOVSKY

In this month’s Health Affairs, Dov Chernichovsky, a professor of health economics and policy at Ben-Gurion University of the Negev, critiques recent developments and calls for change in Israel’s health care system. His core complaint is that many Israelis now must purchase private health insurance to supplement state-sponsored universal care coverage, and they end up spending more out of pocket even for services covered by the nation’s universal entitlement to care. Additionally, many publicly paid physicians moonlight at private facilities to earn more money and refer their patients to these practices.

Chernichovsky proposes that Israel increase public funding for health care and adopt other reforms to reduce demand for, and provision of, private care by publicly paid physicians.

In addition to his university appointment, Chernichovsky is director of the health program at the Taub Center for the Study of Social Policy in Israel and chair of the National Nutrition Security Council of Israel. In the United States, Chernichovsky is a research associate at the National Bureau of Economic Research and a consultant to the World Bank, where he was a staff member and played key roles in shaping health system reform in Romania and Russia and, more recently, Mexico and Colombia. He was a member of Israel’s State Commission of Inquiry that laid the foundations for Israel’s National Health Insurance Law, which was enacted in 1995.

His study of health care systems has led to the development of the Emerging Paradigm, a framework for studying and reforming these systems. Chernichovsky earned a doctorate in economics from the City University of New York and a master’s degree in economics from the Hebrew University of Jerusalem.