

Introduction

Government and recent political history

The State of Israel was established in 1948. An elected president heads a parliamentary and multi-party system. A history of armed conflicts with neighbouring Arab countries and large-scale immigration have posed continuing heavy burdens on Israel's economy. Income inequality is among the highest of developed countries. Administratively, the continuing process of decentralization has led local governments to operate as independent authorities although dependent on central government for much of their financing.

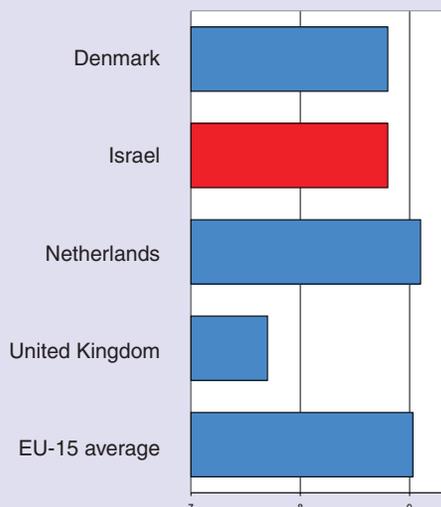
Population

In 2000 Israel had an estimated population of 6.4 million inhabitants of whom 78% were Jews, 22% were mostly Muslim Arabs. Population density is among the highest of the developed countries, with over 60% of the population concentrated along the Mediterranean Sea and only 10% in rural areas. Israel's population is marked by a combination of a relatively high fertility rate (2.95 per woman) and growth in the number of older people, with 29% of the population younger than 15 and 10% over the age of 64. Israel has two official languages: Hebrew and Arabic.

Average life expectancy

In 1999 life expectancy at birth was 76.6 for males and 80.4 for females. Over the past two decades life expectancy has increased by 4.8 years for males and 5.0 years for females.

Fig. 1. Total health care expenditure as % of GDP, comparing Israel, selected countries and EU average, 2002



Source: WHO Regional Office for Europe health for all database, June 2004.

Note: EU-15: EU countries before 1 May 2004.

Leading causes of death

The main causes of death are cardiovascular disease, cancer, cerebrovascular diseases, diabetes and accidents. Breast cancer is the leading cancer among women, while among men it is prostate cancer (Jewish men) and lung cancer (Arab men).

European Observatory
on Health Systems and Policies
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 17 17
Fax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

Recent history of the health system

Over the past century, health care services in Israel have been developed by voluntary health plans (originally called sick funds), non-profit institutions, the government and the British mandatory regime that existed prior to the establishment of the State of Israel in 1948. In 1911 the first health plan was established by workers' associations to provide care for workers and their families and to employ immigrant doctors. All four of Israel's health plans were established formally between 1920 and the early 1940s. The Hadassah Medical Organization has also been key in providing health care services and began establishing hospitals in urban centres in 1918.

Until the introduction of National Health Insurance (NHI) in 1995, the health plans insured their members and provided them with most health services. By the late 1980s approximately 95% of the population was enrolled in one of four competing health plans that provided their members with most curative health services either directly or by contract with other agencies.

In 1988 the state set up the Netanyahu Commission to examine the problems of the nation's health system. This commission made several recommendations highlighting inadequacies in the public health system, disorganization and low levels of employee satisfaction. These recommendations led to legislation introducing the NHI in 1995 and reorganization of the Ministry of Health (MoH).

Health expenditure and GDP

Israel spent 8.8% of GDP on health care in 2002, slightly higher than the EU-15 average. Public spending constituted 68% of total expenditure in that same year.

Overview

The Israeli health system underwent significant scrutiny and reform following the Netanyahu Commission in 1988. While highlighting the deficiencies in the system, the commission made important recommendations that the MoH adopted. As a result of this process, NHI was introduced in 1995. In addition, recent efforts have attempted to change government hospitals into freestanding hospital trusts, so far without success. Despite these improvements to the organization and delivery of health services, the health system has some important challenges such as persistent health inequalities, an ageing population and political unrest.

Organizational structure and management

As a parliamentary democracy, Israel's Knesset (parliament) determines laws and budgets and thus exercises ultimate authority over the health system. However, many key players are involved in health within the government (including the ministries of health and finance) and outside (including health plans, hospitals and health care unions).

The MoH has overall responsibility for the health of the population and the effective functioning of the health system. It is involved in several areas of planning such as public health, regulatory and stewardship functions and owns around half of the nation's acute hospital beds, two thirds of the psychiatric and one tenth of the chronic disease beds.

The Ministry of Finance prepares the budget and monitors its implementation. Furthermore, it seeks to limit public spending on health care and the number of employed physicians. The National Insurance Institute collects the health tax (see below) and the Israeli Defence Force

provides basic and emergency care for military personnel.

Outside of the government, the four health plans are voluntary, non-profit organizations that provide their members with access to a benefits package specified in NHI law. The government provides the health plans with an annual capitation fee per member. In addition to the health plans, half of the hospitals are non-governmental. Health care unions, emergency service organizations and other voluntary organizations are important non-governmental players involved in health.

The NHI law of 1995 addressed organizational problems such as the over-politicized health system (some health plans have political affiliations) and the lack of a comprehensive legal framework for health plans' activities. However, there is a significant problem with the MoH's dual role as regulator and provider as proposed by the Netanyahu Commission, which can lead to inefficiencies and conflicts of interests. Current efforts aim to reduce government provision of health services in the hopes of increasing efficiency.

Planning, regulation and management

Israel has neither a comprehensive national health plan nor an active system for setting and updating national targets. Independent, temporary commissions such as the Netanyahu Commission appear to have a stronger impact on planning and policy development than efforts within the MoH.

Regulation of health services outside of the public sector had been limited to budgetary controls, subsidies and political persuasion until the introduction of NHI and the Patients' Rights Act in the mid 1990s. These two reforms created new areas for MoH regulation such as mandatory fluoridization of community water supplies, long-term care, patients' rights and smoking in public places. These additions built on the previous areas such as food, water and drug safety, licensing of health professionals, major capital expenditures

and hospital per diem rates. However, some areas still require increased regulation including food fortification and quality, health care personnel and the quality of acute care.

Decentralization of the health system

Although the Netanyahu Commission recommended the regionalization of health services in Israel, the ultimate source of authority remains at national level. The national level develops policies and strategies for the regions to implement, with some leeway to respond to local conditions.

In the past decade there have been some notable changes in this area. First, there has been some deconcentration of central authority to lower administrative levels of central government. For example, government hospitals were given more autonomy. Secondly, while there has been no devolution or delegation to regional or local levels, authority actually has been transferred from health plans to central government. Finally, despite various attempts at privatization there has been little success in implementation to date.

Health care financing and expenditure

Health care financing and coverage

The Israeli health system lies somewhere between a social health insurance system and a tax-financed system. It is financed predominantly from public sources through a mix of payroll and general tax revenue. In recent years the share of private financing has increased.

General tax revenues, consisting of income tax, value-added tax and customs levies, make up less than 50% of total financing. The payroll tax earmarked for health accounts for 25% of total health care financing and is collected by

the National Insurance Institute (NII). There are exemptions for various groups such as pensioners and recipients of income maintenance allowances. Public NHI financing is allocated among the four competing health plans.

The introduction of the NHI law instituted universal coverage and specifies the content of the benefits package. Prior to this reform approximately 5% of the population was uninsured, health plans had incentives to cream skim younger and/or healthier people and benefits packages were unclear. Many problems still remain, however, such as worsening financial deficits in the health system.

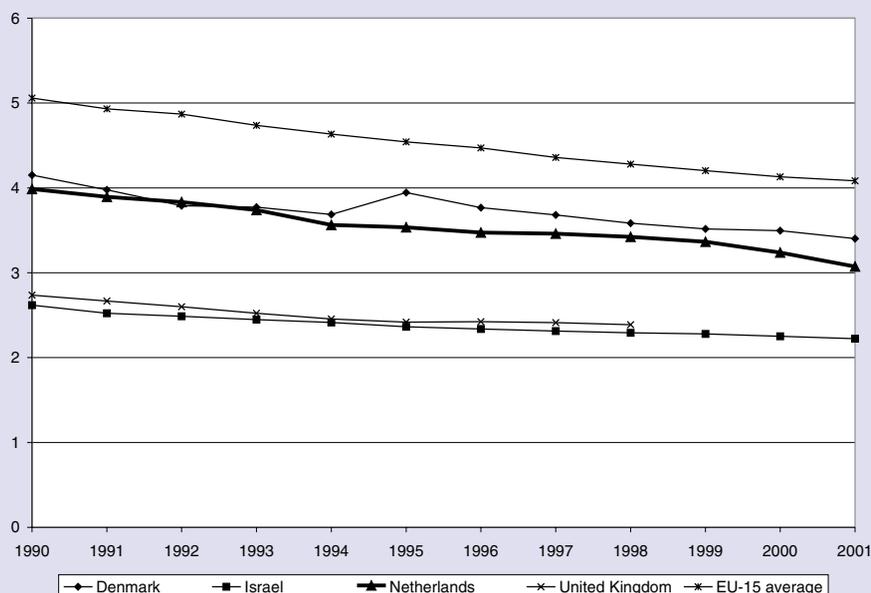
Health care benefits and rationing

The NHI law outlines the benefits package that all Israeli residents are entitled to receive from their chosen health plan. This package includes all hospital care, community-based health care and pharmaceuticals.

Services not included in the NHI benefits package include long-term care, psychiatric care, preventive health care, public health services and dental care. Long-term care financing is shared between households and several agencies such as the NII, government ministries and the health plans. Patients pay out-of-pocket for private surgery and laboratory tests, alternative medicine, private nurses and ambulances, psychological and psychiatric visits, opticians' services and dental care. The government does cover some of the costs of dental care for indigent or elderly people and schoolchildren.

In 1997 Israel established a formal priority-setting process for revising the benefits package based on solid information and a structured decision-making procedure. Although there have been some criticisms of this procedure, such as the limited use of cost-benefit analysis and limited incorporation of the public's priorities and values, it represents an important step in decision-making in health.

Fig. 2. Hospital beds in acute hospitals per 1000 population, Israel, selected countries and EU-15 average, 1990–2001



Source: WHO Regional Office for Europe health for all database, June 2004.

Note: EU-15: EU countries before 1 May 2004.

Complementary sources of finance

Complementary sources of finance constitute approximately 13% of the health plans' revenue; supplementary health insurance makes up around 5% of their revenue. Household expenditure on health has increased in recent years and represented 8.3% of total household consumption in 1999.

Out-of-pocket payments

Cost sharing has been a longstanding part of Israel's health system. Prior to the introduction of NHI, most cost sharing was for government-funded services, while health plans mainly charged co-payments for pharmaceuticals. The NHI law required the health plans to freeze the level of co-payments. The Knesset overrode this legislation in 1998 and authorized all health plans to levy charges on specialist services and community-based diagnostic centres and to increase co-payment rates for pharmaceuticals.

These changes were intended to alleviate some of the health plans' financial deficits.

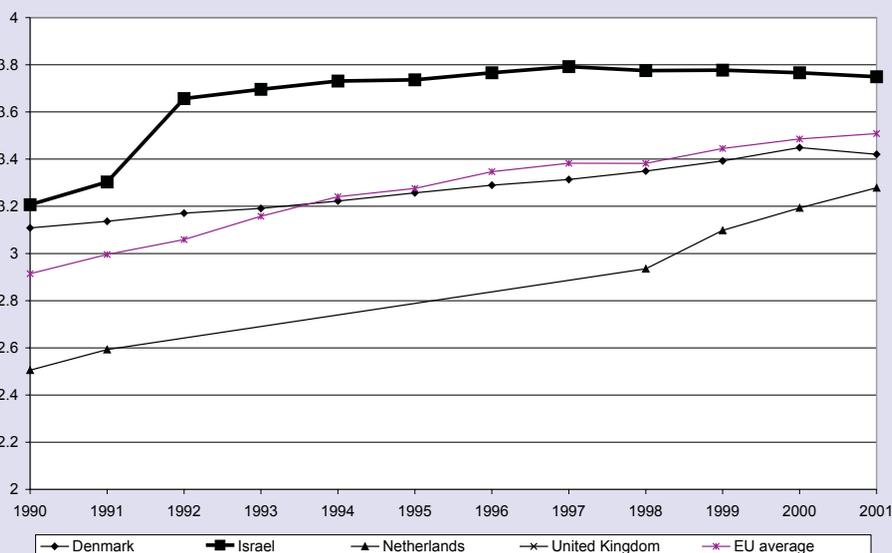
Co-payments are structured so as to minimize the financial burden on individuals. For instance, welfare recipients are exempt and there is a quarterly ceiling on total co-payments at the household level, which is 50% lower for the elderly. However, currently there are no exemptions or discounts for low-income patients thereby creating potential financial barriers to access for these groups.

Out-of-pocket payments also are made to private physicians in community and hospital settings. While private services are illegal in government hospitals and one of the health plans' hospitals, informal payments for these services persist.

Voluntary health insurance (VHI)

Voluntary health insurance exists in Israel in two forms: supplementary VHI offered by the health plans and supplementary VHI offered

Fig. 3. Physicians per 1000 population, Israel, selected countries and EU-15 average, 1990–2001



Source: WHO Regional Office for Europe health for all database.

Note: EU-15: EU countries before 1 May 2004.

by commercial insurers (commercial VHI). In recent years, the proportion of Israelis with supplementary VHI has risen markedly from 37% in 1997 to 65% in 2001. Supplementary VHI covers part of the costs of private physicians, treatment in private hospitals, complementary medicine, etc. Approximately 25% of Israelis have commercial VHI, which tends to offer more coverage than the supplementary VHI, and 20% have both forms. Those with commercial VHI tend to have higher incomes and better health as commercial insurers are free to reject applications on the basis of health status and pre-existing conditions.

In the 1990s there was much debate about who should be allowed to offer VHI: the health plans, commercial insurers, or both. It was believed that allowing health plans to offer VHI would generate revenue and enable reasonably priced VHI to be offered to a wider range of people. However, concerns centred around the health plans' potential marketing advantage over private insurers due to their existing relationship with members; that those with VHI might have faster or more courteous service, thereby undermining the NHI's equity objective; and that the health plans might use public NHI funds to cross-subsidize VHI. While both health plans and private insurers currently are permitted to offer VHI, health plans are restricted from providing long-term care insurance and they must have separate accounts for VHI to prevent cross-subsidization.

Health care expenditure

Health expenditure in Israel stabilised in the 1990s, after a sharp increase in the previous decade. While total health expenditure increased from 6.6% GDP in 1985 to 8.8% in 2002, public expenditure remained constant at 68% of total health expenditure (with a peak of 73% in 1997–1998).

In 1998, services with the highest proportion of total health spending were hospitals and research (41%), public clinics and preventive care (39%), followed by dental care (9%), medicines and medical equipment purchased by

households (6%), private physicians (4%) and, lastly, government administration (1%).

Health delivery system

Primary care

Primary care is highly accessible in Israel and has improved substantially in recent decades. In three of the four health plans, the cost of primary care visits to health plan physicians is fully covered by NHI and waiting times are minimal. Improvements in primary care have resulted from growing competition among health plans, the founding and expansion of family practice residency programmes, computerization of health clinics, upgrading of clinic management skills, increasing patient choice and upgrading and modernizing facilities.

Primary care physicians are employed with a health plan as either salaried or independent physicians (IPs). Private primary care physicians accounted for less than 1% of total primary care visits in 1996–1997. A recent comparative study of IP care and that provided in a clinic setting indicates that although IP care is more expensive, it provides longer patient visits, more health promotion and is associated with greater patient and physician satisfaction. However, there are problems with IPs, such as limited resources available for multiple tasks and quality control, less continuity of care and professional isolation.

Historically the largest health plan (Clalit) made extensive use of nurses in its primary care clinics but their role declined in the 1990s. Recently, there has been growing recognition of nurses' importance in primary care, particularly in rural settings, and Israel's nursing leadership would like to see an expanded role for nurses in both urban and rural areas.

In all the health plans visits to hospital-based specialists require prior authorization, thus primary care physicians act as gatekeepers.

However, members of small health plans have access to community-based specialists without prior authorization. A recent study recommended increasing gatekeeping coordination through patient and provider education to encourage voluntary use of primary care physicians as the sole referring agents, greater decentralization of authority and greater budgetary autonomy for clinics and primary care physicians.

There is a growing belief in Israel that primary care physicians should do more, but the conditions needed to expand their services do not exist. There could be greater attention to the psychosocial components of care, active health promotion, addressing the unique needs of immigrants and vulnerable populations and accounting for resource constraints. However, barriers to these changes include inadequate training, heavy caseloads, lack of incentives and insufficient infrastructure. Recent policy developments, such as the establishment of a National Council for Health in the Community and the provision of economics and management training for physicians, have attempted to address these shortcomings

Public health services

The MoH operates a public health service that coordinates regional and district offices. The recently formed Ministry of the Environment took on some environmental health responsibilities such as noise and air pollution, radiation, and waste collection and disposal. However, the MoH retains responsibility for water quality, recycling and pesticide use.

The MoH plans and coordinates efforts to prevent, monitor and control communicable diseases, with support from health plans and physicians. Family health centres, which are mostly owned and operated by the government, are involved in intensive outreach efforts in immunization and child health. Vaccination coverage is high in Israel, with about 90% to 92% coverage of infants and a 93% level of measles immunization in 2000. There was effective cooperation on communicable disease

control between Israel's MoH and its Palestinian Authority counterpart until the intifada in 2000.

In 1994 the Israeli Center for Disease Control was established to collect and analyse health-related data to increase the evidence base for policy decisions.

Family health centres are the primary source of screening in childhood and the new women's health centres established by the health plans offer screening for women. A recent nationwide effort to increase mammography rates for women over 50 was carried out jointly by the MoH and the health plans. There remains a need to develop an organizational culture of outreach efforts, greater publicity for health promotion and enhanced methods to engage health reporters in order to improve screening efforts in Israel.

The Department of Health Education within the MoH organizes health promotion. Currently, there is no national policy or any clear definition of what should be included in promotion and prevention programmes. While health plans have played an increasing role in health education and promotion, there continue to be problems engaging physicians to be active in this area. The past decade has seen a substantial increase in health promotion activities but these need more evaluation together with increased resources and new programmes.

Key issues in public health centre around the low levels of spending (0.8% of national health expenditure), developing methods for prioritizing and funding public health interventions and changing ownership and modernization of family health centres.

Secondary and tertiary care

There is a rising proportion of specialists among all licensed physicians in Israel, reaching 42% in 2000. Most specialist ambulatory care is given in community settings, with a declining proportion taking place in hospitals. Many hospital-based specialists have begun part-time work in the community in order to supplement their incomes, which may enhance hospital-

community communication. In all but the largest (Clalit) health plan, the majority of specialists work independently in their own facilities. Specialists are concentrated in urban areas and waiting times appear to be reasonable. Rates of specialist visits are substantially lower among Israeli Arabs than Israeli Jews, but the reverse is true for primary care physicians and hospital visits.

In 2000 Israel had 48 general acute hospitals and 21 psychiatric hospitals. The general hospitals are spread throughout the country with an overall general care bed-population ratio of 2.2, which is low compared to OECD countries. Average length of stay has declined dramatically while admission rates have increased in recent decades.

About half of all acute hospital beds are in government-owned and operated hospitals. Clalit (33%), private profit-making hospitals (5%) and voluntary non-profit hospitals own the remainder. Hospital physicians are employed by the hospitals, except for independent physicians in private hospitals.

Recent plans for hospital reform centre on reducing government ownership of hospital beds to improve efficiency and responsiveness. In the 1990s an attempt to change government hospitals into separate legal, nongovernmental trusts failed due to objections from health care unions. Other important issues regarding hospital care include monitoring and improving quality of care and debates about investing in expensive end-of-life care.

Social care

Long-term care financing is the shared responsibility of households and various agencies. The National Insurance Institute provides community services for those with chronic disabilities and mentally frail elderly people. The Ministry of Social Affairs funds homes for the aged and community care for semi-independent and frail elderly people. The MoH is responsible for nursing homes and institutional care for people with severe disabilities. The health plans

provide medically skilled nursing for elderly people in institutions.

About 4.1% of elderly people in Israel live in institutions. Half of these are referred through the government that participates in financing their care, half are self-referred and pay for their own care. The health plans provide professional home care for elderly and disabled people and are considering increasing the amount of services provided, for instance home hospitalization as an alternative to costly hospital stays.

The 1986 Community Long-Term Care Insurance Law defined the government's legal obligation to provide a minimum level of long-term care to elderly people with disabilities based on eligibility criteria. These community services are financed from a proportion of employee wages and general taxation. While the burden of care had rested primarily with the family, now the government assumes some responsibility.

Other services in the community include home-making services, meals-on-wheels, day-care and respite centres. These services are provided and subsidized by the Ministry of Labour and Social Affairs on the basis of a means-tested discretionary programme. Additional services have been provided in order to assist elderly people to 'age in place', such as sheltered housing and supportive communities, planned and developed through collaboration between several ministries including Finance, Housing, Immigrant Absorption, Labour and Social Affairs.

Human resources and training

Physicians

In addition to schools outside Israel, particularly in eastern Europe, four Israeli medical schools train a large number of physicians. Immigration from Germany, the Russian Federation and most recently from the commonwealth of independent states of the former USSR, has yielded a significant number of trained physicians. Approximately half of the large number of immigrant physicians have

found work as doctors in Israel, consequently the physician-population ratio has risen substantially to around 3.8 physicians per 1000 population (compared to the EU-15 average of 3.5). While some analysts argue that the number of physicians should be reduced by limiting the number of medical students, the Israeli Medical Association maintains the need to build a fifth medical school in Israel to anticipate shortages resulting from lower immigration levels. Additional challenges in this area centre on shortages in some medical specialities and urban-rural discrepancies in physician density.

Nurses

Israel has no shortage of nurses, with around 6 nurses per 1000 population in 2001. Mass immigration has impacted significantly on nursing, as immigrants comprise more than half of the country's nurses. Israel is in the midst of a major nursing reform including such policies as shifting from licensed practical nurses to registered nurses in some settings, changing registered nursing education, encouraging masters and doctoral level education for nurses and expanding the role of nurses in health plans and hospitals.

Management training

Health care management training has significantly expanded and improved over the past decade. Degree programmes are offered at several major universities and many mid-career employees of health plans and hospitals are encouraged and subsidized to participate in them.

Pharmaceuticals and health care technology assessment

Pharmaceutical expenditure in Israel constitutes approximately 15% to 20% of total health expenditure, 15% of total health plan expenditure and 20% of total household spending on health. Israel's pharmaceutical industry deals primarily with the manufacturing and distribution of generic drugs; the majority of patented drugs are imported or produced in Israel under licence from foreign

companies. Almost two-thirds of total drug sales are imports. Most pharmaceuticals are dispensed in three types of pharmacies in community settings: health plan clinics, independent pharmacies and large chains. In hospitals the main pharmaceutical services provided are production and inventory management.

The government approves pharmaceuticals for sale, sets the National Health Insurance formulary of drugs that health plans must provide to their members, sets maximum prices, licenses pharmacists and regulates the pharmaceutical market. Individuals face co-payments for all prescriptions and cover the full cost of over-the-counter drugs, medications not included in the NHI formulary and those prescribed privately.

In efforts to contain costs, some health plans monitor physician prescribing but there is no formal penalty for over-prescribers.

Most pharmacists are salaried employees. In 2000, there were 0.61 pharmacists per 1000 population, of whom 50% were women and 20% immigrants who had arrived since 1988.

The pharmaceutical industry has undergone several important changes in recent years. For instance, pharmaceutical chains have grown and there have been increased efforts to speed up the licensing process for new drugs, to increase the use of generics and make more drugs available over-the-counter. In addition, in order to increase competition and reduce drug prices, parallel imports are now permitted despite serious opposition from large multinational drug companies, their agents and subsidiaries in Israel and the Association for Research-Based Pharmaceutical Companies, on the grounds that parallel trade violates patients' rights and international trade agreements.

Dental care

Dental care expenditure amounted to 9% of total health expenditure in 1997. Almost all spending on dental care consists of out-of-pocket payments, since dental care is not included in the NHI benefits package (except for cases of trauma or cancer). However, almost 10% of the

population have full dental coverage through commercial VHI and a further 60% have partial coverage through supplementary VHI from their health plans. For those who are not covered, cost considerations appear to lead many low-income people to forego medically necessary treatment. Improvements to dental care services are being considered, such as expanding the School Dental Service and including dental coverage in the NHI benefits package to ensure appropriate care for vulnerable populations.

While independent private dentists had provided almost all dental care, in 1997 they accounted for two thirds of dental units, with health plans and commercial chains accounting for 9% and 15% of dental units respectively. In 2000 the dentist-population ratio was 1.34 per 1000 population, which is among the highest in the world.

The MoH provides and funds some local oral treatment and preventive services for children and people in need, subsidizes dental costs for indigent people and is responsible for licensing dentists and promoting fluoridization of the water supply.

Mental health care

In 2000 Israel had around 5600 psychiatric beds, of which 5% were in general hospitals and the remainder in psychiatric hospitals. The government owns 10 of the 18 psychiatric hospitals, which accounted for two thirds of beds, 67% of patient days and 82% of admissions in 2000. The MoH finances care in government hospitals, private hospitals and psychiatric departments in general hospitals, while the health plans finance care in their two psychiatric hospitals.

In the community there are many private, independent mental health practitioners and about 90 public mental health clinics, 55 of which are provided and funded by the MoH.

The Mental Patients' Treatment Act of 1991 permits compulsory psychiatric examinations or treatment. The MoH established a Unit

for Addictions Treatment in 1990 to improve treatment in this area. While addiction has been targeted as a priority area for expansion, there is a shortage of services for people suffering from both mental illness and substance abuse.

The past decade has seen declines in the supply of psychiatric beds, utilization of psychiatric hospitals and long-term care admissions along with an expansion of community-based mental health services. Additional changes have resulted from the Community-Based Rehabilitation of the Mentally Disabled Act of 2000 and an increase in government funding of rehabilitation, which has further strengthened community-based mental health care. While rehabilitation services have improved and expanded, still they are available to only 10% of the population.

Rehabilitation

Rehabilitation is included in the NHI benefits package, so health plans provide these services with a standard co-payment. Services include general and geriatric rehabilitation for neurological or orthopaedic impairment provided in hospitals and health plans' community facilities offering physical, occupational and speech therapy.

In 2000 there were about 5700 rehabilitation professionals in Israel, which represents a significant shortage, particularly in geriatric rehabilitation services. In addition to the shortage of human resources, poor physical conditions and other factors lead to lengthy waiting times in community rehabilitation centres. Older chronic patients are the main victims of this situation.

Financial resource allocation

Third-party budget setting and resource allocation

Each year the government sets the NHI budget based on the previous year with adjustments for

inflation and demographic and technological changes. There are disputes over this method of budget setting, for example, health care providers and insurers argue for a formula-based budgeting system rather than annual determination by government. Additional disputes arise over the extent to which demographic changes should be factored into the budget and how the mandated adjustment for price changes should be carried out.

The main actors in the health system believe that the system is under-funded and increasingly strained. Although the per capita allocation to the health system increased from 1995 to 1999, during this time both the purchasing power of health plans and the share of NHI expenditure as a proportion of total health care spending declined.

Public NHI financing is allocated to the four health plans on the basis of a capitation formula and takes account of two factors: the number of members and the age mix. This method of funding has made vulnerable groups such as the elderly more attractive to health plans, but since health status is not taken into account in the funding, the healthy and wealthy still are more financially attractive. Also, the poor and the elderly are less likely to purchase supplementary VHI, an important source of revenue for the health plans. It is also debated whether geography should be a determinant in the distribution of resources to health plans in order to improve access to care for people living in small settlements and the peripheral regions.

While the government has put in place a regional organization of public health services, in terms of curative care, health plans are free to organize themselves geographically and allocate the resources at their disposal across geographical regions. The health plans determine geographical resource allocation according to the number of people in the region, their age mix, health status, the previous year's budget and utilization rates and competitive pressure from other health plans.

The health plans are free to determine their mix of inputs such as human and capital resources subject to budgetary restrictions and prices that are set by the government, collective bargaining agreements or market forces. As a result of this freedom, the health plans differ markedly in how they allocate resources across different services.

Capital investments in hospitals are funded largely by the MoH, through its capital budget, in addition to philanthropy from abroad. However, in the community setting operating revenue and/or bank loans fund a great deal of capital spending, which is perceived as a major problem. The MoH also operates a Certificate of Need programme through which health plans apply for approval before purchasing expensive, high technology equipment.

Payment of hospitals

Currently, the reimbursement of public hospitals (which constitute 96% of acute beds) takes place in the form of fees-for-service, per diem fees and case payments, and is subject to a revenue cap. Outpatient services account for a quarter of hospital revenue and are reimbursed on the basis of a fee-for-service charge list established by the government, with a slightly different system of reimbursement for Clalit hospitals. This fee schedule is believed to be out-of-date with technological changes and overpriced. Thus, a key policy issue that remains unresolved is whether, and how, to modify the charge list.

Most inpatient admissions are reimbursed on a government-set per diem basis that is uniform across hospitals and departments. The rate is determined on the basis of current operating costs in the government hospital sector. Throughout the 1990s, case payments (diagnostic-related groups) were introduced for 30 types of admission that accounted for about 20% of hospital inpatient revenue. These case payments were established in order to shorten waiting times primarily for the more expensive procedures. Their introduction has been found to eliminate most queues but

they have also reduced length of stays, increased admissions and repeat admissions and have had no recognizable impact on mortality rates.

A hospital revenue cap was established in 1995 in order to reduce the growth in hospital utilization by removing incentives and reducing the health plans' expenditure for services above the cap. This reform appears to have achieved its objectives but there has been much criticism. For example, hospitals argue that the cap needs to grow more rapidly in order to account for increasing costs and that it works against hospitals in areas of rapid population growth that are prone to exceed the cap. In 2002 a hybrid approach was taken in order to ensure that major external factors are taken into account when setting the cap. The impact of this change in the health system has yet to be evaluated.

Payment of physicians

Around 40% of the population receive primary care from Clalit clinics with free choice of physician. The clinic-based physician receives a basic monthly salary, primarily experience-based, and a monthly capitation payment for each member on their list above a prescribed basic number. Approximately 5% to 10% of members receive care from an independent physician who is paid a capitation rate set unilaterally by Clalit. In the other health plans, most primary care physicians work independently and are paid on a capitation basis based on either actual patient visits or enrolment lists (as in Clalit).

Community-based specialists are either independent or salaried. Independent specialists, the most common type, mostly work in their own offices and are paid on an 'active' capitation basis in addition to receiving fee-for-service payments. The salary scale is determined through a collective bargaining agreement between the Israel Medical Association and the government. Almost all salaried specialists work in Clalit-owned and operated clinics. Their salary is a function of their extent of full-time work, professional rank and years of experience. There are additional payments for seeing more 'first-time' patients

than the specified norm, teaching residents and for carrying out administrative duties.

Hospital-based physicians are paid a salary primarily based on their clinical/administrative responsibility and years of experience. Some physicians supplement their income through private work on a fee-for-service basis, after-hours work in health trusts, working a second shift in Clalit hospitals to deal with lengthy queues and taking illegal under-the-table payments at rates set by themselves.

Some believe that the frequent physicians' strikes in Israel have damaged public trust in physicians and their representatives. In the most recent strike (2000) physicians called for substantial pay increases, among other things. This strike led to two developments: the Israel Medical Association agreed not to strike for 10 years and the government agreed to a formal commission to examine the functioning of the health system.

Two emerging issues in physicians' remuneration include whether payment schemes should account for quality of care and whether physicians should be at financial risk for the health care expenditure they generate.

Health care reforms

Four major reform efforts in Israel are noteworthy: the NHI law, mental health care reform, hospital trusts initiative and the Patients' Rights Act. In addition, the Netanyahu Commission constitutes an important event in the modern history of health care reform. This commission highlighted the following problems with Israel's health system:

- inadequate public services
- constraints on the MoH
- vague financing and budgeting procedures
- sub-optimal organization and lack of managerial tools
- low levels of employee satisfaction and motivation.

Following this critique the commission made the following recommendations:

- legislation for NHI
- reorganization of the MoH to separate the regulation and delivery functions
- regionalization, decentralization and enhanced competition
- centralized financing system and capitation payments
- introduction of private practice in public hospitals
- financial incentives to increase employee motivation
- information systems and research.

The introduction of NHI sought to address many of the above-mentioned problems and more generally, growing widespread dissatisfaction with the health system. The NHI legislation established universal coverage, reduced cream-skimming by the health plans, created more progressive financing and encouraged (and funded) continual evaluation and monitoring of this monumental social policy. One year after the implementation of NHI the health plans faced financial strain that led to the introduction of co-payments for pharmaceuticals and physician visits in 1997.

While NHI was expected to enhance equity, some recent developments are believed to have had an adverse effect. NHI extended coverage and accessibility of health services but socioeconomic differences in health expenditure and utilization persisted in 1999, particularly between Arabs and Jews.

Mental health care is in the midst of reform. This has sought to address problems including the segregation (and stigmatization) of mental health care, lack of legal entitlement to mental health care and the MoH's dual role as both regulator and provider of services. NHI legislation created

a legal entitlement to mental health care and also called for responsibility for mental health care to be transferred to the health plans within three years. That the latter did not take place is due in part to lack of trust between the health plans and the government, failure to engage health plans in the planning process and the MoH's unwillingness to increased funding levels for mental health. This failure led to a more recent reform effort in 2001 which addressed the previous attempt's limitations. It is likely that these renewed efforts will lead to positive developments in the near future.

The problem of the government's dual role as regulator and deliverer of health services led to the hospital trusts initiative. There are two major proposals to transfer government responsibility for hospitals, but they have yet to be implemented.

The Patients' Rights Act of 1996 represents an important shift from a paternalistic model of care to a more patient-centred model that emphasizes patient autonomy. This law defined patients' rights, set up formal avenues for complaints, established ethical committees and inspection and quality assurance committees.

Finally, an independent commission to assess the overall functioning of the health system was established in 2000 in order to resolve a major physicians' strike. The Israel Medical Association called for wage increases. The final recommendations (in 2002) endorsed the principle that patients in public hospitals should have choice of physician, supported a slight and gradual increase in physicians' salaries, called for uniform licensure exams for all physicians, changes in hospital organization, for health plans to identify a personal primary care physician for each plan member and for outpatient services to be provided in the community setting.

Recent attention has focused on the public-private mix and the status of physicians in the health system.

Conclusions

Israel's health system is interesting as it represents a synthesis of government and market forces, is made up of organizations that combine funding and delivery functions, employs risk-adjusted capitation financing to limit cream-skimming by insurers, has an explicit method of setting priorities and defining the benefits package, and maintains a strong focus on equity.

The health system is predominantly publicly funded through progressive taxation, provides broad population coverage and good geographical access to primary health care. However, equity remains an issue due to the relatively high proportion of private finance. In recent years private health services have expanded and, while health care is highly equitable within the public system, several important components of health care – for example, dental and institutional long-term nursing care – remain outside the public system.

Recent reforms, stimulated by the 1988 Netanyahu Commission critique of the health

system, sought to improve efficiency. Some of these efforts, such as introducing NHI and improving patients' rights were implemented quite effectively, but there have been no attempts to reduce government responsibility for health service delivery. Efforts to reform mental health care are underway and it is likely that there is a strong basis for future improvements in this area.

Current issues on the policy agenda include continuing financial strains and the need to improve the methods of measuring and rewarding quality of care. Challenges facing Israel's health system include adapting to the special health needs of a large number of immigrants, making effective use of the large number of physicians, ensuring adequate and responsive care to Arab populations and managing the strain on emergency and rehabilitative services due to a high number of casualties of terrorism and conflict.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Denmark	3.4 ^a	17.8 ^a	3.8 ^a	83.5 ^a
Israel	2.2	17.6	4.1	94.0
Netherlands	3.1 ^e	8.8 ^a	7.4 ^a	58.4 ^a
United Kingdom	2.4 ^d	21.4 ^f	5.0 ^f	80.8 ^d
EU-15 average	4.1 ^a	18.1 ^c	7.1 ^c	77.9 ^d

Source: WHO Regional Office for Europe health for all database.

Notes: ^a 2001, ^b 2000, ^c 1999, ^d 1998, ^e 1997 ^f 1996.

The Health Care System in Transition profile on Israel was written by Bruce Rosen (Director, Health Policy Research Program, JDC-Brookdale Institute), with the assistance of Rachel Goldwag (Senior Research Assistant, JDC-Brookdale Institute). The editors of the Israel HiT were Sarah Thomson and Elias Mossialos. The research director was Elias Mossialos.

The following persons provided critical input, as noted in the introductions to different sections: Yehuda Baruch, Sharaon Bason, Shuli Brammli-Greenberg, Neta Bentur, Jenny Brodsky, Mark Clarfield, Michael Davies, Leon Epstein, Gary Ginsberg, Manfred Green, Revital Gross, Anneke Ifrah, Avi Israeli, Johnny Lemberger, Adina Marks, Tal Morgenstin, Daniella Nahan, Nurit Nirel, Ari Paltiel, Boaz Porter, Shoshana Reba, Philip Sax, Carmel Shalev, Segev Shani, Shifra Shvarts, Naomi Struch, Israel Sykes, Ted Tulchinsky, Miri Zibzenher, Shlomo Zusman.

Special thanks to Rachelle Kaye (Maccabi Health Services) and Malka Borrow (Israel Medical Association) for their helpful comments on the entire manuscript.

The European Observatory on Health Care Systems is grateful to Gabi Bin Nun (Deputy Director General for Health Economics, Ministry of Health) and David Chinitz (Senior lecturer, Braun School of Public Health, Hebrew University) for reviewing the HiT.

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.