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Achy But Healthy: Lessons from the Israeli Health Sector

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Abstract

Health policy has been for some time high on the agenda of many countries--and where it has not, it should be. Since no ideal model of health services has ever been devised, one may look for favorable elements in the health sector of a given country and examine their applicability to other countries. This paper analyzes Israel's health sector in this context.

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Summary

Surgical treatment is sometimes essential, although risky. In some situations, it may be avoided by using more moderate medical treatment; in many cases, however, both can be avoided if preventive measures are taken early.

This is true for individuals, and not less so for health systems: overall reforms are analogous to surgical treatment; incremental corrections are analogous to moderate medical treatment; and the proper planning of health services ensures the healthy growth of a health sector, just as preventive medicine does for individuals.

There are three fundamental requirements that a health sector has to fulfill in order to be considered satisfactory: universal access, high-quality, and moderate cost. The Israeli health sector, though suffering some symptoms of illness, appears, in general, to pass this three-dimensional test. "Surgeons" and "internists" argue whether the cure should be in the way of radical operations or more moderate, incremental treatment.

In any event, this paper shows that by international standards the health services in Israel do quite well, although they can be improved in a number of respects. This has been achieved by balanced doses of the three types of treatment: drastic, incremental, and preventive. To begin with, the third treatment, preventive--the backbone of the health sector--is a sick fund that was designed and developed on the basis of equity principles,

which were then applied by all other factors. The second treatment, incremental, has been carried out by administrative control and by managed competition that developed over time. The first treatment, drastic, has been applied in various stages, such as the budget cuts that were part of a stabilization policy adopted in the 1980s. All treatments have included efficiency measures to improve the utilization of existing capacity.

The international aspect of the research for this paper reveals an interesting pattern: most OECD countries, ranked by their share of health expenditure in GDP, had the same relative position in 1990 as in 1970, despite the diverse reforms that had taken place in each. This is an indication that the factors acting in each country's health sector are the dominant determinants of the level of health expenditure.

The approach offered at the end of this paper is to classify countries by their scores on the above-mentioned, three-dimensional test. This is suggested as an initial step in applying in other countries the lessons learned from the Israeli experience.

I. Introduction

Health status and medical services are of great concern to everyone, individuals as well as nations. For this reason, health policy has been for some time high on the agenda of many countries--and where it has not, it should be. The search for improvement is a learning process, because there is no agreed upon set of quantifiable targets for a "proper health system," let alone an ideal model of a health sector that will satisfy all needs or expectations. As a substitute for this nonexistent model, one may look for favorable elements in the health sector of a given country and examine their applicability to one's own country. The purpose of this paper is to analyze Israel's health sector in this context, and determine if it contains such elements whose introduction in other countries may benefit them.

Chapter II presents an international perspective, which serves also as an outline of the paper's approach. The OECD countries are examined, and major developments that took place in these countries during the second half of the century are traced. During the first two decades of the century, special attention was given in the OECD countries to the extension of access to medical services; as a result, the health status of the populations improved, a fact which is captured by the increased longevity in all of these OECD countries. However, this was also the period in which health expenditure started to soar, as measured by the share of the health sector in total national spending. An interesting finding exposed in this chapter is that factors intrinsic to each country tend to force on it a constant ranking by health expenditure share in GDP.

Chapter III touches upon the history of Israel's health sector and describes its structure and organization. The backbone of the medical services is a set of four sick funds, dominated by the General Sick Fund (KHC) which is associated with the central labor union (Histadrut). The egalitarian principles that have guided the KHC since its inception (before statehood) have lead to the development of a network of clinics throughout the country, which provide high-quality primary and secondary care. For tertiary care, patients are referred by the sick funds (at no cost to the patient) to hospitals, most of which belong to the Government, to other organizations, or are owned by the KHC.

Chapter III observes the rapid improvement in Israel's health status, as indicated by the rising levels of life expectancy--both in absolute terms, relative to OECD countries, and compared with its own performance one or two decades earlier. The relevance of this latter indicator is discussed, and complementary data are given. Then comes the other test--"how much does it cost?" The basic data show an increase in total expenditure on health, even after accounting for inflation, but there was a sizable slowdown in the 1980s. One interesting finding is that while in the 1970s the relative prices of health inputs increased more than the prices of GDP, the increase in health input prices in the 1980s was in line with the rise in the prices of GDP.

The important aspects of health care cost are further discussed in Chapter IV, in the context of the search for improvement in health services. This search was motivated in Israel in the 1980s by concerns about two basic factors: strikes and interrupted services; and the ongoing deficits of the KHC. These concerns led to public discussions, to the appointment of various committees, and eventually to the establishment of the Government Inquiry Commission.

Chapter IV examines the validity of the contention that high costs were incurred by the Government financing the KHC deficits. Based on the analysis of both national and government expenditures, this contention is rejected and it is shown that, despite this deficit financing, the eventual cost to the Government did not increase--it even declined. On the national expenditure side, Israel has constantly improved its rank among OECD countries. This chapter reviews in detail the criticism of the existing setting of the sector, and while pointing out that there are various operational components in the system that should be modified, the more basic elements that were recommended did exist in the sector, or were introduced incrementally during the 1980s.

Chapter IV also weaves the various elements into an overall picture of a health system that passes the three-dimensional test: universal and equitable access to medical services, a high quality of service, and cost containment--not absolute, but relative to itself in the past or to other countries in the present.

The first target is achieved almost by definition by the fact that the leading provider is the Histadrut, whose *raison d'être* is to provide its members with equal, high-quality medical services, as well as with other social services. Weaknesses in financing have practically become an incentive for economizing, by the mechanism employed in handling the KHC's requests for government financial support. Because this is not an automatic procedure, but is negotiated annually, the Government can force its policies, to some extent, on the service operators, and this has proven to be effective in containing costs.

An additional push to improve the quality of medical services was gained by market forces. During the 1980s, partly in connection with policy implementation, the three smaller sick funds significantly increased their market share, and the KHC managed to improve its services by speeding up their delivery, making access to facilities easier, granting patients more freedom of choice, etc. The need to introduce some of these changes was recognized by the KHC, but the political and organizational bureaucracies prevented implementation until changing realities forced the issue.

An important element in the functioning of the health sector is the multiplicity of factors that are involved in the rendering of medical services. Such a structure may usually be viewed as a complication; however, in this case, the sector is well known for the market failure embedded in it, and a balance of power between conflicting interests seems

to benefit consumers and the authorities who are in charge of carrying out economic and social policy.

Chapter V remarks on the nature, approach, and perspective of this study. The general approach is macro-oriented, and it sees the health sector not as an isolated industry, but as a segment--an important one--of the whole social service network and safety net. The implications of this perspective are stated in the concluding remarks at the end of Chapter V, which deals with the relevance of the study for other countries.

II. An International Perspective

This chapter provides an international perspective for the analysis of the Israeli health sector, and outlines the approach of the paper. Section 1 presents an overview of some major developments in recent decades, focusing on the emergence of a cost crisis in the provision of medical services. Section 2 traces the results of efforts to contain costs.

1. Extended coverage and inflated costs

During the second half of the century, Western countries have undergone a rapid growth of health services, accompanied by major changes in their composition and characteristics. This has been a long process, comprised of basically two stages: the first stage reflected an effort to extend coverage of existing services to larger segments of the population; the second stage emphasized the intensification of medical services and the introduction of new technologies such as organ transplantation, bypass surgery and advanced high-tech diagnostic equipment.

The 1950s and 1960s witnessed the first stage, during which the coverage of publicly financed services constantly widened. This was the era of increasing access to both preventive and curative treatments. By 1960, many Western countries had developed a wide range of publicly provided health services. In some OECD countries, there was already universal eligibility for hospital care; in other countries, the coverage was well under 80 percent (e.g., Canada, Belgium, Austria, the Netherlands, and Switzerland). 1/ During the 1960s, coverage widened very fast in Belgium (from 58 percent to 98 percent), in Canada (from 68 percent to 100 percent) and similarly in several other countries. Portugal, which had very low coverage in 1960 (18 percent) almost tripled its rate in 1970 (to 50 percent).

The above data refer to the percentage of population eligible for medical treatment under some public scheme. A complementary indicator is the share of health expenditures covered by the public sector. 2/ The

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1/ Based on OECD (1985) p. 68.
2/ Op. cit. p. 71.

direction (not necessarily the intensity and the absolute level) of this indicator is similar to the above. In 1960, Sweden and the United Kingdom were unique among OECD countries by having 100 percent of hospital bills paid by the public sector, whereas in Belgium, Canada, Germany, Norway, and others only 60-80 percent was paid. During the 1960s, several other countries, including Denmark, Canada, Norway, Finland, France, the Netherlands, and Greece, came close to Sweden and the United Kingdom in this respect.

The result of this process was a significant improvement in the health status of the population, as reflected, for instance, in increased life expectancy. 1/ From 1950 to 1970, life expectancy increased by about 10 percent (see Table 1 for a sample of seven OECD countries). Life expectancy for females was 69 years in 1950, but increased to 75 years by 1970. The improvement for males lagged somewhat, but progress was still considerable--from 64 to 69 years.

There was, of course, another side to the story--the increased cost of providing medical services. Measured in terms of percentage of GDP spent on health services, spending in 1960 was mostly between 3.5 percent and 4.5 percent, and the average for all OECD countries was 3.9 percent (see Table 8). In 1970, the range increased to around 5 percent (the average for all OECD was 5.2 percent). This reflects a 34 percent increase in the burden on the economy, which marked the emergence of a crisis in health services.

A look at the second stage of the process further highlights the point. By 1980, the populations of almost all OECD countries (excluding the United States) became eligible for hospital care under some public scheme. There was another increase in life expectancy, and, in certain countries, the average female life expectancy crossed the line of 80 years. Costs continued to increase, and the share of GDP spent on health services reached an average of 6.8 percent for all OECD countries in 1980, reflecting an additional growth of 32 percent.

Longevity increased further in the 1980s and health status presumably did too. Females, as well as males, in OECD countries gained, on the average, two to three more years of life. On the cost side, the health share in GDP kept growing, though at a slower pace than in the previous

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1/ The attribution of increased longevity to medical services will be dealt with later, but we apply it here at least as a rough indicator of improved health status.

Table 1. Increasing Longevity in Seven OECD Countries

	Life expectancy at birth (in years)				
	1950	1960	1970	1980	1990
Females					
Belgium	69.0	73.5	74.2	76.8	79.1
France	69.7	73.6	76.1	78.4	80.9
Germany	68.3	72.4	73.8	76.6	79.0
Ireland	66.8	71.8	73.2	75.0	77.0
Netherlands	72.8	75.5	76.6	79.2	80.1
Spain	64.3	72.2	75.1	78.6	80.1
United Kingdom	71.3	74.2	75.2	75.9	78.5
Average	68.9	73.3	74.9	77.2	79.2
Increase (in percent)		6.4	2.1	3.1	2.6
Males					
Belgium	63.8	67.7	67.8	70.0	72.4
France	63.9	67.0	68.6	70.2	72.7
Germany	64.4	66.9	67.4	69.9	72.6
Ireland	64.5	68.5	68.5	69.5	71.0
Netherlands	70.5	71.6	70.9	72.4	73.8
Spain	59.8	67.4	69.6	72.5	74.5
United Kingdom	66.5	68.3	68.6	70.2	73.0
Average	64.8	68.2	68.8	70.7	72.9
Increase (in percent)		5.3	0.8	2.8	3.1

Source: OECD (1985) p. 131 and (1993) pp. 54-55.

decades. 1/ The need to establish cost containment measures has become a pressing issue in all industrial countries. In the words of Brian Abel-Smith, "In nearly all highly industrial countries, there is continuing

1/ Increased longevity is usually thought of in the literature as a factor that puts a greater burden on the economy. This is so because the additional years are assumed to be an economically inactive period in the life cycle. Yet, it should be noted that had retirement not been mandatory (usually at 65), increased longevity would have resulted in an increase in the labor force, which would have contributed to the increase in national product.

concern about rising share of national resources devoted to health care." 1/

The statement, "U.S. health care spending is increasing at a rate that cannot continue much longer" 2/ seems to have been extracted from yesterday's newspaper, but it was written 15 years ago. The statement related to 1977 figures, when the share of health expenditure in the United States was 8.8 percent of GNP. The fact that it did continue to increase--both much longer and much higher--to 13 percent in early 1990s, is mentioned here not to ridicule the prediction, but to point to the price paid by a nation for not responding to the implied warning.

In other countries, however, indications of a slowdown in the trend of fast increasing health expenditure, relative to GDP, started to show up in data of the early 1980s. For the first time in three decades, the elasticity of health expenditure with respect to GDP became smaller than unity for certain countries. Nevertheless, experts felt that it was too early to conclude that this was not a short-run phenomenon. 3/

More updated data reveal that the cost of health services has indeed begun to be contained in many industrial economies, or at least that the toll on the economy was not increasing at the same rapid rate as it did in the third quarter of the century. In fact, efforts to introduce means of cost containment seem to have started yielding positive results. The focus has shifted now to the question of what mechanisms have proved to be most effective in controlling costs.

This does not mean to say that the problems of exploding medical costs are past or that the level reached thus far is the optimal one--optimal in the sense that it ensures proper medical treatment to the whole population, on the one hand, and that it does not adversely affect economic growth, on the other. As a matter of fact, most industrial countries are currently in the process of reforming their health care systems in one way or another. 4/ The call for reform stems from two common concerns: (1) that the medical requirements of the population have not yet been satisfactorily met; and (2) that, given their nature, the health systems, with the market failure embedded in them, need constant surveillance to prevent their costs from getting out of control.

Our major concern here is the following: What should developing countries, when trying to enter the stage of providing adequate universal medical treatment to their populations, learn from the lessons of industrial countries?

1/ Abel-Smith, B. (1980).
2/ See Enthoven, A. (1980).
3/ OECD (1987) p. 57.
4/ See, for example, OECD (1992).

2. Results of efforts to contain costs

As noted above, increased awareness of the rise in health expenditure has caused countries to introduce cost control measures, some of which have been quite successful. Health expenditures as a share of GDP grew in the 1980s by "only" 12 percent (average of all OECD countries), compared with 34 percent and 32 percent, respectively, in each of the two preceding decades. Although this is an average and, of course, does not apply equally to each country, there is a rather constant pattern whereby certain countries have much higher or lower expenditures than the average.

One country that has always had the highest health care expenditures, not surprisingly, is the United States, which has become more and more "isolated" from the other OECD countries. Also high, though lagging far behind the United States, is Canada which by now has probably crossed the two-digit line of health expenditure share in GDP (spending equalled 9.9 percent of GDP in 1991). Sweden has undergone an impressive change in the last decade: after being firmly in second or third position, its health expenditure as a share of GDP fell, and it joined France and Germany in the fourth place with a share only 10 percent higher than the OECD average. (By comparison, in 1980, the share for Sweden was more than 30 percent above the OECD average.)

At the opposite extreme are Turkey and Greece, with shares much lower than the average, followed by Spain and Portugal, which were rather late in starting to develop wide-coverage health services. Low shares of health expenditure, however, may also be found in such more developed countries with extensive medical services as the United Kingdom, Japan, and Finland with shares of 7 percent or less (compared with the all-country average of 8.1 percent in 1991).

To clarify the picture, it may be easier to exclude from the following analysis the high-end (United States) and the low-end countries (Turkey, Greece, Spain, and Portugal). The latter countries were well below the average in the beginning of the period, and inclusion of their data would obscure the picture. Table 2 ranks the remaining 19 OECD countries according to their 1970 health expenditure share of GDP. The country figures are presented in index numbers, using the overall country average of each year as a base (=100).

The table reveals several basic patterns:

- The five countries that were close to the average in 1970, have remained there;

- The countries that were about 10 percent <u>above</u> the average kept their approximate position (Denmark is an exception, but its standing at the beginning of the period is questionable);

Table 2. Health Expenditure Shares in GDP in Selected OECD Countries

	(Index, average all countries each year = 100)				
	1960	1970	1980	1990	1991
Canada	133	132	104	120	121
Sweden	118	130	128	109	108
Germany	123	110	117	111	111
Denmark	91	108	93	85	86
France	108	108	104	111	111
Netherlands	101	108	111	106	106
Finland	96	104	89	99	109
Australia	121	103	99	105	105
Austria	111	101	107	106	104
Iceland	85	99	90	108	101
Italy	91	95	92	103	101
Switzerland	83	93	97	100	98
New Zealand	106	93	100	90	94
Ireland	96	93	113	96	98
Norway	80	90	99	101	103
Luxembourg	--	86	95	89	81
Japan	75	84	90	85	83
United Kingdom	98	84	82	76	81
Belgium	85	77	90	100	99

Source: Author's calculations of data from OECD (1993), Vol. 1, p. 108 and Vol. 2, p. 32.

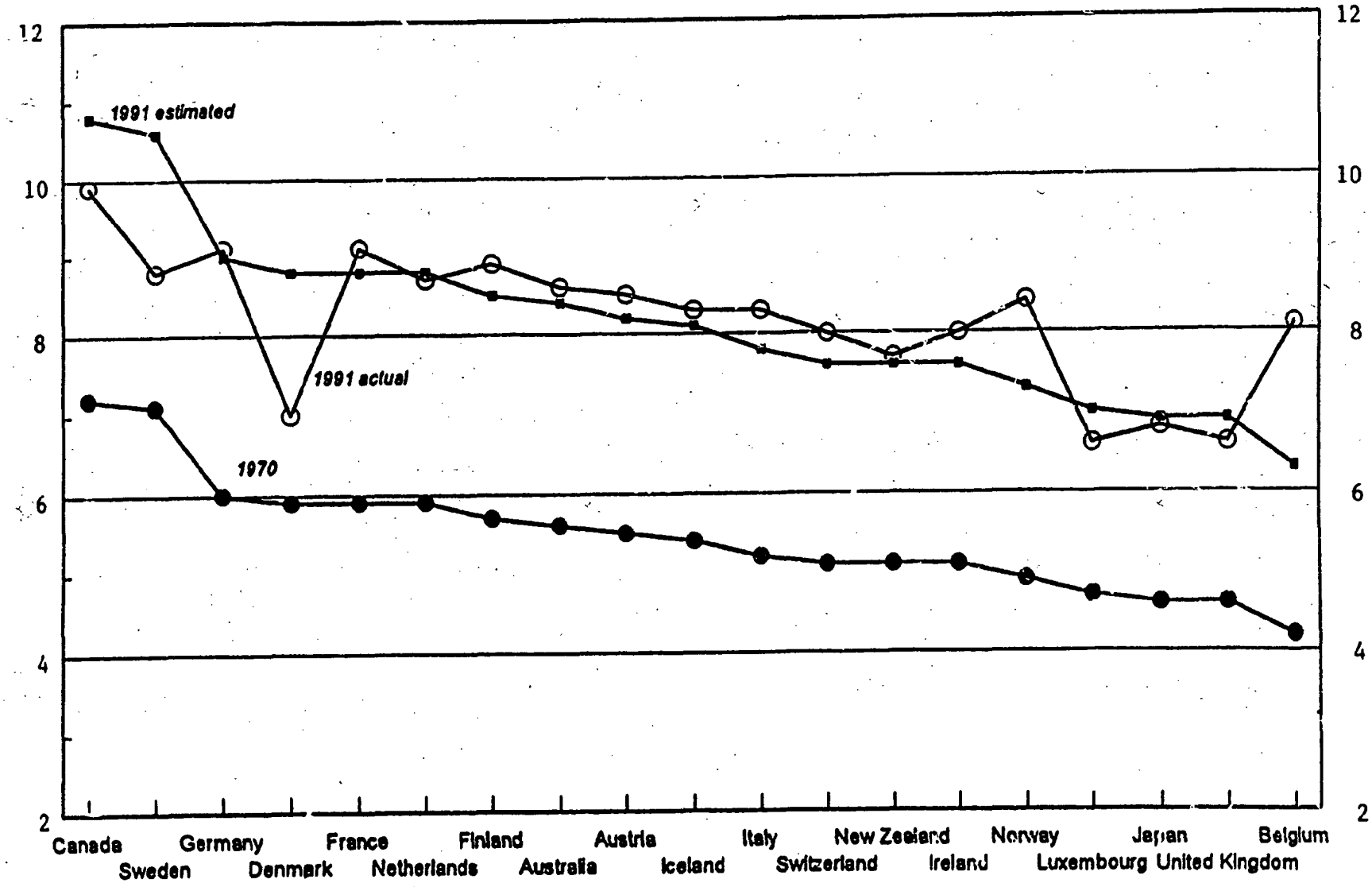
Note: Selection excludes countries with the highest (United States) and lowest (Turkey, Greece, Spain, and Portugal).

- The countries that were about 10 percent below the average, moved up to the average; and,

- Other than Belgium, the countries that had very low levels of health expenditure in 1970 remained where they were.

These findings can be reduced to a more general one if we concentrate on two end points, 1970 and 1990. Most countries kept their relative positions, and all had rapid increases in health expenditures during the 1970s and slower increases during the 1980s. It can be deduced that in each country there were certain dynamics at work that kept them in these relative positions. This can be clearly observed in Figure 1. The lower curve

Figure 1: Share of Health Expenditure in GDP, 19 OECD Countries
1970, "estimated" 1991, and "actual" 1991



depicts each country's 1970 health expenditure share in GDP. The two upper curves refer to 1991, as follows: the "estimated" curve is derived by simply increasing the 1970 data of each country by the 19-country average rate of increase over the two decades; the other curve is based on the actual 1991 share in GDP.

The proximity of the two upper curves demonstrates the finding stated above. It may indicate that the factors acting in each country's health sector are dominant in determining the level of health expenditures against the background of a global upward trend only partly offset by the authorities' efforts to contain costs.

Cost containment measures differ among countries, and there are many ways to check the intrinsic trends of the sector. The next chapter examines how the Israeli health sector fits into this picture.

III. Health Services in Israel

Israel maintains a comprehensive health sector that is practically a universal coverage system, without being formally defined as such. The system has developed gradually in a long and continuous process, with many ups and downs. A brief review of its history precedes the analysis.

1. Evolution of the health sector

A network of well-organized health services with wide coverage was in place prior to the establishment of the State in 1948. As early as the second decade of the century, with the beginning of sizable waves of Jewish immigration, the socialist parties--the driving force in this movement--considered the provision of medical treatment to their members an essential component of social solidarity and mutual insurance. In the early 1920s, the Histadrut was established, and one of its first steps was to combine, under its umbrella, the existing small partisan sick funds into the KHC.

Most of the immigrants were motivated by socialist ideas; therefore, they almost naturally joined the Histadrut and became members of the KHC, thus acquiring medical insurance. These were the roots of the universality--at least for organized workers--of health services in the Jewish community of the country. Moreover, being part of a wider social system, organizational considerations of the health fund were subjected to social (and, to some extent, national) goals. 1/ Loyal to these goals, the KHC

1/ However, the fact that this comprehensive medical service was part of the Histadrut, with its strong political power, has since become an obstacle to attempts to reorganize services. Just recently, for example, the Histadrut blocked the Government's plan to submit to the Parliament a version of a health law, because it was perceived as potentially weakening its political power.

developed a variety of curative, as well as numerous preventive, services. The network consists of community-based clinics in every city and town. In addition, medical centers, including hospitals, were set up in large cities according to need and the dispersion of the population.

As noted, KHC served the members of the Histadrut. Three smaller sick funds were later founded: One by a smaller, non-socialist, labor union; another by a movement that was linked to a market-oriented political party; and another with no political link. 1/ In most years, the three funds together covered only 10-15 percent of the population; during the last decade, they significantly increased their share, to about 30 percent of the population in 1990.

The operations of the sick funds were augmented by a number of other organizations that established hospitals and other medical services. They were more locally based, but still played an important role in the overall health sector. Prominent among them was Hadassa, an organization that has built and maintained hospitals in the three largest cities and a number of community-based curative and preventive clinics elsewhere.

The British mandatory government provided certain primary health services, but, for the most part, the Jewish establishment assumed responsibility for maintaining health (as well as other social) services for the Jewish population. Government health services were targeted mostly to the non-Jewish sector. In addition, the British authorities played a general regulatory role, for example, in licensing doctors, paramedics, health institutions, etc.

This section has described the development of the health sector in Israel in the pre-statehood period. Structurally, it is still much the same today although its size and quality are much more advanced.

2. Structure of the sector

Health services are comprised of two subsystems: curative and preventive. There are three levels of curative services:

- Primary care is provided by the sick funds, through general practitioners in public clinics, and by private doctors in their own clinics;

- Secondary care is provided by specialists in the general clinics or by private doctors; and

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1/ The latter was established as a job creation program for doctors who escaped from Germany during the mid-1930s.

• Tertiary care is provided by the sick funds at their hospitals 1/ or at third party hospitals, some owned by the Government and some by nonprofit organizations.

Preventive services include vaccinations and regular or ad hoc checkups. In addition, various agencies (not necessarily medical authorities) are responsible for environment preventive activities.

Most services are provided for free 2/ to sick fund members, who comprise a vast majority of the population. 3/ Dental services are not included in the coverage; they are provided by private clinics on a full payment basis. Children in primary schools are treated in dental clinics within the school system, at no charge, but this service seems to be underused and is of almost no quantitative importance.

The relative size of each subsystem is presented in Table 3, which examines it in terms of national expenditure on health in 1990, both by type of service and by organization.

As can be seen, ambulatory (primary and secondary) care in clinics accounts for about 35 percent of total health expenditure. A larger share is that of the network of hospitals, which accounts for 43 percent of the total, three quarters of which are for general hospitals--similar to the share of ambulatory care.

Concerning health expenditures by organization (lower half of the table), the share of the sick funds is 43 percent. This, however, does not fully reflect the funds' role, since they continue to be responsible for the ongoing treatment of their patients after they are discharged from the hospital. In any event, the profound role of the sick funds is seen in their share in providing primary care: 81 percent of total expenditures in this category.

1/ The KHC is the only sick fund that operates its own hospitals.

2/ A nominal co-payment has been introduced by one of the smaller sick funds, whereas all others, including the KHC, do not charge patients for visits to a physician. Patients pay a small amount for prescriptions--in the range of 10 percent of the price of the drug. See Chernichovsky (1993), p. 150.

3/ Membership covers about 95 percent of the population, but those who are not covered also have access to services. This point will be discussed later.

Table 3. Israel: National Expenditure on Health by Type of Service and by Organization, 1990

	Total	Govern-ment	Sick Funds	Other NPO	Other
			By Type of Service		
Total	100	100	100	100	100
Current	100	100	100	100	100
Public clinics	35	20	66	21	0
Hospitals	43	79	31	77	16
General	33	60	28	57	7
Mental	4	12	1	2	3
Chronic	6	7	2	19	5
Dental care	13	1	3	1	46
Private phys.	5	0	0	0	21
Purchases (med. equip.)	4	0	0	0	18
Other	2	0	0	0	8
Investments	100	100	100	100	100
Hospitals	76	85	49	92	0
Clinics	24	15	51	8	100
			By Organization		
Total	100	21	43	12	24
Current	100	21	43	11	25
Public clinics	100	12	81	7	0
Hospitals	100	39	32	20	9
General	100	39	37	19	6
Mental	100	63	13	4	20
Chronic	100	25	16	36	23
Dental care	100	1	9	1	89
Private phys.	100	0	0	0	100
Purchases (med. equip.)	100	0	0	0	100
Other	100	0	0	0	100
Investments	100	24	34	42	0
Hospitals	100	26	22	52	0
Clinics	100	15	71	14	1

Source: Author's calculations from Israel's Central Bureau of Statistics (1993), pp. 57-58.

The exceptionally large number of government-operated hospitals does not reflect a predetermined design of the division of labor, but is a result of historical developments; the Government inherited many hospitals from the British mandatory authorities when they left in 1948.

Privately operated and consumed medical services are rather small in total volume, which is another reflection of the defacto universal, public, health insurance that exists in Israel.

It should be noted that more than half of the total nonpublic care is dental care, which is, as indicated, not included in the standard sick fund insurance. This share of dental services, 13 percent of total expenditure, seems rather high 1/ and provides some evidence that privately delivered services tend to be more costly than publicly delivered services.

3. Development of the sector

This section aims at quantifying the development of health services: the size and growth of the health sector in physical terms; indications of outcomes of these services; and the toll on the economy.

a. Size in physical terms

Health services comprise a significant part of the economy. In terms of manpower, the number of persons employed in 1980 was 64,000 workers, and in 1990, 88,000--an increase of 38 percent over the decade. 2/ Most of these workers were employed in hospitals--51,000 in 1990, compared to 37,000 in 1980. The total number of employed persons in Israel was 1,492,000 in 1990, so that the share of the sector in total employment is close to 5.9 percent.

Table 4 presents figures for Israel and for the 12 OECD countries for which 1990 data are available. Excluded are two countries (Sweden and Norway) with extremely high percentages of the labor force providing health care, and four (Greece, Turkey, Spain, and Portugal) with very low percentages. The table shows that Israel has a larger share in total employment than the average for all OECD countries, even more than countries like Germany (before unification), Canada, and the United Kingdom.

Looking from another angle, the picture is different. Measured in per capita rates, Israel has 18 workers serving each one thousand people, compared with an average of 24 in the selected OECD countries. When all OECD countries are included, the Israeli figure is still somewhat below the average.

1/ Available data for eight countries show that only Germany had a similar dental share in health expenditure. The rates are 5-6 percent in five of the countries (Canada, Finland, France, Japan and the Netherlands) and 7-8 percent in two other countries (Japan and Iceland). Calculated from OECD (1993) p. 134 and p. 108.

2/ The figure for 1992 was 94,500. The 1990 figures are used to allow comparisons with other countries for which data are usually unavailable after 1990 or 1991.

Table 4. Health Sector Employment in the Labor Force: Israel and Selected OECD Countries, 1980 and 1990

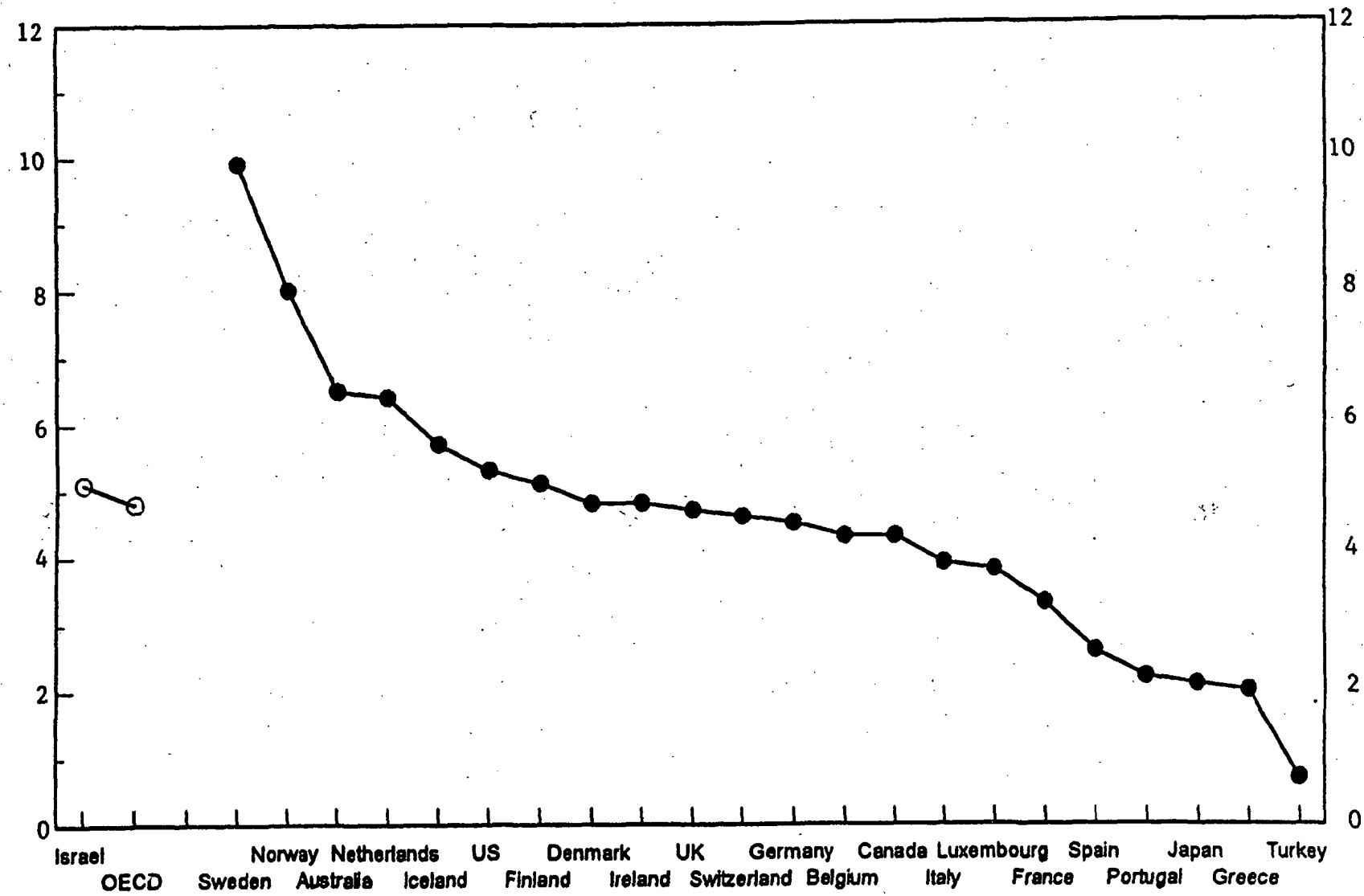
	Health Sector Employees			
	As percent of Total Employment		Per Thousand in Population	
	1980	1990	1980	1990
Israel	5.1	5.9	16	18
OECD average	4.8	5.4	21	24
Finland	5.1	7.0	24	32
Australia	6.5	6.8	28	31
Iceland	5.7	6.4	27	34
Netherlands	6.4	6.3	22	22
United States	5.3	6.2	22	27
Germany	4.5	5.4	20	24
Canada	4.3	5.3	19	25
Ireland	4.8	5.2	16	17
Denmark	4.8	4.7	23	23
United Kingdom	4.7	4.6	21	21
Italy	3.9	4.3	15	17
Japan	2.1	2.4	11	13

Source: Calculated from OECD (1993), Vol I, p. 170 and Vol. II p. 21. For Israel, Israel's Central Bureau of Statistics (1993) p. 362 and p. 718.

The apparent contradiction between these two indicators is explained by the much lower participation rate in the Israeli labor force, which stems from Israel having a much higher percentage of children in its population than in any of the OECD countries. Even so, Israel leads Italy, Ireland, and Japan in the number of health sector employees per thousand in the population.

In all OECD countries, hospital services comprise the main segment of health care provision; this also holds true for Israel, as reflected both in the composition of the employed in the sector and in the composition of expenditure in Table 3. The growth of the hospital services segment and its adequacy can be measured by the number of hospital beds and its level in per capita terms. In 1990, there were 29,000 beds (in 187 institutions), a 10 percent increase over 1980. Most of the beds were in the general (acute care) hospitals; the second largest number of beds was in the mental hospitals; the lowest number was in chronic (long-term) care hospitals. This has rapidly changed in recent years: the number of beds in the third

Figure 2: Employed in Health Sector as percent of Total Employment, Israel and OECD, 1980



group has increased considerably, and nearly closed the gap with general hospital beds. 1/

Prior to 1980, the total number of beds increased with the population, thereby maintaining a fixed ratio of hospital beds per capita. In the 1980s, however, the ratio fell, from about 7 per thousand to 6.2 per thousand in 1989. Up to that point, the decline might be regarded as a result of budget tightening under the stabilization program; 2/ however the further decline to 5.9 per thousand in 1991-92 clearly stems from the mass immigration from the FSU in that three-year period. Demographic pressures were not matched by increased capacity of the hospitals.

This fall in per capita number of beds resulted in a drastic decline of per capita days of hospitalization. Before 1980, the average number of days fluctuated between 2.4 an 2.3 per capita; by 1987, it was reduced to 2.0 days. 3/ The decline in hospitalization days indicates an intensification of the use of existing facilities. 4/ It should be noted, however, that even before the decline in hospitalization days, Israel's rate was significantly lower than the OECD average: 2.3 per capita versus 3.0, respectively, in 1980. (The Scandinavian countries' rates were much higher--4.7-5.3; the Canadian and the U.S. rates were lower--2.1 and 1.7, respectively.) One possible explanation for the relatively low number of days of hospitalization per capita in Israel is the large number of physicians. 5/ The production function of hospitals in Israel seems to be more physician intensive, which may compensate for the decline in days of hospitalization per capita.

The above description portrays Israel's health sector as structurally similar to the average (or even above average) in the industrial economies, with some variations reflecting differences in circumstance. Israel's health sector has been able to respond to economic constraints and to adjust to demographic pressures and changes in population characteristics. To complement this picture, the next section looks at some indicators of health status, or what might be considered outcomes of health services.

1/ See Ministry of Health (1994), p. 60. This increase is due to the aging of the population but probably also to the introduction of a long-term care health law, which boosted the development of health care of the elderly population.

2/ See the next section, and also Kop (1988).

3/ Ministry of Health (1994), p. 63.

4/ This was partly detrimental to those in need of hospitalization, but it may also reflect an increased efficiency.

5/ The number of physicians has since increased sharply, since the FSU immigration brought many doctors and other health care providers. Many have been unable to find work in their profession, due to size limitations of the sector. This, however, did increase the number of physicians per capita to an even higher figure.

b. Indicators of outcomes

An evaluation of the outcomes of a given health sector is a natural step to follow in assessing its performance. Yet, quantitative information on this aspect is hardly available anywhere, and in fact, no comprehensive framework has yet been constructed in the literature to enable such an empirical exploration. The common practice is to use longevity as a rough tool to identify developments in the health condition of a population. Changes in life expectancy as a proxy for observing health improvements raise various reservations, three of which will be discussed here.

- Life expectancy calculations use the age at death, but do not measure physical condition or health status during the life cycle;

- Additional years of the prolonged life are considered as extended periods of poor physical condition, during which people are more ill and dependent; and

- Life expectancy calculations are based on age-specific mortality rates in a given year, rather than the rates that are expected to be experienced by the present population.

With regard to the first reservation, life tables (by which longevity is measured) indicate that many more people, at given ages, are presently surviving, compared to the past. For example, according to Israel's official life tables, applying the 1975 age-specific death rates to a group of 100,000 people, one finds that 92,000 of them will survive after age 50. By 1990, the number of survivors at that age increased to 94,000. Assuming that these additional 2,000 people who in 1990 surpassed the age of 50 were as ill as those who did not make it in the previous period is a strong assumption. It is much more reasonable to assume the contrary, that the extended years of life were gained through improved conditions that prevented illness at that early age.

This argument leads to the second reservation, which relates to the quality of the extended years of life. The question is whether the net gain of years is a prolonged period of poor functioning (not for every one, of course; statistics show that most of the elderly do maintain a healthy day-to-day life), or whether the additional years are split (at least evenly) between the less active period of dependence and low physical potential and the earlier part of the life cycle (of good health and high potential activity). Information on this area is still scarce, but some evidence has been recently made available on changes in "plain life expectancy" and in "disability-free life expectancy" to support the latter assumption. In the Netherlands, for example, between 1981 and 1990, female longevity increased

by 0.8 year, from 79.3 to 80.1 years, whereas the disability-free expectancy increased by 1.8 years. 1/

As to the third reservation, life tables are indeed retrospective in nature, reporting present mortality rates for each age group. We shall not elaborate here on the technicalities 2/ of transverse versus cohort life tables, but an intuitive exposition may clarify the point: a given life table that calculates life expectancy to be 75, for example, may be based on a death rate of 20 per thousand at age 65. But those who are currently 60 years old may be exposed five years from now, when they get to age 65, to lower mortality rates (which has generally been the case in recent years). Therefore, the extended longevity reported may be regarded as a lower limit to the actual longevity expected for a given age group.

Despite the imperfectness of longevity as an indicator of the healthiness of a society, it is useful to look at the gains in life expectancy and at reductions in mortality as reflecting, at least, partially the outcomes of health services provided to the population. 3/ Table 5 presents data on the development of longevity in Israel and OECD countries.

Data in Table 5 show that female life expectancy in Israel is somewhat lower than, but quite close to, the OECD average. For males, however, Israel's figure is much higher than the OECD average, and it is third among all countries compared.

Differences between the longevity of females and males obscure the picture: furthermore, there is no clear-cut explanation for this

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1/ Results for other countries are more moderate and some are even negative. Since compilation of such data is still immature, this is not presented as statistical proof, but as an illustration. See Robine et al. (1992), and OECD (1993), p. 62.

2/ See, for example Caselly (1990). Interestingly, a statement in her article also has some relevance to the previous reservation: "...This can lead us to speculate that better living conditions not only allow more individuals to survive, but also make the survivors more resistant to death until around age 50." I owe this reference to my colleague Prof. Eric Peritz of the School of Public Health at the Hebrew University in Jerusalem.

3/ To what extent changes in life expectancy are related to the availability and quality of medical services is also frequently questioned, since non medical factors, such as environmental quality, also affect health conditions. Preventive health care and medical treatment, however, play a major role in extending longevity and improving health status.

Table 5. Life Expectancy: Israel and OECD Countries, 1980 and 1990

	1980	1990	1990		Ratio
			Female	Male	Female:Male
Israel	73.9	76.7	78.4	74.9	104.7
OECD Average	73.7	75.8	78.9	72.7	108.6
Israel:Average	100.3	101.1	99.3	103.1	
Japan	76.1	78.9	81.9	75.9	107.9
Iceland	76.7	78.0	80.3	75.7	106.1
Sweden	75.8	77.6	80.4	74.8	107.5
Switzerland	75.6	77.5	80.9	74.0	109.3
Spain	75.6	77.3	80.1	74.5	107.5
Canada	75.5	77.1	80.4	73.8	108.9
Australia	74.6	77.0	80.0	73.9	108.3
Netherlands	75.8	77.0	80.1	73.8	108.5
France	74.3	76.8	80.9	72.7	111.3
Italy	74.0	76.8	80.0	73.5	108.8
Norway	75.5	76.6	79.8	73.4	108.7
Greece	74.6	76.4	78.6	74.1	106.1
Germany	73.3	75.8	79.0	72.6	108.8
Austria	72.6	75.8	79.0	72.5	109.0
United Kingdom	73.1	75.8	78.5	73.0	107.5
Belgium	73.4	75.8	79.1	72.4	109.3
United States	73.7	75.4	78.8	72.0	109.4
New Zealand	73.2	75.0	78.0	72.0	108.3
Finland	73.4	74.9	78.9	70.9	111.3
Denmark	74.5	74.9	77.7	72.0	107.9
Luxembourg	71.6	74.6	78.5	70.6	111.2
Portugal	71.8	74.4	77.9	70.9	109.9
Ireland	72.3	74.0	77.0	71.0	108.5
Turkey	62.3	66.3	68.4	64.1	106.7

Source: OECD (1993), pp. 54-55. For Israel, Israel's Central Bureau of Statistics (1993) p. 144.

phenomenon, and it is not unique to Israel. 1/ For simplicity we calculated average female and male life expectancies--columns 4 and 5--which

1/ This can be observed in the third column of Table 5, which calculates the ratio between female and male longevity: Sweden and Iceland are among the countries that have the highest life expectancy for women, but they have the second and fourth lowest female: male ratios of longevity. Similarly, Finland has the highest female: male ratio, but it is the sixth from the bottom in the rank by absolute female life expectancy.

show that Israel was close to the OECD average in 1980 and that by 1990 it had advanced one step, leaving behind countries like Norway, Germany, and Denmark (that were at higher rank orders than Israel in 1980).

As emphasized above, the measurement of health status through life expectancy statistics, though valid, raises some reservations, but other partial evidence also supports the introduction of Israel's health status as maintaining relatively high Western standards. 1/

c. "How much does it cost?"

In Israel, total expenditure on health services constitutes a large share of the economy as a whole and of public outlays as well. In nominal terms, the expenditure increase over the years has been enormous, but, to a large extent, it simply reflects the rapid inflation experienced, especially in the first half of the 1980s. After allowing for the general increases in consumer prices (CPI), the growth of expenditure in real terms amounted to 153 percent in 1970-80 and to only 42 percent in 1980-90.

This measurement reflects the alternative cost of health services in terms of what the average consumer had to give up in return for receiving medical care. It does not reflect, however, the actual volume of services provided, the calculation of which requires further refinement. In general, changes in absolute terms can be basically attributed to three main factors:

- Relative cost of health inputs;
- Actual volume of services provided; and
- Demographics.

Measuring the volume of health services requires a detailed decomposition of the sector and its components, applying to each of them its specific price index and then reaggregating to a total input price index. The total volume of health services, so measured, 2/ increased by 73 percent in 1970-80. At the same time, real GDP increased by 67 percent, while the health share in GDP increased by 28 percent. Table 6 gives a breakdown of these figures, and shows that the increased cost of health inputs exceeded by 23 percent (line 8) the corresponding one for the entire GDP.

1/ A comparison of selected relevant data for Israel and the average for Western Europe has shown that the incidence of some illnesses was much lower in Israel than the European average (such as TB, viral hepatitis, measles); in other indices, Israel was close to the average. See Rosen (1987), p. 12.

2/ See Israel Central Bureau of Statistics (1993), p. 715.

Table 6. Cost Indicators: Israel 1970-80 and 1980-90

	1970-80	1980-90
During decade: percentage increase in		
1. Gross Domestic Product (real)	67	41
2. Population growth	30	23
3. Volume of health services (deflated by health prices)	73	57
4. GDP per capita (1:2)	29	14
5. health services per capita (3:2)	34	28
6. Health share in GDP	28	13
7. Health volume increase beyond growth of GDP (3:1)	4	11
8. Input prices: health relative to GDP (6:7)	23	1
CPI deflated health expenditure	153	42

Sources: Author's calculations, based on data from Israel, State of, Central Bureau of Statistics (1993), p. 192 (GDP), p. 43 (population), p. 715 (health expenditure and share in GDP).

Note: Ratios between two rates of increase were calculated using whole ratios (e.g., line 4 in 1980 is 1.67/1.30=1.29) rather than percentage increases.

Table 6 reveals the following: Due to rapid increases in input prices in the health sector (relative to the prices of GDP), increasing the volume of health services by a proportion that exceeded GDP by 6 percentage points (line 3 minus line 1), required an increase by 28 percent (line 6) in the claim of health services on the economy. The following decade, 1980-90, stable relative health input prices (compared to GDP prices) needed a mere 13 percent additional claim on the economy to facilitate an increase of the volume of medical care that exceeded by 16 percentage points (line 3 minus line 1) the increased volume of GDP.

One further refinement relates to demographics. Population growth was extraordinarily high in the first decade of statehood; even in the 1960s, the growth rate was more than 40 percent for the whole decade. It then started to slow to 30 percent for the 1970s--and continued to decline to 23 percent in the 1980s. 1/ If the demographic change is factored into the above calculation, the extension of services to the public shows an

1/ At the end of 1989, a new wave of immigration from the FSU began. Subtracting the last year of the decade from the above figures would show an even smaller increase for the last decade.

increase of 34 percent (line 5) in the 1970s, exceeding the increase of total uses of GDP per capita by 5 percentage points (line 5 minus line 4) at the price of a 28 percent (line 6) increased toll on the economy. In the 1980s, the relative generosity of health services exceeded all GDP uses by 14 percentage points, at the cost of only a 13 percent increase in the toll on the economy. 1/

An important aspect of health care costs is the source of financing. As described earlier, medical services in Israel are basically provided by the four sick funds (the dominant KHC and three smaller funds). They provide directly almost all ambulatory care (privately owned clinics provide a rather small share) and, when hospitalization is needed--when the patient is sent there by the doctor or goes directly to the hospital in an emergency--the sick fund pays the hospitals directly. 2/ Ultimately, however, the financing of both the sick funds and the hospitals comes from either the Government or households. The typical structure is as follows.

There are three components of public sector financing: (1) government hospitals do not charge the full cost of treatment to the sick funds; (2) direct subsidies to the sick funds and to other providers of medical care; and (3) the so-called parallel tax--a designated tax (the two previous sources are provided by the general tax system) that is paid by employers.

There are two types of household sector financing: (1) the membership fee paid to sick funds (these fees are progressive in principle, but less so in practice); and (2) payments to private doctors--mostly for dental care, which is not presently insured by the sick funds.

The general trend in the 1980s was to reduce the Government's share in the financing of the health services. In 1980, the Government covered 58 percent of total national expenditure on health. By the mid-1980s, the share was reduced to 54 percent, and by 1989 to 50 percent. 3/

1/ Age structure underwent a transition, by which the percentage of the elderly increased gradually from about 5 percent in 1960 to 10 percent in 1980. This, presumably, affected the distribution of services among population groups, and, in any case, increased the need for services.

2/ Until the 1980s, reimbursement to hospitals was on a flat-fee basis per day of stay in the hospital. In recent years, more and more pre-payment has been introduced to the system.

3/ See Israel, Central Bureau of Statistics (1993). The table in the source includes a residual component, "other," whose "normal" share was 1-2 percent, but in some years reached 6-7 percent. Accompanying text in the source, however, states that this item includes deficits of the sick funds and of other organizations. Since these deficits were eventually covered by the Government, we imputed the "above normal" 5-6 percent to the public sector account.

Most of the decline was in the direct subsidy component, and there were also some reductions in the share of the employer's tax. In household sector financing, there was an increase in both membership fees and in payments to private doctors. The latter reflected an increase in both subsegments--dentists and other private doctors.

Though the changes observed are not dramatic, there are signs of greater reliance on nongovernmental financing of health services. Interestingly, this did not contribute to a drastic increase in the cost of health. The next chapter further discusses the implications of these changes, in sources of finance of the health sector, and employs data on the share of health outlays in GDP to show the improvements that took place in the last decade.

IV. In Search of Improvements

Despite this rather positive overall picture of the health sector, voices of dissatisfaction have frequently been heard and have been the a focus of both professional and political debates. This chapter begins with a review of the major issues debated. Then comes an overview of changes that were recommended in order to increase efficiency of the services, and improve quality of care. The chapter ends with a discussion of the main lessons that can be learned from the Israeli experience.

1. Problems and issues

The health care system has long been high on the public agenda, and has been dealt with in various committees' reports published over the years. One of the earlier reports, the Mann Committee report, after mentioning the positive results of medical care in Israel, states that "these statistics were reached with the highest world ratio of physicians to population...and the largest expenditure of the gross national product...," and then, "health services do not appear to fulfill the expectation..." 1/

Most of the Mann report deals with the need to reorganize the system so as to bridge the gaps between public clinics and hospitals. Reference to this report is made mainly to indicate that, as early as the late 1960s, the Mann Committee recommended an integration of all services on a regional basis, a recommendation that thereafter became, in principle, a cornerstone of many of the reform proposals. The idea was to overcome the existing fragmentation of services, by entwining the ambulatory clinics with tertiary hospital treatment. Such a recommendation, if adopted and implemented, would have meant incorporating the KHC clinics and the nearby hospitals, most of which belonged either to the government or to voluntary organizations such as Hadassa. Although the KHC vetoed the recommendation

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1/ An abbreviated version appears in Mann (1970).

for fear of losing its independence, it nevertheless became a basic element in subsequent reports, although not necessarily along the same lines.

The regular functioning of the health sector was interrupted from time to time by strikes of doctors and other medical personnel, the most severe of which took place in 1983 and lasted four months. This strike became one of two subjects that attracted the public's attention. The second was the persistent KHC deficits which were eventually covered by the government. When such deficits ran beyond a "normal" size, the Government turned down the KHC's initial requests for financial aid, and the negotiation process that followed sometimes caused a strong reaction by the KHC. In some cases, the reaction included a withholding of services, typically in the most sensitive parts of the system, to achieve the most dramatic effects.

Suffering caused by the strikes and by withheld services provoked public debates that led to the establishment of several public committees. Discussions on ways to cope with the KHC deficits and with their outcomes were quite intensive during the 1980s. The arguments raised in favor of certain policies and their relative advantage over other proposals are discussed further in the next section, but before doing so it is worthwhile to examine the data in Table 7, which shows the burden on the public sector of health sector financing. This burden has been one of the public's major concerns.

Table 7. Israel: Government Annual Expenditure on Health
(In U.S. dollar per capita)

	1976	1980	1985	1989	1990
1. Total	266	337	304	299	301
2. Parallel tax	101	137	165	192	177
3. Total (1 minus 2)	165	200	139	107	125
4. Transfers	56	54	36	8	16
5. Hospitals	76	100	59	49	55
of which:					
a. Acute hospitals	35	38	14	5	9
b. Other hospitals	42	61	44	44	46
6. Other	32	46	43	49	55
7. Total excluding 6	234	291	260	250	247

Source: Calculated from Kop, et al., 1994.

Total government expenditure increased sharply in the second half of the 1970s, but it then decreased significantly, stabilizing at a level not much higher than that of the mid-1970s. Moreover, according to the last "total" (line 7) in Table 7, the initial increase in the 1970s was almost

entirely reversed in the second half of the 1980s. 1/ It may, thus, be concluded that government health expenditures in the period under discussion were beginning to be controlled, contrary to the impression that may be derived from various discussions on this subject.

Another interesting finding may be extracted from the breakdown of government financing of the health sector. The changes in the components in Table 7 clarify that government expenditure on health services does not reflect a financing of separate medical services, complementary to those provided by the sick funds, but rather a subsidization of the sick funds, which are the insurers of practically all services. 2/ Two of the components are subsidies directed to the sick funds, either explicitly (line 4) or implicitly by charging below-cost prices for hospitalization in acute (general) hospitals (line 5). These two sources practically dried-up during the period, and, as an offset, the support was increased by raising the earmarked employer's (parallel) tax. Two sources of financing have since become dominant in the health industry:

- Membership fees paid by individuals to their respective sick fund (not included in the table, since it deals only with government financing); and

- Government support, through the National Insurance Institute, which collects the parallel tax from all employers and the self-employed (employers' contribution).

By switching to these two dominant sources of financing, the Government made, in effect, a considerable step upward to a more simply managed financing system, which carries some of the most important features of a national health regime.

Returning to the basic approach, let us switch from the public finance aspect to the more comprehensive one--that of total <u>national</u> health expenditure and its share in GDP. Table 8, presenting Israel's position compared to that of the OECD countries, does not support Professor Mann's

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1/ The item "other" (6) stands for government expenditure on granting medical services to certain needy families, such as the unemployed and new immigrants. This expenditure, therefore, does not apply to the general population, and may be regarded as part of the income maintenance programs, so that, for some purposes, the total that excludes that component is more relevant.

2/ Exceptions are the mental and chronic care hospitals, which are partially insured by the sick funds. In these areas, the Government's direct role is significant, but this item comprises only some 15 percent of total government health expenditure.

Table 8. Health Expenditure as Percent of GDP: Israel and OECD Countries

	1960	1970	1980	1990	1991
OECD average	3.9	5.2	6.8	7.6	7.9
OECD 19-country average	4.0	5.5	7.2	7.9	8.2
Israel- simple	5.5*	5.4	6.9	7.8	7.5
corrected	--	5.6	7.2		
Turkey	--	3.1	3.7	3.8	4.1
Greece	2.6	3.7	4.0	4.9	4.8
Portugal	--	3.0	5.1	6.1	6.2
Spain	1.6	3.6	5.4	6.4	6.5
United Kingdom	3.9	4.6	5.9	6.0	6.6
Luxembourg	--	4.7	6.8	7.0	6.6
Japan	3.0	4.6	6.5	6.7	6.8
Denmark	3.6	5.9	6.7	6.7	7.0
New Zealand	4.2	5.1	7.2	7.1	7.7
Ireland	3.8	5.1	8.1	7.6	8.0
Switzerland	3.3	5.1	7.0	7.9	8.0
Belgium	3.4	4.2	6.5	7.9	8.1
Iceland	3.4	5.4	6.5	8.5	8.3
Italy	3.6	5.2	6.6	8.1	8.3
Norway	3.2	4.9	7.1	8.0	8.4
Austria	4.4	5.5	7.7	8.4	8.5
Australia	4.8	5.6	7.1	8.3	8.6
Netherlands	4.0	5.9	8.0	8.4	8.7
Sweden	4.7	7.1	9.2	8.6	8.8
Finland	3.8	5.7	6.4	7.8	8.9
Germany	4.9	6.0	8.4	8.8	9.1
France	4.3	5.9	7.5	8.8	9.1
Canada	5.3	7.2	7.5	9.5	9.9
United States	5.3	7.4	9.2	12.2	13.3

Source: Calculated from OECD (1993) Vol. I, p. 108 and Vol II, p. 32.

* Figure refers to 1962.

contention cited above: The 1970 corrected 1/ figure for Israel, 5.6 percent, is similar to the 19-country OECD average. 2/ Israel was, therefore, not the country with the "largest expenditure of the gross national product on health" 3/--It was preceded by Canada, Sweden, Germany, France, the Netherlands and Finland.

More important, and relevant, is what has followed: during the 1980s, Israel constantly improved its rank, leaving behind eight OECD countries with higher GDP shares in 1980, 13 countries in 1990, and 15 in 1991. To state it even more drastically, the 1991 figure finds Israel in a position where only 4 of the 19 industrial countries channel a lower percentage of GDP to their health sectors. While our main thrust is to attribute cost containment results to the structure of the industry and the cost control features embedded in them, one cannot ignore the contribution of the 1985 economic stabilization program. 4/

As to the cost controlling devices of the system, the change in composition of government subsidies was mentioned above in the context of rationalizing and consolidating the variety of subsidies. Yet, there has also been an improved resource allocation mechanism in the pricing of hospitalization. In the past, a significant subsidy granted to the sick funds was in the form of charging them lower than the actual cost for their patients treated in government hospitals. This, presumably, had distortional effects on the resource allocation decisions made by the funds. The revised subsidy structure made the sick funds face more realistic prices for hospitalization, which may have caused them to reduce their reliance on services that are more expensive to the economy--less so to themselves-- and not necessarily to the benefit of the patient.

2. Pressures for reforms

Ways to make hospitals run more efficiently have been suggested over the years, and, indeed, some corrections have been introduced. A common assumption has been that the sector does not contain efficiency incentives

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1/ The national statistics were revised in fiscal year 1984-85 to reflect the implicit pension liabilities of government employees in the health sector. The available data do not go back to 1970, but the 1984-85 figure appears in both versions--before and after the adjustment. Applying the ratio of these two figures to the official statistics of 1970 and 1980, yields the "corrected" version in the table.

2/ Omitting from the 24 OECD countries the four where provisions of public health services was still rather premature (Greece, Turkey, Spain, and Portugal) and the country with an exceptionally high percent of GDP spent on health care services (the United States).

3/ Mann (1970), p. 168. This was probably true in 1960, but the situation had changed by 1970.

4/ See also Kop (1988), which analyzes budget constraints and their impact on government social expenditure, including hea'th.

for hospital service providers. After reviewing the existing reimbursement methods in other countries, some experts preferred the capitation system. 1/ Under this type of arrangement, the insurer ("third party") pays the provider of the service a given amount per capita, multiplied by the number of patients insured that are included in this arrangement. While this may work well as an incentive-to-economize mechanism, other researchers 2/ point to a different danger, that the savings so obtained may be at the expense of the patients' health. One way to overcome this obstacle is to emphasize additional elements, such as strengthening the balance of conflicting interests of the agencies involved, so as to offset the negative effects.

The lack of efficiency is not the only concern about, or dissatisfaction with, the existing system. As mentioned, following a series of strikes and other interruptions in the operation of the health sector, several public committees were set up to cope with the problems. The most recent one was the Government Commission of Inquiry (the "Netanyahu Commission") which presented its recommendations in 1990. The comprehensive report it submitted covers a wide range of issues and problems, and consists of two separate volumes--the majority report and the minority report, which opposes the fundamentals of the majority's recommendations. Due to their comprehensiveness, it is worthwhile to look at some of the main findings and recommendations of the former as well as the opposing approach in the latter.

Criticism of the existing system is outlined in the majority report in five sections:

Section 1 refers to citizens' dissatisfaction with services: inadequate service that pushes patients to private doctors; service stoppages due to strikes and other interruptions; long lines for both diagnostic and curative treatments; and the sick funds' right to accept or reject members.

Section 2 argues that the Ministry of Health does not fulfill its fundamental roles: policy setting, regulation, and control. Matters such as salaries, which should be in the Ministry's prerogative, are determined, or at least greatly influenced, by the KHC's arrangements with its employees; regionalization has not been implemented as result of the KHC's objection and the Ministry's inability to enforce it; and transfer payments to agencies are based upon political considerations.

Section 3 examines financing and budgeting procedures and points out that: the government health budget is set by the Ministry of Finance without proper consultation with Ministry of Health; there is no linkage between budgets and outcomes of health agencies nor incentive to improve

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1/ See, for example, Ofer (1989).
2/ See, for example, Glaser (1993).

performance; membership fees are regressive; and services to needy families are inadequate.

Section 4 deals with organization and management deficiencies: over-centralization, inflexibility in responding to changing circumstances; fragmentation of services; and dissatisfaction of employees with their salaries.

Section 5 refers to health status in Israel: life expectancy is higher than in Europe, mainly for men; however, infant mortality is relatively high, though its improvement over the last 15 years brings it closer to the European average; cases of death from ischemic heart diseases are higher than the European average; and vaccination rates for children are high, but the prevalence of certain diseases is relatively high.

Some of the above observations may be disputed, as was done in the minority report; before turning to that, however, some of the proposals made by the committee to cure these maladies are reviewed below.

- Health services. A national health law should be legislated to ensure that all citizens are eligible for a specified basket of services; a national health authority, operating five or six regional branches, should be responsible for service delivery; and all health insurance revenues should be transferred to this authority, which should then compensate the sick funds on a capitation basis.

- Ministry of Health. The Ministry should be reorganized so it can carry out its proper role of planning, regulating, controlling, and monitoring all agencies operating in the sector.

- Finance. Total resources allocated to health should not be increased, in general; certain segments, however, should be strengthened, in return for the resources saved by the reform; and financing will be provided by a combination of a national health tax (to replace membership fees) and the existing employers' tax.

- Manpower and salary. The supply of doctors and dentists should be adjusted to meet needs; the status of nurses should be increased; hospital directors should have a Master's degree in health management systems; salaries should be determined by the Government; special compensation should be granted for second shift (or third shift) hours worked; and regional and local headquarters should be entitled to introduce incentive payments to outstanding employees.

- Other. Private medicine should be allowed, but using public facilities for private services should be avoided; ambulatory care services should be strengthening. Other recommendations refer to the structure of hospitals, to mental health services, and to geriatric care.

The minority report challenges the basic approach of the majority. It does not dispute the validity of the majority's list of symptoms of the sector's "illness" but argues that the diagnosis requires more than a list of symptoms. The minority report analyzes the sector from an organizational perspective, and reaches the conclusion that recovery does not need an overall reform, but an incremental approach.

This paper, as designed, does not allow an in-depth analysis of the two reports, or an endorsement of one or the other. The purpose of the above discussion of the reports' major elements is to complement our presentation and present the other side of the Israeli health system, as a counter-balance to the positive aspects stated in this paper. 1/

Curing problematic areas of the types listed above may solve some of the more severe weaknesses of the sector, which is needed in order to maintain in the long-run the goals of high standards of health services to all, that have been achieved in the past. The balance of political power in the field led to the adoption of a drastic comprehensive reform, whereas this paper (Chapter V, section 6), argues in favor of a moderate incremental approach. In doing so, it may have endangered the continued balanced growth of the services, because despite its problems, the sector has demonstrated over the years a vital power of adaptation to rapid changes in needs, in technology and in economic circumstances. Summarizing the premise of this paper may clarify the previous statement. Three criteria have been used to determine whether a health system is satisfactory:

- The system should provide universal coverage, and provide proper services on an equitable basis;

- Outcomes of preventive and curative services should achieve the goals of these services: keeping people healthy, and increasing longevity--with a high quality of life during the additional years; and

- The system should be operated at a reasonable cost, so as not to conflict with overall economic goals and growth-sustaining policies.

The performance of the Israeli health system along these lines, based on the analyses throughout the paper (and some additional information where needed), is examined below.

Regarding the first criterion, the Israeli health care system has provided almost universal coverage for many years. An October-December 1977 official survey 2/ found that 94.5 percent of the total population were insured by one of the four sick funds. This, by itself, is very high, but it should be noted that the remaining five percent also have access to

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1/ It is also provided as a compendium of many of the writings and criticisms that have been raised over the years.

2/ Israel, Central Bureau of Statistics (1980), p. ix.

medical services. The more affluent among them may have alternative insurance arrangements, and the low-income families (on welfare) are treated by the KHC under special arrangement with the Ministry of Social Welfare.

A recent survey by the National Insurance Institute, 1/ found, in 1992, a similar 94.3 percent coverage, and the data provided by this survey shed more light on the composition of the uninsured. One third of them are between ages 19 and 24, which is more than three times the share of this age group in the total population. It is reasonable to assume that many of them are in the military service and therefore have alternative coverage; others may have access to alternative medical care agencies, 2/ or have not yet settled down to care for their membership. Taken together, these facts support our contention that the system may be regarded as practically universal. 3/

The second criterion is the most problematic, mainly because health service outcomes are the least covered in the literature on performance. 4/ This is because, first, the definition of "health" is ambiguous: usually the term is interpreted in a negative way--the absence of illness--which is disputed by experts who prefer to look at it in a positive way--the ability to function independently and comfortably (despite the presence of certain illnesses). Second is the problem of measurement: comprehensive indicators of health are hardly available. Third, "health status"--and its measurements may not be the outcomes of medical services.

This situation leads researchers to use longevity as a proxy, and this paper does the same, bearing in mind the above reservation. 5/ Data on life expectancy in Israel place the country among the more developed countries, even though this observation is not conclusive, for two reasons. First, the data on males and females conflict: for males, Israel is one of five or six nations with the highest longevity; in contrast, female life expectancy lags behind most of the OECD countries. Second, infant mortality in Israel, though it has improved rapidly in recent years, is still somewhat higher than in the more developed countries. According to these combined tests, the sector may be regarded as competitive, albeit not decisively.

With regard to the third criterion, the conclusion is much more decisive. Israel is no exception to the general trend that typifies all

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1/ See National Insurance Institute (1993), p. 252-253.

2/ For example, universities provide health care arrangements for students.

3/ Which does not imply that the point should not be taken care of in a systematic and formal way.

4/ For a concise review of the issue see OECD (1993), pp. 47-48.

5/ It should be noted that the Netanyahu Commission did pay attention to the measurements of health and considered it very important. However, when it came to evaluating health, the report devoted only one page (of more than 450) to it.

Western medical systems, that is, ever-growing costs in terms of burden on the economy. In this process, however, the "deterioration" has been slower than in most OECD countries. Along the way, Israel became the most economizing of all comparable nations, and it now ranks in the bottom five countries, among the 15 OECD countries compared, in terms of health spending as a share of GDP. This is, of course, not a stand-alone target: It has to be accompanied by progress (or the lack of deterioration) in the two other targets discussed above. Such was, indeed, the case in the Israeli health sector in the last two decades, an era of incorporation of high-tech equipment and procedures, the speeding up of the delivery of services, opening of complementary services, and maintenance of universal coverage. On the contrary, in recent years, the sector has gone through the difficult experience of absorbing massive immigration from both the FSU and Africa (Ethiopia).

The practice of running deficits by the KHC, which are then covered by the Government, has negative effects and has to be eliminated. Efficiency incentives need to be introduced for that purpose. It should be remembered, however, that despite the Government's coverage of these deficits, the public sector's part in the financing of health services has declined. Moreover, changes in the structure of Government's financing, such as shifting the focus to direct subsidies (instead of price subsidies), has improved certain aspects of resource allocation in the health services.

V. Conclusions, Lessons, and Policy Recommendations

The enormous efforts being made by the United States to reform its health sector do not stem from dissatisfaction with the quality of services. On the contrary, that country operates the most advanced facilities and procedures which yield, in many cases, miraculous results. The reform efforts are motivated largely by the inequity of access to these services and by their almost prohibitive cost to the economy. 1/ One does not need to resort to this extreme example to show what happens to a health system that lacks equitable access and cost restraint, but this example does emphasize the importance of including these two elements in the prescription for a healthy medical system.

In Israel, the provision of proper medical care to everyone has always been one of the basics of the social network. The health services foundations were based on the desire to build an egalitarian society that would provide the basic needs of all its members, regardless of their economic capabilities. Visions may hardly be considered a basis for evaluating performance of economic and social systems, but as a point of departure for the discussion, this may put in focus one of the principles

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1/ "The good news is that modern medicine can work miracles. The bad news is that it is very expensive," Aaron and Schwartz (1984), p. 3.

that guided the operators of the medical services, and reveal some lessons that may be derived from this experience.

1. Free access as a social right

In reviewing the day-to-day operations of the KHC, one may find instances where the interests of the patients were not an exclusive, or even a major, consideration in the decision-making process or in the management of the organization and its facilities. But more characteristic of the operations of the KHC is its policy and efforts to enhance the health of patients and ensure their equal rights to proper treatment.

The ideology of equality was one of the fundamentals in the KHC and the staff, indeed, followed this principle in their attempts to provide equal services to all. Accordingly, clinics were opened all over the country--in every village and in every neighborhood. 1/ Doctors tended to apply medical procedures that would benefit their patients' health, and had no incentive to unnecessarily increase demand for their services.

Such organizational behavior tended to minimize the excessive use of overly sophisticated medical treatment and similar elements that are implied by the notion of "moral hazard," which is embedded in health services everywhere. Having the nature of an HMO, where the insurer is also the provider of services, cost control considerations worked in the same direction.

Loyalty to this ideology has eroded over time, and real concern about the well being of the patients sometime developed into paternalism, but the basic motives and principles did hold. Since the KHC was the dominant medical care agency in the country, these characteristics constituted a driving force for the whole sector.

2. Budget negotiation processes and controlling costs

One negative feature of the KHC's operational practice was, as discussed, its persistent deficits which were eventually rolled over to the Government. The existence of a third party that takes care of the deficit was a par excellence prescription for inefficiency and for disincentives to economize. Balancing this trend was the responsibility of the Ministry of Finance officials who were to negotiate the size of financial support that was to be granted to the sick fund.

Until 1977, there was a political identity of those who were running both the KHC-Histadrut and the Government, a fact that benefitted KHC

1/ See Shuval (1992), p. 51.

officials in their negotiations with government officials. 1/ Circumstances changed in that year with the loss of power by the Labor Party and the taking over of the Treasury by ministers who were no longer supporters of the Histadrut and its KHC. Negotiations on deficit coverage became tougher, and government officials demanded that the KHC introduce various changes in its operations.

Paradoxically, this development exposed a positive element in one of the sector's most negative characteristics: whereas the very fact that the dominant segment of the sector runs continuous deficits is negative in itself, the dependence on government financing gave the authorities the power to force policies on the sector.

This situation continued even when the Labor Party regained part of its power by joining a coalition government. A clear example of the potential effect on the sector is the ability of the Government to control costs, as part of an economic stabilization program. Financial support for the health sector, which is discussed in the context of overall state budget and general economic policy, proved in the 1980s to be a mechanism that enables flexibility and therefore adjustments to changing circumstances.

3. Market forces--the fruits of competition

As a very large nationwide organization, KHC has developed over the years bureaucratic symptoms that began to adversely affect the quality of services. Long waits in queues became a major source of concern, not only because of the inconvenience, but also because patients were deterred from receiving needed treatment. The KHC's monopolistic status in the health market was detrimental to the consumer and to the industry.

After its loss of political power and the difficulty in negotiating financial assistance, the KHC adopted additional measures, including strikes and withholding services. This, however, intensified public dissatisfaction and antagonism, creating an atmosphere that, combined with political change, became a suitable environment for a push toward reform of the sector to improve services.

Comprehensive reforms have hardly been implemented, but some changes have occurred. Most noticeable is the gradual emergence of competition in the health market. The three small sick funds started to grow during the 1980s and, from a negligible 3-4 percent of the market for each, their

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1/ This is not to say that the Ministry of Finance officials were yielding to the Histadrut in the negotiations. On the contrary, heads of the Budget Bureau were almost traditionally opposing KHC demands, and, to a certain point, were backed by their Minister.

combined share reached almost 30 percent of the total insured population. 1/ Service was typically better, at least in the two "private" 2/ sick funds, and the membership fees were not significantly higher. To retain its original strong position and share in the health insurance business, the KHC was forced to improve its services in order to be competitive. During the 1980s, it began to provide its members with more choices and options that were standard in the other funds, such as the freedom to choose doctors, the elimination of long queues, the shortening of waiting time for surgery and other treatment, the freedom of patients to visit a specialist without a referral from the family doctor. 3/

4. Interaction between Government and market

Although the KHC presumably was not happy with the increasing competition from other sick funds, the above developments forced on the organization a shake-up that was much needed, and strongly felt by its directors. 4/ The net result of the competition, from the consumer's point of view, was a significant improvement in the overall medical system. Pressures from the Government--the Treasury on the financial side and the Ministry of Health on the medical side--intensified the push of the market forces, and helped to improve services, which significantly benefitted the patients.

One of the targets set in 1992, after the national elections, by the Minister of Health was to shorten the wait for major operations and diagnostic procedures. The Ministry introduced some measures (such as stimulating additional shifts) and issued a call to the public, stating that everyone who needs to undergo one of a series of operations, and whose scheduled treatment was postponed for more than three months, should report to the Ministry, which will then take steps to change the schedule. As a result, these long waits were gradually eliminated. 5/

1/ Competition continued and led by 1994 to an increase of the share of the smaller funds to some 35 percent. (The new Health Law encourages further competition among the existing funds, but for some reasons discourages entrance of new funds.)

2/ Both are nonprofit organizations, but they are independent and do not belong to any of the organized labor unions, as opposed to the third (small) sick fund, which belongs to a smaller union (described in Chapter III).

3/ See Steinberg (1992), pp. 151-156.

4/ The Netanyahu Commission report cites a document that was submitted as early as 1970 by the general director of the KHC, who raises the need for structural reform and warns that if the Histadrut does not initiate such reforms, they will later be imposed under less favorable circumstances.

5/ Based on unpublished information received from the Ministry of Health. The change is so intensive that Israeli health experts interviewed for this study, considered the number of open heart surgeries excessive. They felt that some of these operations were unjustified, and the patient would have been better off not having this treatment.

In 1993, the Minister of Health orchestrated a campaign to introduce a National Health Insurance Law, which was based on the majority report of the Netanyahu Commission. The backbone of the proposed Health Law included a restructuring of the services on a regional basis, a change that had been categorically rejected in the past by the Histadrut and the KHC for fear of weakening their power. However, under current circumstances, 1/ it would be difficult to block such a move. Yet another clause in the proposal is the one that eventually failed the Minister in trying to pass the Health Law. This was the attempt to implement another part of the Commission's report which called for abolishing the current arrangement by which the Histadrut collects the health insurance premium as part of its membership fee. This was perceived by heads of the Histadrut as "*casus-belli*," and the Government had to retreat from presenting its proposal to the Knesset. 2/

5. Balance of power and other elements

The modus vivendi in the sector's operations reflects a balance between multiple powers. On the financial side, the Treasury (Ministry of Finance) acts as the defender of budget constraints; its counterpart in negotiating annual budgets is the Ministry of Health, which, however, acts together with the Treasury to control the sick funds; the Government directly runs a significant part of the hospitals, and, as such, has natural interests in conflict with those of the sick funds; three small sick funds have interests conflicting those of KHC's, but all four funds have joint interests confronting the Government's efforts to apply checks and controls; the Histadrut is the owner of the KHC, but it is in itself a labor union that has to protect its members' rights to proper medical treatment.

The above structure was a result of general political structure and realities. In any case, such a complex network of multiple agencies and interests may be considered as a source of troubles and interruptions, which is indeed the case in many respects. However, in a sector that is known to suffer from market failure and lack of adequate information available to consumers, the rules of the games that are applied, in effect, provide a proxy, or a partial substitute, for a mechanism of maximizing welfare through free competition.

The proposed Health Law was supposed to put all these factors and rules in a more systematic setting, and to eliminate some basic distortions. While most experts endorse the general ideas and approach of the proposed Health Law (and of the Netanyahu Commission report on which it relies heavily), there are others who object to them or have reservations (the most

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1/ Less favorable, as predicted in 1970 by the general director of KHC, in the document mentioned in a prior footnote.

2/ Since then, the former Minister of Health lead a new political coalition that won the nation-wide Histadrut election. This will, undoubtedly, lead to the renewed adoption of the proposed Health Law by the Government and the Knesset.

comprehensive ones are, in fact, contained in the minority's report). For our purposes here, what is important is that some major elements in the existing system enabled it to achieve the basic targets of a modern health sector, namely universal coverage and equitable access, high-quality of medical services, and restrained cost.

6. Concluding remarks

Evaluating the performance of health services is a prerequisite in considering reforms of the sector, and, indeed, many works do address this component. Typically, such reports and reform proposals focus on analyzing specific factors that operate in the health sector, and on quantifying the contribution of each factor to the overall performance of the sector. This paper is more macro-oriented, and is less concerned with the detailed role of each factor in the industry. The main difference lies in the basic approach and perspective: this paper looks at the health system not as an isolated sector but rather as one segment--important in itself--of the nation's social network and safety net.

Socioeconomic policy seeks to maximize welfare in a broad sense, which entwines economic goals and social targets. Regarding the economic goals, on the one hand--they are not only to attain maximum growth, but also to improve the distribution of the benefits from that growth and to provide everyone with certain basic services; on the other hand, regarding the social targets--they are to maximize social benefits, but, in doing so, economic implications and budgetary constraints must be taken into consideration.

According to this general guideline, health policy should ensure maximal medical care to everyone, regardless of ability to pay. This is a noble goal, which could be easily abused if not kept within boundaries. The reason is that the medical services, unlike other social services, operate in a realm of life-and-death issues and in a situation where the two counterparts in the market place are not symmetrically balanced, at least with regard to the information needed for rational decision making. Overuse is, per se, a well-known danger in this area, but it may also risk the advancement of other social goals by attracting resources to this sector beyond an optimal level.

The combined approach was applied in this paper by putting the Israeli health sector to the three-dimensional test: it turned out to be equitable in access; advanced in quality; and relatively restrained in cost. So far, achievements have been gradual, which is preferred by some experts. As Karen Davis states, its advantage is "its adaptability to changing conditions...it is especially well suited to the...budget process, which constantly weighs competing budget priorities." 1/ And in CBO's report on the proposed health reform, "Estimating the effects of any proposal to

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1/ Davis (1990), p. 227.

restructure the health care system is particularly difficult because inevitably, the transition from the old to the new system would take several years...the uncertainty surrounding cost estimates increases significantly in the out-years." 1/

This does not exclude the possibility that a well-designed, comprehensive reform will pass the test. But as a warning signal, it is important to keep in mind the difficulties shared by Western European countries, whose health reforms were analyzed in a recent OECD publication: continuing pressures on the cost side; excessive unnecessary medical care; inadequate care for segments of the population; and increases in the waiting times for treatment. 2/

As to the lessons derived from the Israeli experience being applied elsewhere, one should remember the finding in Chapter II regarding the "constant" ranking of countries by their respective health share in GDP. This was interpreted as an indicator of the dominance of intrinsic factors in each country, which tend to determine the size of its health structure. Otherwise, why would these countries, each experiencing different developments and applying different reforms, end up in their initial relative positions of twenty years earlier?

If this interpretation is valid, it points to the importance of differences in attitude, culture, and social fabric. A comparison of the United Kingdom and of the United States, as reported in a Brookings study, emphasizes the relevance of each country's system to the other, but it also gives specific examples of different attitudes and their effect. 3/ Accordingly, in recommending policy changes for a given country, one should carefully examine the specific intrinsic forces that underlie the structure of that country's health sector.

It would be useful to group countries according to their levels of the three basic characteristics, and the recommendations adjusted accordingly. An initial step in this direction would be to classify these countries by levels of coverage and quality of services, as follows:

1. System is still in the embryonic stage; poor medical services;

1/ U.S., Congressional Budget Office (1994), p. xii.

2/ OECD (1992), p. 16.

3/ "...for various reasons British patients and physicians may have responded differently to tight constraints on health expenditure from the way American counterparts would respond...Some of the differences...are due to important differences between British and American society and medical practice..." Aaron and Schwartz (1984), p. 6; and then, "British are less driven than American by the 'don't just stand there, do something' attitude toward disease," p. 25; and "Most patients in Britain appear to accept their doctor's word if he says that no further treatment...is warranted," p. 111.

2. Access is limited; basic medical services are available;

3. Access limited to small segments of the population; good medical services are available;

4. Limited access; highly developed medical services;

5. Universal coverage; low quality of medical services; and

6. Universal coverage; advanced medical services.

Category 1 typically applies to many developing countries in all parts of the world. The main efforts there should be directed to the training of doctors and paramedical staff, and to the development of general clinics--with special emphasis on preventive medicine, including mother/child care facilities. These countries will probably have to rely on government initiatives, since their nonprofit sectors are not prepared for such tasks.

Category 2 characterizes some countries in Middle and Far East, which may need to further develop their medical services, by training staff and opening new facilities. It seems that the best benefit/cost results may be achieved in the local and regional clinics, with proper referrals to tertiary treatment. It is probably too early to establish a full national health insurance system.

Category 3 refers to countries (such as Brazil) in which highly developed medical services do exist, but tend to be only in the major cities--and limited. Other populated areas do not have similar services. For countries in this category, there is a good chance that nonprofit organizations will be developed in the major cities, and that the public sector will take care of the more deprived areas. A balance of forces should be developed along the lines described above.

Category 4 may be regarded as a category of one country--the United States. The U.S. network of medical facilities, equipment, and procedures is probably the most advanced in the world. Its problems lie in its high cost and low coverage. This is the only industrial country that does not have a wide public health insurance, so the process, that other OECD countries went through in the third quarter of the century, should be of top priority. Regarding the other target, cost containment, if it cannot (due to political constraints) be achieved simultaneously with the first target, it should be given second priority.

Category 5 seems to apply at present to the Eastern European countries, where the provision of health services under the Communist regimes was universal, and the administration and financing of the sector was part of the general public sector. The overall deterioration of these economies has eroded the quality and scope of medical services. The tradition and ethos of the social commitment to provide everyone with equitable access to health services is now endangered by economic constraints. There is clearly a need

to transplant to this region the nonprofit sector, which is much less developed than in Western Europe and the United States. As part of such a policy, the health sector may gain from developing medical organizations that are motivated by mutual assistance. If this happens through the labor unions, the links should be restricted, to prevent some of the detrimental results that accompanied the Israeli KHC-Histadrut model, and their eventual negative consequences.

Category 6 refers to most OECD countries. The health sectors in these countries differ in structure and modus operandi, and are strongly influenced by intrinsic country-specific forces. Some basic elements are common to all, and this holds for the Israeli system as well. A close, constant monitoring of the continued development of the medical system is needed, in line with the concluding statement in the OECD report cited above.

This is only an initial step in an attempt to implement the lessons drawn in this paper from Israel's experience in providing a universal, equitable, high-quality, and cost-contained health system. Further development and implementation of this model have yet to be carried out.

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