Adva Center

WANTED:

REDUCTION OF THE PRIVATE IN PRIVATIZED HEALTHCARE SERVICES IN ISRAEL

Barbara Swirski

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WANTED: REDUCTION OF THE PRIVATE IN PRIVATIZED HEALTHCARE SERVICES IN ISRAEL*

The literature describes healthcare in Israel as a mixed public-private system. This appears to constitute acknowledgement that, if it ever was, purely public healthcare is no longer considered viable, due to a chronic situation of insufficient public financing. Indeed, the last public committee that examined Israel's health system reflected that view when it mentioned one aspect of a mixed public-private system that may even be advantageous: competition between public and private sector institutions.[1]

In the following, we will differentiate between the financing and the supply of healthcare,[2] and between the effects of what appears to be an increase in private provision of healthcare services on patients, physicians, health maintenance organizations (HMOs) and hospitals.

Firstly, in contrast to Sweden, Canada and Germany, where public and private health services constitute two distinct systems, in Israel there has been a blurring of boundaries between the public and the private sectors. Public Health Maintenance Organizations (HMOs) market their own, private insurance to members (the so-called supplementary insurance – supplementary, that is, to the universal basket of health services that every resident is eligible to receive), HMOs own private hospitals -- Maccabi Healthcare Services owns a chain of 8 Assuta medical centers (4 hospitals and 4 clinics), Meuhedet Health Services owns three private medical centers; and Clalit Health Services owns 51% of Herziliya Medical Center, a private hospital. In addition, public hospitals sell

* Many thanks to Dr Yuval Livnat and Professor Dani Filc for their helpful comments.

1 The Committee for Strengthening Healthcare Services in Israel and Regulation of the Public and Private Health Sectors ("Ash Committee"). November 2022. (Hebrew). Henceforth: "Ash Committee."

2 Telephone conversation, Dr. Adi Niv-Yagoda, August 16, 2023.

private services; and private hospitals sell public services to the HMOs via a commitment to cover the cost of the service (Form 17).

Among analysts of healthcare systems, the conclusion appears to be that privatization, whether of medical insurance or actual healthcare provision (physicians, hospitals and clinics, HMOs), has a number of negative consequences on both equity in healthcare and on the viability of the public system.[3] Privatization affects equity because not everyone can afford private insurance and private services; privatization affects the viability of the public system, because a private sector that develops parallel to the public sector "reduces the number of staff available to work in the public sector".[4] Moreover, with reference to the UK's National Health Service, but relevant to other public health systems as well, "the public sector is progressively destabilized as private providers offer higher pay and select easier cases but contribute little to training [as training is done in public hospitals B.S.]".[5] Moreover, the private sector tends to recruit stars that serve as magnets for patients as well as for other doctors.[6]

Obviously, the purpose of the healthcare system is first and foremost to provide services to persons in need of preventive and curative care. Just as obvious, the higher the public financing of healthcare services, the higher the potential for equity of access among those persons in need. But if the matter of financing is obvious, the matter of provision is not. If the public services are inadequate to satisfy demand, there is a logic and a praxis that says, why not

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3 Bambra, Clare; Garthwaite, Kayleigh & Hunter, David. 2014. "All Things Being Equal: Does it Matter for Equity How You Organize and Pay for Healthcare? A Review of the International Evidence." **International Journal of Health Services.** Vol 44. No 3. Pp. 457-477. Doi:http://dx.doi.org/102190/HS.44.3; Shoo, K. Lee; Rowe, Brian H. & Mahl, Shukhik. 2021. "Increased Private Healthcare for Canada. Is That the Right Solution? **Healthc Policy.** Vol. 16, No. 3. Pp 30-42. Doi: 10.12927/hcpol/2021/26435; Ash Committee.

4 Modi, Neena; Clarke, Jonathan & Mckee, Martin. 2018."Health Systems Should be Publicly Funded and Publicly Provided," **British Medical Journal.** Vol 362. p.2. https://www.jstor.org/stable/10.2307/26961707; Ash Committee.

5 Ibid. p.3.

6 Schneider, Lior Naamati. 2020. "Public-private: unequal competition: Israeli public hospitals vs the private health-care system following government reforms." **International Journal of Organizational Analysis.** Vol 2. No. 6. pp. 1381-1394. p. 1388.

develop private services so that there are more opportunities for healthcare? This is true, of course. However, lest we forget, the private healthcare market, like other markets, is profit-driven rather than service-driven. It supplies not just services, but also business opportunities.[7] Of necessity, then, private health services usually cost more than public services. In Israel, public health services involve national health insurance fees and copays for medications and physician visits, but not the full cost of the services, and certainly not profits.

If public services (physician visits, diagnostic tests, surgery) are not available in real time, that is, in time of need, the needy turn to private services, if they can afford them. (If they cannot afford private services, they may forego treatment.) But if too many persons turn to private services, these, too, can become inaccessible. The infamous queue for public health services may be reproduced in the arena of private services, because supply is always finite and demand is not. Thus, despite the fact that many persons in need will not be able to afford private healthcare services and are not in competition for the same, the presence of two parallel systems – the public and the private – may very well sow the seeds of their own inadequacy, so to speak.

7 Greene, Jeremy A. 2022. **The Doctor Who Wasn't There: Technology, History, and the Limits of Telehealth.** Chicago and London. University of Chicago Press.

Patients

The development of private services, including private health insurance, alongside public services, leads to loss of trust in the public system on the part of patients, to the preference for private over public health services, and to the purchase of private health insurance policies and private healthcare services by those persons who can afford them (and also by some who cannot -- who as a result encounter financial problems, including debt). Another consequence, for patients who cannot afford services in the private sector, is, of course, the foregoing of healthcare.

According to a 2021 study conducted by Myers JDC Brookdale for the Ministry of Health, "a long waiting time for community-based specialty care was the most common reason for seeking private specialty care."[8] This was also a finding (December 2022) of the bi-annual Brookdale survey regarding consumer satisfaction with the public healthcare system[9]. That survey found that 35% of persons interviewed stated that they forewent medical treatment in the public health system due to long waiting times. Moreover, 51% of those same individuals turned to the private system for the medical care they could not obtain in what they considered real time in the public system.

Two recent examples:

Example 1: In the summer of 2023, Patient A described what happened when he tried to obtain medical assistance for a shoulder injury. He went to his HMO, where he was able to see a physician (this is not always possible), who told him that what he needed was an MRI to ascertain the nature of the damage to

8 Brammli-Greenberg, Shuli; Avni, Elinore; Maoz Breuer, Rina; Elroy, Irit; Luxenburg, Osnat; Wilf-Miron, Rachel & Ziv, Arnon. 2021. "Waiting Times for Community-Based Specialty Care from the Patients' Perspective." Jerusalem: Myers JDC Brookdale (Hebrew).

9 Laron, Michal; Maoz Breuer, Rina & Fialko, Sharvit. 2022. "Population Survey on the Level of Service and Healthcare System Performance 2021-2022. Jerusalem: Myers JDC Brookdale (Hebrew).

his shoulder. However, the physician also informed the patient that the HMO would not provide him with a financial commitment for an MRI, and thus the best he could do for him was to give him a referral to a physical therapist. When the patient called to make an appointment with a physical therapist in the public health system, he was told that the first available appointment was not until the beginning of October, but that he could keep trying; perhaps someone would cancel their appointment and he could get the treatment he needed earlier. As they spoke, the HMO representative saw that an appointment was cancelled for September 27 (still more than a month away). The patient then gave up. He asked around for recommendations for a physical therapist who worked privately; that is, he had recourse to the private sector, due to practices and waiting times in the public sector -- and his own ability to pay for a private service.[10]

Example 2: Patient B was informed by her ophthalmologist that she needed a cataract operation in both eyes, but that due to the complex condition of her eyes, she needed to consult with a top specialist to determine if such an operation could actually be performed. The doctor referred her to a top specialist for cataracts in her own HMO. When she called for an appointment, she was informed that no appointments were available. Not that month, not the next month, and not the month after. No availability, period. The patient then tried to make an appointment with a surgeon with whom her HMO had an arrangement whereby it subsidizes part of the payment. The earliest consultation available was three months away. She then inquired regarding a top surgeon specializing in cataract operations who worked in the private sector -- with whom she received an appointment within a month.[11]

10 Amsterdamsky, Shaul. “If Only the Trouble Were Corona.” August 17, 2023. **Mosaf Calcalist.** (Hebrew)

11 Experience of the author.

Physicians

The development of private sector healthcare provides opportunities for physicians to increase their income by working in both the public and the private sectors. This is problematic, among others, because the number of physicians in Israel has not grown in tandem with the growth of the population, and the public healthcare system is now short of doctors. Indeed, OECD **Health Statistics 2021** singles out Israel as an outlier in this respect: “In most OECD countries, the number of doctors increased more rapidly than population size, so that, on average, the number of doctors rose from 2.7 per 1,000 in 2000 to 3.6 in 2019. Israel was an exception to this general trend, as the 38% increase in the absolute number of doctors was not enough to keep pace with total population growth of 44% between 2000 and 2019”.[12] In 2021, Israel had 3.4 active physicians per 1,000 population (compared to the OECD average of 3.7).[13]

Physicians with dual practices may spend the first part of the day in public hospitals (where the ordinary working week consists of five days a week, from 7:30 am to 4:00 pm),[14] then spend their afternoons in private clinics, where they supplement their hospital salaries. However, this takes place at the expense of the public healthcare system, where they are available for fewer hours. A solution proposed by the German Committee (named after its chair, then Minister of Health Yael German) for the Strengthening of the Public Health System in Israel (2014), and more recently by the Ash Committee (2022), was to pay higher salaries to physicians committing to work exclusively in the public health sector. The Israel Medical Association is in favor of this change, but there is disagreement over the salaries to be paid to “full-timers”. This

12 OECD. **Health Statistics**: https//www.oecd-library7.org/sites/b39949d7en/Index.html?itemld=content/component/b39949d7-en.

13 OECD. 2023. **Health at a Glance. OECD Indicators.**

14 Ministry of Finance, Department of Salaries and Wage Agreements. **Report on Salary Expenditures in the Health System – Public Hospitals for 2021.** May 2023. (Hebrew).

matter is on the agenda to be discussed at negotiations for the next collective agreement between the government and the Israel Medical Association.

One way to keep medical personnel in public hospitals for longer hours, and thus to better utilize hospital resources, and especially operating rooms, has been to pay them for additional hours of work through hospital "research funds" or "health corporations," financed by contributions. The Finance Ministry's 2023 report on the salaries of persons employed in public hospitals in 2021 documented the average percentage of the salaries of hospital physicians (those not in residency) paid by hospital health corporations for hours of work beyond their formal position. The average supplement amounted to 25% of the physicians' total remuneration for their public hospital work. Physicians working in public hospitals were reported to work there, on average, not full-time but rather somewhat less -- 90% of full-time.[15]

A 2018 study, "Remuneration of physicians at government hospitals from public and private medicine – findings and trends," which examined the income of physicians in 2016, found that doctors employed in government hospitals for ten years or more had an average annual gross income of NIS 790,000, of which 29% originated in private medicine. This amount reflects a real increase of 76%, in comparison with gross income in 2007; an increase of 84% for public practice and an increase of 59% for private practice. The authors note that payments from HMOs for consultations in the physicians' private clinics was included in the category of private practice, though these consultations actually constituted public practice.[16]

To gain insight into the role played by physicians in the development of private health services in Israel, two recent studies conducted in-depth interviews with

15 Ibid.

16 Belinsky, Alexi; Ben-Naim, Galit & Hecht, Yoav. 2018. "Remuneration of physicians at government hospitals from public and private practice – findings and trends," Ministry of Finance, Department of the Head Economist, "Studies, Surveys and Statistics." (Hebrew)

specialist physicians. A 2020 study[17] explored what physicians considered their role in society and whether they conceived healthcare as a commodity or as a human right. The research involved interviews, 11 with physicians who worked only in the public health sector and 10 with physicians who worked in both the public and private sectors. The researchers concluded that the institutional context was more likely than not to frame the physicians' perspectives: healthcare as a human right was more frequently voiced by physicians working exclusively in the public sector, while choosing the patient (that is, not accepting every individual who asks for an appointment) appeared to be a norm or practice accepted in the private sector but not in the public one.[18]

A 2022 study,[19] described as having two stages, the first being the previous study, which interviewed physicians in order to understand, among others, their views on private health insurance. This stage was followed later by a standardized telephone survey of physicians associated with the four HMOs, including those working exclusively in the public sector, and those working in both the public and private sectors. The questions addressed issues that had arisen in the previous stage of the study. The conclusion: "Physicians, major key players in healthcare systems, have contributed very significantly to the spread of PPM [public-private mix] either directly engaging in dual practice and spending more time in the private sector, or indirectly through recommending PH [private health insurance] to their patients".[20]

17 Rasooly, Alon; Davidovitch, Nadav & Filc, Dani. 2020. "The physician as a neoliberal subject – A qualitative study within a private-public mix setting. **Social Science and Medicine.** https:doi.org.10.1016/jsocscimed.2020.1.13152.
18 Ibid.
19 Tal, Michael; Filc, Dani & Davidovitch, Nadav. 2022. "What motivates physicians to propose private services in a mixed private-public healthcare system? A mixed methods study. **BMC Health Services Research.** Vol. 22.
20 Ibid. p. 8.21

Health Maintenance Organizations

Israel's HMOs existed prior to the establishment of the state. The National Health Insurance Law (NHIL), which came into effect in 1995, included a minimal list of services that these funds were to provide their members, who paid a monthly health tax based on income, and also quarterly copayments for visits to physicians and copayments for medications in the basket of services covered by the NHIL. An article of the same law stipulated the health services that were to be provided directly by the Ministry of Health.

The law itself did not make provision for updating the basket of services provided by HMOs; in 1999, an innovative system was created by the incumbent director-general of the Ministry of Health, Professor Shuki Shemer, whereby a committee (the Basket of Services Committee) was created to decide annually which medications and medical procedures were to be added to the basket of health services that year, in accordance with a unique model, within the framework of the sum allocated following negotiations between the ministries of finance and health.

The sums budgeted were not in tandem with international standards (which called for an additional 2% for new medications and procedures each year, while the average budget for new health services in Israel has been 1.0%.[21] In order to compensate for the inadequate funding of the NHIL, an article of the 1998 Budget Arrangements Law encouraged HMOs to market voluntary "supplementary insurance" that would enable members to receive services not included in the universal basket. Maccabi Healthcare Services had sold supplementary insurance before 1998; after 1998 the other HMOs created their own voluntary insurance plans, which though private, were open to all

21 Levy, Baruch; Bennun, Gabi & Davidovitch, Nadav. "Examination of the Updating Mechanism of the Cost of Health Services in 1995-2020," in Weiss, Avi (editor). 2022. **State of the Nation Report: Society, Economy and Policy.** Jerusalem. Taub Center. (Hebrew).

members without need for underwriting. In later years, the HMOs added more layers to their voluntary private insurance plans.

It did not take long for commercial insurance companies to follow suit, offering additional voluntary health insurance, which often duplicated the HMO voluntary insurance plans. It took many years before this duplication was acted upon. It was the main focus of the deliberations and recommendations of the Ash Committee in 2022 and was reflected in the 2023-2024 Budget Arrangements Law.

Notably, expenditures for private, voluntary insurance – including policies sold by HMOs and those sold by insurance companies – constitute the largest item of out of pocket outlays on health in Israel.[22] In 2020, these expenditures constituted no less than 40%.[23]

Private “add-on” health insurance policies were not the only private health services developed by Israel’s HMOs. As mentioned above, Maccabi Healthcare Services owns a chain of what are presently 8 privately owned hospitals and medical centers, Meuhedit Health Services owns three private medical centers, which specialize in surgery and include the Elisha Hospital in Haifa; and Clalit Health Services owns 51% of the Herzliya Medical Center, a private hospital.

In 2017, it was reported that the chairperson of the Directorate of the private medical centers of the Meuhedit HMO, then called “Nara Medical Centers,” was none other than Professor Gabi Barabash, past director of the Ichilov Hospital (a pubic, government hospital). Barabash defines himself as a defender of public medicine; he stated that the apparent contradiction between his self-image and

22 Filc, Dani & Davidovitz, Nadav. 2016. “Rethinking the private-public mix in healthcare.” **Journal of Health Services Research and Policy.** Vol 21, No. 4, Pp 249-256.

23 Israel Central Bureau of Statistics. 2023. “Household Income and Expenditures.” **Survey of Household Expenditures 2020 – Summary** (Hebrew).

his new capacity was lessened by the knowledge that the private medical centers he helped to set up and then headed intended to provide services to the public sector through Form 17, just as the Assuta Medical Centers did.[24]

According to Professor Shuki Shemer, Chairperson of the Assuta Medical Centers, 80% of the activities of the Assuta hospitals and clinics actually service the public health system (via Form 17); 50-54% of the referrals are from members of the HMO that owns Assuta, Maccabi Healthcare Services, though the services are open to all HMOs; the remainder of referrals come from the other three HMOs. Some 20% of the activities of the Assuta hospitals are private activities, including medical tourism.[25]

Thus, a public sector institution owns what are legally private sector institutions, which actually aid a public health sector that lacks sufficient funding to provide for Israel's public health needs. When the government provided budgets to shorten waiting times for elective surgery (see below), the lion's share of those budgets went to ostensibly private hospitals.[26] It should be added that there are no differences in the charges made to MHOs for elective surgery for their members (Form 17) by public and private medical institutions.[27]

This phenomenon is reflected in the fact that in 2018, 56% of surgical procedures under the National Health Insurance Law's universal basket of services were performed in private hospitals.[28]

24 Linder, Roni. October 17, 2017. "A new chain of medical centers that is already worth a quarter of a million NIS – And it will compete with Assuta. **The Marker.** (Hebrew)

25 Telephone conversations with Professor Shuki Shemer, September 3, 2023 & December 19, 2023..

26 Barnea, Roy and Niv-Yagoda, Adi. 2021. "Changes in the activity levels and financing sources of Israel's private for-profit hospitals in the wake of reforms to the public-private divide". p. 5. **Israel Journal of Health Policy Research.** https://doi.org/10.1186/s13584-021-00455-z.

27 Telephone conversation with Professor Dani Filc, December 19, 2023.

28 Barnea, Roy and Niv-Yagoda, Adi. Op. cit.

Public Hospitals

Like private hospitals, public hospitals accrue additional income by engaging in medical tourism. According to the website of the Ministry of Health, some 30,000 medical tourists, mainly from eastern European countries and "nearby countries," come to Israel each year. In recognition of the phenomenon, a law regulating medical tourism, whose main focus was on medical tourist agents, came into effect in January 2019. According to *Protocol*, an internet database on the rights and obligations of residents of Israel, the law regulates the work of medical tourist agents, as well as that of hospitals offering medical tourism. [29]

According to Dr. Adi Yaniv-Yagoda, medical tourism was quite developed in Israel prior to 2014. It decreased significantly following the devaluation of the ruble, the development of an alternative for eastern Europeans -- private clinics in Germany, which are less expensive than those in Israel[30] -- and a television expose by a TV investigative program devoted to the ill treatment of medical tourists by medical tourist agents.[31]

At present, medical tourism is limited in scope; the official figures include Palestinians from the Occupied Territories; these patients are not really medical tourists, but rather individuals who utilize Israeli hospitals in accordance with political agreements. The problem with medical tourism in public hospitals is that tourists receive preferential treatment: they do not wait in line for diagnostic tests and they do not have to occupy beds placed in corridors, if the department lacks private space. In the present situation of

29 **Medical Tourism Law** - 2018.

30 Aviad BarTov. October 20, 2020. "Medical Tourism: Israel's Rating Decreased to 8th Place in 2020-2021." **Medinet: Health and Welfare Portal**.

31 Telephone conversation with Dr. Adi Niv-Yagoda, August 16, 2023.

scarcity, that is, insufficient staff, equipment, and hospital beds for Israelis in need, medical tourism is carried out at the expense of locals.[32]

Another example of the private intertwined with the public in healthcare are the so-called hospital research funds, often referred to as healthcare corporations.

The corporations are separate legal entities, though the chairperson of their Boards of Directors are usually the hospital directors; the corporations engage in research and fundraising, and they are utilized to increase the salaries of hospital employees.[33] According to the most recent Ministry of Finance report on salaries in public hospitals, most medical personnel receive salary increments from the corporations; in the case of physicians not in residency, the corporations provide on average of one-third of the total salary they receive from the hospital.[34]

Public hospitals have other private services, perhaps the most well-known of which are hotel services for birthing mothers. They also offer private health services not included in the universal basket of services, like plastic surgery and periodic check-ups for companies with which they contract.

32 Telephone conversation with Professor Nadav Davidovitch, July 28, 2023.

33 “Report on Salary Expenses in the Healthcare System – Public Hospitals in 2022.” May 2023. Ministry of Finance (Hebrew).

34 Ibid.

Recent Efforts to Strengthen the Public System

When asked, “Has the privatization battle been lost?” Professor Nadav Davidovitch, past director of the School of Public Health at Ben Gurion University and chair of the Israel Association of Public Health Physicians, replied that in recent years a number of changes have actually strengthened the public health system.[35] Whereas public financing of national health expenditures was once 70% and decreased to 60%, it is now 64-65%. When additional monies were allocated to shorten waiting times for voluntary surgery, 70% of the total sum went to the Assuta medical centers, where the operations performed were financed publicly (via Form 17). On the other hand, Davidovitch noted that there has been an increase of private rather than public services for long-term care and mental health.[36] And as noted above, private health insurance has proliferated, numerous physicians have dual (both public and private) medical practices, and public and private services are to be found in both public and private healthcare institutions.

In recent years, three reforms were carried out in order to strengthen the public health sector.[37] One (which came into effect in 2016) was to create networks of physicians affiliated either with HMO supplementary insurance or with the voluntary medical insurance offered by insurance companies. Under this plan, patients could have recourse to the consultation services or surgical procedures of physicians not directly employed by or connected to their HMO. The services are covered by the insurance plan (the HMO, if supplementary insurance and the insurance company, if strictly commercial insurance), while the patient is charged a copayment upfront. This changed a previous arrangement by which patients could choose a senior physician, pay directly for the service, and be

35 Telephone conversation with Professor Nadav Davidovitch, July 28, 2023.

36 Ibid.

37 Barnea & Niv-Yagoda. op. cit.

partially or completely reimbursed by the insurer – which resulted in high outlays for insurers and an increase in private expenditure on health. Under the network arrangements, the cost of services was established through negotiations with HMOs rather than on a person-to-person basis.

A second reform was designed to shorten waiting times for elective surgical procedures in the public health system by increasing the number of procedures, and by allocating a larger budget to the public system for such procedures: NIS 870 million for direct support to HMOs and NIS 180 million to public hospitals. In September 2019, a list of 115 authorized public and private providers in the program was published. However, "no specific targets or measures for assessing waiting times were defined";[38] thus we have no information on whether or to what extent waiting times were shortened – that is, whether or not the measure accomplished its aim.

A third reform was the "cooling off period" regulation, which stipulated that a physician who treats a patient in the public health system, be it in a community clinic or a hospital, may not treat the same patient in a private setting until the end of a six months' cooling off period. According to Barnea and Niv-Yagoda,[39] the official aim of this regulation was to limit physicians' ability to divert patients from the public to the private sector, based on their own financial interests. It was also intended to restrain the increase in private health financing stemming from the high copayments for surgical and other elective procedures performed in the private sector. The reform itself (2016) is indicative of the increase of physicians with dual practices: one in the public and another in the private sector.

An additional reform is to be found in the final version (up to the present writing) of the Budget Arrangements Law for 2023-2024,[40] one that reflects the

38 Ibid. p. 4.

39 Ibid.

40 " Budget Arrangements Law: Corrections." February 24, 2023 (Hebrew).

main concern of the Ash Committee: the phenomenon of duplicated insurance. This is coverage for identical health events in voluntary insurance policies -- those of HMO supplementary insurance and of insurance companies. In the case of duplicated insurance – insurance companies are to pay the medical costs, regardless of which insurance plan the patient sues. This change is to take place for new and renewed insurance policies, not for existing ones. The idea is to save money for the patient and reduce the national expenditure on health. In new or renewed policies, commercial health insurance plans are to offer insurance only for medical procedures or expenses not included in the HMO supplementary insurance policies.

This reform is based on the recommendations of the Ash Committee, but it does not go nearly as far. The Committee recommended that insurance company policies cease to cover surgical procedures, except for copayments for those covered by the HMO supplementary insurance plans or medical services or products not covered by supplementary insurance plans, like surgery abroad, medications not included in the universal basket of services, or services that complement those covered by HMO voluntary insurance plans. The Ash Committee also recommended transferring some surgical procedures included in insurance company plans to the HMO supplementary plans, as well as transferring some of the services included in the supplementary plans to the universal basket of services. However, the Committee did not specify which services and procedures should be transferred.[41]

41 Ash Committee.

Conclusions

It appears that Israel's healthcare system will continue to exist as a mixed public-private model, for one, due to the way it has developed, in answer to a lack of sufficient financial resources and the challenge of providing health services in real time. Public institutions have been offering private services, as a way to balance their budgets, as well as a way of providing what the universal basket of services does not. The other side of the coin is that private, for-profit institutions have been offering public services, both as a source of income, and as a partial answer, sometimes initiated by the government, to the challenges to Israel's healthcare delivery system stemming from population growth and aging, both of which involve increasing needs for medical services.

The balance between the two – the public and the private -- is of critical importance, if we aspire to equality in access to healthcare. A major indication of balance is the percentage of public vs private financing of healthcare. Public financing (2019 – before the Corona epidemic) constituted 64% of health expenditure, while the OECD average was 74%.[42] The aspiration should be to increase the share of public financing, regardless of whether the supplier is public or private.

If public financing of health services were adequate, public supply would be preferable, as in the public sector, employees benefit from collective wage agreements and as well as from government regulations regarding employment -- and more protections against discrimination.

In a situation in which resources are insufficient, it is of utmost importance to provide access to healthcare. If private medical services are able to increase the supply of healthcare options, and, at the same time, provide decent salaries and working conditions, they can be viewed as part and parcel of the public system.

42 OECD. 2021. **Health at a Glance 2021. OECD Indicators.**

We have already indicated that the development of private health services is considered damaging to equality in access to healthcare. One way to offset this damage is to ensure that sufficient numbers of physicians spend all or most of their time in the service of public hospitals and clinics, by increasing their salaries; another is by limiting medical tourism in public hospitals, as long as hospital staffs, beds, and equipment are insufficient to serve the local public – which is the present situation. HMO supplementary health insurance, which benefits about 80% of the population, should be integrated into the universal basket of services, so that it will serve one and all. Finally, private services developed by HMOs, which are public institutions, need to continue to serve the public system – the one that benefits all residents of Israel.

מרכז אדוה

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