Journal Homepage: - www.journalijar.com

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)

Article DOI: 10.21474/IJAR01/14338
DOI URL: http://dx.doi.org/10.21474/IJAR01/14338

RESEARCH ARTICLE

PRIVATIZATION OF THE HEALTH SYSTEM

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Manuscript Info

Manuscript History
Received: 25 December 2021
Final Accepted: 30 January 2022
Published: February 2022

Abstract

Foreword In this chapter we will discuss the privatization of the health system in Israel since the enactment of the National Health Insurance Law (hereinafter: "Law") in 1995. As explained below, this law constitutes a nationalization of important parts of the health system. Therefore, when we consider the extent to which the health system is undergoing a process of privatization, it is important to distinguish between two questions: Have fields that were private before 1995 remained so? Has there been a setback in the scope of nationalization within the law and a greater role has been placed on the private sector?

Introduction:-

The public discourse usually engages in privatization in the health system as a whole, while the picture is actually more complex. We should distinguish between areas that have always been privatized and/or largely privatized, and fields that were nationalized, and then a privatization trend was observed in them. Thus, for example, increasing the share of private financing of health services is presented as "privatization", without examining, among other things, on which services exactly households spend those funds. Are the funds spent on services were nationalized or services that were and remain private? As part of the National Health Insurance Law and a significant part of the health system was nationalized and regulated. However, the intent of the law to extend the nationalization and regulation into other areas such as long term care insurance, mental health, dental health (except for preliminary nationalization that occurred recently), health promotion and preventive medicine - has not been implemented, and these areas remain private and/or going through the process of privatization. In this section we wish to carefully examine the claim that there is a trend of "takeover" in some areas that were nationalized by law, in order to investigate the issue of privatization as part of the overall health policy of the country.

In the first part we will examine the multi-dimensionality of the term "privatization", both ideologically and methodologically, while setting four key parameters in assessing the degree of privatization in the system. **In the second part**, we will review the historical background of the developments and great changes in each of the four major parameters. **In the third part** we will present data for the four parameters**. In the fourth part** we will discuss essence of these changes and present an assessment of the degree of privatization in the health system. **In the fifth part** we will demonstrate the implications and recommendations for policy.

1 Definition of the term "privatization" in the context of health systems

The original meaning of the term "privatization" was the transfer of ownership of assets or control over them, from public sector to private sector, with the main objective of furthermore efficiency. Due to the awakening of social movements that cast doubt on the positive contribution of globalization and reduction of involvement of the government in the economy, the privatization subject has become more complex and loaded. Evidence of this can be

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found in various attempts to define the term "privatization" (see Adva Center 2006; Israel Democracy Institute, 2010).

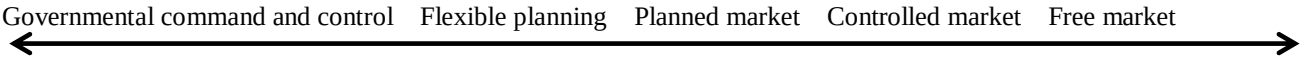
There is a broad agreement within Israeli society that healthcare is a basic social right (Chinitz, 2010). The significant interest in the subject of privatization of the health system in Israel is related to the views and values of equality, social justice and mutual responsibility, and any development that affects these values will be examined through an ideological prism. In our view, the issue of privatization should be approached with an awareness of the importance of ideology, and of the extent it may at times obscure the discussion of the practical components of the system. The assumption that any move of a limit towards the private sector inevitably indicates a government's renunciation of responsibility, disrupts the ability to examine reality more equitably, and eliminates in advance the option of coexistence of privatization, equality and other values.

One way to "rise above" the ideological debate is to make an orderly analysis of changes in the status of institutions and arrangements in the health system, and thus try to drive away the clouds of uncertainty accompanying the heated debate. Without ignoring the ideological context, and considering the complexity of the term "privatization", this chapter shall be based on the definition as it appears in the introductory chapter of this book:

"Transfer of assets, services and products owned, managed and funded (as applicable) by the State organizations, to organizations in the business sector or third sector organizations, or individuals. In its broadest sense this redefines the responsibility of the State, which is, moving the boundaries between the components above. Privatization can be performed into two sectors: from the State to the business sector -- to a commercial entity that operates in the business market; From the State to the third sector -- to a non-business nonprofit corporation. One must distinguish between: (1) "Minor privatization" - to a public nonprofit organization that does not follow business and/or competitive standards (for example, the management of pre-academic preparatory courses by the Association for the Advancement of Education); (2) "Major privatization" – to a non-profit corporation that operates as a business entity and is generally also competitive (health funds); (3) Transfer from a third sector organization to a business entity is not privatization in terms of the formal definition, since there is no fundamental change in the responsibility of the State, but the distinction between "minor" and "major" also applies to it. For example, the difference between existing public health funds and private health funds."

The chapter will focus on examining the changes in the Israeli health system related to this definition, and will examine to what extent these changes should be defined as privatization. A convenient tool for conceptualization is the range between an institutional structure that expresses responsibility and full control of the state on the one hand, and a completely free market on the other hand.

Figure 1:- The scale of institutional structure of social systems.



Source: Saltman and von Otter, 1992

Some comments on Figure 1. **First of all**, it reflects knowledge, understanding and experience in different countries that the institutional structure of the health system should not be based on one of the ends - only on the free market or only be owned by the State. Research suggests the acute failures of health care in both cases. The first one suffers from market failures arising from information asymmetry between doctors and patients, a moral hazard leading to overconsumption of medical services, difficulty assessing the quality of medical service, and inequality in the health insurance market (Arrow 1963, Altman el 1999, Altman and Schachtman 2011). The second one, the government service, also suffers from problems arising from information barriers, especially negative incentives and inefficiency. Therefore, most Western countries that have reformed healthcare systems have sought a solution that combines market mechanisms that encourage efficiency and quality, and state control and regulation tools that will restrain the tendencies to exploit information gaps and create inequality in access to medical services (Saltman and Von Otter, 1992). **Second**, while the scale in the figure moves from private to public, the more significant distinction is between hierarchical government command and control, and a system of distributed exchange transactions within a free market. **Third**, the sequence of points on the scale in the figure reflects institutional arrangements, the definition of which goes beyond distinguishing between private and public, such as choosing

between private or public service providers. **Fourth**, at any point on the range there is a different mix of parameters that make up the system - for example the source of funding and ownership of services - while there is no reason why certain parameters should not move in different directions in the sequence.

The list of parameters below is not comprehensive, but it includes the most prominent elements related to the characterization of the institutional structure of the health system, which are very suitable for the definition of privatization above:

A. Funding;
B. Ownership;
C. Choice[1];
D. Regulation.

The focus of the discussion is the combination of these parameters (Rozen, 1990). The nature of each parameter can range from private to public. The option of different mixes allows focusing more on privatization as a way examine the real and meaningful processes in the system. For instance, if there is more private funding and also more provision of services by private commercial institutions, it goes without saying that moving on the scale will be in the direction of privatization. However, if in addition there is also a regulation restricting the activity of private entities in order for them to serve public tasks - we will see it as a barrier that stops the movement of the system, long before it reaches the left end of the scale, - i.e., the completely free market.

In this context, it can be noted that today in the Netherlands, and subject to arrangements with the EU, all health insurers are private, commercial institutions, but they are limited by strict regulation designed to maintain solidarity and equality in the system, and these insurers tend to become nonprofit organizations. In contrast, in several eastern bloc countries, the dissolution of the Soviet regime resulted in a transition from a system under full control of the government, to a system in which the private sector plays a significant role, for example, establishment of private health insurance organizations without regulatory restraint. Therefore, it is more important to discuss the mixes of parameters beyond discussing the distinction between private and public, as well as about privatization in Israel's healthcare system.

It should be noted that the discussion here deals mainly with privatization of medical care services, which is a key component of the health care system, but not the only one. Other systems, such as medical education, environmental health and social factors affecting health will not be discussed in this chapter. However, the debate over the privatization of the medical care system also serves as an appropriate background for analyzing other areas.

2 Privatization of Israel's health system: Historical Context[2]

In many countries, the voluntary collective organization directed to the funding and the provision of health services was preceded by massive intervention of the government in the field. The system in Israel is unique, since its institutional structure was established about forty years before establishment of the state. Clalit Health Services was one of the arrangements for social services in the period of settlement (Yishuv) and on the way to the establishment of the State of Israel. The fund has acted according to the rules of social health insurance, where membership fees are based on income level, and the service should be provided on a basis of need. Just before the enactment of the National Health Insurance Law in 1994 there were four health funds, after Clalit has lost its dominant position in respect of other health funds due to transition of clients, especially for to Maccabi. Percentage of the Clalit clients has dropped from 82% in 1950 to 66% in 1994 and 52% in 2010. In that period, the amount of Maccabi health fund clients raised from 3.4% in 1950 to 17.6% in 1994 and 25.3% in 2010 (Ben-Nun et al., 2005; the National Insurance Institute, 2010).

During the settlement period there were several prominent hospitals, mostly of Hadassah organization. After 1948, deployment of inpatient system was accelerated both by government and by the Clalit Health Services. In addition,

[1] The selection element suits the definition of privatization used in this article, and is subject to the argument according to which the greater is freedom of choice the government provides to a citizen, the greater is his responsibility for its role as a "client" or "consumer" of the services. A hierarchical system that determines from whom and where the citizen receives health services will be placed closer to the right side of the scale. In contrast, a more flexible system, which allows the citizen a certain choice according to vouchers - even if funding and ownership remain with the government - transfers to the citizen part of the responsibility for the functioning of the system and, therefore, will be placed on the left side of the scale. This concept will be discussed in connection with the subject of Private Medical Service.

[2] For broad overview: See Asa Maron in this book

competition on hegemony in the system has developed between the Ministry of Health and Clalit Health Services, partially as a result of political and organizational relationships between Mapai-Alignment-Labor party, the Histadrut and the Clalit Health Services.

Over the years, and especially in the eighties, the activity of the Ministry of Health in the field of hospitalization led to its taking of two functions at once - service provider and regulator. In several important areas, such as mental health, nursing care and obstetric and infant prophylaxis, the services were provided directly by the Ministry of Health. This situation even more blurred of boundaries of responsibility between the Ministry of Health and non-governmental entities such as health funds. In this study, we will not focus on services provided by the Ministry of Health, but it is worth to consider the lack of clarity in terms of authority and responsibility, and its implications on the definition of civil rights and ways of service provision.

Upon the establishment of the State, some demanded in the name of "statehood" for the institutions that existed before the establishment to be integrated in the government institutions, and accordingly the health funds will be within the government structure. Health funds did not cooperate with this trend, in part because of the opposition of the Histadrut, and therefore the health system from the start was comprised from a mixture of public-governmental institutions and public-non-governmental institutions, without a clear demarcation of responsibility and authority. In contrast, in most Western countries nonprofit health funds and public hospitals were defined as "private", while in Israel they were defined as "public". In other words, these institutions should operate on a nonprofit basis, and be subject to the laws and regulations that restrict their activities and turn them into semi-governmental institutions. It should be noted that before the establishment of the State of Israel, there were also several commercial private hospitals (Ben-Nun et al., 2005). This sector, in terms of its identity, the source of funding and ownership, was not characterized by unclarity: It was completely private.

The crisis in the health system in the late eighties

The development of the health system from the establishment of the State until the end of the eighties led to pressure to perform a structural change. Heavy deficits, particularly in Clalit Health Services, dissatisfaction with the service, an increase in citizen's expenditure on health services and inequalities in access to health services, have stimulated public debate. An external factor which also affected the initiation of change, was the decrease in the power of the Histadrut and formation of conditions for the separation between the Histadrut and the Clalit Health Services.

At the end of the eighties there were long queues for elective surgeries, particularly for Clalit clients. Growth of small independent funds, Maccabi and Meuhedet, as well as unbalanced distribution of clients between the organizations in terms of income, age and health status, have become the focus of discourse in the health system. These two funds have allowed more freedom in choosing the service provider compared to Clalit, and imposed less bureaucratic obstacles to its members. In addition, independent funds attracted more groups of young, wealthy and healthy populations. The ability of these funds to choose their members was also perceived as unfair, since they increased the inequalities in the system.

Technological advancement and success of hospitals - both private and public - to obtain advanced medical equipment, even without permission or control of the Ministry of Health, contributed to the sense of the weakened control in the health system. In the 1980s, Israel had a relatively large number of scanning machines (CT, MRI) per capita compared to the Western countries. This can be seen as an example of a situation where the government has a centralized control under law, but cannot enforce the law consistently. It could be argued that the system in this period was simultaneously public and centralized, and also private and dispersed.

At that time, hospitals in the public sector started to develop new services, while competing for recruitment of reputable team in order to improve the level of service and in an attempt to attract patients. This occurred even though according to the arrangements agreed between Clalit Health Services and the Ministry of Health, every hospitalization or outpatient visit to the hospital was to be determined by regional planning. Another example of the lack of consistent management of regional planning policy was that on the margin of the regional programs, working agreements began to develop between hospitals and health funds, for example, promising to refer patients to selected treatments in specific hospitals. That is, there were clear signs of increasing competition within the health system in Israel. (Chinitz and Rozen, 1993).

Recommendations of Commission of Inquiry headed by the judge Shoshana Netanyahu

These developments formed the background for appointment of a Commission of Inquiry to examine the health system in Israel and its functioning (Netanyahu Commission) in 1988. Although there have been many committees that examined the health care system before the Netanyahu Commission (see also Asa Maron in this book), the prestige of the Commission of Inquiry, as well as political developments within the Labor Party, created the conditions for a structural change and reform in the system. Specifically, there was a struggle within the Labor Party and the Histadrut, in which the former Knesset member Haim Ramon won the Histadrut leadership election and led to the separation of the Clalit Health Services from the Histadrut. This move paved the way for the enactment of the National Health Insurance Law in 1994 (Chinitz, 1995).

The most obvious change that occurred following the recommendations of Netanyahu Commission, was the enactment of the National Health Insurance Law. However most of the Commission members recommended two other major structural moves:

1. Converting government hospitals (and, if possible, also Clalit hospitals) to independent public corporations that will not be budgeted directly by the government, but will compete in the provision of services that will be financed by the health funds.
2. Transfer of the direct provision of services such as mental health, nursing care and mother and child care from the responsibility of the Ministry of Health to the responsibility of the health funds.

Some have seen these recommendations as an attempt to nationalize the system, while others have seen them as privatization. Some also identified in the recommendations a "third way" in the spirit of "New Public Management" (Chinitz, 1995; Rozen and Ben-Nun, 2005). Actually the recommendations included a combination of parameters, when different components of the system were moving in different directions on the scale, following the implementation of the National Health Insurance Law and partial implementation or lack of implementation of the other two measures presented above.

National Health Insurance Law of 1994

The law was a clear expression of the fact that the State takes responsibility for the health insurance of the citizens. Compared to the previous lack of order in the system, the law has unequivocally defined the responsibility of the State in two main aspects: **A. Defining the rights of the insured; B. Ensuring the resources necessary to exercise such rights.**

This was both a regulatory and legal regulation of areas that were previously subject mainly to the discretion of the health funds, who received their income in accordance with the income of their clients and/or from government subsidies in case of deficits. The law established the responsibility of State for provision of medical insurance to all citizens, and thus nationalized the funding of the system. The law states as following:

1. Every citizen is obliged to be a member in one of the health funds - meaning, nationalization of insurance and expansion of coverage to about 5% more of the population, mostly in Orthodox and Arab sectors, who were not covered before.
2. The health funds will be financed by a dedicated health tax paid by citizens to the National Insurance Institute, in addition to government funding, intended to close the gap between revenue from the health tax and the estimated cost of the health services basket, as required by law. Thus, as stated, the payment was nationalized and became a designated government tax.
3. The health funds shall provide a standard health services basket, that may be updated from time to time with the consent of the Minister of Health and Minister of Finance, while the Ministry of Finance allocates the resources necessary to add items to the basket - this means that responsibility of the State is limited and depends on the resources available to the field of healthcare in the government budget.
4. Health funds are paid per capita, based on the number of members in the fund weighted with age - i.e., disconnection of the fund's income from the level of income of its members and its linkage to the index of the expected demand of the fund members for medical services.

This move was intended, and resulted in the funds having an economic incentive to attract more members, and including population groups that were previously less attractive: Elderly, citizens of periphery, Arabs.

By law, the health funds were allowed, subject to approval by the Minister of Health, to offer their members supplementary insurance to cover services not included in the standard basket. It should be noted that supplementary

insurance is already included in the original law (see below the discussion on trends in health care system financing).

3. Trends in the healthcare system before and after 1995

We will present below four parameters that reflect the complexity of the established healthcare system: **Funding; Ownership of health facilities; Freedom of choice; Regulation**.

A. Funding: Public and private

A1. Health system funding in macro

Before enactment of the National Health Insurance Law, two major components in the funding of the healthcare system were public: Direct participation of the government and the corresponding health tax. Although many considered the membership fee to the health funds as public financing (flat tax), payments were in fact private, since they were paid voluntarily from the member's pocket. As shown in **Table 1**, in 1990, five years before the enactment of the National Health Insurance Law - private health expenditure reached approximately 47% under the new formula adopted by CBS, following the guidelines of the OECD from 2009.

Table 1:- Sources of financing of the national healthcare expenditure from 1990 (in percent) - selected years.

Year	Government	Dedicated taxes		Total public	Private		Donations from abroad
		Parallel tax	Health tax		Total	Households	
1990	20.5	26		46.5	46.9		6.6
1994	27.3	22.5		49.8			4.5
1995	24.1	21.5	21.3	66.9	30.3	26.5	2.6
1997	41.3	2.3	24	67.7	30.2	25.5	2.2
2000	36.8	0	25.4	62.2	35.5	29	2.2
2005	34.2	0	25.2	59.4	38.7	29.5	2
2010	33.5	0	26.6	60.1	38.2	27.5	1.7
Source: CBS, Statistical Abstract of Israel No. 39, year 2011 (with adjustments to recalculation of the OECD)							

As mentioned above, the flat tax or membership fee in health funds, were in fact private expenditure, since the membership was voluntary (although in practice over 90% of the Israel's citizens were members in one of the health funds), and indeed this is how the figure appears in the CBS publications.

Table 1 shows that since 1997 there has been a decline in the rate public sources from national health expenditure. However, these figures do not imply that the absolute government funding of the system has decreased. In practice, budgets have been added, for example, to update the health basket by about one and a half percent per year. In addition, public funding continues to cover more than 90% of the cost of the health basket under the law (Horev and Kedar, 2010). Moreover, public expenditure per capita in terms of 2005 prices, rose between 1995-2009 in 99 NIS (Gur Ofer, 2010). It should be noted that public expenditure in the health sector as a percent from GDP has decreased by the smallest rate relative to decrease in other civil areas (Ofer, 2010).

A2. Health funds financing

Before the enactment of the National Health Insurance Law, the financing of the health system reflected the lack of clarity in the roles of various sectors and common perceptions about them: Governmental, health funds and private sector. Clalit Health Services acted more "publicly" than Maccabi Healthcare Services, due to the ability of Maccabi to choose its members, who were often richer and healthier. In addition, the ability of members of Maccabi to choose a doctor was also a sign of its "private" nature. Indeed, the combination of the method for determining the membership fee, which was similar in all the funds, and the ability of citizens who were not bound by membership in Clalit Health Services to switch to another fund - reinforced this trend and was reflected in the income of funds and their expenditure patterns. Clalit and Leumit were "task oriented", paying little attention to economic stability, while Maccabi and Meuhedet acted as profit-oriented organizations and have accumulated significant assets (Gur Ofer, 2010). The relationship that existed between membership in a health fund and being in certain work organization or even working at a certain place (for example, Histadrut Workers' Society) compared to the "independence of Maccabi and Meuhedet, which existed before the Law, contributed to the perception that the former are more public.

Table 2 demonstrates that the membership taxes were regressive in all health funds; That is, as the member's income increased, he paid a lower percentage of his income as membership fee to the health fund. Members of the smaller health funds, Maccabi and Meuhedet ("independent" ones), had higher incomes than members of Clalit and Leumit, so that even though the tax rate was lower in Maccabi and Meuhedet, the revenues from membership fees were higher in these health funds. Compared to the regressiveness that existed before 1995, payments have become progressive following the enactment of the law.

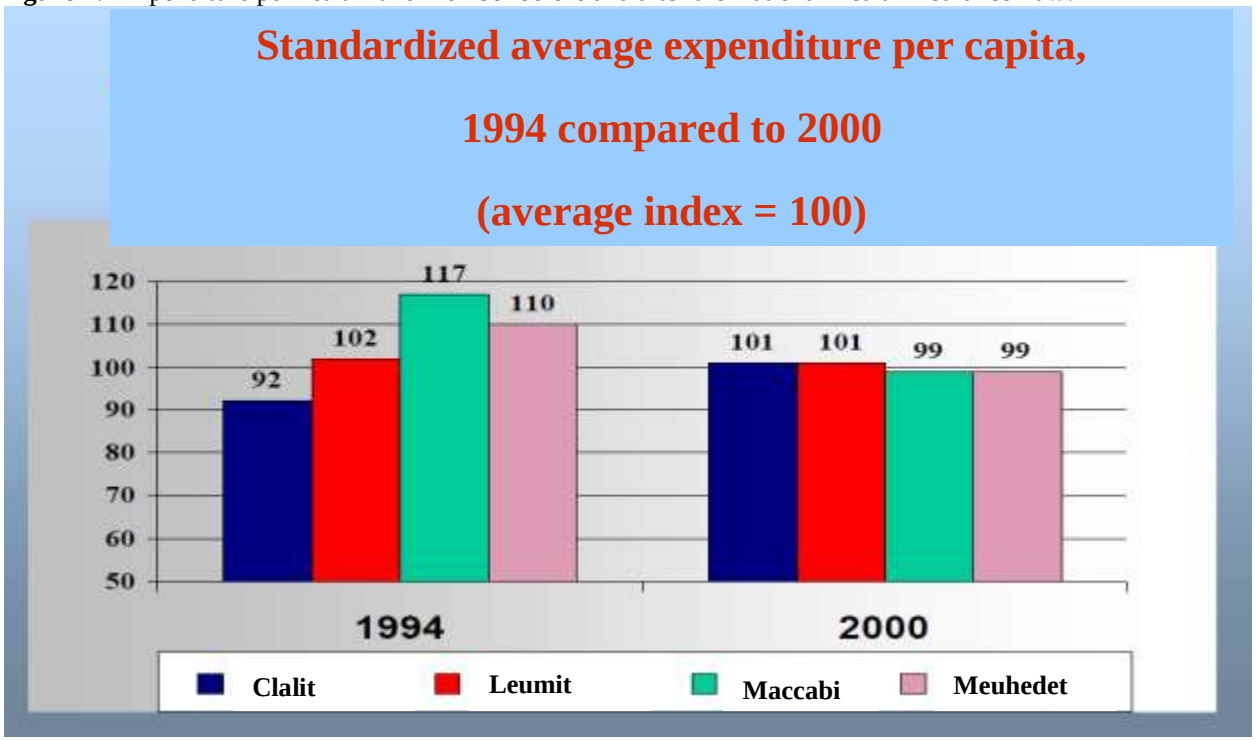
Table 2:- Comparison of health tax payments before and after the enactment of the National Health Insurance Law.

Gross salary (NIS)	Payment of membership taxes before the National Health Insurance Law (as percentage of salary)	Payment of health insurance feesafter the National Health Insurance Law (as percentage of salary)
2000	4.9	3.1
3000	5.0	3.7
4000	4.9	3.9
6000	4.6	4.2
8000	4.3	4.4
10000	3.8	4.4
12000	3.4	4.5
14000	3.0	4.5
16000	2.6	4.6

Source: Ben-Nun and Ofer, 2005

Figure 2 demonstrates that this was also reflected in the expenditure patterns: In independent funds the expenditure per capita was significantly higher than in Clalit and Leumit. Since the independent health funds had higher revenues as a result of higher income level of their members, and since their populations were younger and healthier, they had a reserve compared with the deficits in Clalit and Leumit. Indeed, disconnection of the link between the income of the health fund members and their revenues following the law corrected the situation.

Figure 2:- Expenditure per health fund member before and after the National Health Insurance Law.



Source: Ben-Nun and Ofer, 2005

A3. Private funding

Table 1 shows that while the proportion of private expenditure grew over the years (stabilization was seen in recent years), the portion of out-of-pocket household payments has increased less, while the missing part stems from the financing of expenses through private insurances (about 4%) and the supplementary insurances (about 6%). In other words, the share of expenditure on healthcare from total household expenses has increased, but there have been significant changes in the composition of expenses, as can be seen in **Table 3**.

Table 3:- The monthly expenditure of households on healthcare: 1992-2009.

	***1992**	**1999**	**2003**	**2007**	**2009**
% of expenditure on healthcare out of total household expenditure	**3.5%**	**4.1%**	**4.8%**	**5.3**	**5.1%**
Distribution of the expenditure					
Insurances (supplementary + private)	**5.2**	**16.6**	**19.5**	**25.5**	**29.5**
Dentistry	**43.3**	**33**	**31.2**	**28.3**	**25.5**
Medications	**16.8**	**24.9**	**19.4**	**19.4**	**18.6**
Other _____	**34.6**	**25.4**	**24**	**26.8**	**26.4**

*Excluding membership tax

The increase in household expenditure on healthcare (beyond health tax) consists primarily from participation fee for medications and supplementary insurance. (The question of how to define supplementary insurance is complex, and we will address it later.) Patients pay participation fees when utilizing the services, mainly for medicines and visits to specialists. This participation in payments is to a certain limit, and is transferred to hospitals rather than being retained by the service provider. The revenues of the health funds from this source have increased consistently, from about 5% of total income in 1995 to about 7% in 2009 (for services included in the healthcare basket), and vulnerable groups are refraining from using health services because of these payments (Horev and Kedar, 2010; Valdman Asherov, 2009). According to a survey conducted by Brookdale Institute, and perhaps following increased attempts of the health funds to ensure that patients understand that there is an upper limit to the payments - a decrease has been found in the percentage of those who report that health care payments are greatly burdensome (22% in 2007 compared to 27% in 2005), and increase in the percentage reporting that payments are not burdensome at all (30% in 2007 compared to 19% in 2005). This trend was also observed among vulnerable populations. However, still about a quarter of the chronically ill patients and about a quarter of low-income earners report that health care payments are greatly burdensome (Gross et al., 2007).

Table 3 demonstrates that the share of insurances in household expenses increased from 5.2 in 1992 to 29% in 2009. CBS data shows that 63% of insurance payments are to the health funds, and therefore these expenses cannot be attributed to supplementary insurances. In addition, while in 1995 only 35% of those aged 22+ had supplementary insurance, this percentage increased to 80% in recent years. The big breakthrough was made following the Arrangements Law regulations in 1998, which obligated health finds to allow complementary insurance for any person, and to collect insurance fees regardless of his medical condition. In other words, the increase in supplementary insurance, beyond public expenditure, reflected a desire among the public that could not be exercised until then.

Should the expansion of the coverage of population with supplementary insurance be seen as privatization? Opinions are divided among health system researchers. For example, Chernichovsky et al. wrote:"Private financing in Israel includes also supplementary insurances... which have a 'semi-public' character. Since the health fund must accept any candidate to supplementary insurance without qualification period, the premium is collective and services are provided for it. Nevertheless, supplementary insurance is considered in this discussion as private expenditure." (Chernichovsky, 2010)

In contrast, other researchers specifically highlight the public component of the supplementary insurance, as it is expressed in the following section which summarizes the positions of senior officials in the healthcare system:

"Interviewees agree that Additional Health Services [supplementary insurances], with their establishment, fulfilled a need and catered the interests of the public (the wish to get more than what the state gives), and the health funds (additional income), and the Ministry of Finance (reducing budgetary pressures). In other words, the findings revealed that out of Additional Health Services is the result of a need. It is important to note that all respondents had a positive attitude to the establishment of the Additional Health Services, and did not mentioned any negative aspects in it, besides private insurance company executives who stated that "Additional Health Services is one of the most unfair acts of the government towards its citizens, with laying the funding on their shoulders". This argument of the private sector is strange, since without Additional Health Services, even more from the budget for the health system was placed on the shoulders of the citizen who buys more expensive insurance, which is less equitable than Additional Health Services". (Schwartz-Ilan, 2011)

Another argument regarding the supplementary insurance relates to the impact on health price index. Private health services index rose beyond the general price index. As a result, there is a negative impact on efficiency and equality (Chernichovsky, 2010). An example for this is the phenomenon of specialists leaving the public system and preferring to work in private system, because of the higher wages and better conditions, which undermines the ability of the public system to provide the basic basket of services. Thus, in 2010, about 30% of the supplementary insurance expenses - about 900 million NIS - were allocated to finance private surgeries, according to the report (Barzilai, 2011).

It should be noted that in most regions of Israel supplementary insurance cannot be used to purchase services and choose the treating doctor. However, it is worth noting that, according to the Barzilai report, in 2010 the expenditure on choosing a surgeon among Maccabi members was in fact highest in the southern region. This is obviously related to the operation of Private Medical Services in government hospitals, and this issue will be discussed later.

As for supplementary insurance, lack of equality is expressed in the fact that despite an increase in its volume, about 1.5 million citizens do not have an insurance - in the bottom quintile, only about 62% hold supplementary insurance, compared with 84% in the top quintile (Gross, 2010). This fact indeed indicates inequality, but without the supplementary insurance only a smaller percentage of the population would be able to afford additional insurance in the private sector, which is expensive and less accessible in terms of underwriting. In our recommendations at the end of the chapter we will discuss the extension of supplementary insurance to those citizens who cannot afford it. It should also be noted that the percentage of holders of commercial private health insurance among the public has remained at a scope of 35% since 2003, while the percentage of supplementary insurance holders of the health funds has risen from 72% to 81%. This can be explained by the fact that the increase in supplementary insurance resulted in a slowdown and perhaps in halting of growth of the commercial private health insurance market (Brammli-Greenberg, 2011).

In conclusion, the existence of supplementary insurance is a move toward privatization of the health system, but at the same tame we have to remember the public characteristics of this insurance:

1. Due to the regulation after 1998, the supplementary insurance has the characteristics of social insurance: accessibility, equality and mutual help (Gross, 2010). Thus, for example, currently there is no difference between the percentage of healthy insured versus chronically ill, and even though the payment increases with age, there is an increase in the coverage of the elderly population in which the percentage of insured is similar to the general population (from the Barzilai report, 2011).
2. Supplementary insurance is provided by non-profit organizations (health funds)) and is supervised by the Ministry of Health, which confirming the contents and price, on contrary to private insurances which are supervised by the Ministry of Finance.
3. Supplementary insurance provides services that were not and are not currently in the basic basket (Ofer, 2010). Usually these are services which are not included in the standard services basket in accordance with decisions of the Committee regarding the update of services basket, when it is doubtful whether there is a need to include them as part of public financing. It is important to maintain equality when it comes to services in the basket, but it is unclear how much equality is necessary in services outside the basket, as long as the basic basket includes wide range of services and products (Ofer and Grau, 1997).
4. In order to avoid a situation in which the basic basket is funding the supplementary insurance, since 2002

supplementary programs are paying for use of the health funds facilities which are designated for provision of the standard basket.

However, one cannot ignore the consequences of the growth of population with supplementary insurance, and the feeling among the public that the government is not expanding enough the standard basket. According to the definition in the introductory chapter of this book, this is "privatization by omission".

A4. Donations

Donations, mainly to government and public hospitals, accounting for a relatively small part in the funding of the health care system. However, donations have a leverage effect on current expenses, when the operation of equipment purchased from donation moneys is funded by the current budget of the hospital. Table 1 demonstrates that in the nineties there was a decrease in the weight of donations in the total system funding, from 6.6% in 1990 to 2.2% in 1995, and since then the donations constitute about 2% of the system funding.

B. Facilities ownership - privatization of part of the hospitalization market

B1. General hospitals

Ownership of general hospitals is divided between the government, health funds, nonprofit organizations and the private sector (**Table 3**). Despite the private sector has been and remains small in terms of number of institutions and beds, its share in the national health expenditure was more pronounced. For example, in 2002 only 4% of general inpatient beds were in private hospitals, but they were responsible for 9% of the expenditure on general hospitals (Ben Nun et al., 2005). Perhaps this stems from the fact that private hospitals were dealing mainly with profitable surgeries and could set their own prices.

Table 4:- Ownership of general hospitals, 1988-2010.

Ownership	**No. of beds (in percent) 1988**	**No. of beds (in percent) 2010**
Government	46.5	46.6
Clalit Health Services	30.5	30.3
Public hospitals: Hadassah, Shaare Zedek and other non-profit organizations	20	19.6
Private	3.1	3.5

Source: Ben Nun, Berlowitz and Shani, 2005 - Source: Ministry of Health, inpatient institutions and day hospitalization units, 2010

Table 4 demonstrates that almost no changes occurred in the distribution of ownership of general hospitalization beds in the relevant period. However, according to **Table 5**, in the last decade there has been an increase in the role of the private sector in the field of general hospitalization. Despite the percentage of hospitalization days provided by the private sector has not increased, the number of hospital admissions, most of which are "scheduled", such as in Assuta hospital (mainly elective surgeries) has increased. Most of these surgeries are funded by supplementary insurance, which extends the accessibility of these services not only for the "rich", but also the middle class.

Table 5:- Hospitalization days of and bed occupancy at Assuta compared to government hospitals.

Years	**Hospital type**	**Admissions**	**Percentage of invited patients**	**Hospitalization days**	**Beds occupancy**
2002	Private: Assuta	27,318	72.3	39,078	91.7
	Government	92,895	18.4	486,608	98.5
2005	Private: Assuta	41,984	74	51,410	95.2
	Government	99,123	17	513,063	102.7
2008	Private: Assuta	42,640	74	51,880	95.8
	Government	101,391	17.4	535,244	102

Source: Ministry of Health, inpatient institutions and day hospitalization units, 2008

Contrary to the recommendations of the Commission of Inquiry, government hospitals did not become independent corporations, i.e., there is no movement on the scale towards privatization. The ambivalence of both the Ministry of Health and the Civil Service Commission, played a role in discontinuation of the incorporation process. Studies show that hospital managers and staff at various levels of the organizational structure, began to take strategic and competitive measures, including the development of new services, improving service quality and increasing market share in anticipation of the desired change (Chinitz and Rozen, 1993; Feder Bubis, 2006).

B2. Ownership of other hospitals

As shown in **Table 6**, private beds in areas such as psychiatry and long-term care before 1995 had a much larger share in ownership of hospitals than in the field of general hospitalization. In recent years, most mental health hospitalization beds have disappeared, with some of the private institutions disappearing almost completely. At that time, the share of the private sector in institutions for prolonged hospitalization has increased. We will not discuss this in this chapter, but it should be noted that although the funding of these services comes mainly from the state budget, compared to the field of general hospitalization, more service providers and facilities are held by the private sector. This indicates a policy of purchasing services in this area by the government, instead of expanding government facilities.

Table 6:- Private beds in the field of mental health and long-term care as a percentage of the total number of beds in Israel.

	1988	2010
Private mental health beds	2,419 (about 40%)	(6.6%) 227
Private long-term care beds	3,800 (about 36%)	(59%) 13975

Source: Ben Nun, Berlowitz and Shani, 2005, Source: Ministry of Health, inpatient institutions and day hospitalization units, 2010

B3. Community clinics and doctors

Most of the community clinics were before 1995 and have since remained under the ownership of the health funds. A smaller percentage of the clinics was owned by independent doctors who worked for the health funds. The pattern of the independent doctor was more common in the independent health funds, which contributed to their perception as private organizations compared to Clalit and Meuhedet health funds.

C. Freedom of choice: Insured compared to the health funds

C1. Choosing the health fund

Before 1995, the option to choose a health fund was limited due to the connection between being a client of Clalit Health Services and a member of the Histadrut, as well as the freedom of the independent health funds to choose their members.

The National Health Insurance Law imposed on the state the duty to ensure that every citizen is insured in one of the funds, and at the same time granted freedom of choice to switch between the health funds. In the years 1995-1998, about 3.5% of the insured changed their fund every year, but since then only about one percent of the insured change their health fund every year. However, there is definitely a competition in the behavior of funds and they release advertising campaigns during the registrations period.

C2. Doctor's choice

Before 1995, in Clalit and Leumit, doctors in the community worked under the regional clinic system, and the citizen belonged to a clinic in his area of residence. Within the clinic the citizen could choose his primary care physician. The doctors served as "gatekeepers". The patient was not able to go directly to a specialist doctor or hospital, and he needed a referral from the primary care physician. Maccabi and Meuhedet worked according to "independent doctor" method, which allowed the insured to choose his doctor. In the independent funds, it was also possible to go directly to a specialist doctor and also to outpatient clinics in the hospitals. These features gave the independent funds a more "private" character compared to Clalit and Leumit.

Since 1995, the freedom to choose the therapist within the health fund has been limited to the choice of service providers who have a contract with the health fund. In doing so, the law increased patients' freedom of choice compared to the situation before the enactment, according to which in some funds the patients had to go to the regional clinic.

C3. Choosing the hospital and the attending physician

Prior to 1995, referrals to general hospitals in Israel were mostly done on the basis of regional plans agreed between Clalit Health Services and the Ministry of Health. In Jerusalem, patients had the freedom to choose between the hospitals in the city, except for urgent admissions to hospitals as part of shifts.

The issue of freedom of choice was very prominent in the choice of the attending physician. In the hospitals in Jerusalem, the Private Medical Service was established, which regulated the selection of the doctor through the Private Medical Service office in the hospital, subject to certain restrictions, including the expectation that the selection of the doctor would not result in a promotion in the queue, especially for elective surgeries. Outside Jerusalem, illegal phenomenon known as "black medicine" developed, in which patients paid directly to doctors in order to choose their doctor and receive faster and more personal treatment. It should be noted that in contrast to "black medicine" the Private Medical Service, perhaps due to being regulated, was perceived as a legal private medicine. The desire to choose one's doctor and expedite treatment has contributed to the development of private hospitals such as Assuta Medical Center in Herzliya, where payments were not considered illegal. This development emphasized and even exacerbated the central problem of doctors' work in both sectors - governmental and private. This also raised the question as to the possibility of subsidizing the private sector from public budgets. It should be noted that some of the revenues of private hospitals came from the purchase of services by the health funds.

In recent years, on the other hand, the health funds have increased the number of patients referred to hospitals in accordance with work agreements signed with these hospitals. The only data on this subject, from 1996, indicated that about 30% of patients chose the hospital, and it is possible that the activity of the health funds in referring people to selected hospitalsclashed with habits and expectations for more freedom of choice (Chinitz et al., 1996). From interviews with officials in the health system we find that the health funds surrender in many cases to the pressure of patients who do not want to comply with referrals given by the fund. However, not all patients are equally insistent, and therefore the referrals of the fund have significant weight in the decision in the location where the patient will receive medical care (Feder Bubis and Chinitz, 2010).

Outside Jerusalem, the situation in the hospitals involved a "unique" combination of government ownership and private funding. Government hospitals have created a new pattern of Private Medical Services in Jerusalem by setting up research funds. Instead of paying for being treated by the doctor of their choice, patients were asked to donate to the hospital's research fund. These funds were used to reward the staff outside normal working hours. This area of activity is a privatization within government institutions. The staff may receive more private funding than it would have received if the hospitals had become public corporations. In 2004, the Attorney General of Israel ruled that the management of research funds was contrary to the Budget Foundations Law, the State Property Law and the principle of equality (Rubinstein, 2002), and revoked the arrangement of choosing a doctor within research funds. However, the funds continue to exist and it is unclear whether the choice of doctors was completely discontinued.

The question of running Private Medical Service in government hospitals does not fall off the agenda of the healthcare system. On the one hand, this satisfies patients who want to choose the service provider and puts additional resources into the public system. On the other hand, Private Medical Service the moral risk and threatens equality. It should be noted that in his opinion, Attorney General Rubinstein presented a possible regulation of the Private Medical Service in government hospitals in accordance with the law and the conclusions of the Netanyahu Commission.

Parallel to these processes, Assuta private hospital, most of whose shares are held by the Maccabi health fund, has greatly expanded its activities in recent years. Government hospitals claim that doctors abandon the public system in favor of Assuta, and patients with infections are not accepted in this hospital and referred to public hospitals.

D. Regulation: From the "weak" office to increase of regulation

Before 1995, the Ministry of Health was a regulatory body responsible for the health system in the areas of licensing, monitoring system performance, budget control and financial regulation. However, in key areas of the Ministry of Health was very dependent on the Ministry of Finance. For example, in the area of salary which constitutes about 70% of the expenses of the health care system, the Ministry of Finance had a major role. Most doctors working in hospitals and the community received wages predetermined by negotiations between those offices and the Israel Medical Association (IMA). In addition, the Ministry of Health, in coordination with the IMA

and its professional councils, established the regulation in hospitals. The Ministry of Health, in coordination with the Ministry of Finance, have determined the maximum tariffs for services in government hospitals.

This regulatory structure which should have been reflected in the design, evaluation and enforcement, is characterized by centralization and micro-management that prevent institutions in the field from managing their operations given local circumstances. In addition, the double function of the Ministry of Health - both regulator and major provider of health services (mainly through hospitals), increases the concern of conflicts of interest. Moreover, the Ministry of Health, in coordination with the Israel Medical Association (partially through the Scientific Council), has control over the licensing of personnel in the healthcare system.

Despite the utilization of the above regulatory tools, the Ministry of Health is considered by many to be a weak ministry in the regulatory aspect. This is due to the inability of the Ministry of Health to control the development and expansion of Clalit Health Services, and to the fact that as the owner of the medical services, especially in the field of general hospitalization, the ministry is in a state ofconflict of interest and has difficulty planning for the long term and overseeing medical services in Israel. Although no research has been done to verify these claims, key figures, such as the ministry's CEOs throughout its existence, have argued that when the Ministry of Health seeks to advance a particular issue involving the allocation of resources - positions or budget - it must convince the Ministry of Finance, and does not always succeed in it. The Ministry of Finance also has a centralized monopoly on negotiations with trade unions on the subject of salaries in the health system.

There are historical reasons why the Ministry of Health did not play a more significant regulatory role in the health system in Israel. First, it is not easy to set criteria, take measurements and impose sanctions in the field of medicine (Chinitz 2005, 2007; Chinitz and Israeli, 2011). Sanctions were taken mainly for mistakes, negligence and exceptional medical incidents, but not when deficits were formed and rarely when expensive equipment was purchased without a permit. The blurring of boundaries between the sectors - governmental, public and private - has contributed to the ambiguity regarding the role of the Ministry of Health as a regulator. In addition, the unclear approach to accountability encouraged an ambiguous approach to regulation. From time to time, the deficits of the health fund and the hospitals grew, and the government would inject funds, initiate recovery programs, and back again.

In contrast, the private sector argues that the Ministry of Health was much more rigid as a regulator towards them. It is possible that a sharper separation between the public and the private - as opposed to the blurring of boundaries between the government and the public system (government hospitals, health funds, public hospitals like Hadassah) - was at the root of this feeling. (Chinitz and Israeli, 2011)

State of regulation after 1995

1. **Pricing and wage agreements** - as was the case in the era before the National Health Insurance Law. The Ministry of Health sets the tariffs for the services provided by the public hospitals. The salary of the manpower in the system is determined on the basis of negotiations and decisions of trade unions. The standard is determined by the Ministry of Health in coordination with the Israel Medical Association and its committees.
2. **Licensing of professional personnel and medical facilities** - opening new wards and services and purchasing expensive equipment by hospitals, remained subject to prior approval by the Ministry of Health.
3. **The basket of services** - National Health Insurance Law includes a detailed list of services included in the basket. The process of updating the basket is managed by the Ministry of Health, and the Ministry of Finance allocates a sum for this purpose each year. Supplementary insurance can cover only services that are not included in the basket and options such as selecting the doctor and treatments abroad. In 2007, there was a heated public debate about the inclusion of "life-saving" drugs in supplementary insurance. As a result, these items were removed from the supplementary insurance and considerable sums were allocated to expand the basket in each of the years - 2009, 2010 and 2011. It can be said that the items in the basket of services and its updated are an exceptional example of regulation in the field of health and public policy in general. The process - which includes a professional committee convened to update the basket, which is subject to budgetary limitations set by the Ministry of Finance - is unique on a world-scale scope and features, and has impressive responsibility in the Israeli public administration landscape. Unsurprisingly, the process is also criticized for the "scientific" basis of decision-making, the influence of stakeholders such as pharmaceutical companies and the degree of transparency of discussions. However, this is an overt process of rationing of the health services, for which the political echelon - including the Minister of Health, the Minister of Finance, and sometimes even the Prime Minister - cannot evade from responsibility. The process has

contributed to changes in public preferences for allocation of resources to health services, where the relative rankingof treatment that improve exceeds the ranking of life-saving treatments, or rather, life-extending treatments in non-curable conditions. It also seems that the public believes the decision-making process to be legitimate (Chinitz, Maslin, Grau, 2009).

4. **Quality Control** - the Ministry of Health activates processes of monitoring quality of care both in hospitals and in community. These activities are based on the participation of the audited bodies. Not all necessary information is always accessible and not all findings, especially quality assessments in specific institutions - are widely published. Brookdale Institute measures the satisfaction of the public with the services of the health funds and publishes the findings. The Ministry of Health and the hospitals conduct satisfaction surveys that are not published openly to the public, which could allow a comparison between the service providers (Gross et al., 2007; Linder Gantz, 2012). These days, the National Institute for Health Policy Research publishes comparative information on the performance of health funds (Dan Even, 2012).

4. The degree of privatization in the health system

Some argue that the health care system in Israel is undergoing a privatization process that leads to negative results, especially due to inequality in the system. However, a closer look on key parameters and their place in the scale between a free market and government control, reveals a more complex picture. While some indices point to an increase in private funding, other indices indicate some increase in public funding. Although the hospitals have not undergone a process of incorporation, we are witnessing a more local initiative and autonomous management of hospitals, and their engagements with various funding bodies, mainly with the health funds. The freedom to choose the health fund increased, while the freedom of choice of the service provider undergoes mixed processes. The regulation of the rights of the insured and the basket of services is most strict, but access to information on the patterns of exercising the rights and utilization of the services is lacking, and the information is a private asset of the health funds. Therefore, control of quality of care is based on the voluntary cooperation of health funds and hospitals. Inequality in the health system and in the health status of citizens exists within the public system, but without a direct connection to the privatization process. This means that even if there was no increase in private funding or the number of private service providers in the system, we were still witnessing significant gaps. It is also not clear, since there are still no studies on whether private activity in the system, such as the Private Medical Service, in Jerusalem, causes private funding to subsidize the public system, or, alternatively, the public to subsidize the private system.

Table 7:- Movements on the scale of privatization-nationalization of health system.

Component	Move towards nationalization	Move towards privatization
A. Funding		
Absolute public funding per capita	(increase compared to 1995, decrease compared to 1998)	
Relative public funding per capita ratios		+
Health tax	+	
Private insurance		+ Growth in this market has slowed down greatly
		Perhaps because of the growth of the supplementary insurance of the health funds
Supplementary insurance	+ - Insurances are subject to more regulation; - Expanding accessibility to more groups; - Coverage only for items that are not in the public basket	+ 20% of the population does not have Supplementary insurance
"Out-of-pocket" expense for citizens		+ Especially for items that were not included in the past in the

		public basket
B. Ownership and provision of services in the field of general hospitalization		+
C. Freedom of choice		+
D. Regulation	+	

If privatization is defined as "moving the boundary" between the public sector and the private sector (so that the latter increases at the expense of the former), not all of the parameters presented in Table 7 above have undergone a process of privatization.

1. On the one hand, total public funding for the health system has not decreased in absolute terms, it has steadily increased. On the other hand, funding has not increased at the rate of population growth.
2. Ownership of the services has generally remained public/governmental, but the movement is in the direction of privatization.
3. Freedom of choice and competition have at the same time moved towards the market and towards a stricter restriction by the regulator, but the direction is privatization because more citizens choose the service provider, among other things, by utilizing the supplementary insurance.
4. The regulation of the state mechanisms in the field of healthcare has strengthened, and it balances the competitive incentives mentioned above, which were introduced into the system with the enactment of the National Health Insurance Law.

In addition, and as noted above, areas such fields as long-term care insurance were not included in the basket of services, but this failure should not be attributed to privatization. Things that have always been private in the system, like long-term care and dentistry, have remained private (except for the reform that began in June 2010 and covers certain treatments for children aged 0-8), and constitute the biggest share of the private expenditure on health, apart from the supplementary insurance which mixes privatization with public contents. In many areas, such as setting tariffs and salary levels, standardizing medical institutions and licensing health professions, the system remains centralized and governed by the Ministry of Health. However, there is an increasing freedom in establishing agreements between hospitals and health funds, and in using research funds to add manpower and increase wages.

5. Implications and recommendations for public policy

The privatization process requires to be addressed in a comprehensive policy that will once again clarify the state's responsibility in the field of healthcare, which has become vague in light of the original intentions of the National Health Insurance Law of 1994. For example, former Knesset member, Haim Oron, one of the leaders of the legislation in the field, has told at the annual conference of the National Institute for Health Policy Research (Tel Aviv, 14 March 2012):

"I am not going against supplementary insurance, but when we enacted the National Health Insurance Law, we tried, among other things, to build a 'Chinese wall' between what would be public within the law, and what would be private. Supplementary insurance blurs the line between the public and the private, since it also operates in the public part, when used to fund things that are in the basic basket, even though the law prohibits it from doing so. It also leads to the 'burnout' of the public basket, because instead of the public's money flowing into the basic basket, it flows to the supplementary insurance.

As for the high level of private funding in the health system, it should be emphasized that if we include the areas of nursing, mental health and dental care in the health basket - we would probably be a lot more similar to European countries in the percentage of private funding of national expenditure on healthcare. In my opinion, the problem is that no clear health policy has been established since the enactment of the law. A policy needs to be established that will decide on several issues:

1. The salary that a doctor in the public sector will receive, and in return he must not work in the private sector.
2. Inclusion of nursing care, mental and dental health into the health basket.
3. Raising the health tax in order to cover these items, and at the same time explain to the public that in return they will receive more and pay less. Among other things, in this case the public coverage can be provided at a lower cost and price, because everyone is at "risk pool".

Further to this, we believe that healthcare policy should not be based on the assumption that the emphasis should be on reversing the privatization trend, but to focus on the necessary changes. The same applies to the opposite position that calls to privatize the health system, for example, by establishing a fifth, private and commercial health fund (and even more than one). This proposal is repeatedly raised by the Ministry of Finance under the Arrangements Law (and so far has not received support) following a misconception that a private body will increase competition in the health system.

Instead of focusing too much on the issue of privatization, we should strengthen the positive achievements of the system and develop a process of effective policy learning. It is appropriate to begin by shifting the emphasis from therapeutic medicine to preventive medicine, promotion of public health and closing gaps between groups and areas in the health system. Developments described in this chapter, regardless of the distinction between public and private, indicate that the stage was set for this change. We believe that policymakers and the general public, are ready to deal with the need to develop the health system and close the gaps within it. The Ministry of Health, in contrast to its image as a weak body, has the necessary tools to move in a new direction. This will require an additional budget for the health system, but not further structural reform.

During the doctors' strike (2011), claims were made that the public health system was collapsing and there was a danger that it would begin to resemble the American health system. These claims do not reflect the reality in the State of Israel. For example, in the United States 15% of the population has no health insurance at all, while in Israel there is coverage for 100% of the population.[3] In the United States about 85% of citizens are insured in the private sector, while in Israel only 35% have private insurance, and supplementary insurance is highly regulated by the government.

Although the number of hospital beds per capita in Israel is low compared to other countries, and the government has a plan to increase it, the pressure on hospitalization can be reduced by strengthening community medicine and preventive medicine, for example, in the field of vaccination. A shortage of doctors is expected, but further to the addition of positions, the use of existing resources and the division of roles between the various professions must be examined, and the role of nurses in the management of care must be strengthened.

According to a number of key indicators, the health care system in Israel functions relatively efficiently in terms of ensuring access to a wide basket of services, and its cost is in line with the OECD average, with reasonable results and relatively high levels of satisfaction (Ben Nun and Kedar, 2007). In addition, the system has made important steps towards “accountability”. A prominent example of this is the functioning of committee that updates the basket of health services, which discusses issues that are charged in terms of values and politics, even though its work requires certain improvements. It is precisely in this difficult area that the system has succeeded in creating a decision-making process that is apparently perceived as legitimate by the public. Therefore, it is advisable to take additional change measures so that the progress will be gradual and controlled.

Recommendations and Conclusion:-

In the view of the authors, and in light of the above analysis, the following are a number of desirable moves for the further development of the healthcare system:

1. Strengthening the public discourse on issues such as inequality in health, by presenting up-to-date data and reviewing attitudes and views among the public. We can rely on the discussions of the committee for updating the basket of services, and to examine public opinion regarding the transfer of resources from therapeutic medicine to preventive medicine, health promotion and closing healthcare gaps in the population. A process of public opinion polls on health issues, as well as feedback based on findings for decision makers and the public, should be established in order to create an ongoing dialogue on these ethical issues. Public positions should not be seen as the determining factor in the decision-making process, but as an input to professional discussions and a source of support and improvement of the system's governance.

2. A large portion of private health care expenditure is devoted to long-term care services. Long-term care insurance is an important component of the supplementary insurances of the health funds. Similarly to Germany (where there

[3] 4 The comparison to the United States is presented here because of the widespread claim that the situation in the Israeli health care system is close to that of the United States. The comparison to the OECD requires a more in-depth analysis, partly because in Europe nursing care is complex, and dental care and mental health are a significant part of the public health basket.

is a similar structure of health funds operating under government regulation), we should include the long-term care insurance in the standard basket of services under the responsibility of the health funds. This will involve an increase in the health tax rate by about 1.5%, which will allow coverage for the entire population. In the current situation, the same amount is spent on long-term care insurance premiums that cover only part of the population. This recommendation has already been given by several policy researchers (Taub Center 1999; Kay 1998; Beit Or 2010), and has also been proposed by past and present health ministers.

3. The government should consider subsidizing the joining of vulnerable populations to supplementary insurance, similar to what is done in France. This option was raised by the health funds in a discussion on "life-saving" medications, and won public support (Chinitz, Meislin, Grau, 2009). Tax may be considered on the premiums paid for supplementary insurance as a source of funding for this move. Alternatively, we can consider raising the health tax by a percentage or slightly more to extend the basic basket for everyone. The Israeli public prefers to expand supplementary insurance over raising the health tax (Chinitz, 2010), perhaps out of will to retain a degree of freedom of choice in defining the health services basket.

4. Cancellation of paid participation when consuming health services or returning it to the previous level (4%) before enactment of the National Health Insurance Law. In the professional literature. the assumption is that participation prevents vulnerable populations from consuming essential medical services. A system of exemptions from payment for vulnerable groups also involves administrative expenses. Income of the funds from participation fee for medicines and services included in the standard basket amount to about 8% of their income. These amounts will have to be supplemented by an additional contribution from the state budget to cover the cost of the basket of services or an increase in the health tax rate.

5. The Private Medical Service arrangement used in Jerusalem should be extended to all public hospitals in Israel, subject to a regulation which rises, inter alia, from the opinion of the Attorney General, so that it will ensure, among other things, that the revenues cover the hospitals' expenses for its operation, beyond the wages of providers of the Private Medical Service. This will prevent doctors from leaving to the private sector and introduce additional budgets into the public system. "This is an example of a step of privatization within the public sector and under its effective supervision, which will harness the privatization outside the public sector" (Gur Ofer, 2010). Although it can be expected that as the funding of the Private Medical Service comes from supplementary insurance, the premiums may increase, in such a case the government will have to decide whether to fund the selection of a doctor and shorten appointments from public budgets; and/or provide the option to choose the caregiver by raising the premiums of the supplementary insurance (meaning, leaving the decision to the public of the supplementary insurance purchasers); or, alternatively, to raise the health tax; or find other sources of funding from the state budget. We recommend starting the process on the basis of supplementary insurance, as it is a channel for examining the willingness of the public to pay for freedom of choice and shorter wait. The government must provide information to the public, such as the study by Rosen, Ofer and Greenstein (2006), on the advantages and disadvantages of the Private Medical Service in terms of the quality of care. The process must be done, inter alia, with proper supervision and control, as detailed in the Amorai report (Ministry of Health, 2003).

However, we should not focus on Private Medical Service as a key solution to the problem of insufficiency of public hospital system. Introduction of the Private Medical Service, if such a decision is made, should be made only after thorough improvement of the status of public hospitals (for example: decision regarding the incorporation of hospitals), and the establishment of an appropriate regulatory system.

6. Government hospitals should be turned into public corporations, or at least withdrawn from the direct management of the Ministry of Health. This move will leave hospitals in the public sector, but will allow them more managerial flexibility, including the possibility for hospital managers to grant differential reward to employees and doctors. For example, to increase the salaries of doctors who agree to work exclusively in the public hospital. Such flexibility under effective supervision, will increase efficiency and improve the quality of service without compromising equality. This will also strengthen the public sector and prevent migration to the private sector (Ofer, 2010). The proposed actions may rely on stricter regulation of health corporations operating near government hospitals.

7. Providing information to the public on the considerations that one should make when choosing a hospital and on the pros and cons of the engagement agreements between the funds and the hospitals. The benefits of choosing a

hospital or physician within the hospital by the citizen do not necessarily yield better health outcomes. The Ministry of Health should publish which hospitals are participating in programs for improvement of quality of care and increasing safety.

8. The Ministry of Health should strengthen the monitoring of the safety and quality of care in hospitals. Such monitoring programs are already being carried out in collaboration of the Ministry of Health, hospitals and research teams from the Ministry of Health, academic institutions and research institutes. The Ministry of Health should check and publish data on the functioning of hospitals. The criticism of the Ministry of Health, which performs two functions at once, argues that the fulfillment of its monitoring functions depends on the hospitals' incorporation. In our opinion, the Ministry of Health is already collecting data on the hospitalization processes and organizational behavior of the hospitals, and therefore it can serve as a regulator even before its separation from its hospitals, and before the implementation of the incorporation.

In conclusion, the health care system in Israel is not perfect, but its main problems do not necessarily stem from the privatization processes. There is little logic in the changes proposed each year under the Arrangements Act designed to move the border in the direction of privatization, such as: payment of a percentage of the health tax directly to the funds; establishment of a fifth private health fund; establishment of private hospitals as part of government tenders; other measures based on the assumption that privatization will improve the functioning of the health system.

The health care system is one of the most successful social systems in the State of Israel. Therefore, the recommendations for its improvement should be based on an informed review of the lessons - positive and negative - that were learned from the system's progress over the past decade, in order to prepare for the next stage of health policy planning. This stage will involve a shift from focusing on medical care to focusing on preventive care, health promotion and closing health gaps in the population.

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