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Regulating Life and Death: The Case of Israel's "Health Basket" Committee

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I. REGULATING MEDICAL CARE – AN INTRODUCTION

There was a time, not so long ago, when government provided few services (if any) to the general public. The private-public distinction meant significant autonomy and self-reliance in the private domain, as the state showed little interest in providing the public services such as education or medical treatment. As the famous historian A.J.P. Taylor stated: "Until August 1914 a sensible, law-abiding Englishman could pass through life and hardly notice the existence of the state, beyond the post office and the policeman."[1] This was probably somewhat of an exaggeration, as by 1914 there were already abundant signs of the profound change in the concept of government that would mark the

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Editor's Note: Several of the following sources could only be obtained in Hebrew. The author is a native Hebrew speaker who is also fluent in English. The author certifies that all translations of these sources into English are his own and accurate. In addition, Yariv Brauner, Associate Professor of Law at the Levin College of Law, University of Florida; LL.B., Hebrew University; LL.M., New York University School of Law; J.S.D., New York University School of Law, has translated and verified most of these sources. Professor Brauner is also a native Hebrew speaker who is fluent in English. The editors also wish to express their gratitude to Professor Brauner for his excellent services.

1. ALAN JOHN PERCIVAL TAYLOR, ENGLISH HISTORY 1914-1915, at 1 (Sir George Clark ed., Oxford Univ. Press 1965).

twentieth century. "The state schoolteacher, the national insurance officer, the labour exchange, the sanitary and factory inspectors, with their necessary companion the tax collector, were among the outward and visible signs of this change."[2]

Historically, medicine, like legal services, was privately funded and provided. Few could afford to call on a physician, and those who could were not perceived as *hiring* the good doctor's services; instead, the payment would probably be by way of an *honorarium*, not a fee, salary, or insurance premium.[3] Nineteenth century English doctors recognized that they were not able to charge the majority of the population for medical services and the poor "obtained their medical treatment from collective forms of medical assistance."[4] These circumstances have changed significantly since the nineteenth century.

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2. WILLIAM WADE & CHRISTOPHER FORSYTH, ADMINISTRATIVE LAW 3 (9th ed. Oxford Univ. Press 2004).

3. *See* ALBERT R. JONSEN, A SHORT HISTORY OF MEDICAL ETHICS 44 (Oxford Univ. Press 2000). "For centuries, medical fees had been viewed within the ancient Roman tradition of *honoraria*: those engaged in the learned professions . . . were paid with a gift . . . During the Renaissance . . . [p]hyician writers begin to think of their [payment for compensation] as *salarium* rather than *honorarium* . . ." Well into twentieth century England, the ratio of medical doctors to other people was far below current levels: in 1851, the population-per-doctor ratio was 1 in 1,028. It declined to 1 in 1,396 in 1861; 1 in 1,552 in 1871; and 1 in 1,723 in 1881. It improved to 1 in 1,527 in 1891; 1 in 1439 in 1901; and 1 in 1,539 in 1911 (with 23,469 doctors treating a population of 36,136,000). ANNE DIGBY, MAKING A MEDICAL LIVING, DOCTORS AND PATIENTS IN THE ENGLISH MARKET FOR MEDICINE, 1720-1911 tab. 1.1, at 15 (Peter Laslett, Roger Schofield, E. A. Wrigley & Daniel Scott Smith, eds., Cambridge Univ. Press 1994). The doctors per thousand ratio has been rising steadily in the United Kingdom, however. In 1993, it was 2.3 doctors per 1000 population (or 1 in 435), but was still well below the OECD's average of 2.9. This may lead one to wonder whether more physicians necessarily mean better medicine. Karen Bloor, Vivien Hendry & Alan Maynard, *Do We Need More Doctors?*, 99 J. ROYAL SOC. MED. 281, 281 (2006), *available at* http://www.rsm.ac.uk/ media/ downloads/ j06-06moredrs.pdf. *See generally* STEVEN SIMOENS & JEREMY HURST, ORG. FOR ECON. CO-OPERATION AND DEV., THE SUPPLY OF PHYSICIAN SERVICES IN OECD COUNTRIES (2006), *available at* http://www.oecd.org/ dataoecd/ 27/ 22/ 35987490.pdf (providing data and analysis of the populations of most European countries and the amount of doctors in those countries).

4. Specifically via "poor law, voluntary hospitals or private 'clubs'—as well as from large numbers of alternative practitioners who offered medical care at a cheaper rate." DIGBY, *supra* note 3, at 19.

Today, medical services have become widely available in most Western nations.[5] This occurrence was the result of the decisions of various governments to provide or oversee the provision of medical services or, with some public encouragement, make the services part of employment benefits.[6] And so, the provision of medical care has crossed the divide from being essentially a private matter to a public one.

Most countries gradually came to the conclusion that they bear some responsibility towards the well-being of their citizenry, or at least have a compelling interest in making sure that needy citizens receive medical care.[7] One could link this to a broader picture and note that during the twentieth century the modern administrative state took shape "reflecting the feeling that it was the duty of the government to provide remedies for social and economic evils of many kinds."[8]

This is very loose phraseology, used intentionally, for it is well beyond the scope of this paper to describe the extent, logic, and ideology of the welfare state, its treatment in democratic theory or even in the history of the various nations that have shown an active interest in the health of its citizens.[9] In sum, most modern nations have

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5. This generally admirable achievement has had some detrimental effects as the medicine, much like the law, has gradually shifted from a profession into a business. *See* TAMAR FRANKEL, TRUST AND HONESTY, AMERICA'S BUSINESS CULTURE AT A CROSSROAD 136-151 (Oxford Univ. Press 2006). *See also* M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace,* 55 STAN. L. REV. 919 (2002) (elaborating on these detrimental effects).

6. Historically, it was German Chancellor Bismark who "embraced a compulsory health care system financed by employee and employer contributions, in which the wealthy contributed more than the poor." SUE A. BLEVINS, MEDICARE'S MIDLIFE CRISIS 25 (Cato Inst., 2001). *See also* National Center for Policy Analysis, *Health Issues – Is Employer Health Insurance Really Cheaper?*, http://www.ncpa.org/ ba/ ba344/ ba344.html (last visited Nov. 15 2006) ("Employment-based health insurance covered 155 million Americans in 1998, compared to only 15.5 million who purchase their own policies. People receiving employer-based health insurance receive an enormous tax benefit, worth about $141 billion in 2000 . . . or 40 percent of the cost of coverage.").

7. *See generally* Elizabeth Docteur & Howard Oxley, *Health-Care Systems: Lessons from the Reform Experience*, http://www.oecd.org/ dataoecd/ 5/ 53/ 22364122.pdf (discussing reform measures taken by various nations of the world to help the poor and disparate in the past several decades).

8. WADE & FORSYTH, *supra* note 2, at 3.

9. Wade and Forsyth stress that the expansion of voting rights allowed the public to amass the political power necessary to form the national healthcare service. *Id. See generally* PERSPECTIVES ON HEALTH AND HUMAN RIGHTS (Sofia

concluded that the state must take part in *providing*, *financing*, and *overseeing* the provision of medical care.[10]

In legal terms, the questions (but not the answers) are relatively straightforward: Is there a *legal right* to receive medical care? How is such a right legally secured? What is the extent of such a right? Who are its beneficiaries? What level of treatment and funding is granted to them? The first two questions raise highly controversial matters of principle. In the context of the "rights talk,"[11] there is significant resistance to a recognition of social rights such as the right to medical care, thus granting these rights the same constitutional protections that have long been accorded more "conventional" rights and freedoms.[12]

In several nations, the healthcare policy and practice is normally established by statutes, regulations, and, where applicable, through precedents put forth in case law.[13] Arguably, these methods are less stable than a constitutional provision for the long-term continuity of healthcare services. In essence, setting policy legislatively, judicially, or through regulatory measures turns healthcare funding into welfare payments: a type of discretionary spending the government makes out of its kindness.[14] In hard budgetary times such funding may evaporate when it is most sorely needed.[15]

Gruskin, Michael A. Grodin, George J. Annas & Stephen P. Marks eds., Routledge, Taylor & Francis Group 2005) (discussing the emergence of health and human rights in relation to various aspects of the modern world).

10. *See* Docteur & Oxley, *supra* note 7, at 7-8. "[A]ll OECD countries rely heavily both on public provision of insurance and on public regulation of various aspects of health-care and private health-care insurance markets."

11. *See* MARY ANN GLENDON, RIGHTS TALK THE IMPOVERISHMENT OF POLITICAL DISCOURSE (The Free Press 1991).

12. *See* Frank I. Michelman, *The Constitution, Social Rights, and Liberal Political Justification*, 1 INT'L J. CON. L. 13 (2003) (analyzing the institutional, contractarian and majoritarian objections to the constitutionalization of social rights). *See generally* Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?*, 56 SYRACUSE L. REV. 1 (2005) (analyzing possible reasons why the American Constitution has not been interpreted to create social and economic rights); M. Gregg Bloche & Elizabeth R. Jungman, *The R Word,* 18 J. CONTEMP. HEALTH L. & POL'Y 633 (2002) (arguing that American society is reluctant to recognize the possibility of rationing of healthcare).

13. *See* Colleen M. Flood, Lance Gable, & Lawrence O. Gostin, *Introduction Legislating and Litigating Health Care Rights Around the World*, 33 J.L. MED. & ETHICS 336 (2005). Colleen M. Flood, *Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access*, 33 J.L. MED. & ETHICS 669 (2005).

14. *See* Susan L. Waysdorf, *Fighting for their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Healthcare*, 84

Yet even constitutional protection, where it exists, cannot circumvent the political budgetary process. Constitutions that recognize healthcare rights typically provide a declaration of intent rather than an "iron-clad" guarantee.[16] Moreover, even the most activist supreme courts have been hesitant in filling the vague standards promised by their respective constitutions with concrete demands on the public purse.[17]

While jurists loath to admit it, the legal questions are subsidiary in this instance. If this were merely a legal issue, one might expect to find a huge gulf[18] between nations that seek to provide medical care to all their inhabitants and nations that believe that their people should pay

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KY. L. J. 745, 749 (1995-1996) ("[H]istorically there have been at least two primary models for health care delivery and care: first, universal health care coverage to all, regardless of ability to pay; and second, the welfare medicine-medical apartheid model, a policy-law paradigm linking government provision of health care to economic status and to poverty.").

15. *See generally* David A. Super, *The Political Economy of Entitlement*, 104 COLUM. L. REV. 633 (2004) (analyzing entitlements generally and how they can be maltreated by the American political system).

16. *See e.g.*, S. AFR. CONST. 1996, §27, *available at* http://www.info.gov.za/documents/ constitution/ index.htm.

Section 27. Health care, food, water and social security

1. Everyone has the right to have access to
   a. health care services, including reproductive health care;
   b. sufficient food and water; and
   c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
3. No one may be refused emergency medical treatment.

See also Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285 (2004) (providing an impressive overview of healthcare provisions in constitutions of countries around the world).

17. *See e.g.*, *Soobramoney v. Minister of Health, Kwazulu-Natal*, 1997 (12) BCLR 1696 (S. Afr.). *But see Paschim Banga Khet Mazdoorsamity v. State of West Bengal*, (1996) 4 S.C.C., *available at* http://judis.nic.in/ supremecourt/ qrydisp.asp?tfnm=75597 (India) (finding an abrogation of a constitutional right when a state hospital did not treat the plaintiff).

18. A gulf would be a difference in terms of public healthcare expenditure or the number of people with healthcare problems covered by health insurance, for example.

their own way.[19] In fact, the gulf is smaller than one might expect. With the rising cost of medical care, no government can afford to provide full medical coverage for its people. Take for example America:

> Total health care spending in the United States has been growing faster than the economy for many years, and it is projected to continue doing so. *Between 1960 and 2003, national health expenditure increased from 5.1% of gross domestic product to 15.3% - the result of an average annual growth rate 2.6% higher than the economy as a whole.*[20]

In 2004, "the United States spent about $1.9 trillion for healthcare. Real spending per capita increased from about $1,700 in 1975 to about $6,300 in 2004 . . . ."[21]

In other words, when it comes to handling its healthcare system, the United States, like all other Western democracies, reverts to the basic public policy questions. How much money is the government willing to spend on public-financing of medical treatment? Will it distribute available funds according to the severity of the medical needs? Will this distribution occur equally, among all the people? Or according to a person's income? Will the government establish a public healthcare system? Will the providers of such a system be private entities or will there be a mix of the public/private sectors?

All modern Western governments seem willing to spend some public monies to provide or finance healthcare.[22] The United States provides a comprehensive national healthcare system with its Medicare program (for those over the age of sixty-five and the disabled) and Medicaid

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19. *See e.g.*, Janis Sarra, *Contemporary Corporate Theory Applied to the Health Care Sector: A Canadian Perspective*, 3 SEATTLE J. SOC. JUST. 345 (2004) (discussing how Canada's healthcare system is centered on increasing the value of its services, a goal quite different than the U.S. system).

20. CONGRESSIONAL BUDGET OFFICE, THE LONG-TERM BUDGET OUTLOOK 6 (2005), *available at* http://www.cbo.gov/ ftpdocs/ 69xx/ doc6982/ 12-15 - LongTermOutlook. pdf (emphasis added).

21. *Medicaid Spending Growth and Options for Controlling Costs Before the S. Special Comm. on Aging*, 109th Cong. 14 (2006) (statement of Donald B. Marron, Acting Director, Congressional Budget Office), *available at* http://www.cbo.gov/ ftpdocs/ 73xx/ doc7387/ 07-13-Medicaid.pdf.

22. *See supra* note 7 and accompanying text.

program (for the poor).[23] Regardless, these programs are bitterly criticized from both sides for doing both too much and too little.[24] Canada opted for a publicly-funded universal healthcare system which is a source of national pride and joy, yet at the same time is facing its own challenges. The controversial case of *Chaoulli v. Quebec*[25] attests to such difficulties.[26]

At the end of the day, the conclusion seems clear: healthcare costs are rising continuously and fast; governments are simply finding it harder to pay for healthcare;[27] and if they have ever been able to do so, they cannot continue given the rising costs of medical treatment. Even the world's wealthiest nation, the United States, may not be able to afford such expenses.[28] All of this means that some portion of the medical coverage must remain for individuals to pay out of pocket.

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23. *See generally* Maxwell J. Mehlman & Karen Visocan, *Medicare and Medicade: Are They Just Health Care Systems?*, 29 HOUS. L. REV. 835 (giving an overview of both programs in relation to concepts of justice and equality).

24. For a provocative discussion of these issues, *see* RICHARD EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (Addison-Wesley 1997). *See generally*, William P. Quigley, *Five Hundred Years of English Poor Laws, 1349-1834: Regulating the Working and Nonworking Poor*, 30 AKRON L. REV. 73 (1996)(discussion of English law on providing aid to the poor, which has affected American laws and regulations); PAUL FRONSTIN, EMPLOYEE BENEFIT RESEARCH INSTITUTE, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2005 CURRENT POPULATION SURVEY (2005), *available at* http://ssrn.com/ abstract=850465 (providing data and Discussion on health insurance coverage of America's non-elderly).

25. *See* Chaoulli v. Quebec (Attorney General), [2005] S.C.R. 791 (The Supreme Court of Canada ruling (4 to 3) that the Health Insurance Act and the Hospital Insurance Act, in prohibiting private medical insurance, violated the Quebec Charter of Human Rights and Freedoms. Three of the judges also finding that the laws violated section seven of the Canadian Charter of Rights and Freedoms). *See also* Recent Cases, *Due Process – Right to Medical Access – Supreme Court of Canada Holds That Ban on Private Health Insurance Violates Quebec Charter of Human Rights and Freedoms – Chaoulli v. Quebec (Attorney General), 2005 S.C.C. 35, 29272, [2005] S.C.J. No. 33 QUICKLAW (June 9, 2005)*, 119 HARV. L. REV. 677 (2005).

26. *See generally* Docteur & Oxley, *supra* note 7 (discussing developments in OECD countries in the past decade and how they differ).

27. *See* ORG. FOR ECON. CO-OPERATION AND DEV., Rising Health Costs Put Pressure on Public Finances, Finds OECD, June 26, 2006, http://www.oecd.org/ document/ 37/0,2340,en_ 2649 _201185_ 36986213_1_1_1_1,00. html.

28. *See* CONGRESSIONAL BUDGET OFFICE, *supra* note 20, at ix. "Even if taxation reached levels that were unprecedented in the United States, current spending policies could become financially unsustainable."

Canada may be the outlier, but most countries, including Israel and perhaps the United States, are seriously contemplating how to *ration* healthcare in an equitable and transparent manner.[29]

This paper presents a novel introduction to the Israeli healthcare system. The system is described generally in Part II. Part III discusses in detail one of its main features: the Healthcare Basket Committee (Committee). This government committee is entrusted with life-and-death decisions by deciding which new medications, medical procedures, and technologies should be annually added to the Israeli medical services "basket." Criticism of the Committee is presented in Part IV. The final section of the paper, Part V, addresses a unique feature of Israeli healthcare policy: the decision to include fertility treatment in the "healthcare basket" and, thus, have this treatment receive heavy government subsidization. This case study helps better understand the impact of the Committee on Israeli society. This paper aims to make a small contribution to the rich and lively debate on the regulation and the management of public healthcare systems by highlighting that of the state of Israel.

II. THE ISRAELI HEALTHCARE SYSTEM – A SHORT PRIMER

The story of the Israeli healthcare system can be divided into two eras: the first being from foundation of the system to the great changes of the mid-1990s, and the second from 1994 to the present.[30]

A. Before the "Revolution"

From 1517-1917, during the long rule of the Ottoman Empire in the Middle East, medical services were mostly provided by charitable and religious organizations with minimal government intervention.[31]

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29. *See* Colleen M. Flood, Lance Gable & Lawrence O. Gostin, *Introduction: Legislating and Litigating Health Care Rights Around the World*, 33 J.L. MED. & ETHICS 636, 638 (2005); Thomas R. McLean, *Medical Rationing: The Implicit Result of Leadership by Example*, 36 J. HEALTH L. 325 (2003) (arguing for America to consider rationing healthcare).

30. There is relatively limited academic literature in either English or Hebrew on the Israeli healthcare system. Therefore, in this section, unless otherwise stated, this article relies mostly on Hebrew textbooks dealing with the topic.

31. Various European nations and Christian organizations set up healthcare institutions both to care of pilgrims, and for to gain a political foothold in Palestine. There were also Jewish charities that provided medical services. In 1912, there were about 50,000 Jews in Palestine, and only thirty-two Jewish medical doctors. *See* GABI BIN NUN, YITZHAK BERLOVITZ & MORDECHAI SHANI, THE HEALTH SYSTEM IN ISRAEL 23 (Ministry of Defense Publication 2005).

Matters changed during the British mandate of the land (ca. 1917-1948). First, after World War I, aid from the Jewish-American community allowed the establishment of Hadassah, a hospital and clinic chain, throughout the land. While Hadassah gradually relinquished control over most of its institutions, the organization left its mark by establishing a highly professional nonpolitical medical service.[32] Second, diametrically opposed to Hadassah were the medical cooperatives established after 1911 by the powerful and highly ideological political parties. The formation of these institutions created a longstanding rift between the sectarian and the government-controlled hospital systems.[33] Also, in the mid 1930s, a stream of medical personnel arrived as refugees from Central Europe. Many of these refugees established private practices and hospitals.[34] Finally, the British mandatory government established a health department, the precursor to Israel's Ministry of Health. This department dealt mostly with public health issues such as fighting malaria and other infectious diseases. Over time it began to run hospitals directly, laying the foundations of the current multifaceted government role in healthcare.[35]

The most significant factor in Israeli healthcare is the *Kupot Holim* (KH). The first KH was founded by labor leaders on a firm ideology of mutual help in 1911 to secure medical services for laborers. Its original articles of association state that each member is willing to physically keep night-vigil next to another member's sickbed, or find a

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32. Hadassah is now centered in Jerusalem. *See id.* at 24-26; SHIFRA SHVARTS, KUPAT HOLIM, THE HISTADRUT AND THE GOVERNMENT THE FORMATIVE YEARS OF THE HEALTH SYSTEM IN ISRAEL, 1947-1960, at 16-18 (Hamakhpil Banegev Press 2000). *See generally* Hadassah Medical Center, http://www.hadassah.org.il/ English (last visited Nov. 17, 2006) (the website of Hadassah).

33. *See* BIN NUN ET AL., *supra* note 31, at 26-27; SHVARTS, *supra* note 32, at 10-11.

34. Their number is estimated at 1,200, about 75% of all Jewish doctors in the land. With supply greater than demand, making a living was difficult for them. *See* BIN NUN ET AL., *supra* note 31, at 25; SHVARTS, *supra* note 32, at 28-30.

35. The Ministry of Health is a major provider of inpatient services and owns about a third of all hospital beds, public health services and ambulatory psychiatric care. *See* Revital Gross, *Implementing Health Care Reform in Israel: Organizational Response to Perceived Incentives*, 28 J. HEALTH POL. POL'Y & L. 659, 663 (2003); BIN NUN ET AL., *supra* note 31, at 26. For current data on Israeli hospitals, *see* ISR. CENT. BUREAU OF STATISTICS, HEALTH SERVICES HOSPITALS, BY TYPE AND OWNERSHIP 1, http://www1.cbs.gov.il/ shnaton56/ st06_05.pdf.

replacement should he be unable to keep this obligation.[36] These healthcare associations were loosely modeled (and indeed, named) after Bismark's healthcare provision model that had developed in Central Europe.[37] In 1920 these various cooperatives united into the general healthcare cooperative of the Jewish laborers in Palestine, *Kupat-Holim Clalit* (KHC).[38]

KHC became, and still is, the dominant healthcare provider in Israel.[39] There are two final wrinkles to this story. KHC was deeply linked with the Israeli labor movement, the dominant political force in the country until 1977. In 1937, a link was made between membership in the labor trade union and the KHC, and both fees were collected together. In other words, to enjoy KHC healthcare, one had to be a member of the workers' trade union, and vice versa. This linkage, one that greatly empowered the trade union and the Labor Party, was only severed in the reform of the mid-1990s.[40] Additionally, the political linkage made many people uncomfortable enough to join the much smaller KHs, which were not all politically affiliated.[41]

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36. *See* BIN NUN ET AL., *supra* note 31, at 26-27; SHVARTS, *supra* note 32, at 10-12.

37. The associations were called *Kupat Holim*, literally a translation of the German word *Krankenkasse,* or sick-fund. In recent years, the KHs have dropped this name in favor of the term "healthcare services." *See* BIN NUN ET AL., *supra* note 31 at 26-27; SHVARTS, *supra* note 32, at 10-13.

38. *See* BIN NUN ET AL., *supra* note 31, at 27; SHVARTS, *supra* note 32, at 18-20.

39. *Clalit* means "general." *See* BIN NUN ET AL., *supra note* 32, at 26-27; SHVARTS, *supra* note 32, at 19-23. *See also* Clalit Health Services, http://www.clalit.org.il/ clalitE/ default.asp (last visited Nov. 17, 2006) (English website for KHC, including a history). 2005 figures suggest *Clalit*, with income of around $3.8 billion, served 53% of the insured population and had 68% of the available branches. Maccabi was second with an income of $1.4 billion, serving 24% of the insured and having 17% of branches (together with independent medical practitioners). *See* Roni Linder-Ganz, *BDI Rating: Clalit Healthcare Services is First - 17 Billion NIS in Income, 53% of the Insured*, HA'ARETZ (Isr.), June 19, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

40. *See* BIN NUN ET AL., *supra* note 31, at 27-28; SHVARTS, *supra* note 32, at 28.

41. *See* BIN NUN ET AL., *supra* note 31, at 28-32; SHVARTS, *supra* note 32, at 27, 29. The services of the smaller KHs were not available *everywhere* in the country. Figures from 1948 suggest that the KHC covered 85% of the insured population. *See* BIN NUN ET AL., *supra* note 31, at 27-32, tab. 1.1, at 32; SHVARTS, *supra* note 32, at 25-28. *See generally*, Maccabi Health, http://www.maccabi -health.co.il/ english_site/ index.html, (last visited Nov. 17, 2006); Leumit,

This state of affairs continued, virtually unchanged, from the foundation of Israel in 1948 until 1995.[42] Years of political pressure have brought little change. Only the Labor Party's political decline and growing public dissatisfaction with the current system (beleaguered with strikes, long queues, etc.) finally brought change. The report of a public committee, headed by Israeli Supreme Court Justice Shoshana Netanyahu, in the 1990s, broke the impasse and precipitated the passage of the National Health Insurance Act, 5754-1994 (1994 Act[43]), and two years later, legislation of the Patients' Rights Act, 5756-1996 (1996 Act).[44]

B. The Changes of the Mid-1990s

These two acts were meant to update and clarify the duties of the State regarding the provision of healthcare and the legal rights of the patients in receiving such treatment. The 1994 Act was designed to financially stabilize the healthcare system, provide "universal health insurance coverage, clarify [peoples'] rights to health insurance coverage, increase freedom of choice and transfer among the [KHs] ," and improve the quality and equality of services provided.[45] The 1996 Act basically "embodies a movement from paternalism to autonomy in doctor-patient relations."[46] Specifically, its purpose was to "establish

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http://www.leumit.co.il/ eng/ (last visited Nov. 17, 2006) (English websites for both Maccabi Healthcare Services and Leumit healthcare, two smaller KHs).

42. But not unchallenged; political considerations hindered major reforms. *See* BIN NUN ET AL., *supra* note 31, at 33-36; SHVARTS, *supra* note 32, at 143, 162-174, 182-185, 201-210, 231-234. *See also* Gross, *supra* note 35, at 663-664.

43. Author's note: The 1994 Act was passed in mid 1994 but did not go into effect until January 1, 1995. ISR. MINISTRY OF HEALTH, OMBUDSMAN FOR THE NAT'L HEALTH INSURANCE LAW 1, http://www.health.gov.il/ download/ docs/ units/ complaints/ doc/ english.doc (last visited Feb. 9, 2007). Therefore, some of the sources cited herein refer to a health law passed in 1995, which would be synonymous with the 1994 Act.

44. *See* CARMEL SHALEV, HEALTH AND HUMAN RIGHTS IN ISRAELI LAW 145-47 (Ramot-Tel Aviv Univ. 2003).

45. Gross, *supra* note 35, at 665-66. "Prior to [the 1994 Act], insurance coverage was incomplete: 4 % of the total population and as much as 12% of the [Arab-Israeli] population did not belong to a [KH]." *Id.* at 664. *See also* SHALEV, *supra* note 44, at 159 (putting the number at about 250,000 people).

46. Carmel Shalev, Efrat Freiman, *Monitoring Patients' Rights–A Clinical Seminar*, 21 MED. & L. 521, 521 (2002).

the rights of persons seeking or receiving medical care . . . and to protect their dignity and privacy."[47]

Of particular relevance to this paper is the 1994 Act, which changed Israeli healthcare in several regards. First, it contains a clear national commitment that every resident of Israel (not just citizens) has the right to obtain healthcare services under the Act, regardless of his or her ability to pay. The government is responsible for funding these medical services from a "basket". The source of such funding would be from patients' premiums and the national budget.[48]

Second, healthcare services are still to be provided by the KHs, but with a twist: the political linkage is severed, and the health insurance premiums henceforth would be collected by the National Insurance Institute, a state agency, as a tax that every employee must pay[49] (generally, at a level of "4.8% of income, with reductions granted for the elderly and poor").[50]

Third, measures were taken to ensure that people could freely transfer among KHs and that resources would be distributed among KH*s* according to health needs, with "increase[d] equality in the provision of services to different populations and geographic areas."[51] To ensure freedom of choice and transfer among KHs, the 1994 Act "prohibits sick funds from rejecting candidates for membership."[52]

Finally, and most directly pertinent for this paper: in an attempt to eliminate competition over the range of services, the 1994 Act defined a standard benefits package, the so-called medical services "basket."[53] Once healthcare premiums and benefit packages became uniform, "planners intended [KHs] to compete only over the quality of

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47. *Id.* at 522 (quoting Patient's Rights Act of 1996).

48. *See* SHALEV, *supra* note 44, at 159–160, 179–185. *See also* U.N. Human Rights Committee, *Initial Report of States Parties Due in 1993: Israel*, art. 6, U.N. DOC. CCPR/C/81/Add.13 (Apr. 9 1998).

49. *See* SHALEV, *supra* note 44, at 152-156, 161, 202-204.

50. Gross, *supra* note 35, at 667.

51. *Id.* at 666. Prior to the 2004 act, the four KHs competed over premium fees and provided different benefit packages. *See id.* at 664.

52. *Id.* at 668. Thus, the law prohibits what is known as "cream skimming." *Id.* "Cream skimming results when suppliers seek to reduce their costs by declining to provide goods and services to "high cost" voucher recipients." Michael J. Trebilcock, Ron Daniels & Malcolm Thorburn, *Government by Voucher*, 80 B. U. L. Rev. 205, 212 (2000). For a discussion of these and other aspects of the 1994 Act, *see* Gross, *supra* note 35, at 667-72; SHALEV, *supra* note 44, at 194-96.

53. Gross, *supra* note 35, at 668.

services."[54] The 1994 Act set forth a standard benefits package for all in order to "simplify comparison among sick funds and provide a minimum level of reasonable care."[55] Furthermore, "[t]he cost of providing this standard benefits package was set in the [1994 Act,] and a mechanism for updating the cost was devised."[56]

It is at this point in history that the story *finally* begins. Two specific examples pertaining to the Israeli Basket will be discussed. The first example, which constitutes the bulk of the paper, concerns the committee entrusted to update the Basket with new medications, procedures and technologies. The second is a short discussion of the Israeli policy decision to publicly finance fertility treatments via the Basket.

III. THE ISRAELI HEALTHCARE "BASKET CASE"

A. Controlling Costs

By international standards, the Israeli healthcare system is not very costly. The national healthcare expenditure in Israel is equivalent to the average of countries in the Organisation for Economic Co-operation and Development (OECD), and well below the American or German standards.[57] Moreover, Israeli expenditures on medications are on the frugal side.[58]

The 1994 Act provided two mechanisms for adjustment of the Basket's expenditure level. The first is an automatic update, based on several economic indices, "including the Health Price Index published by the [Israeli] Central Bureau of Statistics and demographic parameters linked to population growth and aging."[59] Additionally, the law implemented a more discretional mechanism that permitted the Minister of Health to make changes to the basic Basket services. Any changes resulting in increased cost, however, require consent of both the Israeli Treasury and government, i.e., the entire Israeli cabinet.[60]

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54. *Id.* at 668.

55. *Id.* at 666.

56. *Id.* at 667. *See also* SHALEV, *supra* note 44, at 160-61, 201-02.

57. *See* Press Release, Isr. Cent. Bureau of Statistics, Continuing Decrease in the Share of the Nat'l Expenditure on Health Our of Gross Domestic Product 6 (Aug. 28, 2006), *available at* http://www.cbs.gov.il/ hodaot2006n/ 08_06_183e.pdf.

58. *See id.* at 3.

59. Gross, *supra* note 35, at 667.

60. *See* SHALEV, *supra* note 44, at 212-213, 229-230, 266-267. In addition, the Minister of Health and the Minister of Finance are to monitor the KHs' financial

At first the statutory framework appeared fine, but when political and economic realities entered into the equation, the Basket ended up never being fully updated.[61] The problem was the government's reluctance to adjust the real-value (as opposed to the nominal value) of the Basket. This unwillingness occurred through various administrative and economic means, primary among them reluctance to update the Basket to accurately reflect demographic, pharmaceutical, or technological changes.[62]

As a result, government and local authority participation in the financing of national health expenditure saw an initial jump from just less than 50% in 1994 to 74.5% in 1996. This increase then saw a steady decline to a current funding level of 66%-68%.[63] As for the Basket, its cost has remained somewhat stagnant,[64] possibly reflecting its gradual erosion.

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performance, to ensure they remain financially viable. Gross, *supra* note 35, at 667.

61. Indeed, in 1997 the government had legislation passed that cancelled employers' obligation for co-payments towards medical insurance of employees, a major source of income of the national health insurance. For information on the political background, *see* SHALEV, *supra* note 44, at 218-32.

62. The update for demographic changes (size and aging of the population) was at a rate of 2% per year, while it was estimated to be, in fact, 3.7% per year. As for adjustment of the healthcare basket on the basis of technological changes, the 1994 act did not contain any reference to this update. Some view this as a reflection of the tension between national economic interests, basically an attempt to limit medical expenditures, and the interests of the national health system, in the form of medical and technological advances. *Id.* at 208. Starting in 1998, the Treasury allowed updating for technological changes, but only at a rate of 1% to 1.5% per year, while estimates place the real figure at 2% to 4% per year. For the various measures used to preclude the full update of the Basket, *see id.* at 229-32. *See also* HCJ 2344/98 Maccabi Healthcare Services v. The Minister of Finance [2000] IsrSC 54(5) 729 (involving a denied petition to the Supreme Court of Israel asking that it order the government to fully update the basket).

63. ISR. CENT. BUREAU OF STATISTICS, NAT'L EXPENDITURE ON HEALTH, BY OPERATING SECTOR AND FINANCING SECTOR 1, http://www1.cbs.gov.il/ shnaton56/ st06_03.pdf.

64. *See* JONATHAN EHRLICH & AMI ZADIK, KNESSET RESEARCH AND INFORMATION CTR., IN PREPARATION FOR THE 2007 BUDGET: SOCIAL EXPENDITURE – REFERENCE TO SELECTED TOPICS (2006) *available at* http://www.knesset.gov.il/ mmm/ data/ docs/ m01499.doc (source only available in Hebrew).

B. How to Expand the Basket?

As mentioned, the 1994 Act established the Basket with a highly specific and detailed list of health services to which every Israeli was entitled. Several problems soon became apparent. First, the makeup of the Basket was not formulated properly. The Basket was simply the result of the adoption of an existing grouping of health and medical services, rather than a careful examination of what was currently available.[65] Further, both the contents of the Basket and the amount of funds available for its financing depended on the complicated political budgetary process of Israel.[66] Third, the written commitments regarding the contents of the Basket turned out to be a double-edged sword. In specifically detailing the Basket's contents and its cost, patients' fears of arbitrariness and vagueness regarding the medical services that the KHs must provide was somewhat dispelled. The definition, however, also brought about an assumption of conclusiveness in that it was obvious what was contained in the Basket.[67] Finally, and most importantly, there was no mechanism to update the Basket for technological changes or advancements in medicine.

In the first few years after the 1994 Act went into effect, all of these troubles became evident and public discomfort began to grow. The people wondered who will pay for services not contained in the Basket or for new medical procedures and medications. Such problems were of no concern to the wealthy; they either bought supplementary insurance[68] or paid out-of-pocket for services not included in the Basket.[69]

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65. SHALEV, *supra* note 44, at 160-161.

66. *See* Carmel Shalev and David Chinitz, *Joe Public v. General Public: The Role of the Courts in Israeli Health Care Policy*, 33 J. L. MED. & ETHICS 650, 651 (2005); SHALEV, *supra* note 44, at 254 (noting that there are, in fact, some differences between the healthcare baskets provided by the four KHs so that there are currently four different baskets available, each defining the services provided under the Act and the prescribed payment for them).

67. This interpretation of the Act was also accepted by the courts. *See* SHALEV, *supra* note 44, at 265-66.

68. *See* SHALEV, *supra* note 44, at 205-06, 255-58, 262-63. The 1994 Act allows the KHs to offer, for an additional fee, "supplemental insurance for services not included in the standard benefits package; this has created a niche in which competition over premiums and the scope of services can and does take place . . ." Gross, *supra* note 35, at 668.

69. *See generally* BRUCE ROSEN ET AL., WORLD HEALTH ORGANIZATION, THE EUROPEAN OBSERVATORY ON HEALTH CARE SYSTEMS, HEALTH CARE SYSTEMS IN

These first few years of the Basket were marked with almost total stagnation. Despite numerous requests to expand services, not much happened. In particular, only two drugs had been added by December 1997, despite frequent requests. The only reason these drugs were included was "due to aggressive legal action taken by an organised group of patients with multiple sclerosis[,]"[70] backed by political pressure from both the Minister of Health and Knesset members who joined forces against the Treasury.[71]

In sum, several facts became abundantly clear: first, there was a real need to expand the Basket and its budget; second, that healthcare providers would be driven to the Basket despite the cost of rising deficits, whether the government approved such spending or not; third, that expansion of the Basket was fiscally problematic but politically very popular.[72]

C. First Things First: Let's Form a Committee

As is common knowledge for any student of government, there are plenty of budget disputes between government ministries, interest groups, and the treasury. Most of them, regardless of how much money is involved, hardly hold the public's attention. In this light, however, the Israeli Basket proved quite different. In particular, the Basket is the concern of every person and every family in Israel; most focus on the highly dramatized fact that the Basket Committee deals with life-saving drugs.[73] Its deliberations became a modern, public gladiator bout, with Committee members having the power to thumb-

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TRANSITION: ISRAEL 29-31 (Sarah Thompson & Elias Mossialos eds. 2003), *available at* http://www.euro.who.int/ document/ E81826.pdf #search= %22co%20 payments% 20medical% 20healthcare% 20israel% 20OECD% 22 (providing further explanation of co-payments being paid out of pocket in Israel).

70. David Chinitz, Carmel Shalev, Noya Galai, Avi Israeli, *Israel's Basic Basket of Health Services: the Importance of Being Explicitly Implicit*, 317 BRIT. MED. J. 1005, 1005 (1998).

71. Zvi Zerahia, *The Threat Worked*, HA'ARETZ (Isr.), Jan. 12, 1996 *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription).

72. *See* Chinitz et al., *supra* note 70, at 1006-07.

73. *See infra* nn. 79, 84 & 97 and accompanying text. An interesting topic worthy of future consideration would be the issue of the Israeli healthcare basket committee's specific decisions in view of the extensive literature dealing with the statistical value of life from a governmental perspective. *See e.g.*, Cass R. Sunstein, *Lives, Life-Years, and Willingness to Pay*, 104 COLUM. L. REV. 205 (2004) (discussing how the government should consider the value of a statistical life when performing cost-benefit analysis).

up for life or thumb-down for death. This accounted for growing public interest and scrutiny of what is essentially an internal professional advisory government committee, with only limited public representation among its members. A full analysis of the Committee's operation is beyond the scope of this paper; only the a brief summary of highlights will be presented.

The potential high drama that the updating of the Basket could raise was revealed early on as cancer patient Tali Levy appeared, in a nationally televised event, before the Israeli Knesset's Labor, Welfare, and Health Committee:

> [a]nd in a heart-wrenching performance [Levy] asked to be allowed to live . . . following this appearance two things happened: 14 vital medications were immediately added to the basket at a cost of 150 million NIS, and a public committee was formed for running updates of the basket. Members of the committee are representatives of the ministry of health, the Kupot Holim, the medical association, representative of the treasury's budget division and public representatives. I may say that this committee, of whom I am member, is unique in the world and does excellent work. The deliberations are conducted with full transparency and on the basis of accurate information, and decisions are reached through consensus.[74]

As public anger began to rise, patients began voicing their grievances.[75] Reacting in true bureaucratic style, the decision was taken by the Israeli government to allow the Committee to stipulate physical and temporal access to the Basket.[76]

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74. Yiftah Goldman, *The Healthcare Basket is Ill*, Social-Democratic Israel, Dec. 12, 2004, http://www.yesod.net/yesod/archives/2004/12/post_75.html (interview with Dr. Yoram Blashar) (website in Hebrew). *See also* Chinitz et al., *supra* note 50, at 1106.

75. *See, e.g.,* Ran Resnik, *Joseph Sherman's Last Hope*, HA'ARETZ (Isr.), July 30, 1998, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription)

> Joseph Sherman, cancer patient is a member of *Kupat Holim Klalit* and insured in 'Dikla' complimentary insurance. Yet the *Kupa* refuses to finance for him the single treatment that may save his life. A report published today holds: it is unreasonable that the *Kupot Holim* deny medical treatment of the severely ill.

Id.

76. Chinitz, et al., *supra* note 70, at 1005, 1006. Additionally, the 1994 Act allowed for the establishment of an advisory council for health issues and the Basket. *Id.* at 1005.

D. It May be a Mess—But What a Fascinating Mess, Indeed!

As a matter of Israeli administrative law and function, the Committee has been highly problematic since its inception. It does not conform to formal or traditional committee models to which the Israeli public has grown accustomed, and since its formation it has been relatively secretive in its operation.[77] Despite a lack of information concerning the origins of the Committee, it seems likely that the Committee was initially formed merely as a professional, non-political, advisory body to the Health Ministry. Israeli law allows for such an occurrence under the government's auxiliary or residual powers which allow it to take non-substantive steps for the operation of bureaucracy.[78]

Providing, rather kindly, that government decision-makers operated under this original intent, this assumption turned out to be a miscalculation. The Committee soon became

> the most important allocations committee in the country. It is important not only because it allocates millions of shekels every year for the purchase of medications and medical technologies; and not only because every decision it makes puts a drug or treatment into the basket of services for many years, and therefore the sums involved are not in the hundreds of millions of shekels, but in the billions of shekels. It is important primarily because every decision it makes affords life and quality of life to hundreds and thousands of people. The committee members determine who will live and for how long, and how much pain and how many side effects patients will suffer.[79]

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77. *See, e.g.*, Haim Shadmi, *The Health Council – Many Functions but Little Influence*, HA-ARETZ (Isr.), Dec. 19, 1999, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription); Haim Shadmi, *Precisely What Power Does the Committee for the Expansion of the Health Basket Operate?*, HA-ARETZ (Isr.), Feb. 4, 2002, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription); Ran Reznik, *The Health Council Approved the Expansion of the Healthcare Basket,* HA'ARETZ (Isr.), Apr. 7, 2005, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription) (stating that the Council approved the recommendations of the public committee for the explanation of healthcare services).

78. Knesset, Basic Law: The Government (2001), para. 32, http:// www. knesset. gov. il/ laws/ special/ eng/ basic14_eng.htm (last visited Jan. 12, 2007).

79. Ilan Shahar, *270 New Political Appointments,* HA-ARETZ (Isr.), Aug. 18, 2005, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ rchBuyArt.jhtml (article available via subscription in English).

As discussed later, these enormous pressures and interests involved—public, political, personal, and financial—overburdened the Committee, bringing it to the verge of resignation, as well as a loss of public credibility and support.[80]

E. How and Why the Committee Works Out in the End

Reports on the workings of the Committee are incomplete. From available records it seems that the Committee was first appointed only by the Minister of Health, more recently by both the Minister of Health and the Minister of Finance.[81] We also know that the Committee examines a very large number of new medications, procedures, and technologies offered for inclusion in the Basket.[82] Submissions are filed with the Ministry of Health, which studies each proposal and prepares for the Committee background materials analyzing the item offered, its functions and alternatives, the estimated number of patients who might benefit from it, and its cost.[83] The Committee has established a 10-tier ranking system: at the top of the scale (receiving an "A10" rating) are life-saving medications, followed by medications that have the potential to significantly improve

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80. *See infra* Part IV.

81. In 1999, the government approved Minister of Health Joshua Matza's recommendations for additions to the healthcare basket; that same year, the committee is first mentioned as a "committee on behalf of the Health Ministry." *See* Iris Krause, *New Medical Technologies Placed in the Healthcare Basket,* HA'ARETZ (Isr.), Mar. 8, 1999, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription); Haim Shami, *Committee Faces Tough Choices on Next Year's Health Basket,* HA'ARETZ (Isr.), Dec. 8, 1999, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English); Haim Shami, *The Committee Whose Function is to Expand the Healthcare Basket was Appointed*, HA'ARETZ (Isr.), Oct. 31, 2000, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (Minister of Health Ronni Milo appointed 23 committee members); Haim Shami, *The Make-up of the Committee that is Meant to Expand the Healthcare Basket in 2002 was Approved*, HA'ARETZ (Isr.), Oct. 29, 2001, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (Minister of Health Nissim Dahan appointed to the Committee together with the Minister of Finance).

82. *See infra* Part III E.

83. For the Israeli government's instructions in order to include a drug in the Basket under the 1994 Act, *see* ISR. MINISTRY OF PHARM. HEALTH, GUIDELINES FOR THE SUBMISSION OF A REQUEST TO INCLUDE A PHARM. PROD. IN THE NAT'L LIST OF HEALTH SERVICES (2004), *available at* http:// www.health.gov.il/ download/ forms/ a28_ aclalaeng2002 .doc. *See also* Goldman, *supra* note 74.

patients' lives ("A09"). These rankings are followed by important but less vital medications, ranked "B" and lower.[84]

While there is a significant amount of public criticism leveled against the Committee,[85] its professionalism and discretion have remained relatively unblemished[86] and its decisions on the specific medications to be included in the Basket remain the final word on the topic. There

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84. *See* Goldman, *supra* note 74. A report of the Knesset Research Department speaks of five main categories for medications, services and technologies that are considered by the committee. These products can: (1) help the survival of the patients (saving or extending life); (2) improve quality of life; (3) rehabilitate the patient; (4) help prevent and; (5) diagnose. *See* BARUCH LEVI, KNESSET RESEARCH DEPARTMENT, OVERVIEW ON DRUGS AND TECHNOLOGIES CONSIDERED FOR INCLUSION IN THE HEALTHCARE BASKET (2004), *available at* http://www.knesset.gov.il/ MMM/ data/ docs/ m01002.doc (document in Hebrew) [hereinafter KNESSET RESEARCH DEPARTMENT, OVERVIEW]. This all looks reasonable enough, but some experts suggest different methods, such as adopting the *Quality Adjusted Life Years* standards. *See* Boaz Ginzburg, *Medications that Worth More and Medications that are Worth Less,* HA'ARETZ (Isr.), Mar. 28, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription); Yuval Yoaz, *Chronic Skin Disease Patient Petitions the Supreme Court: Hospitalization is More Expensive than the Medication,* HA-ARETZ (Isr.), Mar. 21, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

85. *See infra* Part IV.

86. For example, one critique was that the Committee mostly thinks about the short-term, but this is the result of a Ministry of Health policy requiring evaluation of a proposed product's potential effects for the first three years of inclusion in the Basket. *See* Haim Shadmi, *The Healthcare Committee Only Thinks about the Short Term,* HA'ARETZ (Isr.), Jan. 10, 2001, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription). *See e.g.,* Ran Reznik, *The Medication Could Have Alleviated the Suffering of Brain Cancer Patients, but It Will Damage the Position of the Oncologists,* HA'ARETZ (Isr.), Mar. 2, 2004, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (the press suggesting that the Basket's decision not to pay for a brain-cancer medication is part of a larger medical controversy between oncologists and neurosurgeons). Nevertheless, the expertise and foresight of the Committee has also been touted in the press. A Committee member was quoted as saying that the Committee needs to consider dealing with common illnesses that affect most of the population, rather than just a small portion. The Committee member announced this standard when the Committee was determining whether a pneumonia-shot for the over-sixty-five population should be part of the Basket or not. *See* Haim Shadmi, *Panel Opposes New Antibiotics for Health Basket,* HA'ARETZ (Isr.), Dec. 23, 2001, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English).

are a few possible reasons for this deference and respect. First, Committee members are typically senior healthcare officials who are distinguished and well-respected public figures. Their work on the Committee is considered a public duty not envied by most.[87] Moreover, the enormous pressures from interest groups and politicians mean that there is no viable alternative decision-making body in Israeli public life that could replace the Committee and still enjoy an equally high level of public trust. The only comparable entity in Israeli public life, the Supreme Court, has shown little interventionist inclination.[88]

Indeed, the highly activist Israeli Court[89] has recently rejected petitions concerning the exclusion of new medications and procedures from the Basket. In a recent decision, Israel's highest court described the procedure for expansion of the Basket. The Court stated, with concern and honesty, but also with atypical deference, that "[n]o person can deny, first that we are talking about an orderly decision-making process and second, that prioritization is necessary in the circumstances of the healthcare basket."[90] If public advocacy groups that joined the petition in this case had hoped the Court would substantially review the Committee's decision and find improprieties in its operation, they were surely disappointed.[91]

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87. *See* Judy Siegel-Itzkovich, *The Basket Case*, JERUSALEM POST, July 10, 2005, at 7 (discussing the scandals and tough decisions faced by the Committee).

88. *See* Ze'ev Sternhell, *Public Opinion is Dead*, HA'ARETZ (Isr.), Dec. 8, 2006, *available at* http://www.haaretz.com/ hasen/ spages/ 797943.html ("No less dangerous is the Supreme Court's decision to shut itself in to a narrow interpretation of its role.").

89. Yoav Dotan, *The Spillover Effect of Bills of Right: A Comparative Assessment of the Impact of Bills of Right in Canada and Israel*, 53 AM. J. COMP. L. 293, 332, (2005) ("there is a widespread consensus among various commentators that the Israeli Supreme Court can be described as a very activist court (some argue, one of the most activist courts in the world).").

90. HCJ 2974/06 *Isareli v. The Healthcare Basket Expansion Committee* [2006] at 7, *available at* http://elyon1.court.gov.il/ Files/06/ 740/029/ t03/ 06029740. t03.pdf (document in Hebrew).

91. Lower courts have intervened in some petitions concerning the actual supply of medical services by KHs, sometimes requiring them to provide medical services against their wishes and judgments. *See, e.g.*, Roni Linder-Ganz, *A Judge Mandated Meuhedet to Fund Medication for a Cancer Patient*, HA'ARETZ (Isr.), Dec. 7, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (The spokesperson of a sick fund, Kupat Holim Meuhedet, said the holding was incompatible with the 1994 Act). *See also* Shalev and Chinitz, *supra* note 66, at 655, 656.

A third reason for such high regard is ironically derived from the Committee's chief complaint: that it is under-funded.[92] This lack of funding means that the Committee, being guided by efficiency, mostly approves life-saving medications and treatments that have the most potential to significantly improve patients' lives. These products are at or near the top of its priority list. The decision to include them in the Basket is well within the consensus and beyond serious public challenge.[93]

IV. CRITICISM OF THE COMMITTEE'S OPERATIONS

This section identifies various critiques of the Committee. The relative merit of the critiques will be evaluated. Finally, the major overhaul currently planned for the Committee will be explained. Unfortunately, with instability of the Ehud Olmert government,[94] it is difficult to predict a timeline for the planned reforms.

Most criticism of the Committee are *functional* in character, dealing with the operation, membership, and decision-making process. No one doubts the need for a "health care basket" in general, or that the Committee is a high-caliber, professional body that makes reasonable and equitable decisions.

A likely source of most problems observed by critics is that the Committee outgrew its humble beginnings and assumed public significance beyond original expectations. After all, it can be said that the Committee was only created as an internal, ministerial, advisory body. It is akin to a country road which has turned into a highway, without the necessary planning, approvals, or logistical changes. There is only so much that the Committee can do with the enormous burden now before it.

How and why the Committee assumed such responsibility is relatively clear and involves several factors. To begin with, under the 1994 Act the government is responsible for funding the Basket.[95] It has

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92. Those on the current Committee have noted that in 2006 the size of the budget restricted the amount of proposals the Committee was able to accept. *See* Mordechai Shani, *The Heart of the Health-Basket*, HA'ARETZ (Isr.), June 5, 2006, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English).

93. *See* Goldman, *supra* note 74; KNESSET RESEARCH DEPARTMENT, OVERVIEW, *supra* note 84.

94. *See* Steven Erlanger, *In a Divided Israel, Angry Words or No Words at All*, N.Y. TIMES, Jan. 7, 2007, http://www.nytimes.com/ 2007/ 01/ 07/ world/ middleeast/ 07israel.html.

95. *See infra* Part III.C.

the authority to change the Basket, but also the responsibility to make funds available.[96] This power is why the Committee is the only official gateway for expanding the Basket for the entire Israeli population, and why funding is expected to come from the public purse, as opposed to private sources.[97]

Yet, it can be argued that the Committee also grew in stature for several other reasons: it includes very senior members; it is able to reach decisions by consensus; and it is willing to take responsibility for its decisions, heart-wrenching as they might be. None of these traits are common in Israeli public life, either with public actors or public institutions.[98] We now turn to some of the criticism leveled against the Committee due to this emergence.

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96. The Israeli Ministry of Finance 2006 budget proposal for the Ministry of Health claims that the gap between the health insurance premiums collected by the National Insurance Institute and the full cost of the healthcare basket services provided by the *Kupot Holim* is $2.33 billion (of a total expenditure of $5.1 billion). *See* ISRAELI MINISTRY OF FINANCE, DOCUMENTS CONCERNING THE 2006 BUDGET, *available at* http://www.mof.gov.il/budget2006/doc/2006.zip (open the file briyut.pdf, at 60) (document in Hebrew).

97. There were, in practice, at least two other ways to expand the Basket: (a) while the statute sets a base-level healthcare basket, the *Kupot Holim* may raise the bar and has done so, for example establishing funds for 'extraordinary cases'or; (b) private benefactors have, on occasion, helped pay for medicines that did not make it into the healthcare basket. Both instances are, in essence, cases of charity, raising public policy questions. *See* Zvi Zerahia & Haim Shadmi, *Fund was Established for the Financing of Medications not Funded by the Healthcare Basket: Moneys will Come from the Kupot Holim, the Ministry of Finance and Private Donations.*, HA'ARETZ (Isr.), Jan. 18, 2000, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription); Roni Linder-Ganz, *The Kupot Holim are not waiting for the Treasury: Will Independently Expand the Healthcare Basket*, HA'ARETZ (Isr.), Dec. 8, 2005, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription) (reporting that the KHs, *Clalit* and *Maccabi*, announced that they would provide life-saving medications, including Herceptin, to patients who are not eligible now. A Health Ministry official was quoted as saiying that such a move "is enticing in the short run but catastrophic in the long run. The State should pay for the medications."); Roni Linder-Ganz, *Private Fund Will Assist Patients to Purchase Medications Left out of the Healthcare Basket*, HA-ARETZ (ISR.), July 3, 2006, *available at* http:// www.haaretz.co.il/ arch (article available in Hebrew via subscription) (assistance for the patients will include the medication Herceptin).

98. *See e.g.*, Steven Erlanger, *Israeli Admits Big Errors in Lebanon War, but Won't Resign*, N.Y. TIMES, Jan. 3, 2007, at A3.

A. Insufficient Transparency in the Operations of the Committee

The Israeli press has bitterly complained that the public receives too little information about the Committee and its deliberations, which were held for quite some time behind closed doors.[99] From its inception, Committee meetings were transcribed, but it decided to stop doing so in late 2001. The Committee had rational reasons for its decision,[100] but the timing was troubling. It was at a time when an Israeli court was deliberating *Ha'aretz* newspaper's administrative petition to have the transcriptions revealed.[101] Several months later, in a decision heralded as a major step in the advancement of transparency of the government,[102] the Jerusalem District Court mandated that the Ministry of Health provide *Ha'aretz* its protocols.[103]

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99. The Ministry of Health's website provides limited information on the Committee and its workings, and this body does not have its own webpage; there is, however, information on how to submit proposals to the Committee and on its decisions regarding basket expansion. In addition, there is an ombudswoman who hears complaints relating to the 1994 Act, and her website contains a good deal of information on the application of the 1994 Act. *See* Miriam Seibzehner & Osnat Luxenburg, Isr. Ministry of Health, The Adoption of New Medical Technology by the Israeli National Health Insurance Law (2005), http://www.health.gov.il/ english/ pages_e/ default.asp? pageid=29& parentid=24& catid=14& maincat=2. *See also* ISR. MINISTRY OF PHARM. HEALTH, *supra* note 83 (giving the more technical requirements for submission into the Basket).

100. *See* Haim Shadmi, *No More Minutes from Health Basket Meetings*, HA'ARETZ (Isr.), Dec. 5, 2001, at http://www.haartz.co.il/arch (article available in Hebrew via subscription) The committee explained that transcription is expensive and that by the time the transcript is prepared, it is no longer useful to the committee. Apparently the committee also decided that its members maintain secrecy during deliberations to prevent outside pressure.

101. *See id.*

102. The Israeli Freedom of Information Law was only enacted in 1998. *See* Isr. Police, *Freedom of Information Law*, 5758, 1998, http://www.police.gov.il/ english/ Information_Services/ Law/ xx_5759_1998.asp (last visited Jan. 12, 2007).

103. CA (Jer) 295/01 Ha'aretz v. Freedom of Information Supervisor, the Ministry of Health, [2002], *available at* http://www.nevo.co.il/ psika_word/ minhali/ mm01295.doc (document in Hebrew). The Israeli appellate court decided that names of speakers in past protocols be deleted, as such speakers did not anticipate that the protocol be made public. *See* Moshe Reinfeld, *The Court Ordered the Exposure of the Healthcare Basket Committee's Meetings,* HA'ARETZ (Isr.), Apr. 16, 2002, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription). *See also* Ze'ev Segal, *The Limits of Censorship During Wartime*, HA'ARETZ (Isr.), Apr. 16, 2002 *available at* http:www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English) (discussing

While the value of the bare protocols to the medical layman is debatable, there was, initially, a logical and legitimate purpose in keeping the deliberations closed. However, there is a compelling public interest in publicizing the Committee's operations.

In this vein, it is good to see that the Committee has begun to operate in a more transparent manner. Yet there are still shadows in this sunshine. As in other aspects of the Committee's operation, it is probably best to have the matter of the Committee's transparent operation decided in a clear, formal, and orderly manner.[104]

B. The Committee Membership

For quite some time there have been critiques of the Committee's structure. Specifically, it is alleged that the Committee is dominated by representatives from the government and *Kupot Holim*. This, in turn, brought about innuendos of unscrupulous dealings and suggestions that even if there is no outright corruption, the government and the healthcare providers still have, as one reporter put it, "economic interests that do not always fit with the public good."[105]

There appears to be three explanations as to how the Committee membership was eventually structured. Initially, the Committee was set up as an advisory body to the government.[106] It gained stature to become the national decision maker regarding Basket expansion. In theory, however, the Israeli parliament, the Knesset, could bypass the Committee by establishing another health services advisory board before passing its budget. Second, the experts on the needs of the Israeli healthcare market are the managers of the HKs and the

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the Israeli judicial system's treatment of media coverage of the government in relation to national security).

104. *See* Ran Resnick, *What Does the Committee Have to Hide from the Public?*, HA'ARETZ (Isr.), Mar. 30, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription). From 2001 to 2006 the committee did not transcribe its meetings, but only had summaries made, and they too were not made public. In 2006, Committee Chairperson Shani reinstituted the transcribing. At the same time, the Committee meeting of March 29, 2006 was closed to "nosy" reporters, and only at the insistence of the press did the government reopen the doors. *See also* Haim Shadmi, *Would it Not Be Better at This Point to Say "Stop"*, HA'ARETZ (Isr.), Oct. 19, 1999, *available at* http:www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English) (the published minutes of the of the Committee's Febuary 1999 meeting showing how it was decided not to include the drug Herceptin in the Basket).

105. *See* Shadmi, *supra* note 77.

106. *See supra* p. 17.

Ministry of Health. Their professional opinions must represented or at least heard by the Committee. Finally, the Committee includes public representatives, as they should be present to ensure the Committee proceeds in good faith on behalf of the people.

Including public representatives in the process is, however, not problem-free. Legitimacy is one concern. While many public representatives on the Committee are persons of high public standing, there is no senior judicial officer among them.[107] Israelis tend to trust public committees more when headed by judges, active or retired.[108] Some of the public representatives are retired health officials. This occurrence, depending on one's faith in government, can be either troubling or reassuring.[109] Furthermore, if the idea of democratic representation is to be given credence, there is unease in the fact that various groups are not directly represented in the Committee, namely the poor, the elderly, the Arab-Israeli population, and even women.[110]

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107. *See* Haim Shadmi, *Whom do the Public Representatives Represent?*, HA'ARETZ (Isr.), Feb. 14, 2002, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) ("The committee does not include a retired Supreme Court Justice or former Cabinet Ministers . . .").

108. *See* Zeev Segal, *The Power to Probe into Matters of Vital Public Importance*, 58 TUL. L. REV. 941, 944-945 (1984).

> Therefore it seems justified to examine the Israeli Law as a good, although not perfect, example of placing the power to probe into matters of vital public importance in the hands of an independent quasi- judicial commission . . . Many observers, both within Israel and abroad, welcomed the establishment of this independent, quasi-judicial commission.

Id. at 944-945.

109. On the one hand, they are senior, seasoned professionals; on the other hand, they are likely to be deeply committed to the government line or, depending on their current position, to the interests of their current employer (most often KHs and pharmaceutical industries).

110. *See* Haim Shadmi, *Medicine by Committee,* HA'ARETZ (Isr.), Feb. 2, 2002, *available at* http:www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English).

> [The Committee], which decides on the fate of millions of people, does not include a philosopher or clergyman specializing in issues of ethics and morality. There is no former Supreme Court justice or attorney general, as on most public committees. Indeed, there are no top-ranking lawyers . . . [N]either is there a former minister from one of the social ministries. . . Nor is there a professor or senior manager from the field of social work – or for that matter, anyone from a consumers' group. There is no representative from the development towns, Russian immigrants, or the Arab community, even though each one of these communities has special medical needs.

While the Committee was seen as merely an internal body of the Ministry of Health, such arguments seemed minor. This is no longer so, as the Committee became the main discretion-bearing, decision-making body on Basket expansion.

Another set of complaints is that public representatives either do not fully understand the discussion, feel excluded in the deliberations, or feel that they carry little weight. As the Israeli press has portrayed the membership, the Committee "serves as a rubber stamp for the Health Ministry and the HMOs . . . [while also containing] political appointees whose credentials for serving on the committee are in doubt."[111]

There is a simpler, less insidious explanation for the frustration felt by many towards these public representatives: the Committee is a mélange of two different forums. A highly professional technology committee brings into account technical and economic considerations while a public forum makes policy decisions. For the most part, the Committee wears the former hat, and the "real deliberations are managed by doctors and economists. The role of the public representatives on the Committee is to ensure that no irrelevant considerations be brought."[112]

Id. The Israeli committee has long deliberated as to whether to include the breast cancer drug Herceptin in the Basket. The fight over the provision of this drug in various countries – including England – is well worth a paper in its own right. One of the accusations of women's organizations in Israel is that the committee is male dominated and women's representation should be increased to 50%. *See* Haim Shadmi, *Women's Groups Outraged After HMOs Drop Breast Cancer Drug,* HA'ARETZ (Isr.), Nov. 22, 1999, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English). *See also* Kamir Orit, *Women's Lot is Very Little,* HA'ARETZ (Isr.), Feb. 2, 2005, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English) ("Hence it comes as no surpise that much of the information about the discrimination against women in Israel is hidden from the public as well as organization that seek to promote the welfare of women."). *See generally* Women Fighting for Herceptin, http:// www.fightingforherceptin.org.uk (last visited Nov. 19, 2006) (the website of a British advocacy group that wants Herceptin to be distributed more widely).

111. Shadmi, *Medicine by Committee*, *supra* note 110.

112. *See* Dan Michaeli, *The Frustrations of the Public Representatives,* HA'ARETZ (Isr.), Feb. 14, 2002, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (Prof. Michaeli is also a former Director General of the Health Ministry and, in 2002, was Chairperson of the Board at Clalit Healthcare Services, a KH).

C. Public Choice Run Amok

It is difficult to imagine the intensity of pressures placed upon the Committee and its members from politicians, interest groups, private individuals, the press, and others. It is not surprising that these pressures may have changed the Committee's character and brought it to the verge of explosion.[113]

Public pressure is an obvious occurrence. The Israeli public has shown great interest in the life-and-death decisions of the Committee. As previously observed, politicians have realized the public sympathy for any increase in the budget allocated to the Committee. There are a significant amount of potential dividends in supporting such increases (even if only relatively small sums of money are secured) with very few political risks.[114] Politicians have quickly caught on to this trick, as the media keeps reporting their efforts to increase Basket funding.[115]

The government at large also adopted this insight. In the past decade, minister after minister passed along the Health Ministry's portfolio. These ministers, whether from the political right, left, or center, supported significant increases in the budget for the Committee

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113. On the pressures committee-member are under, *see e.g.*, Shani, *supra* note 91. The Committee chairman noted how painful it was to read

> The letters from children who were fighting to add 20 centimeters to their height so that they would not be 'dwarfs.' (One boy in sixth grade wrote to tell me that the children in the school call him and his brother who is in third grade 'the twins,' because he is so short.)

Id.

114. Attacking the miserly Treasury has always been a popular choice for politicians; doing so for the sick and infirm – even more so! The problem for politicians is to get the press to name them as the originators of the budget increase.

115. This reached the point where politicians' efforts began to look slightly disingenuous. An example of this is when 86 of 120 Knesset members petitioned the Prime Minister to place the drug Herceptin in the healthcare basket. Surely such a majority could have legislated the extra budget on its own. *See* Zvi Zrahiya, *86 M.K.s Want to Include Drug for Breast Cancer in Basket*, HA'ARETZ (Isr.), Nov. 4, 1999, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English); Ran Reznick & Zvi Zrahiya, *Health Gets NIS 350m Boost, at Next Year's Expense,* HA'ARETZ (Isr.), May 30, 2006, available at http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English) (Prime Minister Olmert announcing an increase in the Basket's budget for drugs, including Herceptin).

while all coming up short-handed. In the end, however, they appeared with the most saintly image![116]

The happenings at the Committee and the constant shortage of funds available to it provide ammunition for ideological critics of government policy. "The process of establishing the extent of the healthcare basket and its content," stated one critic, "is further evidence of Israel's becoming – like the big brother in the United States – a state where jungle rules apply and only the strong survive."[117] The Treasury has been accused of intentionally undermining the 1994 Act's social intentions, out of "an ideology that is contrary to the spirit of the Act and advocates privatization." If steps are not taken to reverse this course a reporter warned, "the inequality in the healthcare system is likely to rise."[118]

Interest groups are another source of pressure. Committee members face two very formidable types of interest groups.[119] The first is patients' associations and their supporters. While most citizen groups find it difficult to organize, raise funds, and lobby effectively for their causes, patient associations are the exception. The severity of the ailments and the intensity of the suffering bring patients, families, and supporters together. The numerous associations existing in Israel allow patients to seek counsel, comfort, and support. They often have the organization needed to launch successful public campaigns.[120] In

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116. *See, e.g.*, Haim Shadmi, *Two More Medicines were Placed in the Basket after Barak Intervened*, HA'ARETZ (Isr.), Jan. 29, 2001, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (Prime Minister Barak, filling in for the Minister of Health, convinced the government to approve two more drug – one against breast cancer, the other against child respiratory infections).

117. Beni Moses, *Enlightened Democracy and the Healthcare Basket*, HA'ARETZ (Isr.), Mar. 25, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (noting that infant mortality rate in the US, despite its high spending on healthcare, is higher than those of Cuba and 41 other states).

118. Roni Linder-Ganz, *Unhealthy Privatization*, HA'ARETZ (Isr.), Aug. 24, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription). *See also* Barbara Swirkski, Hatim Kanaaneh & Amy Avgar, *Health Care in Israel,* 9 THE ISRAEL EQUALITY MONITOR (Adva Center, Tel-Aviv, Israel), Nov. 1998, at 25-29, *available at* http://www.adva.org/ health98_eng.pdf# search=% 22co% 20payments% 20medical% 20healthcare% 20israel% 20OECD% 22 (discussing privatization of health services in Israel).

119. This is said setting aside the interests of the dominant members of the committee: members from the Ministry of Health and the KHs; the latter are a formidable interest group in their own right.

120. *See infra* notes 123-24.

2005, cancer patients, along with the Israel Cancer Association, demonstrated in front of the Prime Minster's office during cabinet deliberations over the Committee's request to increase funding.[121] In 2006, colon cancer patients went on hunger strike in front of the Knesset.[122] Patients also find other outlets for support and sympathy, as their message can resonate throughout the Israeli Medical Association and the press, who let them voice their grievances[123] or present their case,[124] sometimes overstepping the line.[125]

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121. *See* Ran Resnick, *Cabinet to Discuss Increasing Health Basket Funds Today*, HA'ARETZ (Isr.), Mar. 21, 2005, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English).

122. Committee Chairman Shani stated that the additional cancer drugs were not the Committee's priority, and would not be included in the Basket even if their budget increased. Nonetheless, the government appropriated an additional $78 million and the Prime Minister requested the committee to approve the cancer drugs. *See* Ran Rezink, *Medical Decisions Based on Political Considerations*, HA'ARETZ (Isr.), May 30, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription). The Prime Minister was criticized for not handling the pressure and failing to explain that many of the government's budgetary decisions impact peoples' lives. *See* Nehemia Stressler, *Cheese Giving Holiday*, HA'ARETZ (Isr.), June 1, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

123. *See e.g.*, Irit Inbar, *What Are 5 Million Shekels of 667?*, HA'ARETZ (Isr.), June 29, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) Chairperson of the Israeli Osteoporosis and Bone Disease Association stating in an op-ed:

> [T]he members of the healthcare basket committee are meeting to decide about the final medications to enter the basket. Many patients will demonstrate in front of the government offices and sound their voice. Yet there is a group of about 300 people whose members cannot go out and demonstrate and they do not have a strong enough lobby in government. These are the elderly osteoporosis patients that only one medication can today save...

Id.

124. *See* Haim Shadmi, *Lobbyists At Work*, HA'ARETZ (Isr.), Jan. 27, 2000, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English) (In sympathizing with the misfortune of groups that do not have the ability to organize and lack the political clout to have "their" medicines added to the Basket, the reporter mentions a medication for the treatment of Alzheimer that was added because of a strong lobby. The reporter also noted that additional medications entered for this reason while others, that should have been included, were left out because there was no one to promote them).

The second interest group is the pharmaceutical industry, a lobby that is well organized and financed. This industry is notorious for its aggressive and competitive lobbying practices directed at both medical practitioners and legislators.[126] The industry is seeking to promote its products with the Committee for one major reason: there is a good deal of money on the table. The medications being purchased are typically the most expensive, most modern, and most innovative.[127] Furthermore, it is not just the Israeli pharmaceutical industry battling for the Committee's attention; the entire international pharmaceutical industry is pressing for products to be included in the Israeli Basket.[128]

Most criticism focuses on the influence exerted by the pharmaceutical companies to have their products brought before the Committee and approved for use. Their influence stems from their familiarity with the Committee members with whom they work on a daily basis. The pharmaceutical industry also applies their influence on the other power-broker, the patients' lobby,[129] using what seems to some as underhanded tactics.[130] On the issue of deceitful practices, a

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125. Ha'aretz reporter Benni Zipper severely criticized television reporter Emanuel Rosen's story on the Basket as a a cheap demagogy that is unbalanced and tainted with kitsch-effects. Benni Zipper, *TV This Week*, HA'ARETZ (Isr.), Mar. 24, 2002, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

126. *Cf.* Jim Drinkard, *Drugmakers Go Furthest to Say Congress*, USA TODAY, Apr. 25, 2005, at 1B, *available at* http://www.usatoday.com/ money/ industries/ health/ drugs/ 2005-04-25-drug-lobby-cover_x.htm) (noting a similar dynamic with the pharmaceutical industry in the US); UNITED KINGDOM PARLIAMENT, SELECT COMMITTEE ON HEALTH, REPORT, 2004-5, H.C. 42-II, at app. 26, *available at* http://www.publications.parliament.uk/ pa/ cm200405/ cmselect/ cmhealth/ 42/ 42we30.htm (noting a similar dynamic with the pharmaceutical industry in the UK).

127. S*ee supra* note 122 and accompanying text.

128. *See e.g.*, Pharma Israel - The Association of the Research Based Pharmaceutical Companies, http://www.pharma- israel.org.il/ eng/ Htmls/ article.aspx? C1004=582& BSP=573 (last visited Jan. 15, 2007) (explaining the advocacy group's mission to represent multinational pharmaceutical companies in dealing with the Basket and its process.).

129. *See* Haim Shamdi, *The Companies Give Money – and the Patients' Associations Pressure for the Drugs to be Included in the Healthcare Basket*, HA'ARETZ (Isr.), Dec. 24, 2001, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

130. Haim Shadmi, *The Road to the Healthcare Basket is Paved with Threats, Pressures, Snitching and Dirty Trickery*, HA'ARETZ (Isr.), Jan. 28, 2002, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription)

common complaint that resonates with public opinion is the direct corruption of Committee members. It is safe to say that most Israelis believe their elected politicians are corrupt, a common concern for most countries.[131]

In the first few years following its inception, the Basket Committee was treated by the press and the public with respect befitting the seniority of its members and the gravitas of its mandate. In recent years, as the Committee's public profile increases, its function becomes more politicized, and the economic ramifications of its operation become clear, Committee membership has been beset by allegations of misconduct. Among the charges have been unreported potential conflicts of interests[132] and receipt of gifts from pharmaceutical companies.[133] A seminar held at Jerusalem's Hadassah University

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> Many means are kosher in the eyes of the pharmaceutical companies in the competition over the profitable place in the healthcare basket. Novartis, for example, threatened to stop provision of the Gleevec medication freely provided to 100 leukemia patients, or as a senior Health Ministry official defines it - 'shut down their faucet of life.' The threat helped and the medication got into the basket. Other means: signing politicians on petitions, funding a SHAS [ultra-orthodox political party] convention, snitching to the Ministry of Health and payment to MD for recommendations.

Id.

131. *See e.g.*, Press Release, The Israel Democracy Institute, The Israeli Democracy Index 2006: Only 17% of the Israeli Public Believes that Politicians Keep their Promises after Elections (2006), *available at* http://www.idi.org.il/ english/ article.asp? id=01052006145754 (Israeli perceptions of politicians; entire report available in .pdf format). *But see* TRANSPARENCY INT'L, CORRUPTION PERCEPTIONS INDEX 2005 (2005), http://www.transparency.org/ policy_research/ surveys_indices/ cpi/2005 (showing Israelis as not perceiving too much corruption in their government, especially when compared to other nations).

132. Ran Reznik, *Dr. Brelovich, Member of the Healthcare Basket Committee, Did Not Publicly Announce to the Committee That His Wife Works for Merck Pharmaceuticals*, HA'ARETZ (Isr.), Sept. 1, 2005, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription). Committee member, Dr. Goldman, was not aware that Mrs. Berlovich, the wife of the Associate Director General of the Ministry of Health, had been employed by Merck for 8 years. The company's products are often considered for inclusion in the basket by the committee. *Id.*

133. Senior officials of the healthcare system and some members of the Committee, such as Dr. Blashar, were invited to speak at a conference in St. Moritz, Switzerland. To cover their expenses, conference organizers received donations from Johnson & Johnson. *See* Ran Reznik, *Placing the Holiday Before the Medication*, HA'ARETZ (Isr.), Dec. 7, 2001, *available at* http://www.haaretz.co.il/

Hospital received great publicity when senior professors in attendance declared that the struggle over inclusion of medications in the Basket is replete with bribery and favoritism.[134]

Stepping back, another look should be given to this issue, beginning with these misconduct allegations. The cases just mentioned are isolated, almost petty. Additionally, there are examples of Committee members who adamantly refused to receive any benefits from pharmaceutical companies.[135] Furthermore, the Israeli Civil Service Commission, the agency in charge of employment and discipline for all civil service employees, has ruled against such practices.[136] The Israeli Medical Association has contributed by establishing an ethical code for the relations between doctors and the pharmaceutical industry.[137] These are all reasons to believe the situation has improved.

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arch (article available in Hebrew via subscription). Pharmaceutical companies reportedly subsidized $222 for each of the 100 senior physicians at a professional conference, among them Dr. Berlovich and various other officials. For a detailed and fairly balanced report, *see* Ran Reznik, *The World's Largest Pharmaceutical Company Finances Exclusive Hotel for Ministry of Health Official*, HA'ARETZ (Isr.), Aug. 31, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

134. *See* Haim Shadmi, *Almost Everything is Bribes, Favoritism and Connections*, HA'HARETZ (Isr.), Jan. 8, 2003, *available at* http://www.haaretz.com/ hasen/pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English); Haim Shadmi, *Bribery. . . Everyone Know. Everyone is Getting*, HA'ARETZ (Isr.), Apr. 28, 2003, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English) (explaining that the healthcare basket expansion committee denounces the accusations mentioned). Surprisingly, Committee member Rabbi Yoseph Zvi Ben Porat, when asked whether the trips and goods given by the companies were bribes, replied "Of course [they are] . . . because for money, people will do anything." *Id.*

135. *See* Ran Resnik, *Instead of Rating the Medications, the Healthcare Basket Committee Turned into a Budget Lobbyist*, HA'ARETZ (Isr.), Mar. 20, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription)(mentioning that Professor Alexander Aviram, a senior official of *Kupat Holim Maccabi* and member of the Committee, refused to meet a representative of Roche Pharmaceuticals to discuss his criticism of one of their products).

136. *See e.g.,*. Ran Reznik, *Doctors Receiving Funding from Pharmaceutical Companies for a Conference in a Hotel are Committing a Criminal Offense*, HA'ARETZ (Isr.), Sept. 2, 2005 *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (concerning an announcement of the Israeli Civil Service Commission).

137. *See* Yoram Blashar, *No Bribery, No Favoritism*, HA'ARETZ (Isr.), Jan. 15, 2003, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via

The reason this issue is treated so cavalierly is because the Committee is clearly not corrupt, in the sense that its conduct or operation is illegal. The members are too senior and the proceedings too open. There are valid reasons for public concern over the deep links between the pharmaceutical industry, the medical profession, and political power, but the concern should lie in the decisions made everyday by medical doctors and the influence of private money on medical research.[138]

Moreover, much of the criticism comes from Committee members who are not familiar with the medical market.[139] Novel medical products are expensive and their results are often unpredictable; the number of patients in need of such treatments can be similarly difficult to assess.[140] Therefore, utilization of new medicines may not be the most reliable and cost-effective business model. As just mentioned, on

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subscription) (explaining that the committee's decision-making process is a marvel of a public process).

138. *See* Haim Watzman, *Israeli Research Must be Re-directed*, 6 NATURE MEDICINE 9 (2000), *available at* http://www.nature.com/ nm/ journal/ v6/n1/ pdf/ nm0100_9b.pdf ("Israeli doctors are devoting research time largely to clinical trials for foreign drug companies, an activity that produces no new basic research knowledge, says Dov Lichtenberg, deputy dean of Tel Aviv University's Sackler Medical School."). Similar occurrences are found in America as well. *See* Marshall B. Kapp, *Drug Companies, Dollars, and the Shaping of American Medical Practice*, 29 S. ILL. U. L.J. 237, 241 (2005) ("In 2001, the American pharmaceutical industry spent $12.5 billion on marketing its products, equaling approximately $10,000 per licensed physician, a 50% increase since 1998."); Howard L. Dorfman & Linda Pissott Reig, *Avoiding Legal and Ethical Pitfalls of Industry-Sponsored Research: the Co-Existence of Research, Scholarship, and Marketing in the Pharmaceutical Industry*, 59 FOOD & DRUG L.J. 595 (2004).

> The marketing activities of the research-based pharmaceutical industry have been under intense scrutiny during the past decade as never before. The Food and Drug Administration (FDA) and other regulatory agencies have examined every aspect of a drug company's interactions with both healthcare professionals and the lay public, including promotional contact between sales representatives and physicians, continuing medical education, and direct-to-consumer advertising. Another activity undergoing review is the role of the pharmaceutical company in sponsoring, conducting, and reporting the results of medical research.

Id. at 595.

139. *See* Haim Sadmi, *Seniors at the Committee Talk As-If to the Ears of the Pharmaceutical Industry. It's Scary*, HA'ARETZ (Isr.), Jan. 30, 2002, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

140. THE ECONOMIST, *An Overdose of Bad News*, Mar. 19, 2005, at 73 (discussing the risks involved in developing new drugs).

the whole, Committee members are deeply acquainted with the patients, the bureaucracy, the economics of medicine, and the pharmaceutical industry. The links the Committee has with the pharmaceutical industry may therefore be advantageous as a source of experience and outside resources that can help the Committee better understand this market.

D. The "Funny Economics" of the Healthcare Basket

The economics of the Basket have their peculiarities. The classic story heard in this context is of a patient who vitally needs a drug; she cannot afford to pay its full price out of pocket, and then wonders why the state health insurance won't help.[141] The answer to her question involves the cost of the relevant treatment, the limited budget allotted for annual expansion of the Basket, and the fair and rational decision-making process that takes place in the Committee. Yet from the economic standpoint this story has several wrinkles, not obvious to most:

1. The Price of Innovation

Estimating the precise cost of new drugs, technologies, or procedures under consideration before the Committee poses a real difficulty. In general, new products, especially medication, tend to be very expensive, reflecting research and development costs borne by the pharmaceutical companies.[142] Moreover, there are only educated estimates of how many patients will need and use such products.[143] In

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141. *See, e.g.*, Avital Nitzan, *Keeping Level*, HA'ARETZ (Isr.), OCT. 30, 2000, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription)(relating the story of an anemic cancer patient who needs an expensive drug, not included in the Basket); Yuval Azoulay, *Cancer Patients' Hunger Strike Continues Outside Knesset,* HA'ARETZ (Isr.) May 18, 2006, *available at* http:// www.haaretz.com/ hasen/ pages/ arch/ArchBuyArt.jhtml (article available via subscription in English) (protestors wondering why a cancer drug is not in the Basket with so many afflicted with the ailment).

142. Jonathan P. Glazier, *The Drug Price Controversy: A Review of Actions Taken by the Pharmaceutical Industry and the Federal and State Governments*, 1 J. HEALTH & BIOMEDICAL L. 163, 165 (2004) (stating "a new drug costs approximately $800 million to introduce into the market. Prices are set in order to recoup the investment made in these drugs, including research, development, trials, marketing, etc.") (citations omitted).

143. In 2005, a new psoriasis medication was introduced to the basket at an annual cost of $1.7 million. Kupat Holim Maccabi and the manufacturer presented data suggesting that 400 Israeli patients need the medication. The Israeli

addition, several newspaper reports intimate that perhaps the KHs end up getting a discounted price for medication.[144] If such is the case, the entire cost-structure of the medical services market may be in question, and may require public intervention. The consequences of non-disclosure create the suspicion that the KHs are overcharging the public by requesting co-payments based on the full-price, which raises the public contribution to financing medical products.[145]

2. The economics of co-payments

In a recent petition to the Supreme Court, Justice Rubinstein was particularly troubled by the co-payment system under the 1994 Act which requires the insured to make co-payments. He noted that the co-payments are set at 10% of total cost in most cases, with a minority payment range oft 25% to 50% and a majority payment range of 70%

Dermatologists estimated the number at 130. The Committee approved funding for 150 patients. A Ministry of Health internal report apparently suggests that six months after its approval, the medication was given to only thirty-three patients. See Ran Resnik, Expanding the Basket Won't Solve the Mismanagement in Setting It, Ha'aretz (Isr.), Apr. 10, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription); Ran Resnik, The Prime Benefactor is the Kupa, not the Patients, Ha'aretz (Isr.), Oct. 26, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription); Ran Resnik, How Much Does Each Medication Cost? The Ministry of Health only Replies with "Approximately", Ha'aretz (Isr.), Mar. 21, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (The reporter asked for the cost estimates provided to the committee; he was refused the information and was told by a ministry spokeswoman that "it's all rough approximations").

144. See Ran Resnik, How Much Does Each Medication Cost? The Ministry of Health Only Replies with "Approximately", Ha'aretz (Isr.), Mar. 21, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription)(explaining that the manufacturer of the Psoriasis medication told the Ministry of Health that it sells the drug to KHs at $800 per units—but some of the KHs claimed to be buying the drugs at $960 per unit).

145. See Haim, How Much do Medications Really Cost the Kupot Holim?, Ha'aretz (Isr.), Mar. 30, 2001, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (citing a Committee member, calling it "the best kept secret in the country").

to 80%.[146] Newspaper reports keep the issue in the public's eye with stories of how co-payments adversely affect individuals.[147]

3. Is this all for real?

Many observers find the entire affair, the enormous efforts taken by the Committee and the public attention surrounding it, to be a charade, with the purpose of diverting attention towards the Committee.[148] Nevertheless, the reason is clear: there is simply not enough money involved. Noted one observer:

> Within the array of medications, medical technologies, operations and treatments that the state finances annually to its citizens within the healthcare basket – at a cost of [$5.1 Billion] – this medication is merely a footnote. Its cost is [$1.7 million] and it was supposed to be given to only about 150 patients.[149]

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146. It is 70% for treatment of sleep apnea and 80% for artificial limbs, for example. *See* HCJ 2974/06 *Israeli*, at 8-9.

147. For example, a single mother of four cannot afford an ear operation. Generally, the co-payment for an ear operation is 70% of the total cost, which can be up to $15,000. *See* Roni Linder-Ganz, *For Free Plus $15,000*, HA'ARETZ (Isr.), Mar. 6, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) ("the co-payments of the health basket are too high, preventing the purchase of medication from exactly the people it was supposed to help"). Additionally, a mother of a thirty-two year-old schizophrenic complains about the increase in the monthly co-payment on her son's medications, from $9 to $75, because the medications are now included in the healthcare basket. *See* Haim Shadmi, *The Medication Went into the Government Basket: the Patients Pay More*, HA'ARETZ (Isr.), Apr. 14, 2000, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

148. *See e.g.*, Eli Shamir, *The Basket Is Not All That Matters*, HA'ARETZ (Isr.), Mar. 23, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (Professor Shamir, President of OZMA, the Israel Forum of Families of People with Mental Illness, stating: "We see daily in the press, the Knesset, the election campaign, how the healthcare basket takes over the entire health agenda. This [budget] increase is all that matters. Pressures to increase this basket may block all the vital needs of the healthcare system.").

149. Ran Reznik, *The Main Beneficiary Is the Kupa, Not the Patients*, HA'ARETZ (Isr.), Oct. 26, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription). The conversion ratio used by this author hereinafter is 4.5 New Israeli Sequels (NIS) per 1 U.S. dollar. As of October 24, 2006, the conversion rate was exactly 4.2830 NIS per 1 US Dollar. *See* Bank of Israel, Foreign Currency Exchange Rates, http://www.bankisrael.gov.il/ eng.shearim/ index.php? day= 24& month= 10& year= 2006 (last visited Feb. 10, 2007).

The sums of money involved are so small, and the fuss and public attention so enormous, that surely we are not looking at regular appropriations procedures but rather a "show" presented to the public. Another comment is that the entire budget allotted for the annual expansion of the Basket only equals the price of two military tanks, not much at all.[150] Such is the case with the entire Basket expansion effort: there is relatively little money available.[151] Yet, it is likely that the government, if convinced by outside pressure, could provide the increased budget requested by the Committee, even without the public outcry.[152] So why is the agonizing process still going on?[153]

References to Israeli dollars are clearly marked with "NIS;" otherwise, the amount is in U.S. dollars and, unless quoted by a source, has been converted by the author.

150. *See* Haim Shadmi, *The National Fiasco of Not Expanding the Healthcare Basket*, HA'ARETZ (Isr.), Feb. 6, 2002, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription)(citing Ruth Amir, Chief Instructor at the National Security College).

151. The national healthcare budget is over NIS 46 billion, while total expenditures by the government is over NIS 269 billion. ISR. CENT. BUREAU OF STATISTICS, REVENUE AND EXPENDITURE OF GOVERNMENT, LOCAL AUTHORITIES, NATIONAL INSTITUTIONS AND GOVERNMENTAL NON-PROFIT INSTITUTIONS 1, http://www1. cbs.gov.il/ shnaton56/ st14_11.pdf; ISR. CENT. BUREAU OF STATISTICS, ISRAEL IN FIGURES 2005 15, http://www.cbs.gov.il/ publications/ isr_in_n05e.pdf.

152. There are three arguments that can be made to convince the government to increase the Basket budget. First, Israel should follow other western nations which increase their healthcare budget by 2% per year, rather than maintain its current practice of increasing the budget by only 1% per year. *See* Yoram Blashar, *There is Money, There Are No Medications*, HA'ARETZ (Isr.), Mar. 19, 2006, *available at* http:// www.haaretz.co.il/ arch (article available in Hebrew via subscription). Second, the government should not distribute any surplus money in the healthcare budget to other ministries, rather the health system should retain any surplus. *See* Haim Shadmi, *Health Surplus Will Go to Security Budget*, HA'ARETZ (Isr.), Nov. 11, 2006, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English) (discussing the government's decision to distribute the surplus health budget for 2000 to other ministries, including the Defense and Public Security ministries). Third, the government should oversee and limit healthcare spending. For example, the government is required to, but does not supervise HMO spending on drugs and technology that is included in the Basket. *See* Haim Shadmi, *Medical Basket Funds Go to HMO's Operating Budgets*, HA'ARETZ (Isr.), Dec. 2, 2002, *available at* http://www.haaretz.com/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English).

153. In an apologetic op-ed, Committee Chairman Shani explained how unbearable it is to read letters from the public who are fighting for their own lives

An obvious answer is that healthcare costs are increasing at an alarming rate and a gate-keeping mechanism, in this case the Committee, is likely to be needed for quite some time. Some government body is necessary to ration public funds, even if such funds are a fraction of the true cost of modern healthcare. Moreover, the Committee's decisions to add medications, procedures and technologies are accruing, with no decline in what medications, procedures and technologies remain in the Basket.[154] Simply put, more tough decisions need to come to the Committee.

Yet, as many observers remark, the Israeli government must establish and maintain two crucial elements that are currently lacking. First, the government and the Knesset need to allow an automatic update of the Basket's total value at a rate of 2-4%.[155] Second, as various distinguished members of the Committee have pointed out: Israel needs to establish a clear national healthcare policy.

> There [is a] need to decide about priorities. Facing the technological policy that will establish the most benefit for the general public will stand the private individual with his varied ailments. Some of the patients will not be provided with innovative treatments and they will have to make-do with the conservative basket . . . In the medical and bio-technologically oriented medical world that we are living in, the scarcity will only increase. Only a clear health policy, combining examination of the individual patient's need and society's involvement in the decision-making process, will strengthen health as one of the foundations upon which society is built and will improve health in Israel.[156]

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or for the lives of their relatives. *See* Shani, *The Heart of the Health-Basket*, *supra* note 91.

154. Indeed, it is possible that some of these medications have become redundant and should be removed from the healthcare basket, bringing about millions in savings. *See* Shadmi, *The National Fiasco of Not Expanding the Healthcare Basket*, *supra* note 149.

155. *See e.g.*, Roni Linder-Ganz, *The Remedy for Cancer Patients: Automatic Update of the Healthcare Basket*, HA'ARETZ (Isr.), Mar. 27, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription).

156. Shuki Shemer, *What Will Enter the Basket*, HA'ARETZ (Isr.), Dec. 9, 1999, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription). At the time, the author, Prof. Shemer, was the Director General of the Health Ministry. He is currently Director General of Maccabi Healthcare Services. *See also supra* note 105 and accompanying text. Prof. Michaeli, also a former Director General of the Health Ministry and in 2002 a former Chairperson

Such a policy, conducted with long-term thinking in mind, could bring about a significant increase in healthcare expenditure. This course of action would improve Israelis' quality of life, resulting in reductions in sick-leave, hospitalization bills, and disability pensions.[157]

Unfortunately, such changes are unlikely to take place in Israel in the near future. While the first recommendation, an automatic update, is sound public policy,[158] it is essentially against all political interests. The Treasury wishes to retain its control over the budget, and politicians realize the huge political capital they can gain by securing additional funds for the Committee. As for the second recomendation, the political instability of the country coupled with a high turnover of Health ministers make it unlikely that a serious national policy deliberation will take place any time soon.[159] Such conditions demonstrate why the annual debate over the rising costs of the Basket's services has the potential to develop into an exciting ritual, not to be missed by participants or spectators.

E. How the Committee Has Become a Player in its Own Right

In March 2005, the Committee, headed by Dr. Bolislav Goldman, took an unprecedented step in refusing to rank medications according to their importance and usefulness.[160] Rather, the Committee presented all of its recommendations for fifty-five new medications, technologies, and examinations *en-bloc*. The total costs proposed amounted to 465 million New Israel Sheqel [NIS]; the government only budgeted a mere NIS 200 million.[161] Advocates for this budget expansion claimed that the government needs to take more

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of the Board at Clalit Healthcare Services, called for the establishment of a committee that would define the targets of the Israeli healthcare system.

157. *See* Shadmi, *The National Fiasco of Not Expanding the Healthcare Basket*, *supra* note 149.

158. So much so, that Prime Minister Olmert's government stated as its main health policy goal to adopt "a policy of a measured and appropriate enlargement of the health basket. Beginning in 2007, the drug basket will increase by 4% per annum . . ." ISR. PRIME MINISTER'S OFFICE, GOV'T POL'Y, para. 33, http://www.pmo.gov.il/ PMO/ Government/ Policy.

159. *See* Zvi Zerahia, *The Knesset Rejected Proposal to Establish a Committee to Examine the Medication Crisis*, HA'ARETZ (Isr.), June 1, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

160. *See infra* note 165.

161. *See* Ran Reznick, *Cabinet to Discuss Increasing Health Basket Funds Today*, HA'ARETZ, Mar. 21, 2006, *available at* http://www.haaretz.co.il/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English).

responsibility over its life-and-death decisions.[162] Even though an increase of NIS 70 million was approved by the Finance Minister,[163] it can be said that the Committee has shirked from carrying out its basic function. There is merit in the claim that it has turned into yet another lobby for an increase of the Basket's budget. At the same time, by entering the political budgetary field, the Committee enhanced the public pressure on the government, which has worked as recently as 2005.[164]

In March 2006, the Committee again recommended new drugs and technologies for a price of NIS 104 million, though the government had initially approved only NIS 37 million. Again, the Committee correctly assumed political support would be found to increase the Basket's funding.[165]

The political nature of the Basket became clear during the 2006 general elections.[166] Israeli State Attorney General Menahem Mazuz

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162. *See id.*

163. *Id.*

164. *See id.* Moti Bassok, *150 Million Shekels for the Healthcare Basket Will Be Transferred Immediately After the 2005 Budget is Approved*, HA'ARETZ (Isr.), Mar. 25, 2005, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (Prime Minister Ariel Sharon and Treasury Secretary Benjamin Netanyahu came to an agreement on an additional budget for the healthcare basket).

165. The 2006 Committee is headed by Prof. Mordechai Shani, who reportedly said the members considered resigning and returning their mandate to the government, given the inadequate funding. *See* Ran Reznick, *The Healthcare Services Basket Committee Demand 467 Million NIS for New Medications*, HA'ARETZ (Isr.), Mar. 30, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription); Ran Reznick, Moti Bassok & Nir Hasson, *Compromise: 310 million Shekels Worth of Medications Have Been Added to the Basket*, HA'ARETZ (Isr.), Apr. 10, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription); Ran Reznick & Zvi Zerahia, *Health Gets NIS 350m Boost, at Next Year's Expense*, HA'ARETZ (Isr.), May 30, 2006, *available at* http://www.haaretz.co.il/ hasen/ pages/ arch/ ArchBuyArt.jhtml (article available via subscription in English); Ran Reznick, *Ten More Medications Will Enter the Healthcare Basket Starting July 1*, HA'ARETZ (Isr.), June 19, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (an additional 157 million NIS are added as the government accepts the Committee's budgetary demands). *See also* Shadmi, *Panel Opposes New Antibiotics for Health Basket*, *supra* note 86 (noting, in 2001, that the Committee has never had its recommendations for budget increases denied).

166. Already in late 2005 there was concern in the health system that early elections might delay the passing of the national budget and therefore the

instructed the Committee to postpone its final decisions, as opposed to its deliberations, for two weeks so they would come after election day. This move was part of his policy allowing the interim government to only make such decisions as were essential for the day-to-day running of government.[167] It is possible that the Attorney General was concerned that Committee decisions would be used as part of the election campaign.

F. The End-Run?

The increased political tension around the Committee's operation now seems likely to bring about a major overhaul. There have been various indications that the Committee is losing its professional decision-making autonomy. Recent pressure by the Prime Minister on the Committee to approve cancer drugs demanded by colon cancer patients is one indicator.[168] The Committee has not made a decision, but some sources find it likely that the Committee will cave in to such pressures, or accept some sort of deal with a significant budgetary increase. Should this happen, the cancer patients will have won their public struggle but at the price of politicizing the process.[169] Health

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budgeting of additional funds for the Basket. *See* Roni Linder-Ganz, *Former Health Ministers to the Treasury Secretary: Transfer 400 Million Shekels for the Upcoming of the Healthcare Basket*, HA'ARETZ (Isr.), Dec. 5, 2005, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription); Zvi Zerahia, *The [Knesset] Finance Committee Demands an Increase of the Healthcare Basket Budget by 350 Million Shekels,* HA'ARETZ (Isr.), Dec. 14, 2005, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription).

167. A petition to the Supreme Court against the Attorney General's decision was rejected. *See* Zvi Zerahia, Ren Reznick & Yuval Yoaz, *Attorney General Mazuz: The Healthcare Basket Should not be Decided Before the Election*, HA'ARETZ (Isr.), Mar. 16, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription). The Supreme Court rejected the petitions in a 2 to 1 decision. HCJ 2453/06 Israeli Medical Association v. Attorney General [2006] IsrSC, *available at* http://elyon1.court.gov.il/ files /06 /530 /024 /o04 /06024530.o04.pdf (document in Hebrew).

168. Meirav Arlozorov, *Everything's Politics, Even Human Lives,* HA'ARETZ (Isr.), May 22, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription) (the principle one can deduce from Olmert's capitulation to the strikers' is that in Israel he who presses more gets more, and there is no room for professional judgment in the running of the state, only room for politics).

169. *See* Ran Reznik, *Medical Decision for Political Reasons*, HA'ARETZ (Isr.), May 30, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription); Arlozorov, *Everything's Politics, Even Human Lives, supra* note 168. *See also* Editorial Staff, *Main Editorial*, HA'ARETZ (Isr.), May 23,

Minister Yacov Ben-Yizri set another troubling precedent when he announced the move of NIS 3.3 million from the Committee's budget to pay for medications the Committee previously rejected. The press blamed the Minister in succumbing to public and political pressures and this step seriously undermines the work of the Committee.[170] Finally, the political pressures on the Committee brought them into direct confrontation with the current Prime Minster, risking a potential overhaul of the Committee's membership and work.

The Prime Minister, Mr. Olmert, had openly criticized the Committee's operation and demanded the appointment of a new Committee with a radically changed composition. Olmert's demands include a reduction in the Committee's size (from twenty-five to fourteen members) and the inclusion of four law and ethics specialists, four economists, four retired healthcare specialists and one representative each from the Ministries of Health and Treasury.[171] This means there will be no members of the KHs, no active medical doctors, and no members of the Israeli Medical Association on the Committee. The proposed changes are apparently the result of claims, as outlined above, that current Committee members have possible conflicts of interests. It is important to note that under the new scheme proposed by the Prime Minister there will be two new advisory committees to assist the principal body: a medical committee including active doctors, heads of the KHs and the Israeli Medical Association, and an economic committee.[172]

2005, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription). As noted, senior politicians have tried to influence the Committee in the past, but it's now seen as a political move to woo voters, not help the poor.

170. *See* Ran Reznik, *Tough Questions Regarding the Minister's Functioning*, HA'ARETZ (Isr.), May 26, 2006, *available at* http://www.haaretz.co.il/arch (article available in Hebrew via subscription).

171. *See* Ran Reznik, *Olmert Demands a New Committee for the Healthcare Basket – Without Active MDs*, HA'ARETZ (Isr.), June 9, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription).

172. *See id.*; Ran Reznik, *Ten More Medications Will Enter the Healthcare Basket Starting July 1*, HA'ARETZ (Isr.), June 19, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription). The Sharon government decided that the Committee will have twelve members, none of whom are public representatives. It would have three members from the Ministry of Health, one from the Treasury, six doctors and two health-economists. Shahar, *270 New Political Appointments*, *supra* note 79.

G. A Final Word.

The CEO of Clalit Health Services Group, Ze'ev Wormbrand, nicely summarizes the state of the Israeli healthcare basket:

> [o]ur healthcare basket is the most advanced in the world. We approve medical technologies well before other countries. For example, dialysis is not provided in England for persons older than 65. With us, an elderly 88 year old can receive dialysis treatment. After all, the value of life here is greater.[173]

Moreover, budgeting is clearly a political issue. The Basket is only one of the many services in Israel's waning welfare state. Limited government funds have to cover education; welfare for the young, the elderly, the disabled and unemployed; national security, and all the other obligations of statehood. On a more optimistic note, we now move on to a short discussion of one of the unique budgeting priorities of the Israeli national healthcare system: fertility treatments.

IV. REGULATING LIFE: FERTILITY TREATMENT IN ISRAEL

A. Public Financing of ART: An Introduction

> The United States and Israel are widely regarded as possessing two of the most ART [Assisted Reproductive Technology]–friendly environments in the world. Both countries stand at the epicenter of fertility-related research and practice and support the supply and demand sides of the ART market with avidity.[174]

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173. Meirav Arlozorov, *After All, the Value of Life in Israel is Greater*, HA'ARETZ (Isr.), March 21, 2006, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription). It is the opinion of this author that most of the critique of the Basket is populist. The Israeli Basket is one of the best and most generous of its kind in the world.

174. Ellen Waldman, *Cultural Priorities Revealved: The Development and Regulation of Assisted Reproduction in the United States and Israel*, 16 HEALTH MATRIX 65, 67 (2006). ART includes fertility treatments in which both eggs and sperm are handled in the laboratory (i.e., in vitro fertilization and related procedures). *See also*, Victoria Clay Wright, et al., *Assisted Reproductive Technology Surveillance — United States, 2003*, 55 MORBIDITY AND MORTALITY WEEKLY REPORT 1 (Ctr. for Disease Control, Atlanta, Ga.), May 26, 2006, *available at* http://www.cdc.gov/ mmwr/ preview/ mmwrhtml/ ss5504a1.htm. (stating that IVF treatments account for about 99% of ART procedures in the United States).

Professor Ellen Waldman's statement above is the result of two diametrically opposed models of providing and financing ART.[175] On the one hand is the American model. While the United States is a world leader in ART, as in many advanced medical technologies,[176] ART expenses are viewed in the United States "primarily as a luxury expenditure, the costs of which [are primarily] shouldered by fertility consumers."[177] Indeed, since the 1980s the "baby business" has developed greatly, with about 8 million infertile women in the United States spending around $3 billion a year in order to conceive.[178] The costs are high. A single IVF cycle alone is estimated to cost at least $12,000 and the treatment as a whole may cost upwards of $70,000–and that's before the child-rearing expenses of diapers, orthodontics, and college tuition.[179] Some women are "seeking help in places like South Africa, Israel, Italy, Germany, and Canada, where the costs can

175. ART can be defined as "treatments or procedures which include the handling of human oocytes or embryos, including in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and such other specific technologies . . ." 42 U.S.C.A. § 263a-7(1) (2003). In vitro fertilization (IVF) "refers to the procedure by which a woman's eggs are first extracted from her ovaries and then fertilized outside of her body." *Assessing the Viability of a Substantive Due Process Right to In Vitro Fertilization*, 118 HARV. L. REV. 2792, 2793 (2005). *See generally id.* (describing IVF and its status in the United States).

176. Recent data suggests that 56% of all reported ART cycles (357,884; 2003 figures) were carried out in Europe; almost 50% of the reported cycles in the world were in four countries: USA (112,000), Germany (85,000), France (64,000), and the UK (37,000). Press Release, European Society of Human Reproduction & Embryology, Three Million Babies Born Using Assisted Reproductive Technologies (Aug. 30, 2006), *available at* http://www.eshre.com/ emc.asp? pageId=806 [hereinafter ESHRE]. However, research suggests there is a significant difference in favor of the American system in relation to pregnancy rates and live birth rates. *See* Norbert Gleicher, Andrea Whghofer & David Barad, *A Formal Comparison of the Practice of Assisted Reproductive Technologies Between Europe and the USA*, 21 HUMAN REPRODUCTION 1945, 1945, 1946, 1948, tab. 2, at 1947 (2006). *See generally* THE REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGY (Jennifer Gunning & Helen Szoke eds., Ashgate Publishing, 2003) (giving a more global perspective on the issue).

177. Waldman, *supra* note 174, at 87.

178. David Plotz, *How Making Babies has Become a $3 Billion Industry–and an Unregulated Mess*, THE WASHINGTON POST, Feb. 26, 2006, at BW05 (reviewing DEBORAH L. SPAR, THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION (Harvard Business School Press 2006)).

179. *See id.*

be much lower, becoming in essence fertility tourists."[180] As one expert observed: "The fertility-industrial complex is a stunning array of businesses—practically a microcosm of the entire global economy."[181]

The first IVF birth took place in 1978; over twenty-five years later, there is almost no U.S. federal regulation covering IVF and no government support for IVF research.[182] U.S. regulation of IVF is a patchwork. The states that do have laws concerning IVF regulation all vary greatly in their scope of what procedures and methods are to be regulated. The conclusion is that state regulation, like federal regulation, is limited.[183]

Israel is a stark contrast to the United States. Israel's current status in this field is the result of heavy investment of public resources in providing wide and free access to ART treatment as part of "the basic package of health benefits guaranteed by the government."[184] Additionally, IVF clinics are abundant and Israeli fertility experts are global leaders in their fields.[185] This extremely pro-reproductive policy is a result of the country's religious beliefs, grounded in the Bible's Old Testament.[186] Due to IVF being in the Basket, the Israeli government covers the entire cost of any and all IVF cycles for its women citizens.[187]

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180. Felicia R. Lee, *Driven By Costs, Fertility Clients Head Overseas*, N.Y. TIMES, Jan. 25, 2005, at A1.

181. Plotz, *supra* note 177, at BW05. Other medical costs include "sperm ($275 a vial), eggs (up to $50,000 apiece), and nine months use of a womb ($20,000)." *Id.* *See also* Leslie Grant Timmins, *Ancient Medicine for a Modern Problem*, GLOBE & MAIL, April 15, 2006, at F9 (stating IVF is expensive and doesn't always work, so some are turning to traditional Chinese treatments such as acupuncture); American Society of Reproductive Medicine, *Frequently Asked Questions About Infertility*, http://www.asrm.org/ Patients/ faqs.html (last visited Nov. 21, 2006) [hereinafter ASRM] ("The average cost of an IVF cycle in the United States is $12,400.").

182. *Assessing the Viability of a Substantive Due Process Right to In Vitro Fertilization*, *supra* note 175, at 2792. The lack of regulation can be traced to the federal government's reluctance to fund IVF research. "In the absence of government support, the IVF industry has developed entirely within the private sector. This reliance on private funds explains much of the current laissez-fair state of IVF industry regulation." *Id.* at 2794.

183. *Id* at 2795-96. *See also* Jennifer L. Rosato, *The Children of Art (Assisted Reproductive Technology): Should the Law Protect them from Harm?*, 2004 UTAH L. REV. 57, 62-66 (2004).

184. Waldman, *supra* note 174, at 87.

185. *See* F. Simonstein, *Pressures on Women to Reproduce and the Drive Towards Assisted Reproductive Technologies*, 25 MED. & L. 355, 359 (2005).

186. *See id.*

Most nations are somewhere in the middle of the spectrum, between these two models.[188] Spending public funds on ART treatments is, in general, a difficult public policy question to handle.[189] On the one hand, if a nation has limited public resources and a chronically underfunded public healthcare system, easing the pain and suffering of the living could be viewed as more urgent than producing the unborn.[190] Furthermore, planning and producing a family is a very private matter, an area where public regulation is most unwelcome. The idea of such intervention has troubling implications.[191] In addition to these

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> Jewish women are under extraordinary pressure to reproduce, whether they are married or not. The barren woman is an archetype of suffering in the Israeli-Jewish mentality. From the childlessness of the matriarchs in the book of Genesis about which every Israeli schoolchild learns from the age of six, Israelis learn that barrenness is tragic for a woman. . . . Israeli reproductive policies do not protect women but rather seem to protect the biblical command 'be fruitful and replenish the earth' (citation omitted.).

Id. at 359, 360

187. *See id.* at 362.

188. Sandra Dill, *Consumer Perspectives*, CURRENT PRACTICES AND CONTROVERSIES IN ASSISTED REPRODUCTION, 255, app. A at 263-71 (Effy Vayena, et al. eds., 2002), *available at* http://www.who.int/ reproductive-health/ infertility/ 25-2.pdf.

189. *See generally* Peter J. Neuman, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215 (1997) (discussing the value of IVF, the emotional debate surrounding IVF, and state action in this area).

190. *See e.g.*, Adi Bar-Lev, *Just Allocation of Reproductive Choice: The Case of Israel's Sick Funds,* 00 APA NEWSLETTERS (Am. Philosophical Ass'n, Newark, Del.), Spring 2001, *available at* http://www.apa.udel.edu/ apa/ publications/ newsletters/ v00n2/ medicine/ 14.asp (giving an example that compares two women).

> One wishes to conceive a child, the other seeks to terminate her pregnancy . . . The predicaments at hand are far more similar than they may appear. Neither woman is in grave physical jeopardy; neither requires treatment to prolong her life. Both would suffer a decline in perceived quality of life if denied the procedures they seek. . . . [Unfortunately, with the Basket and] Israel's universal healthcare system, the needs of only one woman would be met. The former would receive all medical interventions modern technology has availed; the latter would not.

Id.

191. Consider the horror with which the Chinese "one-child-per-family policy" was met in the West, and the idea of public involvement in family planning feels quite inappropriate. *See generally*, Ling Jing Zhou, *Provision of Assisted Reproductive Technology for Single Women in China: A New Challenge*, 23 MED.

concerns is the 16% of all couples worldwide who face fertility issues.[192] ART is an expensive, elective treatment; success rates are only around 25-30%.[193] As long as the debate is focused on the medical benefits of ART, as it has been in England, the result can be a stand-off.[194]

& L. 433 (2004) (discussing the Chinese government's modern intrusion into the reproductive activities of its citizenry).

192. An estimated "one in six couples worldwide experience some form of infertility problem." ESHRE, *supra* note 176. *See also UK Only 12th in League for Access to IVF Treatment*, TELEGRAPH, June 22, 2006, http://www.telegraph.co.uk/ news/ main.jhtml? xml=/ news/ 2006 /06 /22 /ntwin122.xml [hereinafter: Telegraph] ("Around one in seven couples in Britain – 3.5 million people – have problems conceiving."). The Israeli Ministry of Health's data suggests that 16% of couples in relevant ages (over 160,000 couples) cannot have children. In about a third of cases the problem is in the man's sperm; in 45% of cases hormonal or mechanical deficiencies of the woman are the problem. The rest are unexplained or are suspected to have a psychological basis. *See* Vared Levy-Barzilay, *Bring Six, Bring Seven, Bring Eight Children*, HA'ARETZ (Isr.), Jan. 28, 2005, *available at* http://www.haaretz.co.il/ hasite/ pages/ ShArtPE.jhtml? itemNo =531823 (article in Hebrew).

193. It has been asserted that, world-wide, "[t]he average pregnancy rate for each cycle using fresh embryos was 25.1% and the delivery rate was 18.5%. However, these rates varied from 13.6% to 40.5% for pregnancy, and 9.1% to 37.1% for delivery." ESHRE, *supra* note 176. In Australia, the 2003 success rates varied from 13.9% (for frozen oocytes) to 18.6% (for fresh oocytes). JENNIFER L. SMITH, AUSTL. HEALTH POL'Y INST., MEDICARE AND ASSISTED REPRODUCTIVE TECHNOLOGIES, 3 (2006), http://www.ahpi.health.usyd.edu.au/ research/ publish/ ivfbrief.pdf [hereinafter SMITH, MEDICARE]. In Britain, "[n]early 30% of treatment cycles lead to pregnancy." Ian Sample, *Britan Given Low Rating on Access to IVF Treatment*, THE GUARDIAN (U.K.), June 22, 2006, http://www.guardian.co.uk/ medicine/ story/ 0,,1803105,00.html. *See also* ASRM, *supra* note 181 ("The average live delivery rate [in the United States] for IVF in 2000 was 29.9 per cent per retrieval."). All of these figures raise an interesting public policy question: is a 25-30% success rate the sign of a highly developed and productive technique, or a highly wasteful and not very pleasant medical procedure?

194. *See* Mark Henderson, *Junk Medicine: IVF Treatment*, THE TIMES (U.K.), June 24, 2006, http://www.timesonline.co.uk/ article/ 0,,8123- 2238654,00.html [hereinafter Henderson, *Junk Medicine*] (describing the debate amongst doctors and administrators, some of who argue that "it is inappropriate for the state to pay for treatment of a disorder that threatens no lives. Others, including most gynecologists and patient groups, [take the other side and] regard infertility as an organic and deeply distressing illness no less deserving of free therapy than any other.").

Recent studies suggest that it makes sound economic sense for the government to sponsor ART treatments. Professor William Ledger of Britain's University of Sheffield estimates that every baby born in Britain through "[National Health Service] IVF treatment carrie[d] a price-tag of £13,000 . . . [but even after her] education, child benefit and healthcare are paid for, [she] will contribute, on average, a net £147,138 to the Exchequer throughout [her] lifetime."[195] Ledger and his team argue that "the data gives weight to the argument that the NHS should fund three cycles of IVF, as clinicians recommend . . . [resulting] in 10,000 more IVF babies over two to three years."[196] In order to provide context, "[t]he NHS currently spends £85 million on providing a single cycle of IVF to women under 40. It would cost about £100 million more to offer three free cycles."[197] Thus, by properly funding IVF births, the British government can contribute over £45,000 to the country's revenue.

Additionally, the research suggests that IVF treatments could also help address another major problem facing Western nations, the demographic problem of an aging population. EU total fertility rates (TFR) are now below replacement levels.[198] Replacement levels are usually gauged to be at 2.1 children per woman; however, European averages for some countries have fallen below 1.5 children per woman.[199] A RAND Europe report on ART suggests that the combination of increased life expectancy and declining fertility will lead to a doubling of the proportion of the population over sixty-five to 30% by 2050.[200] This would create a greater burden on the working class to provide for the growing number of pensioners.[201] The RAND

195. *Id.* ("[She] pays for itself by the age of 31 in tax alone: the model does not include the wealth it creates in the private sector. The "break-even" point is just two years older than for naturally conceived children, who contribute a net •160,069.").

196. Caroline Ryan, *IVF 'Good for British Economy'*, BBC NEWS, June 19, 2006, http://news.bbc.co.uk/ 1/hi/ health/ 5095884.stm.

197. Mark Henderson, *Multiple Births from IVF are 'Dangerous and Costly'*, THE TIMES (U.K.), June 23, 2005, http://www.timesonline.co.uk/ article/ 0,,8122-1665206,00.html [hereinafter: Henderson, *Multiple Births*].

198. JONATHAN GRANT, ET AL., RAND EUROPE, SHOULD ART BE PART OF A POPULATION POLICY MIX? 8 (2006), *available at* http://www.rand.org/ pubs/ documented_ briefings/ 2006/RAND_ DB507.sum.pdf #search= %22Jonathan %20Grant %20RAND %20Europe %20IVF %22.

199. *Id.*

200. *Id.* at 1.

201. *Id.*

study suggests that even small increases in the number of ART cycles provided would amount to an extra 20,000 babies being born per year.[202] The study suggested that increased ART is more cost effective than other methods that may be available to a government.[203]

B. Israel in a Comparative Perspective

Israel is the clear leader in the availability of IVF treatment, even when compared to the leading European welfare states.[204] As a comparison, the British healthcare trusts are required by law to provide one free cycle of IVF to patients.[205] Yet these health trusts, through their internal policies, have been avoiding this government mandate and not providing the free cycles.[206] Alternatively, Danish public health services offer five free cycles of IVF.[207] Australia is the most similar to Israel in funding IVF in that both countries are the only two to offer public funding for ART that is not capped.[208]

Israel's IVF policy is such that "[p]ublicly-funded IVF is provided practically without limitations, for a wide range of indications, with minimal payment at the point of delivery. Women of all ages, marital

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202. *Id.* at 2.

203. *See id.*

> Including ART in a population policy mix may even be more cost-effective than other measures. A comparison of cost per additional birth showed that whereas a 25% increase in child benefits would raise TFR by 0.07, the cost per additional birth was between £50,000 and £100,000. The average cost per additional ART birth was estimated at £15,000–£25,000.

Id. at 8. *See also* Guy Laroque & Bernard Selanié, *Does Fertility Respond to Financial Incentives?,* Ctr. For Econ. Pol'y Research, Discussion Paper (2004) *available at* http://papers.ssrn.com/sol3/papers.cfm ?abstract_id=772706.

204. Kristy Horsey, *Three Million IVF Babies Born Worldwide*, BIONEWS (U.K.), June 28, 2006, http://www.bionews.org.uk/ new.lasso? storyid=3086 ("Availability was found to be at its highest in Israel, which gave 3,260 cycles per million population, followed by Denmark, at 2,031 cycles per million.").

205. Henderson, *Multiple Births*, *supra* note 197. Further, this funding is only for women under 40. *Id.*

206. *See* Severin Carrell & Steve Bloomfield, *The Fertility Gap*, THE INDEPENDENT (U.K.), Feb. 9, 2007 *available at* http://news.independent.co.uk/ uk/ health_ medical/ article356652.ece.

207. Sample, *Britan Given Low Rating on Access to IVF Treatment*, *supra* note 193.

208. SMITH, MEDICARE, *supra* 193, at 3.

status and sexual preference are entitled to treatment, until they have two children from the present relationships."[209]

The reasons for the unique Israeli position have been well explored, and they mostly relate to Israel's cultural context. Across Jewish-Israeli class and ethnic lines great emphasis is placed on the creation and preservation of a family, elevating child-bearing to one of life's central tasks. Both Jewish men and women are subject to societal pressures to reproduce. The Jewish man is commanded to procreate according to tradition and the archetype of the barren woman is the Jewish epitome of failed purpose.[210]

The Israeli policy is not without critics. While the Israeli system legitimates women's reproductive ambitions through the moral and financial support of the state, critics of the Israeli system note that it turns private procreative matters into "public works projects." [211] Other criticisms see the Israeli program simply as a means of implementing a Biblical imperative,[212] or even a way of constitutionally mandating motherhood to those who would otherwise not opt to have children.[213] There is also criticism of gynecologists' eagerness to have couples undergo fertility treatments, although 85% of the young couples will conceive naturally within a year, and 93% within two years.[214]

Finally, it must be noted that some efforts to cap the availability of IVF treatments have been made over the years. Public outrage developed during an initiative in the 1990's to limit state coverage to

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209. Daphna Birenbaum-Carmeli, *'Cheaper Than a Newcomer': on the Social Production of IVF Policy in Israel*, 26 SOC. OF HEALTH & ILLNESS 897, 900 (2004) (citations omitted).

210. *See* Waldman, *supra* 174, at 70. *See also* Frida Simonstein, *Pressures on Women to Reproduce and the Drive Towards Assisted Reproductive Technologies*, 25 MED. & L. 355, 359 (2006); Miryam Z. Wahrman, *Fruit of the Womb: Artificial Reproductive Technologies & Jewish Law*, 9 J. GENDER RACE & JUST. 109, 109-12 (2005) (discussing Jewish cultural attitudes toward reproduction).

211. Waldman, *supra* 174, at 87.

212. Simonstein, *supra* note 210, at 360.

213. Birenbaum-Carmeli, *supra* note 209, at 902.

214. *See* Vered Levy-Barzilay, *Bring Six, Bring Seven, Bring Eight Children*, *supra* note 192.

seven cycles of IVF.[215] In addition, the public has expressed resentment to small monthly co-payments.[216]

CONCLUSION

Between the years 1903 and 1904, Austrian composer Gustav Mahler wrote a song cycle for voice and orchestra titled *Kindertotenlieder*, or *Songs of the Death of Children*.[217] Around this period, he became the father of two beautiful, healthy daughters.[218] Yet in 1907, Mahler's daughter, Maria, died of either scarlet fever or diphtheria at the age of four.[219] Some describe Mahler's obsession with death as prescient.[220] It is fair to suggest he was merely a concerned

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215. *See* Birenbaum-Carmeli, *supra* note 209, at 907-08.

216. Nirit Shapira, *How Much Does a Baby Cost?*, HA'ARETZ (Isr.), Mar. 30, 1998, *available at* http://www.haaretz.co.il/ arch (article available in Hebrew via subscription).

217. MICHAEL STEINBERG, THE SYMPHONY: A LISTENER'S GUIDE 313 (Oxford Univ. Press 1995).

218. *Id.*

219. *Id.*

220. As part of the "Mahler Cult" that evolved in the late 20th century, many compositions of his last years, especially the *Kindertotenlieder* and the Sixth and Ninth Symphonies, came to be interpreted as emotionally foreshadowing of both Mahler's personal-life tragedies and the 20th century tragedies that brought about the destruction of the world-order Mahler knew. Within a few years after his death, the first World War brought down the Austro-Hungarian empire. Later, the Second World War brought additional destruction, especially to Europe's Jewry. Mahler's artistic premonition remains a fascinating issue. *See generally* Vera Micznik, *The Farewell Story of Mahler's Ninth Symphony,* 20 19TH-CENTURY MUSIC 144 (1996) (discussing how the composer's Nonth Symphony was a narrative of his farewell to the world and life); STEINBERG, *supra* note 217, at 313-314 (Mahler's wife Alma was troubled by her husband's interest with the deaths of children, and perhaps felt that he had "tempted providence by composing those songs. Mahler himself saw it differently. He was convinced that an artist has the power to intuit, even to experience, events before they occur."); Stuart Feder, *Mahler, Mourning and Consolation,* 4 NATURLAUT 8 (2005) *available at* http://mahlerarchives.net/ archives/ symp.html.

> What lurked perennially was death and its accoutrements-the trappings, associations and implications of death. This was the unsettling "force" that had touched Mahler at the séance; but he was no stranger to it. Indeed, it might be said that Mahler had a romance with death, which is represented richly in his music from his earliest works.

father, and justly so.[221] A mere century ago, medicine had precious little to offer for those in Mahler's position. At the beginning of the twentieth century both the rich and poor suffered and died in much the same way as Mahler's daughter; often from inflictions that have been completely eradicated or minimized today. Consider that "[i]n 1900 in some U.S. cities, up to 30% of infants died before reaching their first birthday."[222] From 1915 through 1997, the infant mortality rate declined in the United States so dramatically, that the Center for Disease Control proudly noted that "[t]he decline in infant mortality is unparalleled by other mortality reduction this century."[223]

These statistics give hope for expanding families. They may find comfort in the achievements of American public health, social welfare, and clinical medicine (both pediatrics and obstetrics). These improvements may relieve them of their worst fears for expectant-

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Id. at 8. *But see* Richard Bernstein, *Reality Check for the Mythic Mahler,* N.Y. TIMES, Jan. 21, 1998, at E9 ("Jonathan Carr [in *Mahler: A Biography*]. . . finds little to indicate that Mahler's life was burdened by a sense of impending catastrophe.").

221. Mahler was "an expert on the deaths of children," having lost relatives at various ages. STEINBERG, *supra* note 159, at 274. *See also* Nicky Hart, *Beyond Infant Mortality: Gender and Stillbirth in Reproductive Mortality Before the Twentieth Century,* 52 POPULATION STUDIES 215, 226 (1998).

> It is worth reminding ourselves that the national infant mortality rate of nations like Russia or Austria was in the region of 300 per 1,000 live births (excluding stillbirths) in the first decade of [the 20th] century. This level of reproductive mortality seems fantastic today but in some parts of Europe it was routine in the early twentieth century.

Id. at 226.

222. *Assisted Reproductive Technology Surveillance United States, 2003,* 48 MORBIDITY AND MORTALITY WEEKLY REPORT (Ctr. for Disease Control, Atlanta, Ga.), Oct. 1, 1999 *available at* www.cdc.gov/ mmwr/ preview/ mmwrhtml/ mm4838a2.htm.

223. *Id.*

> At the beginning of the 20th century, for every 1000 live births, six to nine women in the United States died of pregnancy-related complications, and approximately 100 infants died before age 1 year(1,2) . . . From 1915 through 1997, the maternal mortality rate declined almost 99% to less than 0.1 reported death per 1000 live births (7.7 deaths per 100,000 live births in 1997) . . .

Id. See also Chicago Public Library, 19th and 20th Century: Infant and Childhood Mortality www.chipublib.org/ 004chicago/ disasters/ infant_ mortality.html (last visited Oct. 21, 2006) ("In 1870, with 4,000 deaths in the 0-4 age group, a Chicago child had a 50% chance of reaching the age 5.").

mothers and children.[224] Unfortunately, the blessings of modern medical research and treatment literally come at a price. As this price consistently rises faster than economic growth, it is clear that in coming years we shall increasingly face tough financial dilemmas. Seeking the most advanced medical treatment may require cuts in other expenditures.

These dilemmas must be faced at various levels: that of the individual, that of nations, and that of the international community. This article only deals with the middle of the three. It seems safe to assume that well-to-do individuals will keep seeking top-notch medical treatment, whatever the cost, and that medical research and development will continue rolling-out sophisticated and expensive medical procedures, treatments, and medications. On the international level it seems fair to say that this current difference in the availability of medical care between the world's richer and poorer nations is already unacceptable. Further advances in Western medicine are likely to widen the gap, but this seems almost irrelevant given the existing disparity.[225]

This article addresses some of the dilemmas raised at the national level, such as how a national government is to deal with the rising costs

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224. The reduction in infant mortality occurred among all Western nations, but the rates among the world's less developed and poorer nations is alarmingly high. *See generally* U.N. DEVELOPMENT PROGRAMME, *Human Development Report: Goal 4 Reduce Child Mortality* (2003), *available at* http://hdr.undp.org/ reports/ global/ 2003/ indicator/ pdf/ hdr03_table_MDG3.pdf (giving relevant data for all major nations). *See also* ORG. FOR ECON. CO-OPERATION AND DEV., OECD HEALTH DATA 2005 HOW DOES THE UNITED STATES COMPARE 2(2005), http://www.oecd.org/ dataoecd/ 15/ 23/ 34970246.pdf ("Infant mortality rates in the United States have fallen greatly over the past few decades, but not as much as in most other OECD countries. . . Among OECD countries, infant mortality is the lowest in Japan and the Nordic countries . . . all below 3.5 deaths per 1 000 live births.") .

225. To use the earlier example of infant mortality: UN 2003 figures suggest that US figures (7 deaths per 1,000 live births) are about eight times better than the world average (56 deaths per 1000 live births), twelve times better than Pakistan (84 deaths per 1,000 live births), and over twenty-three times better than Afghanistan (165 deaths per 1,000 live births). U.N. DEVELOPMENT PROGRAMME, *supra* note 224, at 208-212. *See e.g.* World Health Organization, Health Inequalities, http://www.who.int/ health-systems- performance/ docs/ healthinequality_ docs.htm (last visited Nov. 21, 2006); Economic and Social Research Council, ESRC Society Today Global Health Inequalities, http://www.esrc.ac.uk/ ESRCInfoCentre/ facts/ international/ health.aspx? ComponentId= 14902 &SourcePageId- 14912 (last visited Nov. 21, 2006).

and growing needs for medical care within its budget. This paper presents two aspects of the Israeli experience. The Israeli government is committed to the provision of a "healthcare basket" of medical services to its entire population. The government has formed a professional advisory committee to recommend how to annually update the Basket. The government's chronic under-funding of this Committee resulted in the Committee adopting a policy clearly preferring the purchase of expensive new drugs to treat small numbers of severely ill patients, rather than advancing policies that would improve the public health of a greater number of people. Mounting public, political, medical-professional, and ethical pressures on the Committee led the government back to the administrative drawing board.

The final chapter of this article presented a unique Israeli public-health-policy decision: to provide almost unlimited funding for fertility treatments. For cultural and religious reasons, the Israeli polity has coalesced around two types of patients who have first priority and receive treatment almost irrespective of cost; all other patient categories then stand in line. The Israeli experience should be of interest and possibly of use to other national governments when setting their priorities in allocating public money for healthcare treatment.