Dalhousie Law Journal

Volume 20 | Issue 2 Article 8

10-1-1997

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Recommended Citation

Carmel Shalev and David Chinitz, "In Search of Universality, Equity, Comprehensivenessand Competition: Health Care Reform and ManagedCompetition in Israel" (1997) 20:2 Dal LJ 553.

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In Search of Equity and Efficiency: Health Care Reform and Managed Competition in Israel

Israel's ongoing health reform provides lessons regarding attempts to combine universal coverage under national health insurance with a version of managed competition. Based on principles of "justice, equality and mutual aid," Israel's National Health Insurance Law, 1994 *guarantees access to a broad basket of basic services to be provided by four competing sick funds, and the availability of resources adequate to finance the basket. The new rights of citizens to universal coverage and to move freely among sick funds constituted a major policy breakthrough. However, successive amendments to the Law reflect continuing controversy over the amount of resources required to finance the basic basket. Despite the intention to base the system on decentralization and competition, successive amendments have placed more control over health system finance and sick fund management in the hands of the Ministries of Finance and Health. Updating the basic basket to take account of new technologies and drugs has raised unresolved dilemmas. In the Israeli case the dialectic of management vs. competition and of government vs. market, obscures fundamental issues related to the right of citizens to health services. The process set in motion by adoption of* The National Health Insurance Law, 1994 *calls on public managers and politicians to design institutions which can set priorities within a limited budget and effectively regulate the health care system.*

Des leçons peuvent être tirées de la réforme du système de santé en Israël sur la possibilité de combiner le système de couverture universelle, en place sous le régime national d'assurance-maladie, et une version de la « concurrence dirigée ». Basée sur les principes « de justice, d'égalité et d'aide mutuelle, » la Loi israélienne sur le régime national d'assurance-maladie de 1994 garantit l'accès à une gamme plus étendue de services de base, fournis par quatre fonds compétitifs destinés aux malades. La Loi garantit aussi la disponibilité des ressources adéquatès pour financer ces services. Les nouveaux droits des citoyens à une couverture universelle et à la libre mobilité entre les fonds destinés aux malades ont constitué une percée majeure dans l'élaboration des politiques du gouvernement. Cependant, des amendements subséquents à la Loi reflètent la controverse entourant le montant des ressources requis pour

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financer les services de base. Malgré l'intention de baser le système sur le concept de la décentralisation et de la concurrence, les amendements à la Loi ont placé plus de pouvoirs entre les mains des Ministères des Finances et de la Santé pour contrôler le financement du système de santé et la gestion des fonds destinés aux malades. La mise à jour de la gamme des services de base pour tenir compte des nouvelles technologies et de nouveaux médicaments a soulevé des dilemmes qui ne sont pas encore résolus. En Israël, l'utilisation des mots tels « direction » par opposition à « compétition » et « gouvernement » par opposition à «marché,» embrouille des questions fondamentales reliées au droit d'accès des citoyens aux services de santé. Le processus mis en branle par l'adoption de la Loi sur le régime national d'assurance-maladie de 1994 requiert des directeurs publics et des politiciens la création d'institutions capables de déterminer les priorités tout en respectant les limites des budgets établis et qui peuvent gérer efficacement le système de santé.

Introduction - Social Justice and Managed Competition

On January 1, 1995 Israel inaugurated a fundamental reform in its health system when *The National Health Insurance Law, 1994*[1] came into effect. In this paper we review this intended structural change and its actual implementation, and consider how they reflect fundamental values entrenched in the Law relating to the right to health care as a matter of social justice, equality and mutual aid. *The National Health Insurance Law, 1994* constitutes a major component of a bold and comprehensive health reform. However, it has proven difficult to implement the Law and the other elements of the reform.

The National Health Insurance Law, 1994 was enacted with a vision of equity, fairness and universal entitlement as a matter of right in the health system. At the same time, the Israeli case has some lessons regarding the introduction of managed, or regulated competition, into the health system. Israel's reformed system bears a striking resemblance to models of managed competition recently debated and partially introduced in the United States and other countries, the most prominent being the Netherlands. A comparison of the theory's implementation in Israel relative to other systems is instructive. A key question is, to what degree the two goals of social justice and managed competition are compatible.

Managed competition was the brainchild of Alain Enthoven, an American health economist.[2] Under his proposal, universal health insurance would be provided by health plans competing over both price and

1. 5754 *Sefer HaChukim* 156.
2. A.C. Enthoven, "The History and Principles of Managed Competition" (1993) 12 Health Aff. (Supplement) 25. See A.C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (Amsterdam: North Holland, 1988).

quality, subject to rules intended to promote both equity and efficiency. Such rules include a standardized basket of services, open enrolment in health plans, community rating of premiums and possibly even regulation of the rate of annual increase of premiums. The rules would be enforced by what Enthoven called "sponsors," institutional bodies representing consumers who would provide the latter with information about health plans and organize them to realize increased purchasing power. The sponsors would pay a capitation payment to the health plans for each member enrolled; the consumers would be able to choose among plans based on quality and any difference in price between the capitation payment and the actual premium charged by the health plan of their choice.[3]

Enthoven's plan has proven too complex for any system to adopt in full. The United States has patches of managed competition in various geographic areas, with consumers sponsored primarily by employers.[4] Medicare and Medicaid have introduced programs to encourage, or in some cases require, their covered populations to enroll in managed care organizations.[5] Managed competition has not been introduced in concert with universal coverage, and sponsorship on the part of employers, government or any other form of purchasing cooperative, raises difficult questions of accountability, such as the perception of many that choice is too limited and that employers focus too much on cost containment.[6]

The Netherlands has been attempting to introduce managed competition for a number of years.[7] Sick funds and private insurers are now required to accept all potential enrollees and they can organize networks of care by selectively contracting with providers. However, the program is not universal in that there are still two health insurance schemes in Holland, a private scheme for those above a certain income level and a public scheme for those below. The basket of services has been standard-

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3. Enthoven, *Theory and Practice*.

4. J.R. Robinson, "Health Care Purchasing and Market Changes in California" (1995) 14 Health Aff. 117.

5. S.A. Altman, "The Impact of Changing Government and Private Hospital and Physician Payment Methods in the United States" in D. Chinitz & J. Cohen, eds., *Governments and Health Systems: Implications of Differing Involvements* (Chichester: Wiley, forthcoming).

6. J. Kassirer, "Managing Managed Care's Tarnished Image" (1997) 337 New Eng. J. Med. 338.

7. W.W. van de Ven & F. Rutten, "Managed Competition in the Netherlands: Lessons from Five Years of Health Care Reform" (1994) 17 Aust. Health Rev. 9; A.A. de Roo, "Contracting and Solidarity: Market Oriented Changes in Dutch Health Insurance Schemes" in Richard B. Saltman & Casten von Otter, eds., *Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility* (Buckingham: Open University Press, 1995).

ized only for the sick funds working under the public scheme, though, apparently, most private insurers adopt the public basic basket as a minimum. The Dutch government has also been slow to place the sick funds at complete risk for health expenditures, compromising the efficiency incentives of the funds and reducing the salience of any potential competition over price.[8]

Of the various examples, Israel comes the closest to Enthoven's plan: one hundred percent of the population is enrolled by personal choice in any one of four competing sick funds that provide a standard basket of services against a capitation payment from earmarked revenues of a health tax, the premium for which is set by statute. What is missing in the Israeli system is price competition.[9] Nonetheless, it is interesting to consider what the Israeli case tells one about implementation of managed competition.

This article describes the problems of the pre-reform Israeli health system, and then presents the main lines of reform, focusing on the new *National Health Insurance Law, 1994*. A review of subsequent amendments to the Law in the two and a half years that have passed since it came into effect, provides insights into the problems of the implementation process. A look at court proceedings initiated under the Law brings to the fore a key question of incorporating the cost of new technology. We conclude with a discussion of issues posed by the Israeli case likely to be relevant for other countries engaged in or considering structural overhaul of their health systems.

I. *Background - Problems Calling for Reform*

The issue of major structural reform in the health system has been on the Israeli policy agenda almost since the creation of the State in 1948.[10] Over the years several attempts had been made to enact a law guaranteeing governmental coverage of comprehensive health services but none

8. A.A. de Roo, personal communication, 9 June 1997.

9. There are at least two possible explanations for the exclusion of price competition in the Israeli system: (1) the fear of resultant inequities; and (2) concern that health payments would leak out of the health system (see below, text to footnotes 20 and 48). Enthoven seems to have dealt with the possible inequities of price competition in theory, but might have found it difficult to deal with the idiosyncratic *realpolitik* of the Israeli case. See A.C. Enthoven, "On the Ideal Market Structure for Third-Party Purchasing of Health Care" (1994) 39 Soc. Sci. & Med. 1413. See D. Chinitz, "Reforming the Israeli Health Care Market" (1994) 39 Soc. Sci. & Med. 1447.

10. D. Chinitz, "Israel's Health Policy Breakthrough: The Politics of Reform and the Reform of Politics" (1995) 20 J. of Health Politics, Policy & Law 909.

succeeded.[11] In the 1980s, however, dissatisfaction with the existing system reached a peak. Physicians and other health professionals, dissatisfied with nationally negotiated wage levels, conducted intermittent strikes and work slowdowns. Wage agreements, combined with limited hospital and community clinic operating budgets, caused facilities to close in the early afternoon. As a result, queues for certain elective procedures grew and access to services was believed to be constrained. A special statutory commission of inquiry was therefore appointed to examine the issue of reform. The recommendations of the State Commission of Inquiry into the Operation and Efficiency of the Healthcare System in Israel, known as the Netanyahu Commission,[12] eventually served as the basis for the scheme enacted in *The National Health Insurance Law, 1994*. At the time of its coming into force in 1995, 95% of the population of about 5.5 million received health insurance coverage from four non-profit sick funds.[13] Despite this, the system was plagued by the following persistent problems:

(a) *Uninsured populations*. Approximately 300,000 persons, including seventy thousand children, were not insured with any of the sick funds.[14] Many of these belonged to the Arab minority and could not afford sick fund membership dues.

(b) *Ambiguity regarding coverage*. Each sick fund determined its own benefits package policy and for the most part there was no written

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11. H.S. Halevi, *The Bumpy Road to National Health Insurance: The Case of Israel* (Jerusalem: JDC/Brookdale Institute, 1980). See also A.Y. Ellencweig, "The New Israeli Health Care Reform: An Analysis of a National Need" (1983) 8 J. of Health Politics, Policy & Law 366 and D. Chinitz, "Hiding in the Market Place: Politics and Technocracy in Israeli Health Policy" in C. Altenstetter & J.W. Bjorkman, eds., *Health Policy Reform, National Variations and Globalization* (New York: St. Martin's Press, 1987).

12. State of Israel, *Report of the State Commission of Inquiry into the Operation and Efficiency of the Healthcare System in Israel* (Jerusalem, 1990) (hereafter "the *Netanyahu Commission Report*").

13. Israeli sick funds are similar to U.S. health maintenance organizations (HMOs), with Klalit structured as a large full staff model which employs salaried physicians and owns hospitals, while three smaller funds are more like Independent Practice Associations. Even before the new law they insured their members on a basis of mutual aid, and were at the same time active in the actual organization of care and responsible for the provision of a broad range of health services. The four existing sick funds were officially recognized in the Schedule to *The Parallel Tax Law, 1973*, which imposed upon employers a health tax that was distributed among the sick funds in proportion to the number of their members. *The National Health Insurance Law, 1994* provides in ss. 24 and 25 for the recognition of new sick funds. Criteria in this regard were set out in *The National Health Insurance (Recognition of Sick Funds) Regulations, 1995, Kovetz Takanot* at 134.

14. S. Cohen & R. Steiner, *The Health Insurance Law - Background, Principles and Implementation*, (Jerusalem: National Insurance Institute, 1995). This figure represents 5% of Israel's population. Cf. the *Netanyahu Commission Report*, at 75.

guarantee of access to specified services. As a result, not only were there variations in coverage across the four funds, but the insured could not be certain that the services they required would be available.[15]

(c) *Inefficiency*. The Israeli health system has traditionally been well endowed with medical staff and facilities. It typically spent about 7.5% of its GDP on health care during the 1980s, an amount in line with the average of OECD (Organization for Economic Cooperation and Development) countries.[16] However, methods of budgeting and reimbursement offered at best mixed incentives for efficient performance.[17] Furthermore, the Ministry of Health was itself a major provider of services, being responsible for the delivery of public health services as well as the owner and operator of many of Israel's general acute care hospitals. The bifurcation of services between the Ministry and the sick funds presented problems of continuity of care and efficiency. At the same time, there was a conflict of interest between the Ministry's role as an impartial policy maker and implementer for the entire system and its role as a purchaser and provider of services competing with others within the system.[18]

(d) *Inequity*. One sign of constrained access in the public and non-profit sector was increased resort to privately financed care, and the growth of "black" and "grey" markets in public medicine.[19] These developments contributed to inequality in access to care. This inequity was exacerbated by developments in the sick fund market. The largest of the four sick funds - Klalit - had been established at the beginning of the century by a workers' union and was still owned by the Histadrut, the General Labour Federation. Before the new Law it serviced almost 70% of the population, including most weak socioeconomic groups all over the country. The three other funds were more selective in their membership, preferring young, healthy and potentially wealthy members living in central locations. As a result of long-standing ties between the Labour Federation and the Labour Party, which ruled or shared rule in most government coalitions, the Klalit sick fund was used to relying on generous government support but in the late 1980s, government, sometimes led by the more laissez-faire Likud Party, was less willing and able

15. T. Barnea, *Benefits Packages of Sick Funds in Israel* (Jerusalem: JDC/Brookdale Institute, 1989) (Hebrew).
16. G. Bin Nun & D. Ben Ori, *International Comparisons: OECD Countries and Israel* (Israel: Ministry of Health, 1996) at 28.
17. D. Chinitz & B. Rosen, *A Tale of Two Markets: Hospital Competition in Israel* (Jerusalem: JDC/Brookdale Institute, 1993).
18. *Netanyahu Commission Report*, at 52-60.
19. D. Chernichovsky & D. Chinitz, "The Political Economy of Healthy System Reform in Israel" (1995) 4 Health Econ. 127.

to provide it. The sick fund thus began to lose healthier and wealthier members to the three smaller funds, creating the perception, and perhaps the reality, of a two-tiered system.[20]

(e) *Lack of accountability, especially financial.* As noted, the Klalit sick fund became accustomed to government bailouts when large deficits accumulated.[21] Changes of government and increasing government austerity did not lead to changes in its financial management. Government, including the Ministry of Finance, also seemed to become habituated to crisis management and financial intervention in the affairs of both the Klalit fund and the health system more generally. The lack of financial accountability was also related to the overly centralized nature of the health system, with government and the management of the largest sick fund directly involved in the day-to-day activities of far-flung operating units. Lack of clear boundaries between the organizational centre and periphery of the system, between the sick fund and the government, and between the sick fund and the Labour Federation all contributed to the blurring of lines of accountability.

II. *Visions, Politics and Solutions*

1. *Evolving perceptions of health policy*

As the system and the above problems evolved, so too did visions of policy solutions. Options fluctuated between complete nationalization of the health system similar to the British National Health Service, and various versions of streamlining the competition among the sick funds.[22] Israeli health policy analysts became aware of trends in other countries such as regionalization, managed (or regulated) competition, and purchaser-provider split, not to mention universal coverage. Notwithstanding self-addressed warnings to avoid unduly rapid adoption of models from abroad,[23] the main lines of reform which emerged in the early 1990s, as outlined below, paralleled developments in other countries such as the U.K. and the Netherlands.

Parallel to the substantive focus on structural reform, the political implications of health reform were evident. Any reform which threatened the special relationship between the largest sick fund and the Labour Federation was viewed with consternation by the latter, and favoured by political opponents of the Labour Party. This policy linkage, as well as an

20. *Netanyahu Commission Report*, at 76-7.
21. Chernichovsky & Chinitz, *supra* note 19.
22. Chinitz, *supra* note 10.
23. *Netanyahu Commission Report*, at 45-6.

overriding concern by government leaders with maintaining coalition stability in the face of crucial decisions regarding the Arab-Israeli peace process, should be kept in mind when trying to understand Israeli health policy.

Another factor motivating reform was the perception of increasing inequities in the health system, contrary to the commitment to equal access to high quality health care services which had always been a component of Israel's socialist policies. Health reform came to be seen as a matter of social justice and basic rights. For example, as mentioned, one of the most important forces behind the enactment of the new Law was an ongoing economic crisis in the Klalit sick fund, which repeatedly threatened the collapse of the entire public health system. This was something the government could not afford politically, but neither could it afford to continue subsidizing the Klalit sick fund as it had before. *The National Health Insurance Law, 1994* was an economic reform that appeared to answer this predicament, which could be viewed both as special aid to Klalit but also as striking a blow for social justice in the health sphere, given the makeup of Klalit's insured population.[24]

Casting the issue in this manner perhaps facilitated the overcoming of the political obstacles alluded to above, which involved linkages to policies and interests not strictly within the sphere of the health system. However, it also masked some of the difficult political issues *within* the health system inherent in any reform proposal. By 1994, the time was ripe for enactment of health reform proposals which reflected the policy images discussed above, and which would defer confrontation of some intrinsic health policy dilemmas to the implementation stage.[25]

2. *The main lines of reform*

The recommendations of the Netanyahu Commission of Inquiry were published in 1990. Subsequently, the Likud government decided to adopt a three-pronged health care reform policy, which the Labour Party also adopted after winning the 1992 elections. The first component was passage of national health insurance legislation which would address the

24. Interestingly enough, once Parliament concluded the legislative process, intensive negotiations began between the Ministry of Finance and the Klalit sick fund to settle a debt of 5 billion New Israeli Shekels (approximately U.S. $1.6 billion). The sick fund sold assets and undertook major labour cutbacks. This was accompanied by a political process of separating the sick fund from its owner, the Labour Federation, while dismantling a tax collection bureaucracy seen by some as inefficient, overgrown and redundant. Cf. G. Bin Nun & B. Rosen, "Passage of Israel's National Health Insurance Law: A Case Study of Major Legislative Change" (Jerusalem: JDC/Brookdale Institute, 1996) [unpublished].
25. Chinitz, *supra* note 9.

problems of the uninsured and the inequities in the system.[26] Secondly, government-owned hospitals were to be converted into self-governing corporations, in order to increase their financial incentives for efficiency and accountability. Finally, and contingent on the second initiative, the Ministry of Health would be reorganized to focus not on direct operation of hospitals and provision of services, but rather on policy planning and regulation.

Confronted by stiff opposition from labour unions representing hospital nursing and administrative staff, the second proposal to incorporate government hospitals has been stymied.[27] This impasse, along with the usual organizational resistance to change, has meant that the Ministry of Health has scarcely been reorganized. It is with regard to the first component of reform, passage of *The National Health Insurance Law, 1994*, that the breakthrough has occurred, accompanied by unforeseen problems in implementation.

III. *The National Health Insurance Law - Justice, Equality andMutual Aid*

The National Health Insurance Law, 1994 embodies an authentic view of social justice. It was aimed at solving the equity problems and financial crises mentioned above. The major principles of the right to health services under the Law are stated in section 1: "justice, equality and mutual aid." The drafters of the law sought to ensure universal access to a clear and comprehensive basket of health benefits and the availability of adequate financial resources to make such access a reality. However,

26. The proposal of the Likud government was published in the National Health Insurance Bill, 1992, 5752 *Hatza'ot Chok* 211. The proposal of the Labour government, which served as the basis for the subsequent legislation, was published in the National Health Insurance Bill, 1993, 5753 *Hatza'ot Chok* 204. The two bills differed only in details, e.g., regarding regionalization as opposed to continuing the existing centralized management of the sick funds.

27. A. Shirom et al., *Incorporation of Public Hospitals in Israel: Assessment of Developments and Policy Alternatives* (Jerusalem: Center for the Study of Social Policy in Israel, 1997) at 20-21 (Hebrew). On 1 January 1992 five government hospitals were officially registered as corporations for the public benefit under the *Companies [New Version] Ordinance, 1983* and the *Trust Law, 1979*. Subsequently the labour federation announced a strike. The government petitioned the labour court for an injunction against the strike, and succeeded on appeal before the national labour court; 4-17/52 *State of Israel* v. *General Labour Federation et al.* 26 P.D.A. (4) 87. However, according to the cabinet decision on the incorporation of government hospitals, as well as the articles of association of those that were registered as corporations, any change in the status of the employees is conditioned on the signing of a collective agreement. Meanwhile the employees of the hospitals continue to be state employees. Cf. HC 5684/91 *Barzilai* v. *Government of Israel et al.* 46 P.D. (1) 536 (independent challenge to incorporation dismissed).

implementing this combination has proven more difficult than legislating it. In the following sections we present the fundamental values of the Law and discuss the amendments enacted since it came into force in January 1995, so as to demonstrate the problems of implementation.

1. *Justice - Universal Coverage*

The Law extends coverage to all persons resident in Israel, including those who were previously uninsured. While the Law also imposes an obligation to pay health taxes, failure to do so may not serve as grounds for denial of services. As a result, disadvantaged communities, which previously had high percentages of uninsured, are now completely covered. In some of the Bedouin towns in the south of Israel, new clinics have been opened as a result of competition among the sick funds to gain new members.[28]

2. *Equality - Mandatory Membership*

Everyone must register with a sick fund,[29] but this is a formality required to establish which of the funds is obliged to provide services to the individual. Furthermore, registration with a sick fund is a matter of consumer choice, and there is also a right to transfer from one fund to another. This is a mechanism designed to encourage competition between the funds in terms of the quality of services.[30]

Most importantly, the sick fund is under a duty to respect the choice of the individual. It may no longer be selective in its membership, rejecting the sick, the elderly or the poor.[31] This rule is also supported by an economic device which allocates revenues between the sick funds

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28. Personal communications from the mayors of Rahat and Tel Sheva, August 1996.

29. Before the law, membership in a sick fund was voluntary (if one could afford it); now it is mandatory. This paternalistic constraint on one's freedom of association is necessary to ensure equality. The rule of mandatory membership was challenged by a handful of people who believe in alternative medicine and reject conventional medicine; C. Shalev correspondence with Ministry of Health, July 1995).

30. It is also a response to the previous situation, where individuals who were members of the General Labour Federation, or who were employed by companies owned by or affiliated with it, were automatically members of the Klalit sick fund, and membership dues were deducted from their salaries without any choice. See, in this context, *The National Health Insurance Law, 1994*, s. 4(d): "An employer shall not make employment conditional on any condition whatsoever relating to membership in a particular sick fund, and shall not require an employee to be registered in a particular sick fund."

31. The Law provides expressly that "a sick fund shall register every resident who chooses to be registered with it, shall not restrict his registration and shall not make such registration conditional on any condition or payment whatsoever" (s. 4(c)). Violation of this rule is a criminal offence, punishable by one year's imprisonment or a fine (s. 47(a)).

according to a "capitation formula" that compensates for high risk of illness (i.e., consumption of health services) by an age factor.[32] In addition, for a small number of "serious illnesses" (Gaucher, kidney failure (dialysis), thelassimia and hemophilia), fixed amounts are transferred directly to the sick funds according to the number of their members suffering from such illnesses.[33] It is important to note that these economic devices leave the sick funds without any control over the budget allocated to them even though they have a statutory duty to provide the services included in the basic basket to their members.

3. *Equality - the Extent of the Basket*

One of the major achievements of the Law, in terms of consumer rights, was the publication of a list of the basic health services covered by the scheme. Section 7 defines the basket of basic services, as specified in the schedules to the Law.[34] The Second Schedule includes a list of the health services given by the Klalit sick fund before the Law, which was intended to be a basic basket, allowing sick funds to compete by offering members additional services, at no extra charge, over and above the minimum statutory standard.

The Third Schedule to the Law is a list of all the services provided by the Government, through the Ministry of Health, prior to the Law's coming into effect: "preventive medicine" (otherwise known as mother and child services),[35] geriatric and psychiatric services, and rehabilitation devices.[36] The Law provided that responsibility for the provision of all these services would be transferred to the sick funds (over an undefined period of time) to allow for efficiency in the provision of services, as well as continuity of care.

4. *Mutual Aid - Taxation and Social Exemptions*

The Law provides for universal entitlement, on the one hand, while imposing a progressive health tax on the other. The tax, called a "health

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32. *The National Health Insurance Law, 1994*, s. 17.
33. *Ibid.*, s. 19.
34. According to s. 8(f)(1) of the Law, a committee of experts was given two years to further specify the scope of services, in terms of "the waiting period for a service, the distance from the insured's home within which the service is given, the entity that decides upon giving the service, the manner of its provision and its quality." Although such a committee was convened, it has not yet published any conclusions.
35. These services include primarily prenatal care, monitoring for early detection of congenital defects and illness, immunization and child development monitoring. There is an annual copayment fee of approximately U. S. $40 per family.
36. E.g., wheel chairs, hearing aids, artificial limbs.

insurance fee," is payable in the amount of 4.8% of one's taxable income, up to a ceiling of approximately U.S. $250 per month. Children and housewives are exempt from the tax. Under the previous system, sick fund membership fees were charged per family unit. The Law, however, regards the individual as the taxation unit. The result is that families in which both spouses work are paying more for health insurance than before. There are several exemptions on "social" grounds. Unemployed and elderly persons pay a minimal sum in health insurance fees, set by the Law,[37] of approximately U.S. $20 per month. In addition, at least one of the health funds set a ceiling on medication expenses for the chronically ill.

It is important to note that the right to services from the sick fund is not conditional on payment of health insurance fees. The tax is collected by an independent State agency (the National Insurance Institute, which is in charge of social security). Non-payment or arrears in payment of the tax do not discharge the sick fund from its duty to provide services.[38]

5. *Consumer Rights*

There are several provisions in the Law that address various aspects of consumer rights, including the duty of the sick funds to have bylaws stipulating the rights of their members, and a guarantee of the representation of consumers in two statutory decision-making bodies: by election to the directorate councils of the sick funds, and by appointment to the National Health Insurance Council (known as the Health Council).[39] It is worth noting, too, that the law mandates appropriate representation of women in the Health Council, considering that there is a gender disparity in health needs, that women often provide health care to family members, and that they are a majority of the personnel employed in the health sector. The Law also provides various mechanisms for examination of consumer complaints and resolution of disputes between insured and insurer, including the appointment of a special government official as Complaints Commissioner.

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37. *The National Health Insurance Law, 1994*, s. 14(c)(1) as am. by *The National Health Insurance (Amendment No. 2) Law, 1994*, 5755 *Sefer HaChukim* 50 (now ss. 14(c)(2) and 14(e)(1)).
38. *The National Health Insurance Law, 1994*, s. 21(b).
39. The Health Council is empowered, among other things, to advise the Minister of Health on changes in the basket of health services on the promotion of equality in the quality, availability and accessibility of health services on normative, moral and ethical issues; and on orders of priority in the use of resources for various needs: *ibid.*, s. 52.

IV. *Implementation: the Legal Legacy of Learning by Doing*

Despite the noble intentions of *The National Health Insurance Law, 1994*, it has raised a new set of problems for policy makers to address. The following discussion of amending legislation considers these issues.

1. Activating National Health Insurance - The First and Second Amendments

The first two amendments to the Law dealt with its operationalization. The Law was passed in June 1994 and came into effect on January 1, 1995. In its original version, it was to become operational together with prospective legislation that would provide for payment of a "welfare tax" to trade unions.[40] This was necessary to overcome opposition to the Law from the General Labour Federation, because of the loss of revenue entailed by the new scheme. Previously, fees for membership in the Klalit sick fund were paid together with union membership fees, and the Labour Federation would allocate a certain percentage of the revenues to the sick fund. Under the Law the health tax was to be paid independently to a governmental agency, the National Insurance Institute, and this meant, at the very least, a severely reduced cash flow for the Labour Federation. In addition, the statutory guarantee of choice in sick fund membership gave rise to concerns about possible abandonment of the Klalit sick fund and diminished numbers of trade union members.

These concerns proved to be unfounded over time, and the welfare tax was never enacted.[41] In any event, the connection between *The National Health Insurance Law, 1994* and another as yet unenacted statute was unprecedented as a legislative technique. The first amendment to the Law was thus needed to set a concrete date for it to come into effect: 1 January 1995.[42]

The second amendment to the Law dealt with various technical details necessary to operationalize the new scheme.[43] During the legislative process many administrative matters were delegated to the discretion of

40. An attempt on behalf of one of the sick funds to establish a new trade union so as to benefit from the welfare tax was recently struck down by the Supreme Court. HC 7029/95 *General Labour Federation* v. *National Labour Court* (unreported, 27 February 1997).

41. Among other reasons, there was a legal objection to such legislation, since state support of trade unions by means of an earmarked tax was considered to be a violation of the principle of freedom of association and the autonomy of the trade unions.

42. *The National Health Insurance (Amendment No. 1) Law, 1994*, 5755 *Sefer HaChukkim* 43 (20 December 1994).

43. *The National Health Insurance (Amendment No. 2) Law, 1994*, 5755 *Sefer HaChukkim* 50 (28 December 1994).

the executive and left to be worked out through secondary legislation by the relevant ministries and government agencies (health, finance, welfare and social security). Regulations prepared for implementation of the Law covered many diverse areas, including matters pertaining to registration of members with sick funds,[44] rates and methods of payment of the health tax by different categories of insured persons,[45] the "capitation" formula for allocation of revenues among the sick funds[46] and time schedules for the transfer of funds.[47] In the process of working out the operational details it became apparent that certain statutory amendments were necessary so as to fine-tune the Law in actual practice.

The Law itself contained a three-year transition period during which the basic basket of services would be made completely uniform across the sick funds. Even at this early point, in the fall of 1994, it was already clear that regulations regarding supplementary insurance were needed, but controversial. This remains a major unresolved issue of equality in the health system. The policy of the Law was to define an extremely comprehensive basket. At the same time, under the pressure of a lobby that objected to the so-called "nationalization" of the sick funds, and advocated some measure of free economic activity to encourage competition among them, the Law provided that a sick fund may, for a fee, "offer its members insurance for the financing of additional health services which are not included in the basket of health services."[48] Despite the fact that the Law empowered the Minister of Health, with approval of a parliamentary committee, to enact secondary legislation on this matter, none has appeared. The controversy is due to the concern that supplementary insurance will create two classes of sick fund members with two standards of health care, and that there will be a diversion of funds earmarked for the universal scheme to the supplementary. Opponents of supplementary insurance argue that it should remain in the province of

44. *The National Health Insurance (Registration in Sick Fund and Transferal Procedures) Regulations, 1995*, 5755 *Kovetz Takanot* 490.

45. *The National Health Insurance (Exemption from Payment of Health Tax) Regulations, 1995*, 5755 *Kovetz Takanot* 557; *The National Health Insurance (Exemption from Payment of Health Tax to Residents of Institutions) Regulations, 1995*, 5755 *Kovetz Takanot* 557; *The National Health Insurance (Reduced Rates of Health Tax) Regulations, 1995*, 5755 *Kovetz Takanot* 558; *The National Health Insurance (Special Instructions for Payment of Health Tax Regulations), 1995*, 5755 *Kovetz Takanot* 558.

46. *The National Health Insurance (Allocation to Sick Funds) Regulations, 1995*, 5755 *Kovetz Takanot* 493.

47. *he National Health Insurance (Deduction of Cost of Serious Illnesses) Regulations, 1995*, 5755 *Kovetz Takanot* 492; *The National Health Insurance (Distribution of Revenues) Regulations, 1995*, 5755 *Kovetz Takanot* 652.

48. *The National Health Insurance Law, 1994*, s. 10(a).

private insurance companies rather than pollute the public system of health care delivery. Meanwhile, sick funds are in fact offering supplementary insurance schemes to their members, for a fee, but the practice is not regulated under *The National Health Insurance Law, 1994* nor the general laws regulating the insurance industry.

There were already at this time signs of controversy over whether the amounts budgeted for the basic basket were sufficient. Under section 9 of the Law, the Minister of Finance and the Minister of Health were to decide jointly upon "the cost of the basket" at the time the Law came into effect. This figure was to reflect the legal obligation of the state treasury to finance the national health insurance system over and above revenues from the health tax, the parallel tax and other monetary sources mentioned in the Law. The legislature had stipulated expressly that this figure should not be less than the 1993 expenditures of the sick funds and the Ministry of Health for services included in the basic basket, and that it would be updated annually by a special "cost of health index," the components of which were set out in the Fifth Schedule of the Law.[49] The Ministers, however, were not able to reach any agreement on the cost of the basket until one year later, when the Law called for the first update of the amount.

Despite these difficulties, the law was put into effect as scheduled. Overhaul of any large social system can be planned only to a point, and then societies must depend on their policy making institutions to cope with implementation. Unanticipated problems and by-products, as well as opportunities, need to be addressed.

2. *Universality and the Definition of Entitlement - The Third Amendment*

The third amendment to the Law illustrates this proposition. While the Law eliminated political linkages of the health system to the Labour Federation and to Labour Party politics, links to other policy arenas could not be avoided. Implementing the notion of universal coverage for all residents required a definition of residency. This issue became bound up with the politics of the Arab-Israeli peace process. Under s. 1 of the Law, residency was defined to comport with its definition for the purposes of the social security law, which adopts a test of the centre of one's life. The implementation of the Israeli-Palestinian peace accords at the end of 1994

49. The component factors are: wages in the health sector and in the general public sector, the cost-of-living index, the cost of pharmaceuticals, and the cost of construction. An ongoing issue is that no account is taken of the cost of technology, and of the aging of the population.

required clarification of social security entitlements - and hence of health insurance entitlements - as regards Israeli nationals living in the occupied territories. *The National Health Insurance Law, 1994* was thus amended for the third time on December 28, 1994 as a side-effect of the legislation that implemented the peace accords in domestic law,[50] so as to include in the scope of universal health insurance entitlement Israeli residents of the territories, while excluding Palestinian residents. Interestingly enough, the Ministry of Health was not even apprised of this amendment until after the fact.

The status of East Jerusalem Arabs who had moved to suburbs now under territorial jurisdiction of the Palestinian Authority is now at stake. While many of them had been dues-paying members of sick funds in the past, the amendment to the law now defined them as outside its scope because they were no longer resident in East Jerusalem, despite the fact that the centre of their economic and public activity continued to be there. This could be viewed as an economic move intended to limit the liability of the government under the Law, but also could be perceived, even if not intended as such, as part of a policy to question the residency status of East Jerusalem Palestinians.[51] Almost any contact by such persons with Israeli public authorities, including with hospitals and sick funds, instigates an active examination of their actual residence. This in itself might not be untoward except that the examination usually entails the suspension of their entitlements. Once residency status is lost, it is almost impossible for all practical purposes to regain it. The definition of residency also excludes migrant workers and illegal aliens from national health insurance coverage, despite the fact that due to their special circumstances vulnerable groups such as these are likely to be in need of the system.[52]

3. *The Government as Provider of Services - The Fourth Amendment*

The National Health Insurance Law, 1994 was based on the vision of a comprehensive, integrated basket of services to be provided by the sick

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50. Amendment No. 3 to the Law was enacted within *The Implementation of the Agreement Regarding the Gaza Strip and the Jericho Area (Economic Arrangements and Other Provisions) (Legislative Amendments) Law, 1994*, 5755 *Sefer HaChukim* 66.

51. *The Silent Transfer: Denial of Residency Status to Palestinians in East Jerusalem* (Jerusalem: B'Tselem Information Center for Human Rights, 1997) (Hebrew).

52. There are approximately 100,000 legal migrant workers in Israel, and estimates suggest at least an equal number of illegal workers. Following the death of a male worker from apparent neglect of a treatable health condition in August 1997, the Forensic Medicine Institute published data according to which 18 deaths of migrant workers (from a total of 51 deaths in the first eight months of 1997) had occurred as a result of "illnesses and heavy drinking." *Ha'Aretz* (Tel Aviv) (27 August 1997).

funds. Mother-child, psychiatric and geriatric services were to be transferred from government to the sick funds over an unspecified period of time, but this has proven impossible so far. Out of fear that the sick funds' economic considerations would result in the reduction of services, the Law was amended to ensure that the State continues to be fully responsible for providing mother-child health care. Just over one year after the Law came into effect, it was amended for the fourth time, so that responsibility for mother-child services would remain with the Minister of Health.[53] Government employees working in this sector were unhappy with the prospect of being transferred to the sick funds. In response to these pressures, and perhaps since these services were one area in which the Ministry of Health successfully combined regulatory and operational responsibilities with effective outreach to almost the entire population, the Law was amended so that mother-child services remain the responsibility of government.

At the same time, the transfer of psychiatric and geriatric services to the responsibility of the sick funds is being delayed for similar reasons. On the one hand, there is concern that it will result in a lowering of the quality of services provided to the most needy and vulnerable. On the other hand, the sick funds are reluctant to accept responsibility for these services within the existing governmental budget framework. Several administrative attempts (including setting actual target dates and enacting secondary legislation of questionable validity[54]) have been made to transfer psychiatric services to the sick funds.[55] The sick funds have

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53. *The National Health Insurance (Amendment No. 4) Law, 1996*, 5756 *Sefer HaChukkim* 253. See also *supra* note 35.

54. An attempt was made to transfer responsibility from the government to the sick funds by means of an order issued by the Minister of Health under s. 69 of the Law: *The National Health Insurance (Changing the Second and Third Schedules) Order, 1995*, 5755 *Kovetz Takanot* 1459. The Order was later withdrawn without any explanation: *The National Health Insurance (Changing the Second and Third Schedules) (Annullment) Order, 1996*, 5757 *Kovetz Takanot* 79. The question of validity stems from the view that such an important administrative action cannot be taken without some public debate in the legislature, either by means of primary legislation that would amend the schedules to the Law which set out the services included in the basket within the respective responsibilities of the sick funds and the government , or by regulations that require approval by a parliamentary committee. In the fifth amendment to the Law there was an attempt to clarify the legal procedure for transferral of responsibility from the government to the sick funds, which would require a decision of the Minister of Health, the consent of the Minister of Finance and approval of the Cabinet, on the basis of which the schedules would be amended.

55. M. Mark et al., "From the *Netanyahu Report* Until the National Health Insurance Law - Implementation of the Reform in the Mental Health Area in Israel" (1996) 16 Khevra U'Revakha 185 (Hebrew).

repeatedly expressed reticence over the idea. The issue has been confused by other agendas of reform including deinstitutionalization of long-term hospitalized mentally ill persons, and the matter of independent, financially accountable management of mental health hospitals. In addition, there are serious questions as to the responsibility and capacity for providing community-based services to the mentally ill and those in need of psycho-therapeutic interventions. Some mental health advocates argue that the mentally ill constitute a vulnerable group who will not fare well under a system of capitated, competing sick funds.[56]

Finally, geriatric long-term care continues to be provided by the government within seriously limited resources that do not answer actual needs. As a result, a strong market has developed in supplementary long-term nursing care insurance.[57] The existence of this market will only make transfer of long-term care to the sick fund basket more difficult, since those now relying on supplementary and private insurance, or paying directly out-of-pocket, would then be entitled to receive services at no cost under the National Health Insurance. There is no obvious source of revenue with which to finance adequately this anticipated demand. At the same time, reliance upon supplementary insurance in an area like geriatrics, which serves the needs of a particularly vulnerable population, raises the danger of creating a two-tier level of health services.

The relative merits of separating out these services has received much attention.[58] There is a tradeoff between the coordination and continuity of care which would be anticipated from combining these services with acute care, and the concern that mother-child, psychiatric and geriatric care are related to vulnerable groups unable to fend for themselves in a competitive environment. Given the doubts, it was almost inevitable that the comprehensive vision of the law would give way to maintaining the status quo regarding these changes.

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56. U. Aviram, "Mental Health Services in Israel at a Crossroads: promises and pitfalls of mental health services in the context of the New National Health Insurance" (1996) 19 Int'l J. of Law & Psychiatry 327. See also G. Shefler, "Implementing the Reform of Community Mental Health Services: Danger, Threat and Opportunity" (1995) 9 Dialogue 151 (Hebrew). See also W. van de Ven & F.T. Schut, "Should Catastrophic Risks Be Included in a Regulated Competitive Health Insurance Market?" (1994) 39 Soc. Sci. & Med. 1459.

57. R. Gross & S. Bramli, *Supplemental and Commercial Health Insurance in Israel-1996* (Jerusalem: JDC/Brookdale Institute, 1996) at 48 (Hebrew).

58. H. Palti, "The National Health Insurance Law - Implications for Preventive Mother-Child Health Services" (1996) 47 Bitakhon Sotziali 80 (Hebrew). See van de Ven & Schut, *supra* note56.

4. *Ministry of Finance Control - The Fifth Amendment*

Israel's annual budget cycle is accompanied by a special law — the *Arrangements in the State Economy Law* —which is intended to enact the legislative amendments that are necessary for accomplishing budgetary objectives. This omnibus law is a collection of seemingly unrelated provisions which deal ad hoc with various budgetary items by amending the relevant statutes. For example, in contemplation of the 1997 budget, this Law amended *inter alia* statutes regulating capital investments, the ports authority, income tax, insurance, and local government authorities. Many of the provisions in the economic arrangements law are complex and not readily transparent in any kind of public debate. As a result of its broad and diverse scope, the bill is discussed by the finance committee of the parliament, rather than by the committees to which the various matters would normally be referred (e.g., in matters of health, the normal forum would be the labour and welfare committee). The bill is presented to the parliament two or three months before the end of the budgetary year. There is pressure to enact its provisions within a time frame that is much shorter than in the normal legislative process, since the government budget cannot be approved without it. As a legislative tool, it is designed to meet a limited practical purpose, and is not intended to be used for making major changes that are not strictly required by the budget. Nonetheless, in 1996 this technique was used to enact an extensive amendment to *The National Health Insurance Law, 1994*.[59] This fifth amendment to the Law included several noteworthy provisions.

First, it eliminated the "parallel tax" that had been paid by employers and earmarked for the health system for over twenty years. The parallel tax accounted for a substantial portion of the health system budget and was collected and then transferred on a monthly basis to the sick funds.[60] The elimination of this tax was sought by the Ministry of Finance in order to reduce labour costs and compensate employers for cuts in government subsidies for employment. Apparently, the change left the employers unaffected, as subsidies were reduced by the amount they previously paid for the parallel tax. For the Ministry of Finance, however, the shift eliminated an earmarked tax and a regular source of cash flow to the sick funds. To be sure, the Ministry is still obligated to ensure the availability of funds to cover the "cost of the basket." In that respect, however, the fifth amendment to the Law introduced another significant change.

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59. *The Arrangements in the State Economy (Statutory Amendments to Meet the Budget Goals for the Year 1997) Law, 1996*, 5797 *Sefer HaChukim* 16.
60. Chinitz, *supra* note 9.

The Law had originally intended that the "cost of the basket" would be determined once, when the Law came into effect, and thereafter updated annually according to the cost-of-health index. Legislators had been concerned to establish a fixed statutory obligation of the state treasury to finance the national health insurance system. However, the fifth amendment to the Law established two new figures as the "cost of the basket" for 1996 and 1997. Whatever the reasons for this,[61] the effect is to re-open for annual negotiation or bargaining the extent of the government's financial obligation under the Law. Furthermore, it also introduced a distinction between the cost of the basket for the sick funds, which is supposed to be updated according to the cost-of-health index, and the cost of the basket for the services provided by the government, for which there is no updating mechanism. These measures decrease the extent of the treasury's statutory obligation to cover the costs of the National Health Insurance scheme, and increase its leeway within the annual state budget bargaining process.

Moreover, the fifth amendment also extended governmental control over the financial management of the sick funds. Previously, the Minister of Health had enacted regulations that imposed detailed accounting and reporting requirements on the sick funds.[62] These regulations had been modelled on those applying to companies on the stock exchange. The theory was that the sick funds should be accountable to the government and to their members in much the same way as companies are to their stockholders. The latest amendment to the Law went beyond this and enacted detailed provisions that pertain to control of the sick fund. In addition to vesting in the Minister of Health and the Minister of Finance powers of review over the sick funds' by-laws and their development budgets, as well as imposing various restrictions on their financial

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61. One reason is that the fifth amendment to the Law also reinstated the maternity scheme that had been in effect prior to its enactment. Maternity insurance had been part of the social security system, and there had been an efficient method of accounting between the hospitals and the National Insurance Institute. The new health law, however, had envisaged an integration of all primary care services in the sick funds and had thus included maternity services within the basic basket. This meant that the money earmarked for maternity services was allocated by the National Insurance Institute among the sick funds according to the capitation formula, and the hospitals now had to settle their accounts, like other hospital services, with the sick funds. The commentary to the bill for Amendment No. 5 (5757 *Hatza'ot Chok* 13) explains that the experience under the new arrangement indicated that the previous scheme of direct payment to the hospitals was "more efficient and more just as regards the allocation of resources." Certainly the old maternity scheme guaranteed an independent cash flow to the maternity wards of the hospitals.

62. *The National Health Insurance (Financial Control and Supervision of the Sick Funds) Regulations, 1995*, 5756 *Kovetz Takanot* 323.

activities and holdings, the new amendment would allow the appointment of an "accompanying accountant" to a sick fund operating under a deficit budget. This clearly anticipated future developments. As the three-year transition period of the new Law nears its end, it appears that the system is indeed operating under a deficit that is estimated as ranging between 7 and 14 percent of a total budget of approximately 14 billion New Israeli Shekels.

The result of these changes is that general treasury revenue has become even more important as a source for financing the health system, with potentially more Ministry of Finance control over the management of the sick funds. This outcome demonstrates once again the important linkage between health policy and other policy arenas, and how the overall vision of a guaranteed health budget can give way to a very different outcome; namely, making health finance, and with it access to health services, contingent on Ministry of Finance budgetary policies.

V. *Unresolved Dilemmas - The Cost of Technology*

While the politics of the budgetary process may have created some uncertainty about the guarantee of an adequate health budget, the availability of new technologies creates pressures to expand the basic basket of benefits, and increases its cost. *The National Health Insurance Law, 1994* includes an elaborate procedure for updating the basic basket of services with additions and subtractions. This has been well described elsewhere,[63] and its utilization to date provides additional insights into the implementation process, while it raises the most serious question challenging health systems in all countries - the scope of entitlement within limited resources.

According to the Law, services from the initial basket may be cut only with agreement of the parliamentary Labour and Welfare Committee. Services may be added by the Minister of Health, with the consent of the Minister of Finance and approval of the cabinet, only if the two Ministers can guarantee a source of finance for the additions. With respect to drugs, the Law provides that the Minister of Health shall publish in an order the list of the drugs included in the basket of services and the sums of copayment,[64] and that he may amend the order provided that the amend-

63. D. Chinitz & A. Israeli, "Health Reform and Rationing in Israel" (1997) 16:5 Health Affairs 205.
64. *The National Health Insurance (Drugs in the Health Services Basket) Order 1994*, 5754 *Kovetz Takanot* 749.

ment would not add to the cost of the basket.[65] Almost immediately after activation of the Law, pressure ensued to add new benefits in the form of new drug therapies. The prominent example concerned Interferon-beta, a drug therapy for multiple sclerosis.

In the summer of 1995, a group of patients represented by a tenacious attorney initiated court proceedings in a series of cases, demanding that the cost of the new treatment - approximately U.S. $20,000 per year for each patient - be covered by the sick funds. At that time, the use of the pharmaceutical for the proposed indications had not yet been checked for safety and efficacy, and had thus not been registered by Israel's Drug Administration. It thus seemed evident that the case could not succeed, since the drug was not legally available in the country, and the court did not have the power to circumvent the statutory procedure for adding drugs to the coverage.[66] Nonetheless, despite strong treasury objection, the drug was eventually included in the basket.

First, the Drug Administration was pressured to speed up its evaluation and approve the drug. Then, one of the sick funds began capitulating to individual patient pressure, which gave rise to a claim of discrimination on behalf of all the other patients.[67] Finally, in the course of one of the court proceedings, the Minister of Health forced the hand of the Minister of Finance, and paved the way for Cabinet approval to include the drug in the national health system.[68] The court ordered the sick fund respondents to provide and finance the drug immediately, and the state to pay the litigation costs of the plaintiffs. The judge commented on "a fairly substantiated sense that the filing of the claims and applications before us today hastened the discussions in the Ministry of Health and the Ministry of Finance, and brought about the registration of the drug in Israel and its inclusion in the basket of drugs under the Order".[69]

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65. *The National Health Insurance Law, 1994*, s. 8(G). The Minister is to notify the Knesset Labour and Welfare Committee of the order, and the Committee has power of review within 14 days of its notification.

66. Case 3-2179/95 *Yehudit Rabin* v. *Leumit Sick Fund and the State of Israel* (Tel Aviv Labour Court) - application for interim relief dismissed for lack of grounds for apparent entitlement to the final relief.

67. Case 14-1562/95 *Daniela Eldar* v. *Klalit Sick Fund and the State of Israel* (Tel Aviv Labour Court) (unreported, 17 August 1995) - plaintiff awarded interim relief obligating the sick fund to finance half of the cost of the drug against a bank guarantee, pending clarification of the principal claim.

68. *The National Health Insurance (Drugs in the Health Services Basket) (Amendment) Order, 1996*, 5756 *Kovetz Takanot* 502.

69. Case 7-2,7-4,7-5,4-179/96 *Dorit Shirman and others* v. *Klalit Sick Fund and others* (Tel Aviv Labour Court) (unreported, 18 January 1996).

However, after publication of the order to include the drug in the basket, the Ministry of Health formulated an administrative rider limiting access to the new drug to patients fitting certain clinical guidelines. A petition to the High Court of Justice, seeking to annul the administrative guidelines on grounds of *ultra vires*, inadequate expert evidence, procedural flaws and unreasonableness, was dismissed for lack of jurisdiction, and the petitioners were referred to the Labour Court as the court of exclusive jurisdiction under the Law.[70] In a subsequent claim to the Jerusalem Labour Court, one of the sick funds was obligated by an interim order to supply the drug to the plaintiff on the basis of a physician's prescription, and in disregard of the clinical guidelines. The judge stated that it was not clear who had issued the guidelines and by virtue of what authority, and expressed doubts as to whether any authority was empowered to restrict the right of a patient to receive a drug included in the basket on budgetary grounds.[71] However, the final judgment of the court dismissed the claim and upheld the clinical guidelines, which appeared to conform with the permitted uses of the drug as indicated under its registration. The court stated that it could not order a public body to supply a drug prescribed for use in conditions that did not meet those of its registered indications. One year later, and a month before the decision on the appeal pending in the National Labour Court, the Minister of Health published a new order amending the pharmaceutical basket, with an attached appendix entitled "instructions for use".[72]

On considering the appeal, the National Labour Court decided it could not discuss the validity of the new instructions since the matter had not been argued at first instance. Since all the appellants had received assurances from their sick funds that they would continue to receive the drug as before on a personal basis, and the new instructions allowed for this with respect to patients receiving sick fund funding for the treatment prior to their coming into effect, the Court found it unnecessary to rule on the question of whether instructions for use are, in principle, valid.[73] Since it appears, as a matter of fact, that they do not duplicate the registered indications of the drug, but are more restrictive with regard to

70. HCJ 2570,2743,3293,3179/96 *Medina Bat-Ami and others* v. *Ministry of Health and others* (unreported, 14 May 1996).
71. Case 7-15,7-16/96 *Yossi Barazani and others* v. *Ministry of Health and others* (Jerusalem Labour Court) (unreported, 22 May 1996).
72. *The National Health Insurance (Drugs in the Health Services Basket) (Amendment) Order, 1997*, 5757 *Kovetz Takanot* 887.
73. Case 9-205,7-2/97 *Medina Bat-Ami and others* v. *Ministry of Health and others* (National Labour Court) (unreported, 9 July 1997).

its inclusion in the basket of drugs and the financing duty of the sick funds, the question of the source of the power of the Minister of Health to issue restrictive clinical guidelines remains open.

The litigation over additional new drugs for multiple sclerosis continues,[74] and new debates arise as to the addition of new drug therapies for other illnesses (including schizophrenia, HIV/AIDS, breast cancer, and osteoporosis). While it is too early to draw conclusions from these isolated cases, it is clear that defining the basket results in complex interactions among political, legal, economic, medical, and scientific factors. Those involved in designing the national health insurance scheme could scarcely have anticipated how the processes set in motion by the Law would deal with the challenge of setting priorities in the context of a defined basic basket of services.

VI. *Discussion*

Israel's *National Health Insurance Law, 1994* is based on several key concepts: social justice in the finance of health care; universal and equal access to a comprehensive and integrated basket of services; and a regulated competitive market for the provision of health services. As with any structural overhaul of a major social system, unanticipated problems and by-products have emerged during the implementation stage. Sequential alterations in the sources and amounts of finance raise the spectre of a two-tiered health system. Failure to integrate the full array of services into the sick fund basket raises doubts about the wisdom of pursuing such integration and about equitable treatment of different classes of citizens seeking access to varying categories of health care. Central government control over sick fund management raises questions about the vitality of regulated competition in the sick fund market.

Indeed, Israel has provided a laboratory of sorts for learning about managed competition. Some analysts have labelled the latter an oxymoron,[75] while others have noted that the elegance of Enthoven's theory militates against its adoption by policy makers, who are typically adverse

74. HCJ 2696/97 *Oliver Riva* v. *Minister of Health and others* (unreported, 6 May 1997) - petition to receive Avonex dismissed as being premature; case 14-1544/97 *Lily Carmel* v. *Klalit Sick Fund* (Tel Aviv Labour Court) (unreported, 10 August 1997) - sick fund ordered to provide and fund immunoglobolin for patient not meeting the registered uses of the drug, on basis of special prescription and opinion of treating physician.

75. T. R. Marmor, "Changing Conditions for Healthcare Management, or Hopes and Hyperbole: The Rhetoric and Reality of Managerial Reform in Health Care," keynote address at Conference on Changing Management in Health Care: New Missions, Conditions and Skills, European Health Care Association, Den Hague, June 1997.

to overly complex proposals.[76] Either way, few underestimate the challenge involved in trying to implement the theory of managed competition. As Evans has argued, it is unlikely that markets can totally supplant public management in health care, though competitive mechanisms may be a tool of management in public systems.[77] The question is one of balance between management and competition. In theory, managed competition implies a very particular way of striking this balance which, as noted, has never been implemented in full. Since the Israeli case comes as close as any other to this model, it is suggestive about the tradeoff between management and competition. While only three years have elapsed since the new law came into effect, the implementation process has been extremely dynamic, and even as this article is being written changes in the law are under review and will be alluded to in the following discussion.

In Israel it appears that the "managed" definitely outweighs the "competition." *The National Health Insurance Law, 1994* itself bars price competition among the funds, at least for provision of the basic basket. The sick funds cannot compete on price, reducing their incentive to add services to the standardized basket. The sick funds do advertise heavily to try to attract new members, but this has been a controversial expenditure of scarce resources and has come under considerable public criticism. The competition among the funds does not seem to be the type of competition envisioned by the Law because it is overly aggressive, has been tainted by cases of misrepresentation in the recruitment of new members, and often is focused almost entirely on the supplementary insurance. One overall result is the apparently limited movement of consumers among sick funds,[78] with about four percent of the population switching funds annually. Another is an increasing sense that, at least with regard to the basic basket, there is little to choose from among the sick funds.[79] On the positive side, there is evidence that most of the public feel that service levels have remained the same or improved, though it is not clear if these improvements took place largely before the new Law went into effect, since the data is from mid-1995.[80] One clear effect of the

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76. L.D. Brown, "Knowledge And Power: Health Services Research as a Political Resource" in E. Ginzburg, ed., *Health Services Research* (Cambridge, Mass.: Harvard University Press, 1991) at 33.
77. R. G. Evans, "Going for Gold: The Redistributive Agenda Behind Market Based Health Care Reform" in Chinitz & Cohen, *supra* note 5.
78. A. Berg et al., *Public Perceptions of the Health System Following Implementation of the National Health Insurance Law: Principal Findings from a Survey of the General Population* (Jerusalem: JDC/Brookdale Institute, 1997) at 17 (Hebrew).
79. *Objective - the Consumer Magazine of Israel* (August 1997) at 38-43 (Hebrew).
80. A. Berg et al., *supra* note 78, at 69.

competition introduced by the law has been increased access for Arab minority populations living in remote areas, due to the opening of new clinics by sick funds seeking to attract new members.[81]

There have been no new entrants into the sick fund market. This may be explained in part by the criteria for recognition of a new sick fund under the regulations,[82] including the statutory requirements that a sick fund must invest all its profits to meet the purposes set down in its articles of incorporation, that it may not give out dividends to its members or shareholders, and that on its liquidation the remaining assets are to be devoted to a similar purpose.[83] The apparent primary candidates for entry into this market are for-profit private insurance firms. Current proposals of the Ministry of Finance apparently include allowing private insurers to obtain sick fund status, provided they do not engage in underwriting or cream-skimming and undertake to provide the standard service basket. Still, those opposed to entrance of private entities into the sick fund market appear to base their opposition on the fact that private insurers would be paying dividends to investors.[84]

The basic basket of services mandated by the law has proven another aspect of managed competition easier to "declare" at the outset than to maintain and deal with over time.[85] As described above, it has proven extremely difficult to update the basket. This is, of course, connected quite closely to the budgeting process and the continuing deficits which

81. *Supra* note 28.
82. *Supra* note 13. For example, rule 1(2) of *The National Health Insurance (Recognition of Sick Funds) Regulations* requires a corporation seeking recognition as a sick fund to show a capital investment of approximately U.S. $12 million over a period of three years, and rule 3 requires that it show an intended membership of 35,000 at the time of application for recognition, with a forecast of 80,000 members within three years.
83. *The National Health Insurance Law, 1994*, s. 25(1).
84. *Ha'aretz* (Tel Aviv) (9 September 1997) quoting the Director of the Klalit Sick Fund.
85. Other systems, in places such as Oregon, the Netherlands, and New Zealand, have also gone down the path of trying to define an explicit basic basket of services. In Oregon, a basket of services (applicable only to the Medicaid population) was determined based on cost-benefit analysis relying in part on surveys of public preferences. In New Zealand a Core Services Committee recommended that rather than exclude whole areas of service from public coverage, guidelines should be developed to set priorities within service areas. For further discussion of these examples, see Flood paper, this volume. Finally, in the Netherlands, a Commission laid out a set of criteria for setting priorities, but it has been used sparingly in cutting services from the basket, for example, reducing the number of in vitro fertilizations to which couples may have access, and imposing limits on physiotherapy sessions. It should be remembered that in the Dutch case the priorities are only for the public basket and much of the public is insured outside this plan, at least for now: See Schut & Hermans paper, this volume, and World Health Organization, *European Health Care Reforms: Analysis of Current Strategies* (World Health Organization, 1997). Thus, of all these examples, Israel appears to be the only one with a detailed basket, explicitly including and excluding services, applied universally in concert with managed competition.

have carried over from the previous system. As the bill for the health care system has been laid at the door of the Ministry of Finance, the latter has entered into the realm of the actual scope of health services included in the basic basket, which it previously appeared happy to leave to others, such as the Ministry of Health. The Ministry of Finance is seeking to solve the budgetary problem by suggesting cutbacks in the basic basket of services, or by eliminating the basic basket from the law and allowing each sick fund to determine its own basket. The Finance Ministry is discovering, however, that it is as difficult to eliminate services from the basket as to update the latter by adding new services. Services which would be removed from the basic basket would find their way, one way or another, into the supplementary policies of the sick funds. This is likely to encounter serious opposition because of the concern about a two-tiered system. Since the Ministry of Finance has no grounds to convince the public that services cut from the basic basket are not essential, overcoming this opposition will be difficult.

The perhaps inadvertent way in which the Ministry of Finance has implicated itself in the substance of health policy beyond the financial aspects, might reflect the difficulty of inducing decentralization in a system with a tradition of centralization. While the law sought to centralize the financing of the system and decentralize the provision of services (through transferral of responsibility from the Ministry of Health to the sick funds), the Ministry of Finance has taken steps which imply more centralization in both realms. Abandonment of the employer-paid parallel tax makes finance of the health system even more dependent on general revenues controlled by the Ministry of Finance. The provision for government appointment of controllers for the sick funds increases central control over the sick funds.

In addition, the decentralization of services provision has not taken place, as reflected by the failure to integrate the preventive (mother and child), psychiatric and geriatric services into the sick fund basic basket of services despite the political will of the government to do so. Consumers of these services, and to a large extent the sick funds themselves, appear reticent about their integration into a unified basket, especially in view of the already dismal financial position of the sick funds. While doubts have been raised in the literature as to the wisdom of such an integration,[86] in the Israeli case the failure to integrate adds to the uncertainty regarding the degree to which the system can be based on competing sick funds.

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86. See van de Ven & Schut, *supra* note 56. See G. Robinson et al., *Mental Health in Health Policy: A Cross-National Comparison* (Washington, D.C.: Policy Resource Center and Office of Technology Assessment, 1994).

The heavy emphasis on managing the system has, ironically, promoted activity of the parts of the system providing benefits not concerned with the basic coverage. Most of the actual competition is over supplementary insurance, and it has proven difficult for government to promulgate regulations for this market. This leads to inefficiency and inequity, since there is no mechanism for determining whether the services offered under supplementary insurance are worthwhile, and because the supplementary policies use screens to accept applicants. Until now there appears to be more screening by health status, than by income or education.[87] Moreover, since the supplementary insurance is provided by the sick funds there is concern that those with such coverage will receive better treatment. As mentioned, the Ministry of Finance wants to return to the sick funds the right to levy direct premiums for the basic basket, to open up the sick fund market to private entities, and to allow sick funds to determine their own basket of services.

Conclusion

The Israeli case resents an example of managed competition not as an integrated strategy but as a pendulum swinging between the two alternatives included in the term. Traditional tendencies to centralized management give way, at least in policy formulations, to extreme reliance on the market. The lesson here, perhaps not surprisingly, is that it is difficult to find a blend of management and competition, of government and market. However, seen optimistically, the swinging pendulum is part of a dialectic learning process wherein, at some point, a stable point in the middle might be found.

One missing element in the Israeli case, which may be necessary to slow down the pendulum, is significant public debate of the issues. The National Health Council, which was intended by the Law to serve as a forum for such discussion, has barely been activated. Press reporting of developments in the health system tends, in sporadic fashion depending on the budget cycle, to emphasize the polar opposites of public vs. private, rather than provide an ongoing assessment of the issues.

Much like Pareto optimality in welfare economics, there are many points along the curve of the pendulum's path which probably would be preferable to either extreme and to the continual swing between them.[88]

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87. R. Gross & S. Bramli, *supra* note 57.

88. Pareto optimality is the term used by economists to describe a situation in which no reallocation of resources will make any individual better off without making at least one other individual worse off.

However, finding an equilibrium amounts to establishing a social consensus concerning the issues raised by managed competition — the basket of services, freedom of choice of provider, the amount of inequity society is prepared to tolerate. Evans has stressed that health care policy comprises a series of conflicts which must be solved politically.[89]

The lack of a formal process for including public debate in the decision-making process is very striking as the three-year "interim period" of the Law comes to its close. Serious structural changes are being proposed by the Ministry of Finance without any attempt to discuss the lessons learned from the first three years of the Law's operation, or to find solutions that would live up to the statutory purpose of social justice, equality and mutual aid. The pendulum of the managed competition discourse obscures the implications as to the health rights of the insured. The ping-pong of late-night bargaining sessions between the Ministry of Finance and the Ministry of Health civil servants leaves the public uninformed about matters that do not have any magic solution, but which affect directly their legal rights to basic health services. The key dilemma is how to define a core basket of services within budgetary constraints and limited resources, on the one hand, and increasingly costly technological innovations, on the other. This is also a key issue in a rights analysis of the system. Under the *International Covenant on Economic, Social and Cultural Rights*, the government has a duty to take steps to the maximum of its available resources, with a view to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Who decides when the maximum has been reached? How do we share the resources justly and fairly? And how do we decide on the method of distribution? What is the process of decision-making, and who is included in it?

The Israeli case suggests that introduction of health reform, especially through passage of seminal legislation such as *The National Health Insurance Law, 1994*, constitutes only the beginning of a political dynamic concerned with resolving conflicts and dilemmas in the health care system. It seems that while the law instituted major change, behavioural patterns linked to the problems which brought the law into effect still persist: a strong tendency to centralization, linkages of health policy to other policy areas, inequity, and lack of accountability. Successful policy implementation requires flexible adaptation to the new set of

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89. R.G. Evans, "Life and Death, Money and Power: The Politics of Health Care Finance" in T.J. Litman & L.S. Robins, eds., *Health Politics and Policy* (Albany: Delmar, 1991) at 287-301.

issues that arises and a realistic appraisal of whether responsive policy mechanisms are in place. Public managers, broadly defined to include the political leaders of the system, are now confronted with the challenge of designing institutions capable of resolving the dilemmas which the reform process has brought into sharper focus.