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Managed Competition in the National Health Insurance System of Israel

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Abstract

Regulation of health insurance systems is a complex undertaking considering the complexity of health insurance markets and the diverse stakeholder interests to be managed. The theory of "managed competition" proposes regulation of health insurance systems by a "sponsor" who manages the market of insurers and sets rules for their participation in the system. Conceptually envisioned at the level of a company's employees, the concept has found application in national-level systems in multiple countries. One such country in Europe with a strong solidarity orientation has implemented the theory's tenets to a large extent. We characterise the National Health Insurance system of Israel, its universal public healthcare system, as one which has adopted managed competition and achieved remarkable outcomes. We place the establishment of the system in the country's political-economic context to determine the role of the structural factors in shaping health policy in the country. We trace the original values and structures of the healthcare system and the subsequent reforms that arose due to competing institutional and political interests. The system remains mired in the challenge of meeting its equity objective of providing effective healthcare access to all while balancing the country's overall policy goal of efficiency.

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1 Introduction

Israel is located at the intersection of three continents and is home to a population of 9 million. It is categorised as a high-income country by the World Bank. Its healthcare system is composed of national, supplementary and private health insurance. Israel has achieved remarkable health outcomes evident in its low DALY rate[1] and high life expectancy despite modest health expenditure. However, it also faces emerging challenges such as the rising share of private healthcare and a corresponding increase in out-of-pocket expenditure.

In 1995, the health system was reformed through the National Health Insurance Law (NHIL), creating a public health system that subsumed the not-for-profit private health insurance entities called sickness funds. The reform was facilitated by a political window and aimed at increasing efficiency, accountability and equity. We trace the underpinnings of this reform in its history and set the context which explains the path dependencies culminating in the system's adoption. This background also helps interpret the larger ideology informing the implementation of the reform and the subsequent reforms. Following an outline of the reformed financing structure, we briefly explain the concept of managed competition (section 3) and identify the features of the system which are consistent with the principles of the concept (section 4). We then evaluate the health system's performance (section 5) and its inherent limitations (section 6) and conclude the paper in section 7.

[1]Disability Adjusted Life Years (DALY) measures the burden of diseases on a country's population. It is calculated as the sum of years of life lost (YLL) due to premature death (compared to life expectancy) and years lived with disability (YLD).

2 Background

The healthcare system in Israel has its roots in the structures established in the early 20th century (Clarfield et al., 2017). These were sickness funds that provided care to their members in return for contributions. The rise of sickness funds was prompted by the healthcare needs of the Zionist immigrants who had come to Israel in 1908 (Shvarts, 2002). While many immigrants were assimilated into the Jewish settlements in Jerusalem and urban areas, they were boycotted by the orthodox Jewish agricultural settlements in rural areas.[2] To meet their healthcare needs, the Jewish immigrants began to organise among themselves, starting from a few make-shift clinics to fully equipped hospitals. Subsequently, the labour parties at the time took up the issue of workers' healthcare as well. In 1911, the Judea Workers' Federation passed a resolution for comprehensive healthcare and mutual aid for workers following the unfortunate accident of an agricultural worker. Consequently, the Judean Health Fund was established. Similar resolutions were passed in Galilee and Samaria in 1912 to establish sickness funds.

With the advent of the first World War, the Judean Health Fund became responsible for the health needs of the entire Jewish working population. The Galilee and Samaria Health Funds were established only in 1915. In 1920, the various workers' sickness funds amalgamated to form the General Sick Fund or *Kupat Holim*. It was established and owned by the Labour Federation or *Histraduth* (Shvarts, 1998). *Histraduth's* ownership of *Kupat Holim* was instrumental in continuing the political and social importance of the Labour Federation among the working-class Jews in the beginning, and later the Arab working population as well. This was because membership in the trade union *Histraduth* was required to access the services of *Kupat Holim*.

Following World War I and the League of Nations mandate, Palestine came under the control of the British empire. The British limited their involvement in the economic and social development of Palestine to the bare minimum. Their contribution to healthcare provision was similarly confined to the prevention and treatment of epidemic-related diseases and other matters of public health. Hence, *Kupat Holim* continued to provide basic healthcare services for a large number of

[2]There were ideological differences between the resident Jewish population and the Zionist immigrants (Shvarts, 2002). The resident Jews held orthodox religious values while the immigrants practiced a secular way of life. Moreover, the religious Jews had employed Arab workers since they were cheap labour, sparking opposition by the secular Zionists who advocated for the employment of Jewish labourers exclusively. The ensuant response to the clashes was a decision by the residents to boycott the immigrants and deny them employment, housing or healthcare in the region.

workers in Israel. At the same time, the *Hadassah* Medical Organisation established another major sickness fund called the *Amamit Kupat Holim*. *Hadassah* was supported by the American Jewish philanthropic community and received massive financial aid for its operations (Clarfield et al., 2017). It also enjoyed good relations with the British government and became the primary provider of inpatient care, and maternal and child care as public services during the British Mandate.

Between 1918 and 1924, the massive immigration of Jews increased the population of Palestine and posed a significant economic burden on the already limited resources of the colony (Shvarts, 1998). The heavy unemployment affected *Kupat Holim's* financial stability by draining its resources. To ensure its survival, *Kupat Holim* lobbied for the introduction of a mandatory universal health insurance law to be funded by the British Mandate and provided by *Kupat Holim's* healthcare infrastructure. The incessant efforts of *Kupat Holim* lasted 70 years, since the beginning of this conversation in 1925 to the final passage of the law in 1995 (Shvarts, 1998). *Kupat Holim* requested the *Histraduth* (Labour Federation) to introduce a proposal for the universal health insurance system to the British Mandate. The *Histraduth* postponed discussions on the proposal citing the burden of the economic crisis as the reason for its de-prioritisation. However, the underlying reason was the fear of losing political mileage among the labour class. *Kupat Holim* had become a major provider of healthcare and became an attractive feature of the *Histraduth*, especially considering the meagre healthcare services available otherwise. The passage of the universal health insurance system, funded by the British Mandate, would have broken the link between the *Histraduth* and *Kupat Holim*. To prevent the same, the *Histraduth* opposed the reform throughout British rule and after. During the British Mandate,*Kupat Holim* forwarded multiple proposals to the British High Commissioner for Palestine in 1930 and 1931, initiated lobbying in the British Parliament through a Labour Zionist activist in London in 1931, and wrote a letter to the General Secretary of the *Histraduth*, Ben Gurion in 1934. The *Histraduth* was successful in countervailing all these efforts. During this time, *Hadassah*-led *Amamit* had not offered any support for the proposal since, unlike *Kupat Holim*, it was not financially troubled and did not want to compromise its amicable relations with the British government. *Kupat Holim*'s last attempt under British rule to introduce the proposal was made during the Royal Inquiry Commission's deliberations on the brewing Jewish-Arab conflict following the Arab Revolt (1936-39).

In 1948, the State of Israel was established with Ben Gurion sworn in as the Prime Minister. Following independence and establishment of the state, the *Histraduth* feared the dilution of its political, institutional and social role in Israel (Shvarts,

1998). It was especially aware of the strength of *Kupat Holim* and the political mileage it garnered the Federation. As the Prime Minister of the new government, Ben Gurion's political motivations had shifted in support of the compulsory health insurance proposal, which he had continuously blocked as the General Secretary of *Histraduth* earlier (1921-1935). He introduced several bills in the Parliament i.e., *Knesset*, which were continually opposed by *Histraduth* and hence did not pass in 1955, 1957, 1958, 1967 and 1973. With the election of the right-wing Likud-led coalition towards the end of the 1970s, the bill was again introduced in Parliament. However, it was struck down by the still-powerful *Histraduth*. Only towards the end of the1980s, with the severe economic crisis of *Kupat Holim*, the weakening of the *Histraduth*, and the formation of the Netanyahu Commission, was the law finally passed in 1995 (Cohen, 2012).

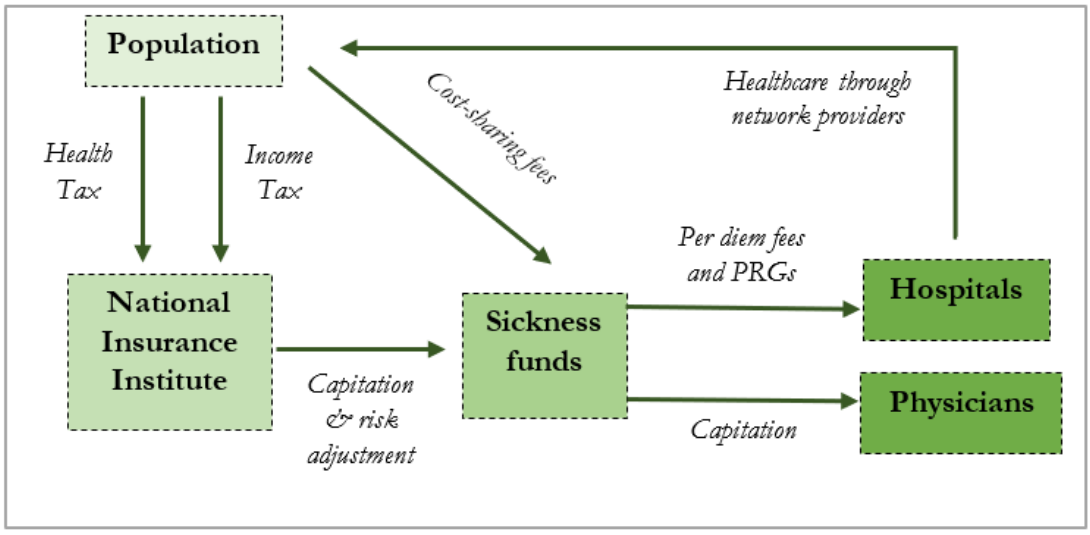
The Netanyahu Committee was widely accepted as a reputable and impartial committee (Cohen, 2012; Shvarts, 1998). Furthermore, the persistent financial troubles of *Kupat Holim* had weakened the stance of the Labour party, creating the window of opportunity for comprehensive reform. However, the dominant reason for the reform has been attributed to the role played by then Health Minister Haim Ramon. Despite his affiliation with the Labour party, he recognised the opportunity to advance his political career by supporting the national health insurance legislation, which was also a crucial matter included in his campaign promise (Cohen, 2012). The health system was also facing overall financial troubles, long waiting lines, workers' strikes and widespread dissatisfaction with the quality of care. These conditions together paved the way for the NHIL and the establishment of a universal social health insurance system leveraging the four sickness funds that operated in the country (*Clalit*, *Leumit*, *Maccabi*, and *Meuhedet*).

The underpinnings of the 1995 reform can also be traced to the larger trend in the 1980s and 1990s wherein the Israeli social security system moved from a welfare state model to a neo-liberal competition-based one (Doron, 2001). The ideological differences between the Labour party and the conservative Likud party led the different policy changes over the years that alternated between these two orientations. Moreover, the Finance Ministry further advanced the prioritisation of efficiency and budget constraints through economic laws accompanying the budget laws, thereby bypassing the Parliament, i.e., the *Knesset* and the Labour and Welfare Committee. These economic laws were passed under the Law of Economic Arrangements, initially intended as emergency legislation following the 1983 economic crisis. However, it has been routinely used by the Finance Ministry to pass amendments to the NHIL, among other legislations which would be blocked by the Knesset. For instance, the benefits of dental and mental health care were added

through administrative decisions and not through legislation to fast-track the opposed reform (Rosen & Waitzberg, 2018).

The law's passage changed the source of financing from income-based premiums charged at different rates by sickness funds to a health tax. Figure 1 depicts the financing flow implemented in the NHI system. Supplemented by general taxes, the health taxes are pooled by the National Insurance Institute (NII) and then reallocated to sickness funds on a capitated basis, essentially reimbursing funds for the number of members they enrol. The capitation formula includes risk adjusters that compensate sickness funds based on their members' age. Payments to sickness funds were consequently based on the number of members (through capitation) and their higher health risks (through risk adjustment). This pooling and reallocation of funds enable redistribution of the contributions fulfilling the principle of equity subsidy, i.e. the rich subsidise the poor. Sickness funds can purchase healthcare from physicians (general and specialist) on a capitation payment basis and purchase services from hospitals based on per diem fees or procedure-related group (PRG) payments (Rosen et al., 2015). The sickness funds were also allowed to charge cost-sharing fees following Knesset's approval in 2012. While stated as a policy move to curtail unnecessary physician visits, the primary objective was to ensure the financial sustenance of the sickness funds. Moreover, since the amounts charged by funds could differ, these were intended to bring about some price competition and enhance efficiency (Gross & Harrison, 2001).

Figure 1: Financing Flow in the National Health Insurance System



The creation of a public healthcare system, consolidating coverage under the four sickness funds and enveloping those that were left out, was accompanied by a slew of regulatory and structural changes. Many of these have been found to resemble the theory of regulation of health insurance systems through "managed competition". In the next section, we briefly outline the objectives of the theory, the principles that underlie it, and the context in which it was envisioned. Following the same, in section 4, we delve into Israel's implementation of this concept and evaluate the extent to which the regulations follow the principles.

3 The Theory of Managed Competition

In the 1980s, health economist Alain C. Enthoven proposed a theory of regulating a health insurance system. Coined "managed competition", the theory conceptualised a sponsor who manages health insurers and sets rules for their participation to ensure outcomes favourable to consumers (Enthoven, 1993). Essentially, the sponsor's interest in consumer welfare is the bedrock of such a system since the oversight and regulation of insurers act as the safeguard against profit-motivated actions of insurers that may be incompatible with consumers' interests. Insurers functioning in an unregulated market can be expected to enrol healthy customers over their sicker counterparts (risk selection), create hurdles for new entrants into the market and differentiate their product features to avoid direct competition for price and quality (Enthoven, 1993). The sponsor hence tries to address these tendencies of the insurer by setting in place rules of participation and monitoring insurers' compliance with these requirements.

Theoretically, the application of managed competition is slated to produce its intended objectives when the health system comprises integrated entities of insurers and providers (Enthoven, 1993). The relationship between insurers and providers is defined by selective contracts or even complete integration where the insurer and the provider are the same entity. This feature, broadly called managed care, addresses the moral hazard problem on the part of consumers and providers. By linking payments to performance, insurers can circumvent over-provision of care due to provider-induced moral hazard. Secondly, employing gatekeeping ensures that consumers do not access specialist care without the necessary diagnosis and treatment at the primary care level. Such entities can take multiple organisational forms with varying degrees of integration but are usually characterised by a few core functions meant to maximise the value of health insurance for the consumer (Ashraf, 2021). We observe the application of these features in the managed care entities that operate in Israel.

The core principles of the theory are realised through the sponsor's functions of ensuring equity, selecting the participating plans, monitoring the enrolment process, striving to create price elastic demand and managing risk selection in the system.

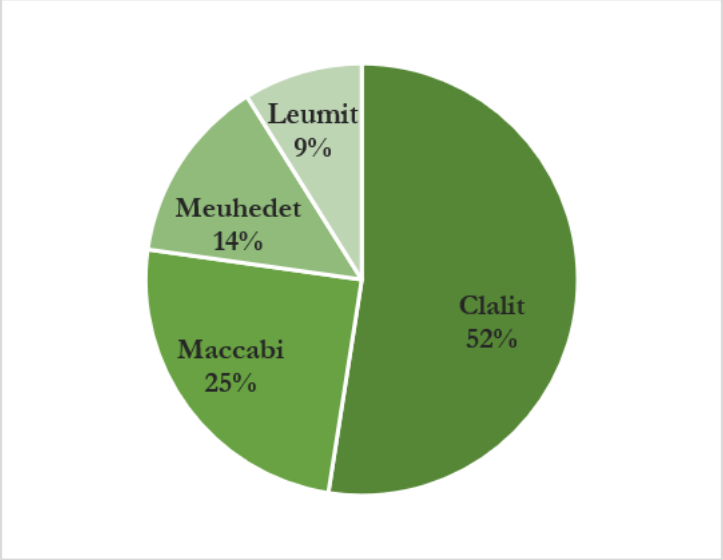
4 Application of Managed Competition in Israel

In this section, we describe how the system resembles the features of the concept of managed competition. We identify the managed care entities in operation and the nature of the sponsor in the system. The principles that underlie the concept have been elaborated on in their implementation in the Israeli health system.

4.1 Sickness Funds as Managed Care Entities

In Israel, the four sickness funds in the NHIS are entities that manage both financing and healthcare provision for their members. The degree of integration of these two functions varies among the four funds. While *Clalit* owns its clinics and hospitals, *Leumit*, *Maccabi* and *Meuhedet* sign exclusive contracts with physicians and hospitals. Figure 2 depicts the market shares of the sickness funds in 2015. *Clalit* covers more than half of the market share (52%) (Rosen, 2011). All the funds have closed physician networks, allowing for competition among integrated entities, as envisioned by Enthoven. There exist some exceptions. Around 5% of physicians belong to multiple funds, while most are salaried or contracted in a single fund at a time.

Figure 2: Market Share of Sickness Funds in 2015



Source: Ministry of Health-State of Israel (2015)

A peculiar feature of the system is that the Ministry of Health (MoH) is also involved in healthcare provision while being the system's regulator or sponsor. The

MoH owns about half of the hospital beds in the system (Rosen & Waitzberg, 2018). Hence for specialist care by physicians and hospital care, there may exist overlaps between provider networks. Scholars have raised concerns over this aspect due to the conflict of interest arising from the regulator's participation in the system as a provider (section 4.2).

Managed care organisations across different forms perform some core functions such as an emphasis on preventive care, coordination of care across treatment levels, provision of appropriate care and alignment of incentives between insurers and providers (Sekhri, 2000). The incentive alignment objective is fulfilled either through ownership (*Clalit*) or through the selective contracting mechanism. Moreover, payments accorded to providers also aim to transfer some of the risk to healthcare providers. The procedure-related-group payments to network hospitals are meant to reduce the over-provision of care which would tend to arise from fee-for-service payments. The provider has to cover the patient's treatment within the payment package they receive for the procedures performed. Similarly, the capitation payments to physicians also transfer a portion of the risk to them. The primary care physicians act as gatekeepers in the system and coordinate care for sickness fund members (Rosen & Waitzberg, 2018). This feature is mostly documented in *Clalit* Health Services (Shmueli et al., 2015).

The seamless management of providers, especially physicians, by sickness funds is facilitated by the information technology infrastructure and its prudent use by the sickness fund management. The sickness funds manage the care provided by their network physicians to ensure efficiency, quality of care and equity in healthcare delivery (Rosen, 2011). Close monitoring, devolution of accountability and incentive structures, both financial and non-financial, are employed to regulate physicians and many network hospitals.

4.2 The Ministry of Health as the Sponsor

Consistent with other social health insurance systems, many of the sponsor's functions are fulfilled through regulations (Nambiar, 2021). While the NHI law acts as the core legislation determining how the system operates, continuous regulation and oversight are exercised by the Ministry of Health (MoH) in Israel. Hence, the MoH can be considered the sponsor in the NHI system since it oversees the financing, functioning and performance of both the insurers (sickness funds) and the providers in the system (Rosen et al., 2009). The MoH regulates the sickness funds by determining the compensation they receive, mandating financial reporting, and specifying the types of benefits they can offer and the caps for such benefits. It

governs the mechanism of fund allocation to sickness funds through a periodic review of the parameters included in the risk adjustment scheme. Moreover, it determines the co-payment amounts sickness funds can charge and regulates the pricing and content of the supplemental packages. The MoH regulates providers by controlling their licensing process and requirements for both hospitals and healthcare personnel and regulating the forms and caps of payments to providers (Rosen et al., 2009). The MoH does so by setting maximum price lists for pharmaceuticals and setting the mode of payment to hospitals.

Despite the MoH being the principal regulator of healthcare and health insurance in Israel, it is also a part of the system it regulates. The Netanyahu Committee had recommended the divestment of the Ministry of Health in the hospitals it operated. However, the MoH still continues to provide most of the acute healthcare (Rosen & Waitzberg, 2018). MoH operates the majority of hospitals and hospital beds in the country and provides inpatient care under the NHI system as well as private healthcare. This conflict of interest is a cause of concern since the theory assumes that consumer welfare is the sponsor's sole consideration. Hence, the sponsor's impartial regulatory and oversight function is imperative for managed competition to achieve its intended objectives. Scholars have highlighted the conflict of interest inherent in this system design as a cause of concern and argue that this dual role performed by the MoH is diverting the ministry's efforts from regulating the healthcare system in a concerted manner (Rosen & Waitzberg, 2018).

4.3 Establishing Rules of Equity

In managed competition systems, equity-related concerns can largely be addressed by mandating universal health coverage. Additionally, standardising a basic benefits package and setting contribution levels based on means to pay are mechanisms used to ensure equal coverage. The NHI system has adopted all these features.

The system covers 100% of the population.[3] It is important to note, however, that 95% of the population was covered before the establishment of this system in 1995. Hence, the driving forces for universal coverage had been in operation for decades with an incremental increase in coverage under the sickness funds. The NHI law brought the remaining 5% of the population under the ambit of health coverage. Regardless of contribution levels or even non-payment of contributions[4], all resi-

[3]Undocumented migrants, temporary residents, foreign workers and tourists are not covered under the NHI system (Rosen et al., 2015).

[4]While statutorily mandated to contribute a health tax based on income level (based on the percentage of average income) or category (e.g., self-employed, student, unemployed), non-payment of this contribution does not preclude access to healthcare. Everyone can seek treat-

dents are entitled to a basic benefits package which is standard across the sickness funds. An expansive benefits list ranging from preventive to tertiary care ensures coverage throughout life for the healthcare needs that might emerge for members. Covered services include primary care, hospitalisation, medication, diagnostics, in vitro fertilisation, dental care for children and mental health care[5] (Rosen et al., 2015). The few treatments and medications not part of the package are available through supplementary insurance subscriptions. In 2014, 87% of the population availed the supplementary package (Rosen et al., 2015). Supplementary insurance packages usually provide services not covered or partially covered under the NHI benefits package, such as dental treatment, medical second opinion, complementary medicine, periodic check-ups, transplants, surgeries abroad and drugs not covered by the NHI package (Ministry of Health, State of Israel, n.d.). An annual committee comprising representatives of the ministries of health and finance and the four health plans review proposals for additions of new medical technologies to the package (Rosen & Waitzberg, 2018).

Before the NHI system, consumers would pay premiums charged by sickness funds at different rates, usually a percentage of their income (Rosen & Waitzberg, 2018). With the passage of the NHI law, the mechanism of premium payment was dissolved and replaced by contributions paid directly to the National Insurance Institute. The contribution from members takes the form of a health tax, which is paid at different rates based on income (Rosen et al., 2015). Income upto 60% of the average income is taxed at 3%, while income beyond this threshold is taxed at 5% of income. Unemployed residents pay a minimum sum of NIS 103. However, a peculiar feature of the system is the cap on taxable income levels. Monthly income beyond NIS 43,000 is not taxed, which acts as the upper limit for the taxable amount (Waitzberg & Rosen, 2020). The health tax is hence less progressive than income tax which does not have such an upper limit (Rosen & Waitzberg, 2018).

In 2012, the Knesset allowed sickness funds to charge cost-sharing fees through co-payments and co-insurance for certain services (Rosen et al., 2015).[6] Co-payments are fixed charges levied from patients for visits to the provider for a few services. In the NHI, patients have to pay a flat co-payment amount (€7) for the first visit in a

ment, and non-payment of contribution results in government action to enforce payment (Rosen et al., 2015).

[5]In 2012, the provision of mental health care was transferred from the Ministry of Health to sickness funds which set up multi-disciplinary mental health clinics for the same.

[6]Members pay cost-sharing fees by swiping their membership cards (Waitzberg & Rosen, 2020). The sickness funds withdraw the corresponding amount from the members' bank accounts at the end of each month. Subsequent payments to providers are made through the usual arrangement of capitation.

quarter to a specialist physician or when seeking oral healthcare for children (Rosen & Waitzberg, 2018). There are quarterly ceilings on co-payment amounts to cap households' out-of-pocket spending. Another form of cost-sharing is co-insurance, wherein consumers foot a percentage of treatment costs while the sickness fund covers the rest. The NHI allows co-insurance for patent and generic medications (Rosen et al., 2015). In 2016, the co-insurance rates were 15% for patent drugs and 10% for generic drugs (Rosen & Waitzberg, 2018). The co-insurance is set at discounted rates for the elderly, chronically ill, veterans and Holocaust survivors are exempt from co-insurance payments (Rosen et al., 2015). The co-insurance and co-payment amounts can differ among health plans, but must be approved by the Ministry of Health (Rosen et al., 2015). Visits to a primary physician or hospitals are exempt from these charges.

4.4 Selecting Participating Plans

The theory proposes an active selection of plans by the sponsor. This allows the sponsor to make a higher-level choice for consumers by generating a list of plans for them to choose from. In the case of Israel's NHI system, the four existing sickness funds were included as participating plans. Hence, the Ministry of Health in Israel does not actively choose plans for its population. Instead, it mandates sickness funds to accept all applicants and leaves the choice of plans to the consumers themselves. The MoH further attempts to inform their choices by disseminating information on the performance of the plans. Many social health insurance systems that have adopted the principles of managed competition in some form opt for this feature as a substitute for the direct selection of plans (Nambiar, 2021). The Ministry of Health in Israel has undertaken efforts to increase the availability of information on health plans' performance on its website and on those of other research institutes (Rosen et al., 2015; Rosen & Waitzberg, 2018). The Supervision Department of the Ministry of Health runs a website called Call-Habruit that displays the health rights of citizens and the benefits included in the NHI benefits package (Brammli-Greenberg et al., 2014). It further allows comparison between health plans on the additional benefits they offer and the copayment amounts they charge for certain services.

4.5 Managing the Enrolment Process

Theoretically, a sponsor would have the capacity, both in terms of resources and capability, to oversee the enrolment patterns of all insurers in the system, gauge their compliance to set rules, and correspondingly penalise any circumvention of the same. While more feasible at the scale of a company, this function is less direct in the case of systems at the national scale (Nambiar, 2021). In Israel's NHI

system, the law provides the right to coverage by sickness funds for all residents and allows consumers to exercise their choice of plans by switching among them.

Consumers enrolled in a sickness fund can choose to change their membership to another at six pre-determined points of time in a year. Consumers can switch plans up to twice a year at any of these six time points. This option acts as an implicit tool for regulating insurer behaviour by incentivising them to prioritise the price and quality considerations of the consumers. The switching rate in Israel has remained low at around 1-2% annually (Brammli-Greenberg et al., 2018).

4.6 Managing Risk Selection

While the selection of plans and monitoring the enrolment processes enable the sponsor to ensure universal acceptance, managed competition systems also need to employ compensation mechanisms to deter any form of rejection of members. In Israel, like many managed competition systems at the national scale, the law mandating universal acceptance of applicants acts as the explicit sanction against risk selection behaviour. However, implicit selection mechanisms can operate by which insurers nudge "high-risk" consumers to switch to other insurers by their own choice. The system institutes a risk-adjustment mechanism to subvert such tendencies (Enthoven, 1993).

With the advent of the NHI system, the health taxes collected from members were redistributed across the funds to delink the income level of members with the payments received by insurers. Hence, the capitation mechanism of reimbursement at the level of the insurers acts as a safeguard against targeted marketing and preferential treatment of the high-income population. Apart from capitated allocations to sickness funds, the system also provided additional compensation to cover the costs of the high-risk members that the sickness funds covered. Initially, this mechanism called risk adjustment only addressed the possibility of higher costs for old-aged members of sickness funds. Factors of sex and geographical location were added to the risk adjustment later in 2010 (Rosen & Waitzberg, 2018). The latter's inclusion was prompted following the extensive selection of applicants located in the central parts as opposed to those from the periphery of the country.

While the switching rate remains low in the system, an enquiry into the characteristics of those that switch plans provides valuable insight into the probable reasons for the same. One of the causes of switching could be the imperfect risk adjustment mechanism and the corresponding endeavour of plans to target some consumers over others. As a result, plans would aggressively market themselves to populations for which they get over-compensated by the imperfect risk-adjustment mechanism.

In the NHI system, higher switching rates have been observed in certain localities. In 2015, as compared to the national average of 2%, higher switching rates of 8% and 6% were observed in populations located in Arab and orthodox Jewish localities, respectively (Keidar & Platonic (2016) as cited in Brammli-Greenberg et al. (2018)). These localities usually have large families who are attractive consumers due to the system's generous rate of risk adjustment for children.

The system also provides for grievance redress in case of denial of benefits covered under the NHI system. In case of violation of rights under the NHI law, members can lodge complaints with the Public Complaints Commission. Recently, the Ministry of Health published the activities report of the Public Ombudsman under the NHI Law for 2019 (Ministry of Health, 2020) to generate awareness regarding common issues faced by the insured. Moreover, it aimed to facilitate comparisons between sickness funds and making informed choices.

4.7 Creating Price Elastic Demand

One of the intermediate goals of managed competition is to create price elastic demand among consumers. If consumers' choices are driven by the price of the plan and this demand is highly elastic, insurers would be incentivised to cut their costs relative to one another (Enthoven, 1993). This setting will allow the emergence of vigorous price competition in the system, which is one of the ultimate objectives of managed competition. Since the choice of plans is also governed by the quality of the services and the product features, Enthoven coined "value-for-money" competition as the more appropriate goal being targeted and not just price competition alone. Suppose the sponsor can ensure that these considerations drive consumer choices. In that case, it can act as an implicit form of regulation as it incentivises insurers to deliver on these metrics and compete with other plans.

The NHI law revoked differential premium setting and collection by sickness funds, removing a primary element of competition. As a consequence, insurers are left to compete with one another based on the quality of their services regardless of the health tax consumers pay. However, an element of differentiated prices was introduced later through the supplementary insurance (SI) option. The SI services were to be provided by the sickness funds themselves and acted as a voluntary component in the NHI system above the basic benefits package (Rosen et al., 2015).

5 Health System Performance

To assess the performance of the Israeli health system, we compare the country's metrics of financing and health outcomes to that of countries with comparable income levels and levels of health coverage provided. We rely on World Bank data for identifying countries in the high-income economies (per capita income of $ 12,696 or more) category (The World Bank Group, 2022c) and select a few of those that score more than 90 on the UHC index[7] (The World Bank Group, 2022a). The financing and health outcomes in Israel are provided in Table 1 along with the figures for the comparable OECD countries.

Table 1: Comparison of Financing & Health Outcomes with OECD Countries

Country	Total health expenditure (%age of GDP) 2019	Per capita income PPP (in 1000 US$) 2020	Tax revenue (%age of GDP) 2019	Out-of-pocket expenditure (%age of total health expenditure) 2019	DALY rate 2017
United States	16.8	66.69	10	11.3	30,958
Germany	11.7	56.37	11.4	12.3	20,834
United Kingdom	10.2	45.87	24.9	13.8	27,664
Australia	9.4	52.23	23.4	17.8	24,508
Italy	8.7	42.42	24.6	21.1	27,217
Israel	7.5	39.1	22.4	21	19,302
Slovakia	7	31	18.7	19.2	32,009
Hungary	6.4	32.19	22.5	28.2	37,054

Sources: Total health expenditure and out-of-pocket expenditure (Organisation for Economic Cooperation and Development, n.d.); Per capita income (The World Bank Group, 2021); Tax revenue (The World Bank Group, 2022b); DALY rate (Institute for Health Metrics and Evaluation, n.d.)

[7]The UHC index is calculated as a geometric mean of service coverage (for essential services) and financial protection (incidence of catastrophic health expenditure) (The World Bank Group, 2022a). Catastrophic health expenditure (CHE) is calculated as out-of-pocket health expenses exceeding 10% of household consumption or income.

Relative to comparable OECD nations, Israel has a very low DALY rate (19,302), indicating a low disease burden. Another health outcome indicator on which Israel performs well is life expectancy. Israel's average life expectancy for men and women is above the global average, and its male life expectancy is the highest among OECD nations (Rosen & Waitzberg, 2018). Moreover, the expenditure incurred by the country as a percentage of GDP is also close to that of many similarly placed countries (Table 1). A prominent issue is the high proportion of out-of-pocket expenditure in the total health expenditure. Combined with the additional expenses of private insurance and supplementary insurance, private funding of healthcare in Israel is at 38%, the highest among the OECD countries. The rise in such sources of insurance and private funding has been detailed in section 6.1.

6 Challenges Faced by the System

Despite remarkable achievements, the system continues to face certain challenges such as the rise in private insurance memberships despite coverage under the universal health system, prioritisation of efficiency over the emerging equity concerns, and the poor risk adjustment mechanism used in the NHI system.

6.1 The Rise of Private Insurance

The first decade of the 21st century witnessed a dramatic increase in healthcare expenditure from private sources, both for supplementary and commercial insurance (Rosen & Waitzberg, 2018). This trend was driven by a lack of trust in the capacity of the public healthcare system and a preference for services provided through private providers by paying out-of-pocket or through other forms of insurance (supplementary and/or commercial). Consumers face significantly lower waiting times as compared to care under the NHI coverage and can choose their physician for treatment which is a feature absent[8] in the NHI system (Brammli-Greenberg et al., 2018).

The private provision of healthcare is closely intertwined with the public healthcare system. The public hospitals owned by the Ministry of Health provide many private health facilities besides the NHI benefits (Filc et al., 2020). The supplementary insurance is also provided by the NHI sickness funds themselves (Brammli-Greenberg et al., 2018). Moreover, support from physicians for such reforms also allowed the introduction of private healthcare services (Filc et al., 2020). Hence, patients of both the public and private insurance systems visit the same hospitals but receive different levels of treatment, such as different waiting times and choice of doctors, in some cases even at the same hospital (D. Zeltzer, personal communication, February 22, 2022). Recent regulations in 2016 and 2017 have introduced measures to decrease the channelling of patients to private services (Barnea et al., 2021). First, physicians must adhere to a "cooling off" period of 6 months to privately treat a patient they had served in the public system. Secondly, additional funding has been provided to public hospitals to bring down the long waiting times associated with elective surgeries.

[8]For care sought under the NHI benefit package, members are assigned doctors by the hospital or clinic they visit (Brammli-Greenberg et al., 2018). Hence, while patients can choose the clinic or hospital of their preference from their health plan's network, their choice is restricted regarding the physician that will provide the treatment. For choice of physicians, the patient can avail of private healthcare and pay out-of-pocket charges for treatment.

6.2 Equity-Related Concerns

While the NHIS has been hailed as a highly efficient health system, evidenced by its excellent health outcomes despite its modest total health expenditure per capita, it falls short of the equity objective. Despite the system providing an expansive list of benefits ranging from primary to tertiary care, the persistent budgetary restraints on the system have culminated in low volumes of care, low beds to hospital ratio being an example, and posed a challenge to the delivery of adequate and timely care. The consequence of this policy choice has been the expansion of the voluntary health insurance system, characterised by supplementary insurance within NHI and private health insurance. The rise of private insurance also raises concerns about equity in the system. The option of circumventing the NHI system-provided care by opting for private insurance creates a divide between high-income and low-income populations concerning access to quality and timely care. A predominant issue with Israel's healthcare system is the relatively low level of public funding (D. Zeltzer, personal communication, February 22, 2022). Israel spends less on healthcare as compared to other countries with similar per capita GDP levels. For example, it spent 8.3% of its GDP on healthcare while Slovenia, Japan, and Italy spent 9.5%, 11.1%, and 9.5% respectively in 2020 (Organisation for Economic Cooperation and Development, n.d.).[9] Moreover, the share of public funding in the total healthcare expenditure was 64% in Israel while that of Slovenia, Japan and Italy were 80%, 84%, and 74% in 2019 (OECD, 2020). Despite requests to increase funding by hospitals, sickness funds and providers, the Ministry of Finance continues to prioritise efficiency and tight budget controls.

Another dimension of unequal access to healthcare is the difference between urban and rural areas. The urban areas in Israel are characterised by more competition among sickness funds. In contrast, in less densely populated rural areas, a single clinic might belong to just one sickness fund, effectively wiping out the choice of funds for the rural residents (D. Zeltzer, personal communication, February 22, 2022). Like in other countries, urban areas also enjoy greater access to tertiary care.

6.3 Poor Risk Adjustment Scheme

While the risk adjustment mechanism has been modified and improved with the addition of gender and regional factors, it still falls significantly short of the sophisticated mechanisms used in other health insurance systems which have adopted

[9]Israel also spends less than some developing countries such as Colombia and Chile which spend 9% and 9.5% respectively on healthcare (Organisation for Economic Cooperation and Development, n.d.).

managed competition for regulation. For instance, the social health insurance systems in Netherlands and Germany provide risk adjustment not only based on age and sex but also include disease categories that individuals may belong to (Nambiar, 2021). Kohn & Shmueli (2020) calculated adjustment rates based on an expansive set of risk adjusters and arrived at higher compensation amounts compared to the Israeli risk adjustment scheme for mental health care. Accounting for such adjusters is essential to counter risk selection by matching, as closely as possible, the costs incurred by the insurer.

7 Conclusion

The Israeli health system is characterised by the country's historical institutions and interactions among them. Multiple stakeholders, including the sickness funds, Ministry of Health and Ministry of Finance, have shaped the health system to its current form. Interactions among these institutions also determine the health policy decisions taken by the country and how they are implemented. The health system has achieved good health outcomes with modest health expenditure. However, a closer look at the system reveals the inequities arising from the recent trend of rising private health insurance coverage. The constant budgetary restraint on the public system also indirectly contributes to this trend by under-delivering healthcare and forcing people to opt for dual coverage. The case of the NHI system is an example of a managed competition system which, while established over existing structures, wholly reformed the financing pathways of healthcare. This reform is also symptomatic of the more significant efficiency concerns of the Ministry of Finance. The system's emerging concern is in balancing the objective of efficiency with equity to preserve the long-held core values of effective universal health coverage to its population.

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