ABSTRACT Israel reformed its health care system in 1995. In contrast to many other developed nations, it has since experienced relatively low rates of growth in health spending, even as health outcomes have continued to improve. This paper describes characteristics of the Israeli system that have helped control rising costs. We describe how the national government exerts direct operational control over a large proportion of total health care expenditures (39.1 percent in 2007) through a range of mechanisms, including caps on hospital revenue and national contracts with salaried physicians. The Ministry of Finance has been able to persuade the national government to agree to relatively small increases in the health care budget because the system has performed well, with a very high level of public satisfaction. It is unclear whether this success in health expenditure control can be sustained because of growing signs of strain within the system, the rapid increase in nongovernment financing for health care services, and the growing prosperity of Israeli society.

Israel reformed its health care system and created a national health insurance program in 1995. Under the new structure, insurance coverage was provided to all citizens and permanent residents who selected one of four competing nonprofit health plans, with the entire premium paid by the government. Since then, the proportion of the Israeli gross domestic product devoted to health care has remained stable, and the country’s aggregate health outcomes, already excellent, have continued to improve. This paper focuses on the approaches that the national health insurance program used to contain health care costs, and possible reasons for its success.

Health Reform And The Israeli Health Care System

PAYING FOR CARE Israel’s national health insurance program changed the financing of basic health insurance. The program pays a premium to the insurance plan that a patient selects, according to a capitation formula that primarily considers the person’s age. Insurance plans also get extra payments for patients who have one or more of five especially costly diseases—kidney failure, hemophilia, AIDS, thalassemia, and Goucher’s disease.

The plans are required to provide coverage to all Israeli citizens and permanent residents for a relatively broad package of services, which the government updates each year. A committee—which includes representatives of health plans, provider groups, and the government, as well as academic experts and public figures outside the health care sector—recommends additional services each year to be paid for by the government’s annual allocation of new funds.

Most of the funds for the plans come from payroll and general tax revenues, which are channeled to the plans in the form of capitation.
payments. These payments accounted for 77 percent of health plan revenues in 2009. Additional funds come from individuals’ copayments for pharmaceuticals, physician visits, and certain diagnostic tests; these constituted about 6 percent of health plan revenue in 2009. In 2009 the remaining 17 percent of plan revenues came from sources including supplemental health insurance and the sale of products such as over-the-counter medications in plan facilities such as clinics.

Overall, in 2008 public financing covered approximately 56 percent of total health care expenditures in Israel, including capitation payments to health plans and direct payments to providers for specific populations, such the indigent in nursing homes. Employers and patients paid for most of the remaining 44 percent, with donors—such as Hadassah—accounting for the rest.

The share of national health spending that falls outside the national insurance program has been rising. For example, patients pay through voluntary health insurance or direct out-of-pocket payments for services that the national insurance program does not cover at all, such as alternative medicine, or covers only partially, such as in vitro fertilization. Patients also pay for services from providers not covered by their health plan, if they want increased choice of providers, faster access to care, or more advanced facilities.

Over and above the national insurance program, two forms of voluntary insurance are available in Israel: supplementary insurance, offered by the health plans to all of their beneficiaries; and commercial insurance, offered by commercial insurance companies to individuals or groups. In 2009 approximately 81 percent of the population had supplementary insurance, and 35 percent had commercial insurance.\(^2,3\)

The proportion of the population covered by both of these forms of insurance has stabilized in recent years.\(^1\)

Both supplemental and commercial insurance enable policyholders to use the private health care system for services that may also be available through the public system. However, voluntary insurance cannot cover copayments required by the public system. A standard package of supplemental insurance is offered by each health plan to all of its policyholders, with relatively low fees that are determined solely by age. No policyholder can be denied coverage. Commercial insurance policies for individuals or groups can be tailored to the purchaser’s requirements and can cover any medical service, including long-term care and expensive life-extending therapies. Individuals must apply for coverage, giving information about their health status, and premiums are adjusted based on risk.

Health plans reimburse providers for the services received by plan beneficiaries. The plans’ payments to hospitals constitute approximately 80 percent of hospitals’ revenue, with the remaining 20 percent coming from the sale of health-related services paid for by supplemental and commercial insurance and of other goods, such as food in the cafeteria and items in the gift shop. Plans use a variety of reimbursement methods to pay hospitals, including payment rates based on per diem charges and lengths-of-stay. The government sets a cap on hospitals’ annual revenue from each health plan, however, which affects the payment rates negotiated by the plans and hospitals.

Individual providers who work in hospitals or health plan clinics receive most of their compensation as salaries. Independent primary care physicians affiliated with health plans are paid by capitation, and community-based specialists affiliated with plans are paid through a combination of capitation and fee-for-service.

**Sources of Care** Israel’s Ministry of Health has overall responsibility for the health of the Israeli population and the effective functioning of the country’s health care system. In addition to its regulatory, planning, and policy-making roles, the ministry also owns and operates hospitals containing about half of Israel’s acute care hospital beds, as well as the majority of hospitals providing inpatient mental health services and five inpatient chronic care facilities. Another third of the acute care beds are in hospitals operated by Clalit, the largest health plan. The remaining beds are in facilities operated by other organizations, some of which are nonprofit and some for-profit.

Clalit has a market share of slightly more than 50 percent of the population. It provides community-based services, primarily using salaried physicians working in clinics that it owns and operates. The next largest plan, Maccabi, has a market share of approximately 25 percent of the Israeli population and provides care through a network of independent physicians. The other two plans are Meuhedet, with a market share of 13 percent, and Leumit, with 9 percent. Meuhedet resembles Maccabi and Leumit resembles Clalit in their provision of outpatient care. More than half of both inpatient and outpatient mental health services are provided directly through government-owned facilities. Private or plan-owned facilities provide the remainder of these services. Dental and nursing home services are generally private and paid for out of pocket by the patient or through commercial insurance; however, the government pays
for these services for low-income patients.

In 1997 a dispute arose between the Ministry of Finance and the Ministry of Health regarding the mechanism for setting the annual government funding level for the health care system. The Ministry of Health argued that the funding level should be based on need, and it called for a formula to set the level as a function of population growth, age mix, service prices, and technological advances. The Ministry of Finance maintained that although health care system funding levels should reflect health needs, as in other areas of public funding, macroeconomic developments and competing budgetary pressures meant that priorities and budgets should be decided by policy makers and not by a formula. The Ministry of Finance prevailed in this dispute and since then has generally been far more influential than the Ministry of Health in health care decisions that have budgetary implications.¹

Spending Trends
Exhibit 1 presents health care spending data for Israel and for an average of the thirty-four countries (which include Israel) in the Organization for Economic Cooperation and Development (OECD). Israel’s expenditures are both lower and more stable than the thirty-four-country average expenditures. Israeli outcomes such as changes in life expectancy and neonatal mortality remained at least as good as average outcomes for the OECD countries over the same period.

We used data from the Ministry of Health and the health plans to divide expenditures according to the degree of direct government “control.” We chose this classification because the government has a different perspective on the use of health care resources than that of individual providers and patients. The government, dominated in this respect by the Ministry of Finance, tries to minimize health care expenditures, subject to political constraints on maintaining acceptable levels of access and quality. Patients and providers, however, generally prefer to have more health care services, especially when insurance covers the majority of the costs. Given this difference in perspective, it is important to identify each party’s degree of control over health care spending decisions.

It is easy to see that the government controls some categories of expenditures—for example, services delivered by salaried physicians, whose salaries are specified in nationwide contracts approved by the Ministry of Finance, or services delivered in government-owned hospitals. In other cases, the government’s control is less obvious. For example, hospital reimbursement appears to be fee-for-service, on a per diem or per case basis. That would seem to be controlled by providers or patients, but—as previously mentioned—the government caps hospital revenue from health plans, which effectively gives it overall control over much of hospital spending.⁴

On the other hand, the decision to buy voluntary health insurance is clearly not under government control, nor are services that patients pay for out of pocket. We categorized payments to hospitals not subject to the cap as controlled by individual patients and providers, along with pharmaceuticals that were purchased through plans but outside the national health insurance formulary.

Because some cases were ambiguous, we created a third, intermediate category. This included, for example, ancillary services and pharmaceuticals paid for primarily by health plans for which plans have adopted policies and incentives that are specifically designed to limit such expenditures.

Exhibit 2 shows Israeli health care expenditures for 2007 and their average annual rate of increase over the 2004–07 period—years for which consistent data are available. During this period, total health care expenditures increased by an average of 6.5 percent annually. Some 39.1 percent of health care expenditures were under government control in 2007, compared to 45.1 percent in 2004 (data not shown). The difference in the rates of growth between expenditures controlled by the government and those controlled by individual providers and patients is striking (Exhibit 2).

Discussion
COMPETING STAKEHOLDERS The Canadian economist Robert Evans says that a typical national health care system is characterized by the
dynamic interactions of various constituent groups who use the leverage at their disposal to protect their interests. He uses an engineering analogy to categorize the forces at play.

First, there is tension, as providers (broadly defined) attempt to increase their incomes. Because each dollar spent on health care is also a dollar of income for a provider, cost containment is really a struggle to control the growth of providers’ incomes. Second, there is compression, as payers try to keep their resources from being diverted into the health care system. There is also shear, as both providers and payers try to reduce conflict by shifting the financial burden to third parties. And the more complex the financial arrangements are, Evans argues, the more likely it is that cost containment will fail. This is because when one revenue source is limited, providers will tap other sources.

Evans stresses the importance of central financing in containing health costs, pointing out the large difference between US and Canadian costs since Canada established government-financed health insurance. He argues that the provinces—which in Canada are primarily responsible for managing health care budgets—have the means to constrain health care spending because they set global hospital budgets and physician fee schedules. Of course, public financing is not enough. There must also be political will to constrain costs, because these payments compete with other budget priorities.

The performance of the Israeli health care system largely supports Evans’s argument. All participants in the system—such as health plans, hospitals, physicians, and nurses—exert pressure on the government in any way they can to expand their revenues. And the general public, especially the subgroups most in need of particular services, lobby to expand the services that the national health insurance program covers.

The Ministry of Finance, which is responsible for developing the government’s budget, must negotiate with various interest groups and other ministries—including the Ministry of Health, which tends to represent the perspective of segments of the Israeli health system, such as physicians and patients—to reconcile their competing demands. Clearly, cost controls cannot be arbitrary. The Ministry of Finance recognizes that problems with the quality of, or access to, care have clear political costs and that expenditures may have to be increased to prevent these problems from reaching politically unacceptable levels.

A recent dispute is indicative of this internal conflict. The Israeli Medical Association, representing physicians, is negotiating with the government over a new contract that is primarily focused on salary levels and workloads. The Ministry of Health appears to be supporting an arrangement that would allow physicians to see patients privately and receive extra payment for these services, but the Ministry of Finance is

<table>
<thead>
<tr>
<th>Spending category</th>
<th>Government control</th>
<th>Intermediate government control</th>
<th>Individual control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>9,590 (3.0%)</td>
<td>—</td>
<td>3,184 (10.3%)</td>
</tr>
<tr>
<td>Independent physicians</td>
<td>—</td>
<td>—</td>
<td>13,743 (7.6%)</td>
</tr>
<tr>
<td>Health plan physicians and other employees (salaries)</td>
<td>7,467 (4.5)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Ancillary services purchased through health plans</td>
<td>—</td>
<td>2,538 (10.4%)</td>
<td>—</td>
</tr>
<tr>
<td>Pharmaceuticals purchased through health plans</td>
<td>—</td>
<td>4,794 (4.2)</td>
<td>1,380 (23.9)</td>
</tr>
<tr>
<td>Health plan spending on administration</td>
<td>1,566 (2.6)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Copayments for physician visits</td>
<td>—</td>
<td>458 (4.1)</td>
<td>—</td>
</tr>
<tr>
<td>Health care services purchased outside of health plans</td>
<td>—</td>
<td>—</td>
<td>2,378 (18.2)</td>
</tr>
<tr>
<td>Voluntary health insurance</td>
<td>—</td>
<td>—</td>
<td>5,502 (15.2)</td>
</tr>
<tr>
<td>Other direct government expenditures</td>
<td>3,191 (0.8)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>21,814 (3.1)</td>
<td>7,790 (6.0)</td>
<td>26,187 (10.9)</td>
</tr>
</tbody>
</table>

A large number of factors have contributed to the good performance of the Israeli health care system.

opposed. It, like Evans,\(^5\) sees this additional source of funds as a loss of financial control.

POLITICAL ACCEPTABILITY Debates about health care within the government focus on the budgetary allocation needed to keep the system operating at a politically acceptable level. The Ministry of Finance has been able to persuade the government to agree to relatively small increases in the health care budget because the system is performing well. Not only has the health system shown itself to be relatively efficient and continued to improve health outcomes, but 90 percent of Israeli adults surveyed in 2009 indicated that they were “satisfied” or “very satisfied” with their health plans.\(^7\)

Not surprisingly, a large number of factors have contributed to the good performance of the Israeli health care system. Some are idiosyncratic, such as the immigration of a large number of trained health care personnel from the former Soviet Union. Others—such as the effectiveness of the system’s quality improvement program—are facilitated by the relatively small size and cohesiveness of the system.\(^8\) Effective system management plays a part in still other factors, such as the implementation of a nationwide electronic health record system.

Because in Israel the government controls both the executive and legislative functions, once the annual budgetary allocation has been determined, its enactment and implementation are relatively straightforward and effective. Most important, the government has multiple levers to control health care expenditures and operations. As noted above, the system is predominately financed, directly or indirectly, through capitation payments from the national health insurance program to the health plans. On average, these capitation payments, together with government-determined copayments, represent 83 percent of plan revenues. Capitation payments have increased only slightly from 2004 to 2007. Plans, therefore, have every reason to control their operating expenses (primarily administrative employee compensation) and to constrain their payments to providers.

The government also has ways to keep costs down elsewhere in the system. General acute care hospitals are owned by the government or Clalit—the largest health plan, affected by the government constraints described above—or are subject to government revenue caps. Many physicians are salaried, working in hospitals or in community clinics owned by the plans. Their salaries are determined through a process of collective bargaining with the government, represented by a unit of the Ministry of Finance. Similar processes limit salary increases for all other employees, administrators, technicians, and support staff at hospitals and clinics.

These multiple levers enable the government to control a large portion of total health care expenditures, and to make sure that changes in one part of the system are aligned with changes elsewhere. For example, when the salaries of unionized physicians increase, the capitation rates and hospital revenue caps will be adjusted to reflect the increase.

The annual budget debate in the Israeli parliament—particularly the portion dealing with the new goods and services to be covered by the national health insurance program—gives the general public an annual lesson in cost-benefit analysis. The debate clearly identifies the other areas besides health care that are in competition for additional resources. In the process, it paves the way for the conclusion that some medical interventions, especially those that are not cost-effective, will not be covered.

The description so far of the process by which the Israeli government controls health care spending is entirely consistent with the approach described by Evans.\(^5\) The Israeli health care system extends Evans’s argument for central financial controls. First, control over aggregate expenditures alone is a very blunt tool. It does control total expenditures, but it often leads to serious quality deterioration because of its limited ability to influence system operations. Furthermore, control over Israeli expenditures took place despite the complexity in the financing of the health care system. In Canada, provincial governments pay for core services, and private insurers are precluded from competing with government insurance by offering to cover additional services. In Israel, however, both supplemental insurance and commercial insurance do cover services that the national health insurance program does not.

Supplemental insurance offers less competition to the national program than commercial insurance does because supplemental insurance
provides only relatively modest extensions of the national health insurance benefits. In contrast, commercial insurance policies cover substantial extensions of the national program’s benefits, including some services that could save or extend a patient’s life. Providers presumably see patients with commercial insurance as a source of additional revenue because that insurance pays them on a fee-for-service basis—an approach that has inherent incentives to increase the use of services. In fact, as Exhibit 2 shows, starting from a relatively low base, premiums for voluntary health insurance have been expanding at double-digit rates.

It is possible that the net impact of private insurance will have a relatively benign impact on health spending growth in Israel. First, the widespread availability of voluntary insurance reduces public demands for the national health insurance program to expand its coverage—particularly by satisfying the demands of influential groups that want more coverage and can afford to pay for it. Second, these additional sources of revenue for providers may remain relatively small. The fact that commercial insurance policyholders pay the expected costs of the services they use, plus substantial overhead, and also make extensive copayments should limit the total size of this market to those few who both value health insurance for services not covered by the national program and have the ability to pay the premiums.

LESSONS FOR OTHER COUNTRIES

▸ THE UNITED STATES: The Israeli experience has limited relevance to the United States, given the differences in the structure and scale of the two countries’ health care systems, and in the political and commercial environments in which they operate. The local health insurance exchanges created by the Affordable Care Act of 2010 may loosely resemble the Israeli health care system in terms of financial arrangements. However, just implementing the exchanges is unlikely to slow the increase in US health care spending very much, in the absence of a political consensus on the acceptability of “rationing” care—especially the need to limit covered services. In fact, Medicare is now forbidden to consider cost as a relevant factor in deciding whether or not to cover a service.

Until there is a political will to limit the resources used by the US health care system, in spite of any consequences in terms of access and quality, it is irrelevant which specific cost-control mechanisms are in place. A debate on reducing spending for entitlements may force the American public to accept limits. However, although the debate is occurring, a political endorsement of limits in any broad sense remains unlikely.

▸ ELSEWHERE IN THE WORLD: In any case, the tight controls over Israeli health care costs might not be sustainable over the long term, and thus they might not be a useful model for other countries. One potential source of pressure to increase government spending is that the current good outcomes reflect a health care system that may be temporarily able to operate beyond its true capacity. As physicians, for example, demand more pay and shorter hours, current satisfaction levels will suffer unless substantial resources are added.

Another factor undermining this degree of cost control is the rapid expansion of the Israeli economy: The Ministry of Finance may be much more willing to increase health care expenditures with the rapid growth of tax revenues. Finally, the rate of health spending growth will increase almost automatically as the proportion of the system under strong government control shrinks. If current trends persist, the overall rate of growth will more closely parallel that of components under the control of providers and patients. Of course, an increase in the health care spending growth rate may be a perfectly acceptable result if Israeli society becomes more affluent over time.

CONCLUSION The governments of all industrialized countries face the same intractable problem: how to provide services for an aging population without letting the increased use and cost of the health care system overwhelm other financial needs. Israel’s experience in dealing with this problem through the use of considerable government leverage over the health care system provides a useful case study, especially for countries with national health insurance and a political tradition that recognizes the legitimacy of limiting health care services.
In this month’s *Health Affairs*, Jack Zwanziger and Shuli Brammli-Greenberg report on features of Israel’s health system that have enabled it to experience relatively low rates of spending growth even as health outcomes have improved. A key factor, they note, is that nearly 40 percent of overall national health spending is under government “control”—and at least to date, Israel’s Ministry of Finance has been able to hold the line with relatively small increases in the nation’s health care budget.

Zwanziger became familiar with the Israeli health care system while on sabbatical from the University of Illinois at Chicago from January to May 2010. Eager to identify lessons for the United States on how to restrain spending, he learned that “some forms of restrictions (‘rationing’) are inevitable”—and that the best option would be using evidence on effectiveness as a basis for reimbursement.

Zwanziger is a professor of health policy and administration at the University of Illinois at Chicago’s School of Public Health and director of its Division of Health Policy and Administration. He also serves as director of the University of Illinois at Chicago’s Center for Health Services Research. Additionally, Zwanziger is associate director of the Center for Clinical and Translational Sciences and director of that center’s Research Education and Careers in Health program. He received a doctorate in physics from Cornell University and a doctorate in policy analysis from the RAND Graduate School.

Brammli-Greenberg is a senior researcher at the Myers-JDC-Brookdale Institute. She also serves as a lecturer at the University of Haifa’s School of Public Health and an external lecturer for Tel Aviv University’s Berglas School of Economics. Brammli-Greenberg received her doctorate in health economics from the University of Haifa’s Berglas School of Economics.