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Perspective

Not "Socialized Medicine" — An Israeli View of Health Care Reform

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In 2007, the United States spent about 15% of its gross domestic product (GDP) on health care, whereas Israel's health care spending was about 8% of its GDP (see graph, Panel A). In other words, on average, Americans work almost 2 months a year to pay their medical bills — nearly twice as long as the average Israeli does. Reflecting higher U.S. earnings and incomes, as well as the U.S. population's older average age, these figures translate into per capita U.S. spending (standardized for age) amounting to more than three times that of Israel — over $6,000 versus nearly $2,000 (see graph, Panel B). And the spending gap is widening, not only between the United States and Israel but also between the United States and the average of the 22 other most affluent countries in the Organization for Economic Cooperation and Development (OECD) (see Panels A and B).

Yet despite substantially lower spending, the average Israeli lives longer than his or her U.S. counterpart (see graph, Panel C). The latest comparable data indicate that Israeli life expectancy at birth is 80.3 years, as compared with 77.8 years in the United States. Moreover, all Israelis have the peace of mind and the income protection that come with the right to medical care, whereas at any given time, some 15% of U.S. citizens lack health insurance and are therefore deprived of orderly access to care and protection of their incomes from unforeseen medical spending. When seeking a job, the average Israeli is concerned about prospective earnings and job satisfaction but need not consider medical insurance, and Israelis do not have to cross borders or travel long distances to seek affordable care.

By enacting the National Health Insurance Law (NHIL) on January 1, 1995, Israel joined other developed countries such as Australia, Canada, France, Germany, the Netherlands, and Britain[1] in embracing what can be considered the emerging paradigm of developed health care systems.[2] The principles of this paradigm are apparent in Israel's system. First, the system involves universal entitlement to a set core of medical benefits that is based on medical conditions and indications, not on employment status, place of work, or the level of one's mandated contributions to the system. Accordingly, the NHIL provides every Israeli resident with a basic package of health care.

Second, such entitlements are funded through the pooling of

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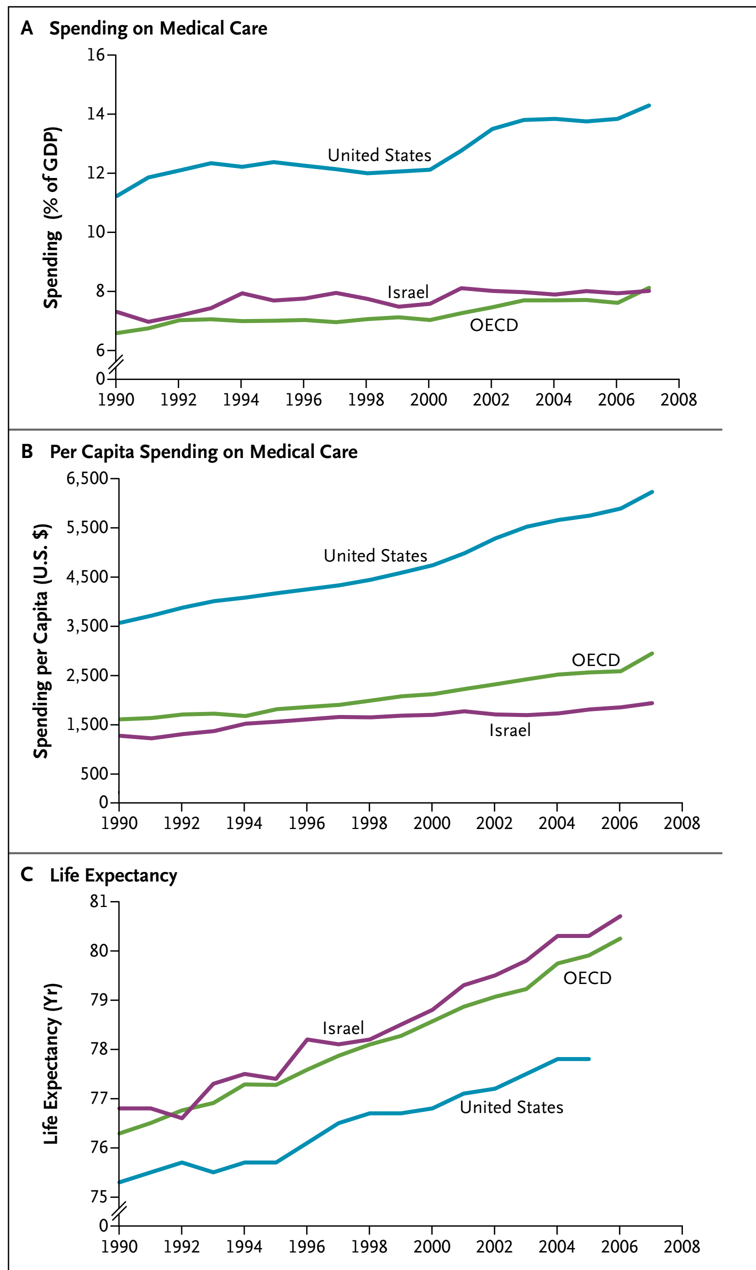

Medical Care Expenditures and Life Expectancy in Israel, in the United States, and on Average among Countries in the Organization for Economic Cooperation and Development (OECD).

Panel A shows spending on medical care as a percentage of the gross domestic product (GDP), and Panel B per capita spending on medical care, in terms of purchasing power parity, 1990–2007; in both panels, the data have been adjusted for the age distribution of each population by means of the Israeli 2005 risk-adjusted capitation formula. The OECD average was calculated on the basis of the 22 countries with the highest per capita incomes, excluding the United States. Panel C shows life expectancy at birth. The information in all three panels is from the Taub Center for Social Policy Studies in Israel and is based on data from Israel's Central Bureau of Statistics, the OECD, and the United Nations.

compulsory, usually income-related, contributions that, at least in some cases, do not take the form of general state taxes; these can be mandated contributions or taxes that fund only health care. Since the passage of the NHIL, core benefits in Israel have been funded through general-revenue taxation combined with an additional income-based tax collected for the sole purpose of funding health care. To reduce labor costs and boost employment, an employers' tax for funding medical services was abolished in 1988 and was replaced by funding from additional general revenues.

The third principle, the ability to contribute private funding — including out-of-pocket payments and voluntary medical insurance — allows citizens to obtain additional benefits if they so choose. Israelis can purchase private insurance to bolster their publicly supported protection.

Fourth, the pooled contributions are distributed nationally, according to criteria of need and efficiency, to fund holders — either competing plans or a noncompeting state administration — that act as purchasing agents for their membership or constituency. Israel implemented a risk-adjusted capitation mechanism based on age, through which the pooled funding for the basic package of health care, or 80% of the public budget, is allocated to four competing sickness plans or funds that organize, manage, and procure care for their membership. These sickness funds operate similarly to the plans in Medicare Advantage or the Federal Employees Health Benefits Program in the United States. Because Israel's reform is incomplete at least in one regard, its system also has noncompeting fund holders, which

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are responsible for the remaining 20% of the public budget. The state oversees entitlement to preventive care, mental health care, and state-assisted long-term care. The National Insurance Institute (the equivalent of the U.S. Social Security Administration) oversees maternity benefits. Israeli policymakers still face the challenge of integrating all entitlements under the institutional umbrella of the sickness funds.

Fifth, participating plans must maintain open enrollment during set periods. According to the NHIL, Israeli plans must accept all applicants who want to join or switch from their current plan. Similarly, participating providers must accept all patients, in accordance with the plan's provisions.

Finally, health care is supplied by provider organizations that may be public, wholly privately owned, or nongovernmental but not for profit. The plan or the appropriate state administration contracts with providers through any of several types of arrangements. The largest Israeli plan — the General Health Services — is also the largest provider of care, with its own clinics and hospitals. In some ways, this fund operates like Kaiser Permanente. The second-largest fund — Maccabi Health Services — contracts for almost all care from private clinics and from hospitals that it does not own.

The implementation of these principles results in an integrated, equitable, efficient, and sustainable system. Like many other developed countries, Israel has learned that as important as it is to expand coverage, such expansion alone will not address the most pressing challenges related to health, costs, and patients' satisfaction. In the United States, these challenges concern the current fragmented rules of eligibility, funding, and delivery of care. Israel, for its part, implemented the NHIL when 96% of Israelis were already voluntary members of sickness funds that provided good coverage and the country's performance indicators were already superior to those of many other countries (see graph). At issue were the equity, efficiency, accountability to clients, and sustainability of the Israeli health care system, which was at serious financial risk during the 1980s.

A key objective of the Israeli reforms under the NHIL was to break the coercive powers of the General Federation of Labor (or Histadrut Klalit) in the health care market. These powers limited choice and transparency in the system. The General Federation of Labor lured workers by securing health care benefits, yet it prevented its members from joining plans other than the one it controlled — the General Sickness Fund — and used contributions that were designated for health care to serve other, nonmedical purposes. The wider competition and choice offered through the NHIL make plans and providers today more accountable to their members or constituents, who now have the freedom to switch plans.

An integrated yet decentralized health care system guided by these principles is not socialism, no matter how one defines it. Systems designed according to this emerging paradigm have been upheld by such conservative political leaders as Britain's Margaret Thatcher and, more recently, Australia's John Howard, who understood that good health care is not only a matter of technology but also a product of the funding and organization of care.

It may be that the current economic crisis will provide the perspective and momentum required for effecting change in the United States. First, the crisis shows that although free markets are sometimes a blessing, they may become a curse if not adequately regulated. This is the accepted wisdom regarding health care markets in most developed economies. The crisis also threatens to leave even more Americans without adequate care; during such difficult financial times, relieving Americans of the burden of unpredictable, unavoidable, and unbearable medical spending could amount to the most practical and effective "tax relief" of all.

The United States would do well to shake off unfounded rhetoric and perceptions about "socialized medicine" and align its health care policies with those of its close allies among developed countries. I believe that doing so would save American lives and make U.S. citizens even healthier and more prosperous than they are today.

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