HEALTHCARE IN THE U.S. AND ISRAEL

COMPARATIVE OVERVIEW

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WHAT IS THE MYERS-JDC-BROOKDALE INSTITUTE?

A leading center for applied social research, serving Israel and the Jewish world, established in 1974.

An independent nonprofit organization, operating as a partnership between the American Jewish Joint Distribution Committee (AJJDC), the Government of Israel, and the David and Inez Myers Foundation.

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A knowledge resource committed to assisting policymakers and service providers in the planning and implementation of effective social services.

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The Institute's research involves an interdisciplinary approach.

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Jewish Healthcare Foundation (JHF) is a nonprofit, public charity established in 1990 that offers a unique blend of research, education, grantmaking and program management to advance the quality of clinical care and health of populations. JHF focuses on promoting safety, best practice and efficiency at the front line of care, and building a workforce to sustain this. To accomplish its goals, JHF created:

- ***The Pittsburgh Regional Health Initiative*** (1998): PRHI is a regional, multi-stakeholder coalition of medical, business and civic leaders. Guided by the conviction that quality is the best long-term cost containment strategy for health care, PRHI was one of the earliest U.S. coalitions formed to address patient safety, and healthcare quality.
- ***Health Careers Futures*** (2003): HCF aligns regional supply and demand of healthcare workers. It collaborates with all stakeholders to attract, support and retain healthcare workers and contribute to long-term regional economic development of southwestern Pennsylvania.
- ***The Center for Healthcare Quality and Payment*** Reform (2008): CHQPR encourages comprehensive, outcome-driven, regionally-grounded approaches to achieving higher-value healthcare. CHQPR identifies and encourages: (a) action on major opportunities for improving quality and decreasing costs in the U.S. health care system; (b) payment systems that reward efforts to improve value in healthcare delivery; and (c) organizational structures and relationships among healthcare providers that improve value in healthcare delivery.

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TABLE OF CONTENTS

FOREWORD

Israel's healthcare system has significant relevance and important lessons to lend to healthcare reform efforts in the United States. In 1995, as the US failed to enact healthcare reform, Israel achieved significant redesign of its healthcare system. Through the adoption of a National Health Insurance law, Israel created an overall framework for its healthcare system, provided universal coverage and delineated a basic benefits package to which all citizens and permanent residents are entitled. Fourteen years later, with government-financed insurance coverage provided through four competing health-maintenance organizations, Israel's per capita costs are half those of the United States and its outcomes in many areas are superior.

Some of the differences between the two systems emerge from a divergence in basic values: in Israel, healthcare is a "universal good," which society is responsible for making available to all its members, while in the US, healthcare is an individual good that is "organized" largely through market forces and includes many for-profit actors. These basically different values set in motion a series of processes that yielded, in the US, a health sector involving multiple, competitive providers and payers emphasizing high yield, acute care, inpatient health information technology (HIT) and expensive medical education, but also cutting edge R&D. By contrast, Israel's emphasis on social solidarity prompted the development (as early as the 1920s) of organized systems of care focused on improving population health efficiently via an emphasis on primary care, supported by heavily subsidized medical education. In recent decades, the Israeli healthcare system has benefited from major investments in outpatient HIT and the creation of a process for prioritizing investments in new technology that is among the most advanced and transparent in the world.

In important respects, the US health reform debates have been about the best way to move the US toward a more integrated model aligning payment with care delivery and targeting safety, efficiency, access and quality. Therefore, as the US moves to implement the March 2010 Patient Protection and Affordable Care Act – which aims not only to expand access to health insurance, but also to strengthen primary care, contain costs and require multi-provider accountability for coordinated high quality care – there is much to learn from Israel, where these concepts are already at work.

To explore key lessons from the Israeli system for the US, the Jewish Healthcare Foundation engaged the Smokler Center for Health Policy Research at the Myers-JDC Brookdale Institute in Jerusalem, an affiliate of the American Jewish Joint Distribution Committee, to prepare a series of monographs comparing the two systems along dimensions critical to ongoing US reform efforts. In particular, the monographs offer in-depth analyses of how Israel addresses questions that remain at the heart of the transformation of the US delivery system:

1. What is the role of government in containing costs, prioritizing resources within budget constraints and promoting better services and outcomes of care?
2. How do the overall intent, structure and financing of Israeli HMOs create incentives for sophisticated primary care delivery models?
3. What are the multiple consequences of low-cost medical education on the healthcare system?

To set the stage for in-depth examination of these questions, this first report, by Bruce Rosen, PhD, Director of the Smokler Center, and Keith Kanel, MD, Chief Medical Officer of the Pittsburgh Regional Health Initiative, provides a high-level overview of the key similarities and differences between the two systems. A companion document, ***Healthcare in Israel for US Audiences*** has been prepared by Bruce Rosen to provide in-depth source material on the Israel healthcare system for interested readers.

Karen Wolk Feinstein, PhD
President and CEO
Jewish Healthcare Foundation

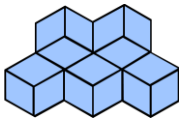
1. INTRODUCTION

All too often, attempts by one healthcare system to draw lessons from another are made without sufficient background and context. In fact, even when the goal is to adapt one particular policy idea or system component, it is important to have an overview of both healthcare systems and an understanding of their similarities and differences. This becomes all the more important when the objective is to identify promising foci for the exchange of ideas and experience for a multi-faceted process of cross-national learning.

Accordingly, this document has been prepared as the first stage in the collaboration between the Myers-JDC-Brookdale Institute and the Jewish Healthcare Foundation, which seeks to draw lessons from Israeli healthcare for the US, and vice versa. In the next stages, we will be zooming in on particular issues, but our expectation is that this monograph, along with its companion document, ***Healthcare in Israel for US Audiences***, will continue to inform both the questions we ask and the answers we provide. We hope that the analysis of similarities and differences laid out here will also inform the efforts of others engaged in cross-national learning aimed at improving healthcare systems in both countries and around the world.

We begin with brief overviews of the two systems and then highlight key similarities, but the longest chapter focuses on key *differences*. This is because it is the differences that offer the greatest opportunities for learning and at the same time make the transfer of ideas so challenging. The differences have been grouped in the following categories: financing/coverage, the insurance market structure, the care delivery system, the healthcare workforce, the role of government and miscellaneous.

This is a continuously evolving document. Comments, corrections or suggestions regarding additional similarities or differences can be sent to Bruce Rosen at: bruce@jdc.org.il



2. Overview of the Israeli Healthcare System[1]

In Israel, the 1995 National Health Insurance (NHI) Law guarantees universal insurance coverage. All citizens and permanent residents are free to choose from among the country's four, competing, nonprofit health plans (HMOs). The health plans are required by the NHI Law to provide their members with a stipulated package of benefits in a timely and accessible manner. In return for this, the government gives the health plans a capitation payment that reflects the number of members in each plan and their age mix.

The overall NHI system is financed primarily by income-linked taxation. However, over a third of Israel's national health expenditures are covered by households, through a mix of out-of-pocket payments and supplemental insurance packages.[2] Payments by households cover co-payments for certain services included in the NHI benefits package (such as visits to specialists and pharmaceuticals), as well as services not included in that package (such as dental and optometric care).

Israel has 46 acute-care hospitals, with approximately 15,000 acute-care beds. The Ministry of Health operates about half of those beds, another third are operated by the largest health plan (Clalit Health Services), and the remaining beds are operated by a mix of for-profit and nonprofit organizations. The hospitals are financed primarily via the sale of services to the health plans, and they do so through a complicated mix of reimbursement arrangements.

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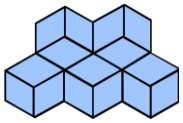
[1] For further details on the Israeli health system, the reader is referred to a companion piece being published by MJB and JHF entitled ***Healthcare in Israel for US Audiences***, which will be available shortly on the Institute website http://brookdale.jdc.org.il. Another valuable source is ***Israel: Health System Review*** by Bruce Rosen and Hadar Samuel, which was published by the European Observatory of Health Care Systems and is available at: http://www.euro.who.int/__data/assets/pdf_file/0007/85435/E92608.pdf. The authors and the JHF are greatly indebted to the Observatory for permission to use material from that document in this analysis.

[2] All the health plans offer supplemental insurance packages to their members and over 80% of the population has purchased such a package. In addition, approximately one-third of the population has purchased a commercial insurance add-on package from a private insurance company. Israelis purchase these additional insurance packages because they want access to services of a type or quality perceived to be unavailable through the NHI basic benefits package.

Israel has four medical schools and is planning to open a fifth. Until recently, Israel relied heavily on immigration as a source of new physicians, with fewer than 40% of all licensed physicians up to age 65 having studied in Israeli medical schools. With a major decline in immigration from the former Soviet Union, Israel needs to increase its capacity to train the next generation of physicians.

Key challenges facing Israeli healthcare include a decline in the publicly financed share of national health expenditures, a growing shortage of nurses and a projected shortage of physicians, and persistent gaps between population groups in health outcomes and healthcare utilization.



3. Overview of the US Healthcare System

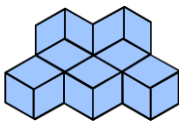
In the United States, citizens receive healthcare through a complex public-private marketplace. The majority of Americans have coverage through their workplace. Premiums paid to private insurance companies are usually shared between the employer and employee. The concept of employer-based benefits proliferated in response to World War II wage and price controls and has endured. In many situations, the employer administers the benefits package and sets the parameters of coverage, including pharmaceuticals. More than half the commercial insurance plans are through for-profit companies and the remainder through nonprofit entities (which are legally permitted to accumulate substantial reserves as net assets).

Approximately 28% of the population receive care through government-sponsored entitlements, mainly the federal Medicare program (for seniors age 65 years and older), the state/federal Medicaid programs (for low-income citizens and children), and the Department of Veterans' Affairs. Combined, government programs account for about half of all US

healthcare expenditures. The Medicare program is financed by a public trust fund, built through payroll deductions.[3] In addition, the government serves as the purchaser of health insurance for several million of its employees.

There are approximately 5,000 hospitals operating in the United States, with 70% functioning as nonprofit private entities. Medical education is provided at 131 accredited medical colleges.[4] Medical research is primarily funded by the National Institutes of Health (NIH), and is conducted at academic medical centers, private biotechnology firms, universities, the NIH itself and teaching hospitals.

The US healthcare system faces many challenges. Until enactment of the Patient Protection Affordable Care Act (PPACA), 15% of US residents lacked health insurance – although the number is projected to drop gradually from approximately 55 million in 2010, to 23 million by 2019. The PPACA, however, has not immediately addressed rising healthcare costs, which pose a long-term economic threat to both individuals and businesses. Instead, it proposes to conduct a series of regional experiments aimed at demonstrating the impact on quality and efficiency of various approaches to healthcare payment and delivery.



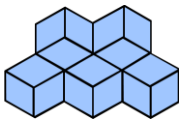
4. Key Similarities between the Two Systems

- Both countries rely on a mix of public and private sources to finance healthcare. This refutes the common misconception that Israeli healthcare is "socialist" and US healthcare, completely "private."

[3] Medicare enrollees can opt to receive their care from a managed care plan, through the Medicare Advantage program, and about 15% do so. These plans are the most similar to Israeli health plans, which also operate within a governmentally financed framework.

[4] These medical schools apparently produce more physicians than any other country in the world, but still not enough to meet US needs.

- Both countries provide healthcare via a mix of governmental and non-governmental organizations (albeit governmental providers play a much larger role in Israel).
- The US and Israel are among the few countries in the world to make extensive use of competing managed care organizations in general and HMOs/health plans in particular.
- Both countries face significant shortages of nurses and are expected to face shortages of physicians in the future.
- Both countries tend to be early adopters of new medical technologies and to use them intensively.
- Both value consumer choice, and attempt to build it into their system (albeit more so in the US[5] than in Israel).
- Both have made special efforts to provide access and service to large immigrant and minority populations[6] (albeit in Israel there is probably more intense activity to address the needs of legal immigrants).
- Both have voluntary medical associations that seek to advance physicians' rights and maintain professional and ethical standards while having influence on national health policy.
- Both have large-scale, voluntary efforts to develop measures of quality of care in the community. Neither country has a national error-reporting system for either community or hospital care.
- In both countries, insurers are playing a growing role in directing patients to particular hospitals, and this has emerged as a controversial issue.



[5] Some observers believe that freedom of choice in the US is eroding, with growing co-payments for care from out-of-network providers.

[6] Recent efforts to reduce disparities in the Clalit and Maccabi Health Plans are particularly notable in this regard.

5. KEY DIFFERENCES BETWEEN THE TWO SYSTEMS

There are many differences between the two healthcare systems. Here we review only the key differences, organized into the following categories: financing/coverage, the structure of the insurance market, the organization of the delivery system, workforce issues, the role of government and miscellaneous.

5.1 Financing/Coverage

- ***Coverage:*** Israel has universal health insurance coverage; in the US, approximately 15% of the population is uninsured.
- ***Role of government:*** In Israel, it is the government that organizes and finances basic health insurance coverage for the entire population; in the US, the government's insurance role focuses on the elderly (Medicare), the poor and disabled (Medicaid), low-income children not included in Medicaid (CHIP), veterans (VA), the military, and federal employees.
- ***Role of employers:*** In the US, employers play a major role in paying for health insurance. Large firms typically contract with a small number of insurers among which employees can choose, while smaller firms typically contract with a single insurer.[7] Employers play no such role in Israel.[8]
- ***Basis of premiums/taxes:*** In the US, the premiums paid by employers to insurers are based on actuarial calculations reflecting the use of services by employees in prior years. In Israel, the National Health Insurance system is financed largely by taxes, which are largely linked to personal income.[9]
- ***Risk adjustment for government-financed health plans:*** The risk adjustment formula that Israel uses to distribute the National Health

[7] Employers may make significant year-to-year changes in the scope, auspices and provider networks of the plan or plans that they offer.

[8] Until 1997, a payroll tax paid by employers funded part of the National Health Insurance system, but in 1997, this was replaced with funding from general revenues. Even prior to 1997, employers were never active in influencing healthcare policy or provision.

[9] The composition and funding level of the health package are determined through the political process, with substantial professional input.

Insurance monies among its health plans is much simpler than the formula used by Medicare to distribute funds among Medicare Advantage plans. The former relies almost exclusively on age, while the latter also includes health status indicators.

- ***Age-related coverage:*** The US provides governmental insurance coverage to citizens upon their 65th birthday, through the Medicare program.[10] There are no age-specific insurance programs in Israel, where National Health Insurance coverage begins at birth.[11]
- ***Nature of benefits packages:*** In Israel, there is a standard basic benefits package prescribed by law that applies to all the health plans and all the nation's citizens and permanent residents. In the US, in contrast, the benefits packages vary significantly across insurers and across employers.
- ***Scope of benefits package:*** The benefits package offered through the health plans in Israel includes hospital care, outpatient care, medications and a wide range of additional services. However, well-baby care, mental health care and long-term care are not included as they continue to be direct (though underfunded) governmental responsibilities. Dental care (for persons over age 8) and optometric care are not covered by the health plans or the government. In the US, many insurers do cover dental, optometric and mental health care, at least to some extent; however, it is not unusual for those services to be subcontracted to a separate insurance company.
- ***Financing of new technologies:*** Each year, the government of Israel determines how much additional money will be allocated to the healthcare system to finance new technologies. Through a combination of in-depth staff work and a broadly representative public advisory council, the health system then prioritizes new technologies and determines which will be funded. In the US, both the amount of monies to be spent on new technology and the prioritization among

[10] Medicare hospital insurance is a retirement benefit that Americans have funded throughout their working lives via a payroll tax, while Medicare Part B, which pays for physician and ambulatory services, is an insurance program with a government-subsidized premium.

[11] In Israel, the elderly have the added benefit of paying a relatively low, flat rate health tax that is not linked to income.

technologies are determined internally by the health insurers (for commercial plans) or by the government (for Medicare and Medicaid).

- ***The role of public financing:*** Public sources account for approximately 48% of healthcare expenses in the US[12] compared with 56% in Israel.[13] In the US, the share of public financing is growing, while in Israel it is declining.

5.2 Structure of the Insurance Market

- ***Number and nature of insurers:*** In Israel, the basic NHI benefits package is available through only four nonprofit health plans, which compete for enrollment in the Israeli marketplace and are national in scope. In the US, several hundred insurers (many of them regional) offer basic benefit packages and they include a mix of for-profits and not-for-profits, competing for members in a fragmented insurance marketplace.

- ***Extent of choice:*** In Israel, residents can choose any one of the four plans. In the US, because of the employer-funded nature of health insurance, most citizens can choose only from those insurers available via their employer-sponsored program.[14] Employers typically allow their employees to choose from a limited selection of plans with which they have negotiated arrangements.

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[12] In a 2010 estimate from the CMS actuary, the amount of public financing is expected to overtake private healthcare in the US by 2012. See Truffer, C.J. et al, "Health Spending Projections through 2019: The Recession's Impact Continues," ***Health Affairs***, published online February 4, 2010, http://content.healthaffairs.org/cgi/content/full/hlthaff.2009.1074v1 (accessed August 2010).

[13] This is the latest Israeli figure from the OECD, and is substantially lower than previous figures, with the bulk of the change due to refined accounting techniques. The main components of private expenditure in Israel are dental care, supplemental and commercial insurance, eye care and pharmaceuticals.

[14] In proposed healthcare legislation, however, US citizens may have access to a much broader array of plans through a national insurance exchange.

- ***The basis of competition among insurers:*** In the US and in Israel, consumer perceptions of service accessibility and quality are important considerations in the choice of insurer.[15] Another consideration in both the US and Israel is the health plan affiliations of desired physicians. In the US, price (in terms of premium and co-payment levels) seems to drive many consumer decisions regarding plan choice. In contrast, in Israel there is no difference among plans in terms of the level of the health tax (which takes the place of the insurance premium), and any differences in the levels of co-payments are minor.[16]

- ***Care management:*** All four Israeli health plans directly provide a significant portion of the services (particularly in the ambulatory sector) and are very active in managing the content of that care; in the US, approximately 21% of the insured population is covered by health maintenance organizations (HMOs) or point-of-service plans,[17] and approximately 65% is covered by preferred provider organizations (PPOs). All the Israeli health plans intensively manage the care provided by their clinicians, while in the US, care remains predominantly encounter-based and only a few HMOs intensively manage that care. All the Israeli health plans and some US HMOs provide disease management services; this is less common in the case of other insurance frameworks in the US.

5.3 Care Delivery System

- ***Hospital ownership:*** In Israel, the government operates approximately half of the acute care beds; in the US, even when all levels of government are taken together, they account for less than 10% of the

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[15] Data on these issues are imperfect in both countries. In the US, comparative quality data are available on almost all HMOs, but only 20% of PPOs; while Israel collects such data on all its health plans, plan-specific results are not yet publicly available. In contrast, Israel does have publicly available national comparative data on consumer assessments of the quality of services provided by all the plans from a bi-national survey carried out by the Myers-JDC-Brookdale Institute (Gross, R.; Brammli-Greenberg, S.; Waitzberg, R. 2009. ***Public Opinion on the Level of Service and Performance of the Health-Care System in 2007 and in Comparison with Previous Years***. RR-541-09). There is less of this sort of data available in the US.

[16] There are also some differences in the composition and premium levels of the supplemental insurance packages, but these too are minor.

[17] Kaiser Family Foundation, State HMO Penetration Rate, July 2008, http://www.statehealthfacts.org/comparemaptable.jsp?cat=7&ind=349

beds. For-profit hospitals play a larger role in the US, although they still account for less than 20% of US hospital beds. In Israel, for-profit hospitals account for only 5% of beds and tend to provide a limited range of services (mostly elective surgery).

- ***Responsibility for hospitalized patients:*** In the US, the community-based personal physician will typically make the decision to admit the patient to hospital and will continue to supervise that patient's care in the hospital (though this is changing with the growth of "hospitalists"). Patients tend to be directed to the hospital(s) preferred by their physician, from among those at which the physician holds privileges and the patient's insurance is accepted. In Israel this is not the case, as only a minority of community-based physicians are authorized to work in hospitals. Moreover, in Israeli hospitals, patients are the responsibility of the department to which they are admitted, rather than the responsibility of a particular physician.
- ***Hospital physicians:*** In Israel, most doctors working in hospitals are salaried employees of those hospitals;[18] in the US, most doctors work with hospitals as non-employee attending physicians who are reimbursed separately on a fee-for-service basis, although the employed hospitalist model is becoming more prevalent.
- ***Primary care physicians:*** In Israel, two-thirds of primary care physicians (PCPs) work for a single health plan and most of the others work for 2-3 plans.[19] In the US, with the exception of a few staff model HMO's, physicians are independent business people who charge the patient for services, but may bill the insurance company directly for mutual convenience. A typical US doctor submits bills to dozens of insurers. In Israel, PCPs are paid through a mix of salary and capitation arrangements, while in the US they are paid primarily on a fee-for-service basis. Interestingly, in the US, a growing percentage of PCPs are being employed on a salaried basis.

[18] The most sought-after physicians also work privately after the regular workday, when they are usually paid on a fee-for-service basis.

[19] Most of the single-plan physicians (but by no means all of them) work as salaried physicians in Clalit Health Services, Israel's largest health plan.

- ***Electronic health records:*** EHR systems are more widespread in Israel than in the US, particularly in community-based settings, where almost all Israeli physicians use EHRs. In most American communities, less than 30% of physicians use EHRs. In part, this may be because a greater percentage of Israeli physicians work within large organized systems of care.
- ***Quality monitoring:*** Quality monitoring in hospitals is more advanced in the US than in Israel. In community settings, a greater range of outcomes and processes is monitored in the US and a higher proportion of insurers participate in quality monitoring in Israel.[20]
- ***Professional liability:*** Malpractice suits are far more common in the US than in Israel, though their prevalence in Israel is increasing rapidly. Malpractice laws are state-based in the US, with some having caps on damages. In Israel, the malpractice laws are national and there are no official caps. Awards in the US are much higher than in Israel.
- ***Care of complex and rare conditions:*** Highly specialized centers of excellence in the US are better equipped than are Israeli hospitals to handle certain complex and rare conditions. This is – at least in part – a function of the much larger US population and the resultant greater number of cases. Another factor may be that the Israeli Ministry of Health has not been successful in focusing the care of rare conditions in a small number of centers of excellence.
- ***Hospital conditions:*** US hospitals tend to be more spacious and comfortable than their Israeli counterparts.[21] They also tend to have higher staffing ratios, allowing greater attentiveness to patient needs.[22]

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[20] The US also has fairly high participation rates among its HMOs (around 90%), but much lower participation rates among its PPOs (around 20%), and PPO enrollment is much higher than HMO enrollment. In both countries, participation is voluntary. In Israel, all four health plans participate.

[21] The gap has probably narrowed over the past decade, due to major construction and upgrading projects in many Israeli hospitals.

[22] This may also be related to differences in the culture of care, staff attitudes toward their jobs and pay levels.

- ***Availability of new childhood vaccines:*** New vaccines are made available to the public more rapidly in the US,[23] particularly vaccines targeted at older children and adolescents, such as the human papillomavirus vaccine.

5.4 Healthcare Workforce

- ***Use of physician extenders:*** In the US, nurse practitioners and physician assistants are used extensively. These professions do not yet exist in Israel.[24]
- ***Scope of nursing practice:*** In most states in the US, the scope of nursing practice is much wider than in Israel. This is particularly apparent in the role that advanced-practice nurse practitioners play in the US, but not in Israel.
- ***Cost of medical education:*** In Israel, most of the costs of medical education are borne by the government, with students paying less than $3,000 per year. In the US, students often pay 10–20 times as much.
- ***The role of collective bargaining:*** In Israel, collective bargaining agreements play a major role in determining wage levels for nurses and physicians. They are much less significant in the US. In general, unions are also more prevalent in Israeli healthcare, as are strikes, work stoppages and slowdowns.
- ***Physician incomes:*** No comprehensive data are available on physician incomes in Israel. Nonetheless, it appears that physicians in the US earn a great deal more than their Israeli counterparts – both in absolute terms and relative to average national incomes.
- ***Subspecialty training:*** The US is a world leader in subspecialty training; many Israeli physicians pursue fellowships in the US.
- ***Duration of licenses and certifications:*** In the US, most states require physicians to renew their licenses periodically; specialty certification is also time-limited.[25] No such time limits exist in Israel.

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[23] Fifty percent of vaccines are purchased by the government for low-income children and >90% of insurance plans in the private market cover the vaccines.

[24] Israel also does not currently have nurse assistants.

[25] Failure to recertify in a subspecialty affects subspecialty recognition but not the basic medical licensure. It can also affect hospital privileging.

- ***Physician organization and bargaining power:*** The Israeli Medical Association (IMA) is generally considered to be more powerful than the American Medical Association (AMA) or other US physician groups in influencing physicians' salaries and terms of employment.
- ***Membership in medical associations:*** Less than 30% of practicing physicians have AMA membership (as many physicians have decided to be members of their professional specialty societies, such as the American College of Surgeons, instead). By contrast, over 90% of practicing physicians in Israel are members of the IMA.
- ***Supervision of residency programs:*** The IMA's functions also include supervision of medical residency and the process of specialization, whereas in the US, the specialty boards and the Accreditation Council for Graduate Medical Education (ACGME) do this.

5.5 The Role of Government – Attitudes and Practice

- ***Attitudes:*** It would be inaccurate to refer to the Israeli system as "socialist," but there is a greater acceptance of government involvement in regulating healthcare. This permits the government to apply elements of explicit redistribution and also transparency and accountability.

  United States citizens have traditionally favored public-private partnerships in the country's service sectors – some with low, but growing privatization (e.g., education, the military), and some with high private oversight (e.g., transportation, the arts). American healthcare has been pulled in different directions depending on the way the political winds in Washington are blowing.[26]

- ***Setting limits and priorities:*** In Israel, the government fixes the annual allocation of public funds to the NHI system, which constitutes the core of Israeli healthcare. Thus, healthcare must compete with other potential uses of government funds. In the US, the public sector does impose some constraints on spending (as with the VA system), although, as entitlement

[26] As an example, right-leaning legislation of the 1990s facilitated an expansion in the use of private health plans to provide care funded by Medicare. A leftward swing in the 2009-10 Congress may lead to a scaling back of this program (due to concerns that the payment levels are too high). Similarly, there have been swings in the extent to which successive administrations have sought to expand coverage to uninsured children and adults, many of whom are among the working poor.

programs, efforts to reduce costs of Medicare and Medicaid are complicated by political considerations (this is particularly true of Medicare, due to is political support among the elderly). In the US, private sector prices and spending are functions of the relative power of insurance companies and medical providers.

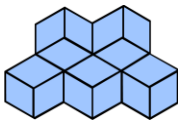
- ***Levels of government:*** In the US, both the federal and the state governments play an important role in shaping healthcare; local governments sometimes also play a role. In Israel, there are no states and healthcare policy is handled exclusively at the national level.[27]
- ***Public health capacity:*** Generally speaking, per capita investment in public health is greater in the US than in Israel and, as a result, capacities are greater. This is true at both the national and local levels. One key example is the US Centers for Disease Control's extensive investigatory and laboratory capacities. Planning for large-scale public health emergencies is probably an exception, as Israel's security situation has led it to become a world leader in this area.

5.6 Miscellaneous

- ***Health promotion and disease prevention:*** Immunization rates among children are slightly higher in Israel; however, more types of vaccines are given to children in the US. Moreover, in most other areas of health promotion and disease prevention, the US appears to be further ahead than Israel. This is particularly true in the area of health communications and other efforts to change risky health behaviors.
- ***Addressing the needs of new immigrants:*** In the 1990s, Israel's population grew by almost 20%, due to massive (legal) immigration of almost one million Jews from the former Soviet Union and approximately 50,000 from Ethiopia. Israel invested major resources to address the unique health and healthcare needs of these groups. The US, with a much steadier and controlled rate of legal immigration, has relied u*pon assimilation of new residents into* the existing employer-based or public healthcare system. Serious health disparities persist in both countries.

[27] Two of the municipalities, Jerusalem and Tel Aviv, are involved in providing well-baby care, but here, too, the municipalities have no policymaking role.

- ***Hospital reimbursement systems:*** In the US, most payers reimburse hospitals for all inpatient care on the basis of a detailed set of diagnosis related groups (DRGs), which also take patient severity into account. In Israel, DRGs cover only a portion of inpatient care (with the rest covered via per-diem payments); further, the Israeli DRGs are less detailed than their US counterparts. On the other hand, hospital revenue caps play a greater role in Israel. Contracts between insurers and hospitals that grant price discounts in return for a commitment on volume are becoming increasingly common in both countries.
- ***Medical research:*** The resources invested in medical research differ sharply between the US and Israel. In the US, the National Institutes of Health (NIH) is the primary federal agency conducting and supporting medical research in the United States and annually invests over $30.5 billion in medical research. In Israel, state investment in medical research is between NIS 32-38 million a year (approximately $8.4-10 million). The gap between the two countries is large even after adjusting for differences in population size; on a per capita basis, the US government spends more than 70 times its Israeli counterpart on medical research. Adjusting for differences in per capita income would further reduce this differential, but it would, nevertheless, remain very large.



6. Statistical Overview

In comparison with the United States, the State of Israel:

- Spends substantially less per capita on healthcare
- Expends a much smaller proportion of its GDP on healthcare
- Has more physicians per capita, but fewer hospital beds
- Has a higher life expectancy and a lower infant mortality rate

Table 1 – Key US-Israel Comparisons

	Israel	United States
Per capita spending on health	$2,141 (2008)[1]	$7,421 (2007)[2]
Expenditure on health as percent of GDP	8% (2008)[1]	16% (2007)[2]
Percent uninsured (persons under age 65)	0% (2009)[1]	17% (2007)[2]
Physicians per thousand population	3.4 (2009)[3]	2.7 (2007)[2]
General acute hospital beds per thousand population	1.9 (2008)[4]	2.7 (2007)[2]
Infant mortality rate*	4 (2008)[5]	7 (2008)[6]
Life expectancy at birth		
- Males	80 (2009)[5]	76 (2008)[6]
- Females	84 (2009)[5]	81 (2008)[6]

*Infant deaths (one year of age or younger) per 1000 live births

The data in this table are the most recent available at time of publication and relate to the year shown in parenthesis.

Sources:

1. Keidar, N. and Horev, T. 2010. ***National Health Insurance – A Statistical Compendium, 1995-2009***. Ministry of Health (Hebrew).
2. National Center for Health Statistics. 2010. ***Health, United States, 2009***. DHHS Publication No. 2010-1232. US Department of Health and Human Services.
3. Haklai, N. 2010. ***The Healthcare Workforce, 2009***. Ministry of Health (Hebrew).
4. Haklai, N. and Stavit, H. 2010. ***Licensed Hospital Beds and Units, January 2010***. Ministry of Health (Hebrew).
5. Central Bureau of Statistics. 2010. ***Statistical Abstract of Israel****, 2010*.
6. World Health Organization. 2010. ***World Health Statistics***. Geneva.

INVITED COMMENTARY

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There is a consensus among health policy analysts in the United States that shifting away from fee-for-service payment to alternative payment systems will be critical to reducing healthcare costs and improving quality. Concerns have, however, been raised about the potentially perverse incentives that may result from alternative payment systems. For example, capitation payment may lead doctors to prefer healthier patients and salary payment may lead to reduced effort.

The discussion of payment arrangements in the US often abstracts from issues of institutional structure. Israel, which already relies mainly on salaried and capitated physician payment, offers an illustration of the distinctive institutional frameworks required to support the widespread use of such alternative payments without perverse consequences. Unlike in the US, where community physicians continue to attend in hospitals and receive fee-for-service payment, most hospital-based physicians in Israel are salaried as hospital employees. Hospitals can monitor the productivity of their staffs and can use mechanisms other than compensation to ensure that productivity is maintained. Whereas in the US most community physicians participate in multiple private health plans and also receive fee-for-service payments from Medicare, most Israeli physicians work for only one or at most 2-3 plans. These tight links to plans minimize their capacity for opportunistic behavior in selecting patients. Finally, unlike in the US, where many physicians act as small business owners, most Israeli physicians are union members who bargain collectively with hospitals and health plans. Bargaining over terms may lead to contracts that use a broad range of mechanisms to respond to perverse incentives.

The shift toward alternative payment structures in the US is likely to require more than simple payment changes. Policymakers here in the US can learn from much the Israeli experience about the relationship between compensation arrangements and institutions.

Larry Lewin, *CEO (retired), The Lewin Group*

The US healthcare system has had a brief flirtation with capitated systems of care with mixed results. The 1990s, when enrollment in HMOs reached its zenith (40+%) was the only time in recent US history when there was a real reduction in the rate of increase of per capita health spending (a bending of the cost curve); and this reduction was widely attributed to the efforts of at-risk managed care systems to contain spending. These results were achieved primarily through spending limitations like: prior approval for costly procedures, primary care gatekeepers, limited provider panels and tough negotiations over reimbursement rates by HMOs for hospitals and physician groups.

However, strong opposition by physician groups and rising resentment by patients seriously eroded the attractiveness of HMOs. Despite reduced demand for HMOs in the private insurance market, about 20% of the insured population in the US is enrolled in HMOs.

There are several reasons why managed care has not been more successful in the US to date:

- Except in the Federal Employees Health Plan (and, now, in Massachusetts), most individuals have little discretion in their choice of plan, so the plans were not really accountable to beneficiaries, only to the employers who chose the plan
- Most HMOs were managing cost, not care, and there were few measures for holding them accountable for health outcomes or quality
- Integrated systems of care, like the Israeli plans, were not the predominant structural form in the US, although some examples like Kaiser, Intermountain, etc. are fully integrated
- Even when there has been a desire to manage care, few plans have the IT capabilities, especially electronic health records (EHRs) to enable them to do so.

The recent passage of health reform in the US now suggests that many of these obstacles will decline in importance. The creation of insurance exchanges will require health plans to be more consumer-friendly. The demographics of the physician workforce are changing dramatically as American physicians are now less inclined to enter private practice, and

more likely to become salaried employees of healthcare organizations. Prohibitions against medical underwriting mean that insurers will have to achieve profitability by effectively managing care, especially as bundled and population-based reimbursement approaches replace fee-for-service payments

While it is unlikely that Israeli-style integrated health plans will become the dominant mode in the US in the foreseeable future, over the next decade, there is an opportunity, under the new legislation to significantly increase the number and coverage of accountable care organizations (ACOs) that more closely resemble Israeli health plans.

This is desirable for several reasons. First, the transition away from fee-for-service payment is unlikely without fairly widespread ACO structures. ACOs and Medical Homes offer patients the possibility of more coordinated care, and thus not only better quality, but the avoidance of duplication, omission, and adverse drug outcomes. In addition, absent an integrated system, it is extremely difficult to capture all the relevant patient data that appropriate provision of care requires. Pouring huge sums of money into EHRs in a fragmented system may prove an unwise investment.

Getting US providers of care and consumers to embrace widespread use of ACOs/HMOs, given past experience, will be a challenge, but no doubt easier than in the past. This can best be advanced by:

- Continuing to support demonstrations, research, and incentives for population-based and bundled fee arrangements to replace fee-for-service reimbursements
- Educating consumers and provider systems about the documented benefits of successes by Israeli and other health plans
- Conducting and publicizing research about cost control and quality successes by managed health plans in the US
- Developing and testing gain-sharing reimbursement systems for ACOs and other plans to replace the "add-on" incentives of Medicare Advantage
- Promoting the use of clinical effective research results as measures of effectiveness.