

Finding the Optimal Competitive Model for Public Health Services: Israel as a Case Study/ Michal Halperin

The Israeli health sector is divided roughly to the public health sector that is financed mainly with public funding and the private health sector. I intend to research the public health sector.

What is the meaning and structure of the "public health sector" in Israel?

Since 1995, Israel has had a national health insurance system (NHI) that provides all residents of Israel a package of benefits and health services, the content of which the government determines and updates on a yearly basis. The care services that are included in the governmental package of benefits are provided by 4 health funds (HF). The HFs provide care in the community and either procure or directly provide hospital services. The government funds the HFs from its health budget. The budget is transferred to HFs according to a capitation formula that depends on the age, gender, and geographic periphery of the insured population.

There is no competition between the four HFs on the price of the basic package of benefits. The HFs are allowed and expected to compete on the quality of service that is provided. Each Israeli resident is allowed to switch from one HF to the other. In 2019, 200,000 residents (2% of the insured population) switched from one health fund to the other.¹ This rate has remained fairly stable in the last decade. This is a relatively low rate of switching. Nevertheless, there are clear indications that the HFs compete with each other and are well aware of the need to solicit more members.

With respect to hospitals: for historic reasons the two owners of most of the general hospitals are the government itself (the Ministry of Health (MoH) owns 50% of acute care beds) and the biggest HF (Clalit Health Fund owns 30% of acute care beds). In recent years the second biggest HF (Maccabi) acquired a few for-profit hospitals, but it holds only 3% of the acute care beds.

How is the Israeli public health sector doing?

The Israeli health sector is generally considered efficient and effective. Quality parameters such as infant mortality and longevity position Israel above the OECD average while the national expenditure is lower than OECD average (7.4% of GDP vs. 9% of the GDP for the OECD). However, both the HFs and general hospitals are working on budgetary deficit. In most cases the Ministry of Finance (MoF) will oppose increasing the fiscal spending on public health services due to budgetary limitations. The Ministry of Health (MoH), the HFs and the hospitals are constantly pushing to increase their budget as they claim that they are underpaid to provide the mandatory services.

At the same time the MoF and the MoH are challenged in enforcing budgetary discipline on the HFs and the hospitals. On one hand, HFs and hospitals are formally not allowed to

exceed their budget and on the other hand, they have a built-in incentive to create deficits in order to put pressure on the government to increase their budgets.

What is the goal of my research?

My work on finding the right model for competition in the public health sector will be done under the following assumption: When health services are provided by the government the public health sector should be focused on providing the best health services to all residents for the lowest economic price possible. The competition between health providers (HFs or public hospitals) should be a tool that helps in achieving that goal. The competition model should promote high standard, high-quality services and lower costs. Under this assumption I would like to concentrate my work on two competition issues:

1) Does vertical integration between HFs and hospitals create a competitive problem and is it good for the public health sector?

As of today, there is only one HF (Clalit -holding 52% market share) that is vertically integrated with a network of hospitals. In some geographic areas the only available general hospital is the one owned by Clalit. The general hospitals of Clalit are required to provide services to all patients whether enrolled with Clalit or not. Nevertheless, one would expect there will be an advantage to Clalit over all the rest of the HFs where it is integrated with a network of hospitals. Even if the hospitals of Clalit are required to provide services to all on equal terms they can easily discriminate on waiting time for procedures, on level of treatment, etc. In addition, hospitals owned by Clalit will probably receive their payments for services more easily from Clalit than other HFs. Clalit may be in advantage in hiring doctors – a resource that is in shortage. A system in which only the biggest HF is integrated with hospital network allows an advantage to the biggest and most powerful competitor. I would like to investigate if in reality this vertical integration gives Clalit an advantage in competition. If such an advantage exists, then the next question will be whether we should aim to divest Clalit of its hospitals and eliminate the vertical integration or move in the opposite direction and allow or even incentivize the other three HFs to acquire the general hospitals that are owned by the government. In considering the best vertical structure it is necessary to consider the efficiencies that vertical integration creates (such as better flow of information between the primary care provider and the hospital, ability to share facilities, etc.) The question of how to examine if the vertical integration indeed influences the ability of the HFs to compete is still an open one. There are a few potential directions that I would like to explore, among them: complaints received by the MoH and the Competition Authority on discrimination by Clalit owned hospitals between Clalit's members and members of other HFs; differences in the discounts given to HFs by the hospitals owned by Clalit; The ability of Clalit to steer its members to its own hospitals and how substantial is this effect. This will be the first stage that is required in order to understand if the vertical integration of Clalit in fact causes foreclosure or partial foreclosure of other HFs.

2) How does the design of the capitation formula influence the competition objectives of the HFs?

The main funding of the HFs comes from the government that provides funding according to the capitation formula. Hence, the capitation formula is a tool that

determines which populations will be the target for competition between HFs. It is clearly more profitable to enroll a healthy child than an elderly person diagnosed with chronic disease. The current capitation formula takes into account, to a certain extent, the age of the beneficiary, but healthy adults and sick adults will entitle the HF to the same funding. By law, the HFs must enroll any resident regardless of its health status. Nevertheless, the current capitation formula incentivizes the HFs to compete aggressively for young and healthy members and not sicker residents. The government can influence the level of adverse selection through its design of the capitation formula. Since the first capitation formula was determined in Israel in 1995 a few changes were made to it. More emphasis was put on the age factor. In 2010 two new considerations were included in the capitation formula – gender and geographic periphery. The amendment of the capitation formula in 2010 can be the basis for evaluation of how it influenced the competition incentives of the HFs. Furthermore, capitation formula is used in many other public health systems around the world. It will be valuable to compare the capitation formula of Israel with ones used in other jurisdictions and how the capitation formula is used to incentivize the HFs in providing high quality services with minimal adverse selection.