TPG International Health Academy

CEO Trade/Study Mission

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Executive Summary

Israel claims the enviable position as the fourth most efficient healthcare system in the world as designated by the World Health Organization. Israel spends 7.7 % of the GDP on healthcare while achieving high levels of quality in its care. Thirty- two participants of TPG International Health Academy traveled to Israel in March 2014 to identify potential learnings from this small country, which is about the same size as New Jersey. Overall, Israel has a younger population due to both the age of the country (founded in 1948) and the age of its founders. A whole generation is without grandparents due to the holocaust.

Healthcare Basics

The foundation of Israeli health care is built on universal health insurance for all residents, a public utility of sorts. In summary, a process facilitates national health insurance where each resident of Israel must enroll with one of the four HMOs. The HMOs are paid a government-defined premium per life enrolled, and must offer a government-defined basket of services. The program is funded by a designated 4.8% national income tax in addition to a smaller percentage from other tax sources. In order to keep the national health insurance solvent, health care services are limited by the government. All Israelis have this foundational tier of insurance coverage. There is a second layer of insurance, a supplemental insurance plan, which allows access to drugs and services not in the national basket and faster access to care. Approximately 90% of the population purchases this second layer of supplemental insurance. Finally, there is a third layer of health insurance, private coverage which approximately 30% of the population purchases. This allows the patient to even greater access of services such as medical tourism.

The Israeli healthcare system operates under a regulatory framework, which was implemented into law as the National Healthcare Insurance Act of 1995. The impetus for this law was caused by the fact that their oldest HMO in the country was going bankrupt. The new law created a system where government controlled the financing and regulated the insurance.

Coverage of the services that are offered by the HMOs is defined by the national medical basket also known as the sick fund. This is a standardized set of medical services mandated by the Ministry of Health. It includes both basic services and some specialty services and includes limits associated with these services. Under law, every person is entitled to have access to services identified in the medical basket. The insurance companies (HMOs) must cover these services for all the people who enroll in their plan.

Once every year, the medical basket is updated to consider coverage of new drugs and new technologies, which undergo efficacy and financial review before being approved for use and added to the budget. These new technologies are listed for public debate, and are vetted against evidence and against the defined budget increase, before being added to the medical basket. Once a new technology, drug, or a new indication for an existing drug is added to the basket, then everyone has access to it. The Minister of Health and the Minister of Finance share equally in balancing availability, demand, and supply within the set financial framework.

Although Israelis have the opportunity to change their HMO six times a year, there is very little movement and switching (less than 1%). All of the HMOs offer the same coverage through the health basket. Competition is through access of physicians (hours), locality of services, quality and patient satisfaction.

Secondary Supplemental Insurance (Shabam)

The second layer of health insurance is supplemental insurance for services that are not covered by the national medical basket of the public plans. This level of insurance is also known as Shabam. Services under supplemental insurance plans might include expansion of services (compared to services in the basket) e.g., additional fertility treatments or drugs that are not part of the national basket. It might include access to services more quickly than defined in law (e.g., organ transplantation, or overseas surgeries). In addition, supplemental insurance frequently allows access to a doctor more quickly than public insurance. Secondary supplemental insurance also allows Israelis to have greater choices such as the use of a private hospital as well as choice of doctors.

The government must approve services covered by supplemental insurance that is not part of the national basket. The supplemental insurance plans are heavily marketed with 90% of the population purchasing them. Even with this high level of participation, the role and scope of supplemental insurance is a topic of great public debate.

Third Level Insurance

Private insurance is the fastest growing segment in Israel's insurance industry. It offers choice, quality, accessibility, and financing. Commonly covered services include medical expenses not included in the health basket or supplemental insurance, medical tourism internationally, long term care, critical illness and dental services.

There is great controversy brewing in Israel about the risk that private insurance poses to the public system. Private healthcare is seen as a viable threat to the national insurance plan because residents may have less confidence in the public healthcare system. In addition, the private insurers pay doctors more than the public system does, which is dangerous to the public system because the success of the public system is dependent on keeping the salaries of doctors low. There have been proposed solutions that include government restrictions on the supply of private healthcare or to allow public hospitals to expand services to be able to compete with the offerings of the private plans. At the same time, the Minister of Finance sees that the stability of the system is reliant on the relationship between the private and public systems, noting that the private system offers some respite for thinly stretched public system.

Healthcare Workforce

Healthcare workers in Israel, from home health aides to nurses and physicians, are paid artificially low salaries to keep overall costs down. The government usually directly employs hospital staffs, but physicians may also work for an HMO or own a clinic.

While workloads are high and pay is low compared to other nations, physicians are offered free medical school tuition and low malpractice insurance rates in Israel. To supplement their salary, physicians who work in a hospital may work their off hours in another setting, which many do.

Currently, there are not enough doctors and nurses in the system. The government engaged in some exercises to increase medical and nursing school admissions, which have been successful. HMOs have also created programs to encourage physicians to choose to general practice, due to the dire shortage of GPs in Israel.

HMOs

Israel has some of the largest HMOs in the world, as there are only four HMOs for the entire nation. All residents (not necessarily citizens) must enroll with an HMO. Payment to the HMOs occurs through a capitation formula for premiums that allocates money depending on the number of enrolled membership and the ages of the members.

Additional funding is given to the HMO when they provide services in rural areas, due to the increased cost of providing these services.

Because the HMO does not collect any money directly from the patient, that changes the relationship between the plan and the patient. Funding from the patient comes from a 4% "tax" — which also has a ceiling. Approximately 95% of the country's healthcare is non-profit.

HMOs are responsible for payment of all health services including drug therapy. Because of the large number of lives that are covered, the government has significant influence on drug purchasing, enabling access to lower drug prices. For hospital care, an HMO must authorize and issue a guarantee of payment for many procedures before a hospital will make an appointment for an HMO's member (patient). In larger hospitals, there is an HMO booth to facilitate the needed communication between the consumer and their health plan. The review process of the HMO ensures that conservative therapies are used first, before authorizing the procedure. Once it is deemed medically necessary, then the consumer is usually scheduled far in advance (3, 6, or 12 months) at a public hospital. Mission faculty was assured that if there were a true medical emergency, hospitals would treat the patient and chase payment afterwards.

HMOs build and support robust community health services, which serve to keep their membership healthy and out of the hospital. There is a high penetration of availability of community services offered by the HMOs, as well as a high reliance on community services by residents, which helps to contain and manage costs. The HMO tries to offer community services that will replace unnecessary emergency care, offering services to meet the needs of the people who live in that region. HMOs also support call centers staffed by clinicians who have access to clinical guidelines and protocols. The call centers offer basic telephonic triage, where a member can call, report symptoms, and receive guidance. HMOs also support and encourage use of urgent care centers, often used for stitches and x-rays, since urgent care costs less than the hospital emergency room.

HMOs have very little opportunity to compete for lives for the national insurance plan, with limited allotted marketing resources and no differentiation in the medical basket offering. However, there is infrequent movement of members between plans (<1% annually). Thus, HMOs try to offer community services in desirable locations and may create an attractive ambiance. HMOs may also offer supplemental insurance plans that include differentiating services, such as traveler's consultation clinic, designed to attract membership.

Every three years there is a process by which the HMO receives a supplement to their payments from the government as "a supplement to the budget", which is called a stabilization agreement. The stabilization agreement allows the HMOs to be financially balanced if premiums and copayments are not enough to cover costs.

Public Health

The government has begun to create public health programs, which include immunization and wellness programs for children, initiatives to promote an active and healthy lifestyle and reduce exposure to an unhealthy environment (including certain foods, tobacco and alcohol) for adults and children. For example, schools are shipped fresh fruits and vegetables and children are encouraged to walk or bike to school. There are also attempts to change the prices of food, so that food with low nutritional value (white bread) will cost more with a goal of encouraging people to buy whole grain bread. The public has not wholeheartedly agreed with each of these initiatives, and there has been pushback that making food more expensive is very detrimental to the poor in society.

There are similar but separate social wellness programs, developed by the HMOs, which are seen as an investment for member health related cost reductions. The health plans encourage people to walk and exercise, to pay attention to obesity issues, and to reduce cigarette smoking. Unlike in the United States where health insurance turnover is significant, there is very little churn in HMO membership. This makes public health and prevention programs of more long -term value in Israel.

Hospitals

There are of three types of hospitals in Israel:

1. 50% are owned by the government (Ministry of Health)
2. 2.30% are owned by HMOs
3. 3.20% by NGOs

Like the United States a great portion of hospital care is given by hospitalists. There is a conflict of interest that was brought up several times whereas the governmental (through hospital ownership) acts as a regulator, supplier and buyer.

Hospitals continually run over budget and are under-funded. The official government budget helps pay for staff and basic resources, and there is little-to-no flexibility. Additional funding comes from two sources:

1. Private insurance and Private pay: Activities within the hospital prior to 3:00pm in the afternoon are government insurance activities. After 3:00 pm, private insurance activities can occur. The money from this activity has a bit more flexibility associated with it.
2. Private Independent Expenditures: Private money can come from medical tourism and philanthropy. An example of this is the new Emergency Department that is being built at a

Clalit-owned hospital, which is being funded to a great extent by a private family from Mexico.

The government through a partnership between the Ministry of Finance and the Ministry of Health closely manages hospital beds. Hospitals regularly run at 100% capacity. Prior to a hospital adding additional beds, the government must issue a license for the addition. Likewise, a hospital manager must obtain permission from the government before adding any hospital staff and revenues must be available to match projected salaries. The philosophy is that staff salaries drive costs, and all costs are managed very frugally. In addition to limiting the number of hospital beds, medical equipment purchases within the hospitals are also limited. Another tool that is used to control hospital costs is prospective budgeting, causing some public hospitals to delay care for patients until the next round of annual funding is appropriated.

The public hospitals must provide all the services in the national basket, although quasi-private and HMO-owned hospitals may specialize in limited areas and therefore offer greater diversity in services. . Another difference between public and private hospitals is that in the private hospitals, consumers are allowed to choose which doctor they receive care from. This is not allowed in the public system.

Facility Visits

After spending the first day in Tel Aviv, the group traveled outside of Tel Aviv north to Haifa. The purpose of the trip was to visit Rambam Healthcare Campus. The hospital is a great example of Israel as a whole. As Israel is a cultural mix of Jews and Arabs, so is Rambam Hospital. 25% of the employees of Rambam are Arabs with most of the remainder being Jews. The hospital cares for both Jews and Arabs alike.

Rambam utilizes technology as a foundation of the hospital. The entire hospital is paperless and interconnected. This allows for improved data analysis and coordination of care. These tools become even more important in the event of war. Due to its proximity to its Arab neighbors, many of which are not considered friends of Israel, Rambam has prepared itself for the potential onset of war. It has created a fully contained 2,000 bed hospital that replaces its underground parking structure if the need arises. TPG-IHA delegates were fortunate in that they were able to participate in the first official drill of the underground hospital. The term “necessity is the mother of invention” could have been coined in Israel, as our group experienced first-hand. Although there is less likelihood of the United States being in a war zone like Israel, we have experienced a number of mass casualty situations over the last few years. There are clearly lessons that we can learn from our time at Rambam Healthcare Campus.

Throughout the week, the delegation had an opportunity to visit several other healthcare facilities including Maccabi Healthcare Services (second largest HMO in Israel) which provided in-depth information on Electronic Medical Records (EMR) as well as explored how Maccabi is embracing and utilizing big data. TPG-IHA also visited Rabin Medical Center, which is part of Clalit – the largest HMO in the country. Rabin unveiled its brand new, state-of-the-art completely fortified hospital to the delegates. In addition to visiting healthcare facilities, we spent time understanding how the highly successful incubator system works while touring Trendlines, a venture capital firm that invests, incubates and develops early-stage, high promise medical and agricultural technology companies in Israel.

Lessons Learned

The mission offered many potential lessons for us to take home. These lessons include:

1. Individual patient identifier: Each Israeli is given a unique identifier at birth. This allows the country and the HMO to have a life-long longitudinal record of the individual. The ability to track a person allows for better data collection and analysis as well as an increased ability to coordinate care. The United States has talked about a unique patient identifier for a number of years. Unfortunately, patient privacy advocates have placed barriers to this moving forward.

2. EMR: The EMR can positively affect health- We have recently seen significant uptake in the use of electronic medical records in the United States. Israel has been utilizing the EMR for a number of years. The strong IT infrastructure in Israel has created a system that has greater interoperability. They continue to struggle in integrating ambulatory and hospital EMR systems but this has been an area of focus for them over the last few years with great success in overcoming this issue. Organizations, such as Macabbi, the second largest HMO have gone a long way to address the integration of records in the ambulatory and hospital setting. The United States for the most part has not yet begun to address this issue. The electronic medical records in Israel have decision support tools integrated into them. As we learned from a practicing physician, most of the doctors follow the information available in the EMR as it takes more time to opt out than to follow the recommendation. This is different from what occurs in the United States where there is a great deal of “alert fatigue.”

3. Data: Data is both available and usable in Israel. Data availability is greater in Israel due to the patient identifier and the broad use of EMR throughout the country. Data is shared across the HMO system as well as with the government. Data is increasingly used to propagate policy through insights that are gained. There are over 100 disease registries within Israel. During our visit to Maccabi, the group learned that performance information is available on a daily basis. Having this almost real time data almost allows providers to make necessary healthcare changes mid-course and to continually focus on the quality and efficiency of care that they deliver.

4. Innovation: Israel is a country of innovation. It is found just about everywhere within the healthcare system. There are a variety of reasons that there is such a great focus on innovation but probably the greatest reason is cultural and the second reason is the funding mechanism. A great deal of innovation is federally funded through incubation programs. Like the United States, Israel does have challenges in funding a good deal of the innovation that exists.

5. Behavioral Health: This is one place where both countries are challenged. Like the United States behavioral health lags behind medical health in focus and research in Israel. At this time, behavioral health is not covered under the Israel medical basket. This is in the midst of changing. It will be interesting to see if Israel is able to move ahead in the area of behavioral health due to their use of data within their healthcare system.

6. Member Costs: As in the United States, out-of-pocket costs in Israel are rising. The difference between the two countries is that there are very few complaints from the Israeli people regarding the issue. Healthcare is very important to the people of Israel. Because of its importance they are willing to spend their money to get what they need as well as to purchase as much insurance as they can possibly afford.

7. Quality indicators: Both the United States and Israel are increasingly focused on quality indicators. Many providers in the United States complain of the lack of consistency in quality metrics across organizations. In Israel, we found greater consistency. There are 35 quality metrics that are shared across all of the organizations. We did find, however, that each of the HMOs did have additional metrics that they followed. In addition to the HMO metrics, hospitals have also begun to collect metrics. Until recently, hospital quality initiatives lagged ambulatory metrics. As of 2015, JCI (Joint Commission International) will be required. This will move the hospital quality programs forward. All quality metrics will begin to be transparent beginning in 2015.

8. Manpower: In the United States physicians are typically not affiliated with a single insurance plan, with only a few exceptions (e.g. Kaiser Permanente). In Israel this is not the case, as most of the physicians (80%) work with only one plan. This decreases the administrative burden for the providers as well as allowing physicians to better align themselves with the payor with which they are working. The need of a physician to practice a specialty is decreased in Israel due to the moderated cost of medical education (under $5000/year) and a less significant medical malpractice burden. This allows for a greater emphasis on primary care. One area that both countries have in common is the recent focus on a primary care model that places the patient in the center of care. In Israel they are calling this the “Personal Physician Program” while in the United States we are calling this the “Patient Centered Medical Home”.

9. Healthcare as a political “fire rod”: Healthcare in Israel is not as politicized as it is in United States. This may be due to other issues such as the security of Israel – which is a far more important issue in the eyes of the Israeli people.

10. Non-communicable diseases: Both Israel and the United States struggle with non-communicable diseases as both a major healthcare cost driver and a public health issue. Both countries are challenged in addressing the issue of patient engagement; Israel is working to utilize their individual identifier and their almost real time data capabilities in addressing the issue. The United States has recently chosen to utilize levers such as pay for performance and third party organizations to address the quality and cost challenges that come with non-communicable diseases and the associated multi-morbidities associated with them. Israel does not utilize these tools to the same degree.

11. Diversity and disparities: Both Israel and the United States struggle with the challenge of healthcare disparities. This issue includes both the diversity in socioeconomic structure as well as cultural diversity. The major difference in Israel is their cultural challenge between the Jews and the Arabs whereas in the United States, the cultural diversity is much broader due to the "melting pot" diversity that exists among numerous nationalities.

12. Preventative care: Both Israel and the United States have identified the importance preventative care plays in overall health. The United States has chosen to address preventative care through reduction of out-of-pocket costs for the healthcare consumer. Israel has taken a different tactic. In Israel, preventative care is not part of the health basket and is not addressed for the most part by the provider. Instead preventative care is part of the public healthcare system and is either addressed through the school system or through a parallel set of providers.

13. Utilization: Israelis take their healthcare very seriously. Because of this they tend to pay for the highest level of insurance that they can afford. They utilize care freely. For example, Israelis see their doctor approximately 6 times a year on average whereas the U.S. average is 3 times a year. The difference in utilization between the two countries is supply – not demand. Specialists and hospital care are tightly controlled in Israel. In the United States, supply is great so that it can address the demand that may be placed on it (the exception of this is in some rural and underserved areas)

Summary

The Israelis are a pragmatic people. Healthcare in Israel is organized as a regulated utility.

Their healthcare system is based on three foundational attributes:

1. Universal coverage

2. Defined package

3. A clear and consistent capitation formula

This model has worked for Israel for the past 20 years. Like most other countries that TPG-IHA has visited, there are increasing pressures on the system to manage costs while keeping up with medical advancements. In general, Israel has found a successful way to offer basic services and some specialty services for the entire resident population while

creating a structure that allows for buy-up of services for a great majority of the country. The levers that Israel has utilized to manage their costs include volume based purchasing for drugs, limitations on supply of services, prospective budgeting and almost real-time use of data. Current political currents make it likely that there will be modifications made to ease cost and access pressures that are regularly felt in the system, as well as to address the perceived threat posed by supplemental and private insurance plans. The potential changes that may occur in the Israeli healthcare system are of concern to many but have not created the political fervor that has been seen in the United States. This is not due to the lack of importance but due to greater issues such as security that exist in Israel.

TPG-IHA (www.tpg-iha.com) develops and conducts educational programs in countries outside the United States for senior healthcare executives.