Public/Private Mix in the Provision of Health Services: The Tension Between Greater Care Co-ordination Across Providers, Increased Competition and Freedom of Choice

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Expenditures on Private Health Insurance in Israel, 2010 (Billion NIS)

- Supplemental Health Services, 2.878 Billion NIS
- Commercial/Private Health Services, 2.970 Billion NIS
- Long Term Care Insurance, 1.933 Billion NIS

Total: 7.8 Billion NIS
Financing

Provision

Public

- Sick funds
- Public Hospitals

Private

- Private hospitals, clinics or labs providing services to the public health systems
- Student Health Services

Private

- Medical tourism
- Private Services provided on the premises of public hospitals
- Patient co-payments

Public

- Physicians in private practice
- Private Institutes
- Private Hospitals
Services provided in the Israeli health system fall under a wide axis starting from "Fully Public" to "Fully Private".

- **Fully Public**
  - Primary medicine
  - Pediatrics
  - "A drop of milk"
- **Public with patient co-payment**
  - Drugs
  - Primary medicine
  - Specialized medicine
- **Supplemental insurance**
  - Tier 1
  - Tier 2
- **Commerical Insurance**
- **Fully Private**
  - Full patient payment
Insurances that are in addition to the public health insurance

- **Supplemental Insurance:**
  sold by the sick funds, in order to expand the basic package of services

- **Commercial or Private Insurance:**
  bought from commercial or private insurers, to cover health services

In Israel, there is quite some overlap between the private coverage's and services offered through the Supplemental Insurances by the sick funds.
Trends in revenues from premiums of commercial Insurances and Sick funds (100=2005)

Source: Horev and Keidar (2012)
Main Advantages of Private Medicine

- Allows to expand the breadth of health services offered, its availability to the public
- Allows keeping patient privacy and freedom of choice of health services
- Contributes to the competitiveness of service provision in the health system
Main Disadvantages of Private Medicine System

- Negatively impacts the equality of receiving medical services, especially where private (commercial) insurers place eligibility restrictions based on health status or risk for morbidity (cream skimming).
- Create two levels of healthcare.
- Can cause an overuse of health services (moral hazard).
- Increases national expenditures for health care.
The Key Factors of a Proper Health Care

- **Integration** of all the medical data relating to the patient's status.

- **Coordination** - Directing and managing treatment
As private medicine takes or will take a larger share of the medical services provided, it can be assumed that health management will become more divided and less integrated.
Factors that influence the balance between the public medicine versus private medicine

- National Public Health Expenditure
- Individual /Public freedom of Choice
- The values citizens place on medical treatment
- Confidence in the public health system
- The health care providers
- Private Insurers potential to make profit
The extent or proportion of private health care expenditure of the total national health care expenditures is a prominent sign of the status of a health care system in general.
The proportion of private expenditures alone is not a sufficient marker

- We need to see if this proportion is rising
- Remains constant
- To examine significant trends:
  - What are these trends?
  - how do they influence certain factors such as the quality of medical treatment?
  - What are the long term implications
Erosion of the public health system leads to:

- developing new substitutive paths
- Irreversible implications on the public health systems

All decisions on public health expenditures need to be reviewed from time to time to examine the implications on the public health.
The most important marker in assessing the proper equilibrium between public and private medicine is to define the main constituents of the public health system and the role of the private system.

Important to understand what extent does the private expenditure cover the core medical needs versus marginal needs.
Private expenditure coverage

- Surgery and medical advice abroad: 1%
- Dental: 12%
- Pediatric services: 3%
- Prenatal and childbirth: 9%
- Medicines and vaccines: 9%
- Other: 8%
- Surgery and choice of surgeon: 38%
Recommended criteria for assessing the "equilibrium" and its effects on the public health

Preventive Medicine and Early Detection of Diseases

- Preventive Medicine is a key public interest and must be supported by the public funding.
- Vaccinations and screening for early detection of diseases (eg. Mammography) and prevention of chronic NCDs

Service Availability – Long wait-times for appointments for ambulatory services and for surgical procedures that cannot be delayed

- Under-budgeted services cause long wait-times.
- The impact of low service availability needs to be assessed vis a vis irreversible health
- Removal of skin lesions suspected as Melanomas or BCC
- Child development
Examples of recommended criteria for assessing the "equilibrium" and its effects on the public health

Service Availability – Appointments for ambulatory services and for surgical procedures that relate to quality of life

e.g:

• Joint replacement
• Cataract operations
• Prescriptions- Additional payment for ethical drugs
Examples of recommended criteria for assessing the "equilibrium" and its effects on the public health

- **Luxuries.**
- **Extras. Personal choice**

  e.g.:
  - Choosing the surgeon or other health care provider
  - Accommodation facilities in hospitals
  - Plastic surgery
  - Additional physiotherapy sessions (beyond those defined in the health package)
  - Life style procedures
“Israel: excellent primary health care, but hospitals must improve”
Primary prevention of hyperlipidemia

Clalit instructed the primary physicians to treat hyperlipidemia aggressively

This intervention was parallel to Clalit's complex diabetes program and with guidelines and decision support system in the EMR for treating other risk factors

The results show that these programs lowered PCA's by 18% and CABG's by 22% in all Clalit patients

Prevention of disease is the right move for an HMO that has long term incentives due to very low attrition rate

Clalit embarked on a data mining process to identify the populations at risk for severe or chronic diseases and initiate preventive indicators in these populations.
New & Existing Programs

- Predicting and preventing deterioration of elderly patients
- Preventive programs in nephrology
- Guided care program for identifying and treating chronic NCD's in adult patients
- Control correct antibiotic regional use to lower antibiotic resistance
- Predicting and preventing high risk pregnancy, including Gestational Diabetes.
Integration Structure

- Overall perspective on patient status
- Decision Support system, through computerized medical files
- Proactive/preventive treatments for populations at risk, based on data bases and D.M systems
- Health Indicators
- The patient - has a single point of contact - his primary care physician who can access all of his medical information
- The private market – a contractor for the public health providers who transfers medical information to the same public medical information system
Private Services in Public Hospitals ("SHARAP")

- In 2002, the Attorney General, Mr. Elayakim Rubinstein issued a review of the legality of this practice.
- "We have seen that in the essence of Private Services in Public Hospitals is a suspected impairment of the principle of social equality and thus we cannot allow it".
- "At this point, without any regulation to maintain the basic obligation of providing equal medical services as required by law the SHARAP in the government hospitals is against the law"
The average number of hospitalization days for SHARAP patients was an average of 2.7 higher than the non-private services.

<table>
<thead>
<tr>
<th>Department</th>
<th>Average Hospitalization for Clalit Insured Patients</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private Service (SHARAP)</td>
<td>Non-Private Service (Public only)</td>
</tr>
<tr>
<td>Oncology</td>
<td>9.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Urology</td>
<td>5.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>9.9</td>
<td>6.2</td>
</tr>
<tr>
<td>Gynecology</td>
<td>4.1</td>
<td>2.3</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>8.1</td>
<td>1.2</td>
</tr>
<tr>
<td>General Surgery</td>
<td>7.7</td>
<td>5.0</td>
</tr>
<tr>
<td>Internal</td>
<td>8.8</td>
<td>6.0</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Total</td>
<td>7.2</td>
<td>4.4</td>
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</tbody>
</table>
Availability of some Surgical Procedures:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time to get a regular appointment</th>
<th>Time to get an appointment for SHARAP (private service) in the same hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery (not including oncology)</td>
<td>1 year</td>
<td>3-4 months</td>
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<tr>
<td>Plastic Surgery</td>
<td>6 months</td>
<td>3-4 months</td>
</tr>
<tr>
<td>ENT Surgery</td>
<td>6-12 months</td>
<td>1-2 months</td>
</tr>
<tr>
<td>Eyes, Cataract</td>
<td>10 months</td>
<td>3-5 months</td>
</tr>
</tbody>
</table>
Who treats the SHARAP patient outside the Operating Room?

SHARAP services are listed by the SHARAP physician by name.

But in most cases, with the exception of the actual operation, the patient is treated by the organic team in the hospital ward, at the expense of the regular patients.
Recommendations & Solutions

- Maximize all fields related to integration and minimize inequality.
- Pool data from services by private health suppliers into the IT systems of the public health sectors.
- As for the principle of equality:
  - proper mechanisms need to be in place to lower the co-payments
  - provide exemptions to copayments, for those in need

We don't need to work against the pluralistic models. We need to find creative solutions for integration and coordination of medical information to ensure proper medical decisions.
# Recommendations & Solutions

## Coordination and Integration

<table>
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<tr>
<th>Provision</th>
<th>Public</th>
<th>Supplemental</th>
<th>Private</th>
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<td>Public</td>
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## Equality

- Coordination and Integration
- Finance

- Recommendations & Solutions
All of the above recommendations in addition to stopping the erosion of public financing as seen below

Health Expenditure per capita compared to GDP per capita 1970-2012 (1970= 100)
THANK YOU