



TACKLING INEQUALITIES IN HEALTH AND HEALTH CARE IN ISRAEL

OECD Reviews of Health Care Quality - Israel
Francesca Colombo, OECD



What I will be talking about today

- Initiatives to address inequalities in health and health care in Israel
- Evidence on inequalities in health and health care on Israel
- Strengthening measures to address inequalities in health and health care in Israel



INITIATIVES TO ADDRESS INEQUALITIES IN HEALTH AND HEALTH CARE



Several valuable initiatives to address inequalities in health and health care

- Strong political commitment
 - Equity is enshrined in the legislation
 - Health inequalities are high on the policy agenda
- Several ongoing plans and interventions
 - The Pillar of Fire action plan outlines goals and deliverables to address inequalities
 - Policies and interventions have a broad scope (e.g., reductions in cost-sharing, incentives for professionals and plans, development of service delivery)
- Strong operational commitment by health funds
 - Clalit and Maccabi inequality-reduction action plans are a commendable sign of strong commitment



BUT...

Despite valuable efforts by the Ministry of Health and funds, there is evidence of wide and rising inequalities in health and health care in Israel

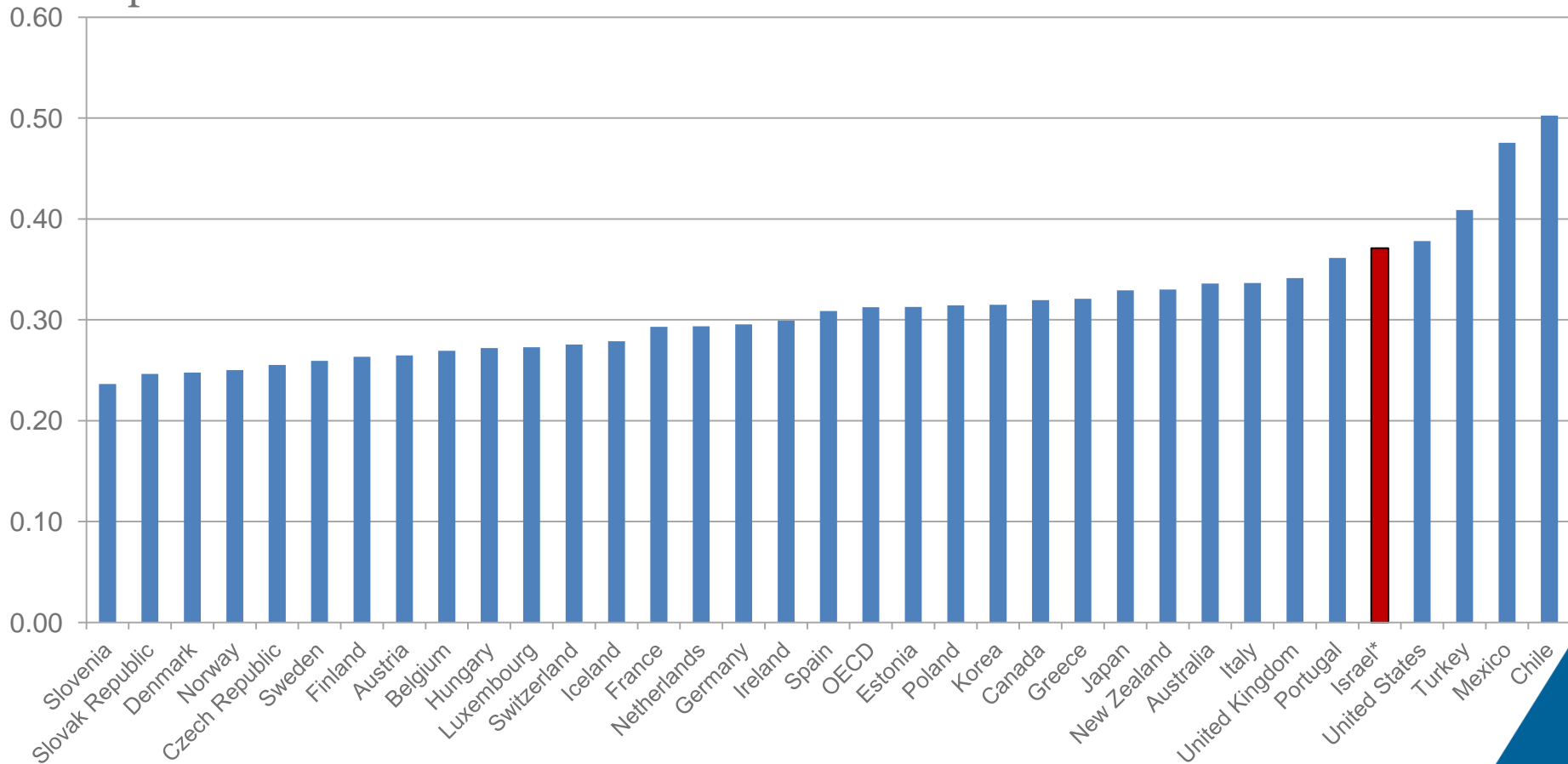


INEQUALITIES IN HEALTH AND HEALTH CARE IN ISRAEL



Wide income inequalities set a difficult environment for action in health

Levels of income inequality (Gini coefficient) in OECD countries, prior to the financial crisis



Source: OECD Reviews of Health Care Quality - Israel



Wide variation in health status and disease prevalence across groups

- For Israel as a whole, life expectancy is high and IMRs are low, by OECD standards
- However the following population groups have worse health indicators
 - Non-Jews
 - People living at the periphery
 - Poor SES groups
 - These characterises are often correlated but can also have independent effects, making tackling health inequalities a complex undertaking



Arabs have worse health status than Jews on many indicators

	Jews		Arabs	
	Males	Females	Males	Females
Life expectancy				
2000	77.1	81.2	74.6	77.9
2009	80.3	83.9	76.3	80.7
Age-adjusted mortality/100000:				
Heart disease	148.7	96.2	220.7	133.1
Diabetes	41.3	30.5	90.1	90.6
Lung cancer	46.1	17.7	75.1	14.1
Child mortality <5 /1000 live births	3.2		9.1	
Infant mortality/1000 live birth	2.9		6.7	
Stillbirth rate/1000 births	5.3		6.8	



North and South districts have higher mortality rates than the Centre

District (provisional data)	Infant mortality per 1 000 live births 2010	Standardised death rate per 1 000 population 2010
Central	2.4	4.9
Tel Aviv	2.7	5
Jerusalem	4.1	4.8
Haifa	4.1	5.4
North	4.4	5.5
South	6	5.4
TOTAL	3.7	5.1

Source: Ministry of Health (2010), *Health in Israel: Selected Data 2010*, Central Bureau of Statistics, Jerusalem.



Poor SES is associated with worse health indicators and variable treatment outcomes

- Regardless of ethnic origin, low SES groups have higher prevalence of diabetes and asthma
- Among Arab Israelis, mothers with less than four years of schooling have four times higher IMRs than women with 16 years schooling
- Treatment outcomes for low SES groups vary
 - Some measures are worse than average: worse cholesterol control following heart surgery, fewer prevention measures, less adherence to treatment protocols, poor glycaemic control
 - Some measures are better than average: e.g., BMI assessment, prescription of drugs post cardiac surgery, flu vaccination for people with asthma



STRENGTHENING MEASURES TO ADDRESS INEQUALITIES IN HEALTH AND HEALTH CARE



1. Information on health inequalities is good but there are gaps

- A good information system
 - QICH data provide information on quality of services delivered to population groups, by age, sex and SES
 - The largest funds use disaggregated data on their insured populations to implement disparity reductions interventions within quality improvement efforts
- But there are gaps:
 - Measure of SES is linked to eligibility for income support and is a crude measure of disadvantage
 - QICH data not (yet) disaggregated by locality and other social indicators (e.g. ethnicity, education, employment)
 - Population groups is not routinely recorded in medical records
 - Generally less developed information infrastructure for hospitals



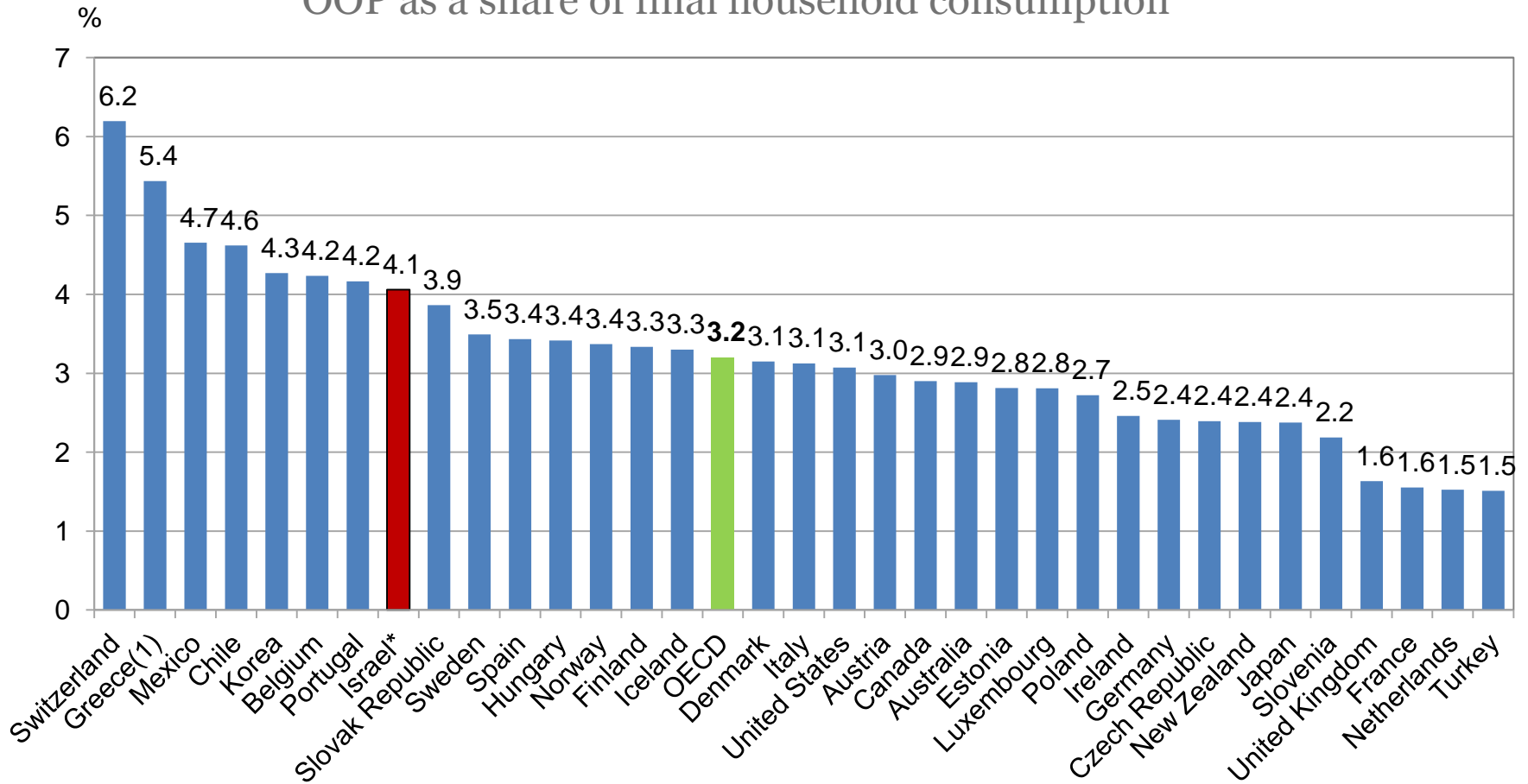
Strengthening the use of information for tackling health inequalities

- Use information on fertility, morbidity, mortality and utilisation to assess need and target interventions to high risk groups at district level
- Use disease registries data to analyse disease prevalence and quality of care by population groups
- Use electronic health records and QICH to identify patients with multiple morbidities
- Make more information on variations in health care need and quality available publicly



2. Out-of-pocket payments nearly a third higher than the OECD average

OOP as a share of final household consumption



Source: OECD Health Data 2011



Addressing inequities linked to high out-of-pocket payments

- Important valuable steps already been taken:
 - Removal of fees at maternal/child centres
 - Widening of coverage for dental care for children
 - Reduced cost-sharing for medicines for elderly patients
- The effectiveness of safety nets ought to be monitored regularly, and exemptions reviewed accordingly
- Co-payments are not a good way of raising money for health and can discourage good behaviour



3. Regions with the greatest health needs are underserved by health care services

Health care infrastructure by district, 2009

Variable	National	South	North	Tel Aviv	Centre	Haifa	Jerusalem
Delivery room beds/100000 women aged 15-44	14.7	9.9	12.8	18.5	13.0	16.6	23.7
Delivery room beds/1000 live births	1.5	0.9	1.4	2.0	1.4	2.0	1.8
Operating rooms/100000	5.8	3.3	4.0	8.4	5.5	6.9	8.6
Recovery room beds/100000	10.2	4.4	8.0	15.4	9.7	15.3	12.7
Emergency dept beds/100000	14.9	9.0	14.0	15.0	13.9	19.3	24.9
Dialysis stations/100000	15.4	13.6	14.3	18.8	12.2	21.5	19.7
Inpatient beds: acute/100000	193.2	138.4	148.3	250.3	201.2	258.0	223.0

Source: Health in Israel: selected data 2010. Ministry of Health, State of Israel, Jerusalem 2010



Monitoring and strengthening initiatives to reduce geographical inequities

- Many initiatives are underway that need to be implemented well, for example:
 - New medical school in Galilee
 - Incentives for additional funding targeted to and training of nurses from Bedouin communities
 - Incentives for health funds investing in the periphery
- Consider introducing morbidity, mortality and SES differences in the resource allocation formula, in addition to remoteness
- Increase efforts to recruit medical professionals from remote areas and train them there



4. Support health promotion and health education for disadvantaged groups

- Despite an excellent primary care sector, primary prevention could be a more important area of focus for health funds
- There is a strong potential for targeted preventative services to reduce inequalities in health (e.g., smoking among Arab men, counselling on healthy diets for Arab women)
- Culturally tailored services can be used to improve uptake of preventative services
- Clinical guidelines can be tailored to reflect the needs of different population groups



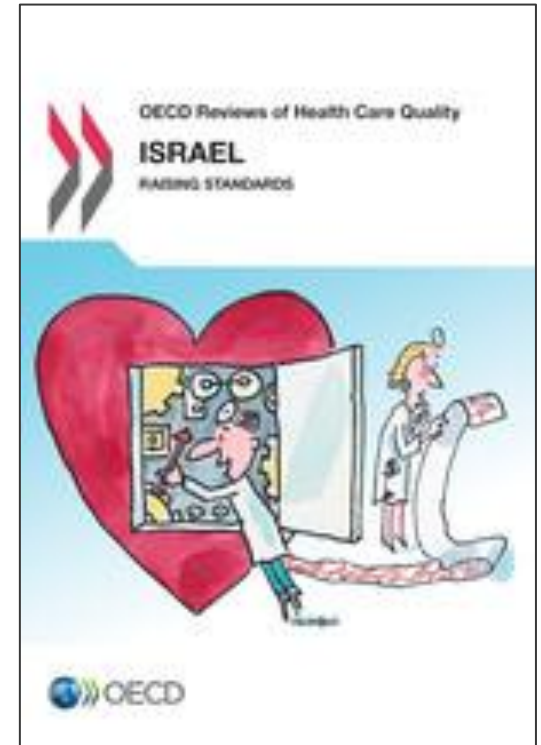
To conclude...

- Israel has an excellent primary care system
- Dedicated health programmes for the disadvantaged are commendable; they ought to be encouraged and renewed
- Further efforts in the health sector should be accompanied by wider efforts to tackle the social determinants of health.



Whant to learn more?

- OECD Reviews of Health Care Quality – Israel
- Other countries reviewed or underway: Korea, Denmark, Sweden, Turkey; 3 to 5 more to come.



www.oecd.org/health/qualityreviews