

Position Paper

**Co-payments for Health Services:
Everyone Agrees that Something Needs to be Done
But Nobody Does Anything**

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But Nobody Does Anything**

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There is broad agreement that access to health services should be as egalitarian as possible. There is also broad agreement that co-payments for drugs, visits to doctors and tests make these services less accessible to low-income persons. And there is agreement that the degree of access to health services influences a person's health.

Thus, there have been many proposals to improve equality of access to health services by eliminating or reducing co-payments and replacing them with alternative sources of funding.

If everyone agrees, the question that begs to be asked is: Why isn't anything being done? Why doesn't the government take the steps needed to improve equality of access to health services?

The relevant data:

Here are some new data describing the current situation:

- a. The overall situation: There has been a continual increase in the contribution of households to national expenditures on health, and a decrease in the government's contribution.
 - In 1994, the government's share was 50%, and that of households, 24%.
 - In 2000, the government's share was 42%, and that of households, 28%
 - In 2006, the government's share was 38%, and that of households, 33%.

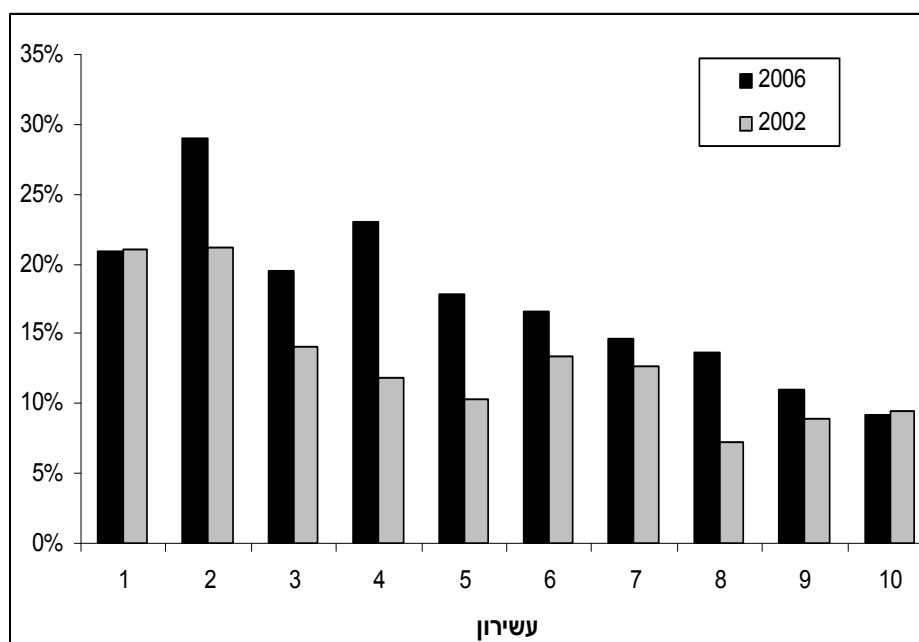
Moreover, households' share of national expenditures on health in Israel is among the highest in the western world.

- b. Looking only at the last five years (the only years for which the Central Bureau of Statistics has data), there has been a significant increase in the proportion of Israeli household expenditures on health that is spent on prescription drugs.

Monthly expenditure on prescription drugs as share of household expenditures on health

By deciles of net money income per standard person (percentages)

In 2006 prices



Source: Adva Center analysis of data from the Central Bureau of Statistics, Dept. of Consumption and Expenditures, May 12, .2008

Between 2002 and 2006, mean monthly expenditure rose from NIS 60 to NIS 89.10, an increase of more than 50%; the share of total expenditures on health rose from 11.6% to 15.6%. The mean expenditure in shekels of all households increased, and expenditure as a percent of all household expenditure on health rose in all deciles except for the lowest and the highest. Households in the upper deciles obviously spend more on health in general, and on prescription drugs in particular, and also spend more on all consumption goods.

- c. If we look at the mean total household expenditure on health as a percentage of total consumption expenditure, we find that expenditure on health increased from 3.8% of consumption expenditure in 1997 to 4.8% in 2000, and 5.1% in 2006.
- d. If we look at the **revenues** of HMO's from co-payments for drugs and equipment included in the basket of health services, as a percentage of total HMO **expenditures** for drugs and equipment included in the basket, we find that in 2006 consumers of health services paid no less than 36% of the cost of drugs and equipment (calculation based on Waldman, Asharov and Hillman, 2008, *Summary Public Report on the Activities of HMO's for 2006*)

- e. The increase in household expenditure on co-payments for drugs and other health services, and the increased revenues of the HMO's from these co-payments, are reflected in the growing percentage of people reporting that they had foregone purchasing drugs or other health services because of their cost:

Proportion of persons reporting they had foregone medical treatment or drug purchases because of cost, and the proportion of persons in the lowest income quintile who reported forgoing treatment or drug purchases, 1999-2005

	Percent forgoing medical treatment	Percent among lowest quintile forgoing treatment	Percent among quintile purchasing prescription drugs	Percent among lowest quintile forgoing purchase of prescription drugs
1999	6	11	11	21
2001	5	11	11	16
2003	6	10	14	24
2005	8	13	15	23

Source: Gross, Ravital, Shuli Barmeli-Greenberg and Ronit Matzliah, *Public Attitudes toward the level of services and the functioning of the health system one decade after the passage of the National Health Insurance Law*, Jerusalem: Brookdale Institute, March, 2007.

According to the table:

- There is an increase in the proportion of people reporting that they forwent medical treatment or drug purchases because their cost has risen. In other words – **because of co-payments;**
- The proportion of people forgoing medical treatment is about half the proportion of those who forgo drug purchases;
- The proportion of people in the lowest quintile who forgo treatment or drug purchases is double that in the population as a whole.

The published summary of the 2007 Brookdale Institute survey notes a decline in the proportion of insured persons reporting forgoing treatment or drug purchases. Data from the coming years is needed in order to interpret these findings.

Recommendations

A number of recommendations have been put forward for addressing the co-payment issue. One set of recommendations was presented by Physicians for Human Rights-Israel and the Adva Center; a second by researchers Leon Epstein and Tuvia Horev; and a third by Gabi Ben-Nun, the former Deputy Director of the Ministry of Health.

1. **Recommendations of Physicians for Human Rights-Israel and the Adva Center, June, 2007:**
 - Eliminating co-payment for medical services.

Co-payments are a source of income for HMO's. Their funding can be increased in the following ways, as an alternative to imposing co-payments:

- Removing the income ceiling on health tax payments, which today stands at five times the mean income;
- Increasing the health tax to make it more progressive;
- Reinstating the employers' contribution, which was eliminated in 1997;
- Expanding exemptions and discounts on payments for drugs and medical services in order to ease the burden on the insured (Shlomit Avni, *Justice, equality and mutual assistance: Challenges in the Israeli public health system*)

2. **The recommendations made by Leon Epstein and Tuvia Horev, Taub Center, September, 2007:**

- Eliminating co-payments for preventive services, such as the Well-Baby clinic fees, immunizations, embryonic protein tests, and equipment for self-monitoring by diabetics;
- Exemption from fees for procedures carried out at medical institutes and those paid to specialists in the case of doctors' referrals for preventive medical procedures, such as mammography, screening for cervical and colon cancer, genetic counseling for groups at high risk for birth defects and dietary counseling for persons with diabetes or who are overweight;
- Exemption from co-payments for legally entitled groups (such as persons who receive income supplement payments) for **all** services included in the health basket that today require a co-payment from the person receiving the service;
- Exemption from drug fees for chronically-ill patients who receive income supplement payments and are entitled to an exemption from the fee for doctors' visits, as well as population groups having special needs, such as holocaust survivors and persons with handicaps. The exemption would cover drugs included in the health basket for treating chronic conditions. As an alternative: reducing the payment ceiling for these persons to half of the ceiling set for chronically-ill patients who do not receive income supplement payments (*Health inequalities in the health system: The problem, and policy proposals for addressing them: 33-34*)

Epstein and Horev propose various alternative sources of funding: raising the income ceiling for health tax payments, using some of the income from cigarette taxes, and direct government allocations to make up the difference. They also propose raising co-payments for persons not in high-risk groups who do not receive income supplement payments. They estimate that the discounts and exemptions they propose will cost between NIS 160-200 million annually (ibid, p. 34).

3. **Gabi Ben-Nun's proposals, April 2008:**

- Elimination of co-payments
 - During the first three months of complex nursing care;
 - For embryonic protein tests;
 - For self-monitoring diabetic equipment;

- For preventive screening (mammography, cervical and colon cancer);
- For Well-Baby clinics;
- For flu and pneumonia immunizations for groups at risk;
- For genetic counseling for groups at high risk for birth defects;
- For outpatient visits with specialists, and for specialized medical services for all insured persons 65 and older;
- Establishing ceilings, discounts and exemptions such as:
 - Ceilings on payments by families for chronic patients, including prescription drugs;
 - 50% reduction in the quarterly ceiling for drugs for chronic patients;
 - 50% reduction in the family ceiling on payments for households receiving income supplement payments;
 - 50% discount on prescription drugs for persons 65+;
 - Exemptions for persons 65+ receiving income supplement payments from paying for prescription drugs.
 - Set a ceiling on the percentage of the cost of the basket of services to be covered by co-payments, so as to prevent the gradual increase of revenues from this source. In cases in which this percentage exceeds the ceiling, government revenues are to be increased in accordance with the over-payment (*Reinforcing the Public Nature of the Health System*, April 2008: 18).

Ben-Nun proposes to cover the revenues lost by exploring the following alternatives: (1) increasing the income ceiling for health tax payments to six times the mean salary, and (2) intelligent use of pricing to reduce harmful behaviors – for example, increasing cigarette taxes (ibid: 19).

Not all the proposals are equal in worth

The three proposals overlap considerably.

In our opinion, multiplying exemptions and discounts will be burdensome for the health system. Moreover, we can assume that not all those eligible for discounts or exemptions will be aware of their eligibility, so these measures may not achieve as much as expected.

Rather than introducing a long list of exemptions and discounts, we propose to eliminate co-payments for drugs and services included in the basket. The revenue HMO's received in 2006 from co-payments for drugs and services included in the basket totaled NIS 1.939 billion, comprising 8.07% of HMO revenue (Waldman, Asharov and Hillman, 2008, *Summary Public Report on the Activities of HMO's for 2006*, January, 2008: 28). This is not a negligible amount, but social solidarity requires replacing it with alternatives such as raising the health apparatus that persons with high incomes spend a greater proportion of their income on health tax payments than they do now – and re-imposing a small health tax on employers – so that they contribute more to the welfare of their employees

than they do now. In 2005 Israeli employers contributed 15.7% of the value of the wages of production workers to employee welfare, while the average in Europe was 23.3%, and that in the United States 22.5% (Swirski, Shlomo and Ety Konor-Attias, *Israel: A Social Report - 2007*, Adva Center, December 2007: 15).

Co-payments for drugs and other services included in the basket of services can be gradually reduced. For example, all co-payments can be reduced by 20% each year for the next five years. At the same time, the health tax income ceiling can be raised gradually, and the imposition of a health tax on employers can also be done gradually. Another possibility: The process can begin by eliminating co-payments for preventive services, and by reducing payment ceilings.

It is also possible to adopt the proposal to dedicate cigarette (and gasoline) tax revenues, as well as revenues from fines imposed on polluting enterprises, to health services.

Universality is a principle worth adhering to. Taxes should be imposed progressively, but services should be equal for all and based on need, regardless of income. Only in this way will it be possible to preserve a health care system designed for all whose underfunding is turning it into a service for the poor, while persons who can afford them benefit from semi-private or fully-private services. Reviving the all-inclusive nature of the system is the only way to ensure the support of the middle class for high quality public services, and the only way to maintain social solidarity.