

**Steering Committee**

Mr. Uzi Baram Chair  
Dr. Yossi Beilin, MK  
Mr. Hermann Bünz  
Ms. Amira Dotan, MK  
Mr. Gilad Erdan, MK  
Mr. Shai Hermesh, MK  
Ms. Nadia Hilou, MK  
Ms. Orit Noked, MK  
Mr. Ephraim Sneh, MK

**Former members of the steering committee**

Former Chair,  
The Late President  
Chaim Herzog  
Former Chair,  
The Late Mr. Haim J.  
Zadok  
Dr. Yehuda Lankry,  
Mr. Michael Eitan, MK  
Adv. Yossi Katz  
Dr. Winfried Veit  
Mr. Gideon Saar, MK  
Mr. Isaac Herzog, MK  
Minister  
Ms. Eti Livni, MK  
Mr. Eitan Kabel, MK  
Minister

**In cooperation with:**  
**Friedrich Ebert Stiftung**

**Sponsors:**

Moshe Kornik

**צוות ההיגוי**

מר עוזי ברעם, יו"ר  
ח"כ גלעד ארדן  
מר הרמן בונץ  
ח"כ ד"ר יוסי ביילין  
ח"כ אמירה דותן  
ח"כ נדיה חילו  
ח"כ שי חרמש  
ח"כ אורית נקד  
ח"כ אפרים סנה

**חברי צוות ההיגוי בעבר**

יו"ר ראשון,  
הנשיא חיים הרצוג ז"ל  
יו"ר שני,  
מר חיים י. צדוק ז"ל  
ד"ר יהודה לנקרי  
ח"כ מיכאל איתן  
עו"ד יוסי כץ  
ד"ר וינפריד וייט  
ח"כ גדעון סער  
ח"כ יצחק הרצוג, שר  
ח"כ אתי לבני  
ח"כ איתן כבל, שר

**בשיתוף:**

קרן פרידריך אברט

**חסיונות:**

משה קורניק

## Senat 288 on Socioeconomic Policy Issues: The Battle Over the Health Basket

**Main Conclusion:**

- The health service basket and the list of medications specified in the *National Health Insurance Law* (1994) are based on the services and drugs provided to members of the Histadrut's General Sick Fund on the eve of the law's of legislation.
- The drug prescribed for multiple sclerosis was added to the basket after a legal battle. Drugs for the treatment of prostate cancer, breast cancer, osteoporosis, depression and Alzheimer's disease were added after public protest.
- The *Health Insurance Law* established a structured mechanism for adjusting the basket in response to increases in the cost-of-living index but left the decision to add new drugs to the political level, subject to "the economy's capacity and budgetary priorities."
- Cancellation of the parallel tax that financed 40% of the drug basket effectively increased government participation in the basket's financing from 10% to 45% and contributed to a reduction in the number of drugs included.
- Attempts to base recommendations for new drugs on medical-technical criteria have failed.

On occasion, a group of patients suffering from a serious disease is able to recruit public support, and media coverage for its battle, pity and sympathy for the addition of a new medication to the drug basket. The last confrontation involved sufferers of colon cancer, who conducted a 16-day hunger strike while demanding that the drugs Avastin and Erbitux be added to do the basket. Their successful battle forced the government to add NIS 350 million to the drug basket in 2006 beyond the sums already allocated to update the basket (NIS 360 million).

Such events raise weighty questions: Is the state able and required to finance every drug, medical technology and existing treatment for its residents? Is the decision regarding which drugs and treatments are to be included in the drug basket and which excluded a professional medical decision or does it require a broader perspective that takes into account ethical, economic and political considerations as well? What role do the pharmaceutical company and drug importer interests play?

How can we prevent the entry of immaterial considerations by doctors who receive funding for research and participation in conferences held abroad from the pharmaceutical manufacturers? Why did the crisis regarding the drug basket break out subsequent to passage of the *Insurance Law* and why did the law not permanently solve the outrageous distress faced by patients dependent on new drugs? How can we prevent this continual state of crisis?

### ***The National Health Insurance Law (1994)***

As of January 1995 every resident of Israel is entitled to receive from the health care provider of choice a list of services indicated in the health service basket detailed in the *National Health Insurance Law (1994)*. The state is obligated to finance the basket from sources also designated in the law. At the time of the law's passage, the available resources were: the health tax paid by all insurees, the parallel tax paid by employers, the provider's independent income (that is, the individual policyholder's participation) and state participation.

In 1997, an amendment to the law freed employers from payment of the parallel tax (5% of workers' wages) that had financed until then up to about 40% of the cost of the health services basket.<sup>1</sup> The *National Health Insurance Law* charged the government with financing the deficit arising between the cost of the basket and the other sources. This increase in government participation, despite it being offset by a reduction in expenditures in other budgetary items (employer compensation) created the illusion of vast government expenditures for this purpose. It thus appeared that government participation in the health basket's financing had grown from 10% in 1996 to 44% in 1998 on. This accounting adjustment nonetheless had a significant effect on the drug basket's deterioration.

### **The Health and Drug Baskets**

The *National Health Insurance Law* defines a health service basket covering 11 areas of provision (para. 6): (1) preventive medicine and health education, (2) medical diagnostic services, (3) ambulatory medical services especially mental health services, (4) general, psychiatric, chronic–nursing care psycho-geriatric hospitalization, (5) medical rehabilitation, (6) drug provision, (7) medical instrumentation and devices, (8) preventive dental care for children, (9) medical first aid, (10) on-the-job medical care, and (11) medical and psychological care for drug addicts and alcoholics.

The basic health basket was constructed on the foundations of the services provided to members of the Histadrut's General Sick Fund (currently: General Health Services) on 1 January 1994 ("the determining date"). The list of drugs determined was based on the same principle. The law requires the Minister of Health to publish a list of the medications included. In 1995, the health basket was valued at NIS 12.2 billion: it currently stands at NIS 23 billion. "The drug basket" (a term missing from the law) represents about NIS 4 billion of that sum.

### **Updating the Health Basket**

According to the law, the health basket is to be updated annually according to the health cost-of-living index. This index is constructed by weighing various indexes published by the Central Bureau of Statistics:

The Average Wage Index for the health sector: 36%

The Average Wage Index for the public sector: 22%

The Cost-of-Living Index: 23%

The Wholesale Drug Price Index: 17%

The Construction Inputs Price Index: 2%

Until 1997, the government was satisfied with adjustments of the basket according to the health cost-of-living index, which is not responsive to demographic changes and technological advances. The law's amendment (by means of the *Budget Arrangements Law, 1997*) enabled expansion of the basket in response to demographic changes (population increase and change in the age distribution). In 1998, an additional amendment (the fifth) allowed the basket's adjustment in light of technological advances. Contrary to the structured annual mechanism for adjusting the existing basket in response to cost increases, the new amendment stipulated that the drug basket be updated annually by the addition of drugs and new technologies, as determined within the framework of the budget debate and in consideration of

---

<sup>1</sup>The rate of national insurance (Social Security) payments then paid by the employee or his was about 5%. Cancellation of this payment permitted the Ministry of finance to reduce expenditures of the item (employer compensation), which had reached NIS 10 billion annually.

the economy's capacity and budgetary priorities. By December 1997, only one new drug was added, and that in response to a legal battle initiated by multiple sclerosis sufferers.

As of 1999, the Ministry of Health initiates a process to identify new technologies appropriate for inclusion in the health basket. Each year, hundreds of potential new medical technologies, the majority of them medications, compete for admission. Due to budgetary limitations, only a small number are eventually added to the basket. The public committee established to update the drug basket ranks the suggested technologies and drugs by their necessity, within the framework of the budgetary limitations imposed by the government, and issues its recommendations to the Health Council (as stipulated by para. 48 of the *National Health Insurance Law*) and the government.

Over the years, a procedure for "prioritization" of new medications and technologies<sup>2</sup> has been introduced, based on medical and technical indices. The crux of the problem regarding decisions to include a costly medication targeted at a small group of patients while denying a different medication to other groups of patients lies in it being, of necessity, a political decision having public implications. The dominant representation given to physicians as members of the committee updating the basket as well as among those recommend and ranking medical technologies exposes them to ethical issues rooted in the link between the physicians and the pharmaceutical companies that finance medical research and participation at conferences held abroad.

The *National Health Insurance Law* weakened the bargaining power of the sick funds as opposed to the pharmaceutical manufacturers and importers. In the past, the drug companies were forced to contend with a strong Histadrut and powerful sick funds that were able to determine autonomously which drugs to purchase. By determining a mandatory drug basket, the law introduces a structural failure that allows drug manufacturers to price drugs in a way that reaps huge profits and increases the usefulness of aggressive marketing campaigns directed at physicians and patients. The drug basket has thus become an arena for confrontation between drug companies, drug importers, physicians, politicians, patients and their families. As of 1999, a model of public protest has evolved meant to promote one or another drug. In this model, the media play a crucial role by publicizing the heart-rending stories of patients needed drugs excluded from the basket and by forcefully covering the protests, as observed in the hunger strike waged by a colon cancer patients in May 2006.

In the first five years after the law's enactment, no new drugs were added to Israel's drug basket. In early 2000, new drugs, valued at millions of new shekels, were added, including drugs for the treatment of prostate cancer, breast cancer, osteoporosis, depression and Alzheimer's disease. In 2002, the Ministers of Finance and of Health decided on a rate for updating the drug basket for the years 2002–2004; in 2005, they did the same for the years 2005–2007. In 2005, the government confirmed additions valued at NIS 120 million out of requests valued at about NIS 1 billion. In 2006, the Ministry of Health received a proposal to add new technologies and drugs valued at NIS 1.5 billion although the government had allocated only NIS 310 million to the basket's expansion. The basket's update committee recommended additions valued at more than NIS 467 million, although the Budget Department at the Ministry of Finance pressured the relevant ministers to refuse the requests. The aftermath of this process is well known: After 16 days of a hunger strike held opposite the Knesset, the government caved in and located the additional NIS 350 million (taken from the 2007 budget) to increase the medications budget for that year in addition to the NIS 50 million previously promised in the appendix attached to the coalition agreement concluded with the Pensioners Party. The total of value of the increase to the drug basket for 2006 is valued at about NIS 710 million, the largest one-year increase in the drug basket to date.

The manner in which the issues are treated forces us to reach a clear conclusion: The public voted quite clearly for a set of priorities radically different from that advocated by the government, indicating their desire that the state allocate greater resources to health. The public has become rather skeptical regarding the way in which its representatives and the government attend to their health and have realized that the government lacks a clear health policy. This vacuum created provides opportunities to activate pressure tactics for the purpose of increasing greater funding.

---

<sup>2</sup> The Israel Medical Association presents its recommendations to the committee responsible for updating the health basket based on a model for the evaluation of medical technologies developed in cooperation with the Technion and Ben-Gurion University. Each scientific association rates the technologies proposed, by discipline, at two stages. At the first stage, it ranks the technologies according to need on a 5-point scale. In the second stage, it scores the technology according to 14-16 criteria, including contributions to life expectancy, rates of treatment success and side effects, in comparison to existing technologies. At the third stage, the evaluation team scores each technology based on evidence in the medical literature.