This document contains links to websites where you can find national legislation and health laws. We link to official government legal sources wherever possible. Where we link to unofficial sources this is noted and users should take this into account before relying on these materials. We recommend checking with the relevant national government if you have questions about the currency or validity of any unofficial source of law.

**Legal system**

Mix of civil law, common law, Jewish law and Islamic law

**National law database**

- **Language:** Arabic, Hebrew and English
- **Link:** [www.knesset.gov.il](http://www.knesset.gov.il)
- **Nature:** Official website of the government of Israel
- **Organisation responsible for the website:** The Israeli parliament

**Legal UHC start date**

1995


**The health system and policy monitor: regulation (PDF)**

As part of its Health Systems in Transition (HiT) series the European Observatory on Health Systems and Policies systematically describes the functioning of health systems in countries as well as reform and policy initiatives in progress or under development. The HiT health system reviews cover the countries of the WHO European Region as well as some additional OECD countries. This PDF includes information about the country’s regulation. To see the complete HiT report of this country go to: [http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits](http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits)
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Israel

HIT: 2009 - Rosen B, Samuel H, Merkur S

HSPM Members: Myers-JDC-Brookdale Institute

HSPM Contributors: Rosen B, Merkur S
Israel: Regulation

4. Regulation and planning

4.1 Regulation

Until the mid-1990s, outside the public health arena, Israel did not have a well-developed culture of government regulation in the health sector. Instead, the Government relied primarily on budgetary controls, offers of subsidies and moral and political persuasion to influence nongovernmental providers. Since the introduction of NHI and the Patients’ Rights Act in the mid-1990s, the Ministry of Health has developed new capabilities and launched many new initiatives in the regulatory field.

In the public health arena, key areas of regulation include:

- food safety
- water safety
- pharmaceutical safety and efficacy
- filtration of community water supplies
- mandatory fluoridation of community water supplies
- smoking bans in public places.

With regard to the health care delivery system, some of the main interfaces and areas regulated by government include: the interface between the Government and the health plans; the health plan–consumer interface; the Government–hospital interface; the pharmaceutical sector; health care personnel; and the hospital–health plan interface. These are discussed in turn in the following subsections.

4.1.1 Regulation and governance of third-party payers

The Government regulates several aspects of the health plans and their operation. First, the total amount of government financing to be allocated to the NHI system is regulated, with separate decisions regarding the amount to be paid for the existing benefits package (to reflect population growth, inflation of key inputs and so on), and the amount to be made available for expansions of the benefits package. Next, the Government provides the authorization necessary to operate a health plan.

Furthermore, the capitation system that governs how the bulk of NHI funds are distributed among the health plans is set by the Government. In part, this involves determining what parameters will be included in the capitation formula, for example, determining whether health status, socioeconomic status and/or quality measures should be added, alongside age and sex. In addition, the coefficients of the existing parameters – age and sex – need to be updated periodically. A related decision is the extent and nature of payments to the health plans outside the capitation formula, such as the payments for “serious illnesses” and various safety net payments (see Section 3.4 Revenue collection/sources of funds).

The Government also specifies the health plans’ financial reporting requirements and ensures that the plans’ financial and operational activities are consistent with various legal requirements (for example, limits on advertising expenditures).

With regard to the health plan–consumer interface, regulation involves determining the extent and nature of the co-payments that health plans and others can charge their members. The content and pricing of supplemental insurance packages offered by the health plans are also regulated. This includes such issues as whether the VHI packages can include coverage for life-saving pharmaceuticals (see Section 7.2 Introduction of national health insurance) and choice of hospital-based physician (see Section 7.8 The Patients’ Rights Law). A related issue that is also regulated is whether the health plans can use their VHI programmes to cross-subsidize their core activities (that is, those related to the basic benefits package), or vice versa.
4.1.2 Regulation and governance of providers

In terms of hospitals, the Government regulates hospital licensure and oversees the authorization process for opening a new hospital or department. Furthermore, the number of hospital beds is regulated, along with their distribution in terms of ownership, specialty and location, as are major capital expenditures, such as the acquisition of magnetic resonance imaging (MRI) scanners and other expensive equipment. In Israel, monitoring of nonmedical components of quality takes place through a system of inspections and other types of reviews. There is talk of also developing measures for the medical components of quality in the coming years.

In the pharmaceutical sector, the maximum prices that pharmacies are allowed to charge consumers in direct sales to them are centrally set. Also regulated are the types of pharmaceuticals that can be sold in Israel, from a safety and efficacy perspective. Further controls include which pharmaceuticals and other technologies will be covered via the NHI basic benefits package.

In terms of health care personnel, the requirements for licensure as a physician, nurse, or other health care profession are regulated. There are also requirements for specialty recognition (together with the IMA) through the jointly operated Scientific Council.

Israel has an extensive system of advanced courses for nurses and, in recent years, increasingly more units are requiring nurses interested in filling positions to be graduates of such courses. These requirements do not vary by ownership type.

There are no legal requirements for physicians to participate in continuing medical education courses. However, many of the organizations encourage such participation through mechanisms such as funding the time for participating.

As in other countries, there is a trend in Israel of increasing medical specialization and sub-specialization. Even in primary care, it is difficult for a nonspecialist general practitioner (GP) to find a new job (although the system continues to employ many older GPs, including immigrants from the FSU).

4.1.3 Regulation and governance of the purchasing process

The hospital reimbursement system governs the financial interface between the health plans and other payers. This involves determining both the forms of reimbursement (per diem, DRGs, fee-for-service payments, and so on) for various services and the rates (such as the per diem rate, the rate for various outpatient procedures and so on). The nature of hospital revenue caps are also regulated, as discussed in Subsection The revenue cap, within Section 3.7 Payment mechanisms. Furthermore, there is monitoring and authorization of contracts between hospitals and health plans, which grant the health plans various types of discount, typically in return for a guaranteed volume of activity.

With regard to the health care system, almost all regulation is handled by the national headquarters unit of the Ministry of Health. This contrasts with many of the regulatory activities involving public health, where the policy is developed at the national level, but implementation takes place through regional and district offices.

4.1.4 Regulating quality of care

Monitoring quality of care in hospitals and other facilities

The Ministry of Health licenses and monitors the quality of Israel’s hospitals, outpatient surgery centres, dialysis centres, clinical labs and other key health care facilities.

The licenses granted to hospitals are valid for 1–3 years, depending on the results of the latest inspection. The licences are very detailed. They refer to a specific number of beds, by department, as well as specifying the types of outpatient clinics the hospital is authorized to operate.

In the early 2000s the Ministry of Health’s Quality Assurance Unit began a system of quality inspections of hospitals and other health care facilities (irrespective of whether the facility is run by the Ministry or another provider). The inspections are carried out annually and, in the case of hospitals, involve a large
multidisciplinary team of up to 25 inspectors. The inspections include detailed reviews of a sample of records. Hospitals are forewarned so that they can prepare for the inspections. During this period, three facilities have been closed due to severe and persistent quality problems; many others have been cited as having serious deficiencies which have subsequently been addressed. The Ministry has begun to carry out inspections of the health plans' operations on a district-by-district basis, even though health plans operate under the auspices of the NHI Law, and as such are not licensed by the Ministry of Health.

The Ministry of Health's Department of Health Services Research develops quality monitoring tools with an emphasis on outcomes. Major in-depth studies have been carried out regarding such topics as hospital-acquired infections, coronary bypass operations, ICU care and transplants.

Another Ministry of Health project focuses on antibiotic-resistant infections.

Several Clalit hospitals have been accredited by the Joint Commission and the Ministry of Health is exploring the possibility of working with the Joint Commission on the accreditation of the hospitals that it operates.

Israel's National Blood Bank is operated by the national ambulance service (MDA) and adheres to the highest international safety standards.

**Monitoring quality of care in the community**

The National Quality Measures Program is an exemplary case of how research findings translate into policy decisions and action plans. The programme began as a research project initiated by a team of researchers from Ben Gurion University, in cooperation with all four health plans and funded by the NIHP. During the research stage, a unified standardized measures system was developed, mainly for primary care. This enabled a reliable and ongoing assessment of the quality of care in the community to be established, in accordance with national and international goals. In 2004 the project was adopted by the Ministry of Health and elevated to an operational national programme run by the initiating team, with the sponsorship of the NIHP.

The programme allows routine and dynamic quality assessment of the preventive, diagnostic, therapeutic and rehabilitative services supplied by the health plans. To date, 69 indicators have been developed in six principal medical fields and are regularly measured in the total Israeli population of over 7 million.

This ongoing scientific infrastructure helps with national prioritizing during the policy-making process and induces quality improvement. The information is also available to the general public, inviting them to assess the quality of services in Israel and access them in an informed and responsible way.

The 2008 report of the National Quality Measures Program (Porat, Rabinowitz & Raskin 2008) indicates that, in the wake of the project’s implementation, there have been significant improvements in many of the measures being monitored, including those related to diabetes, cardiovascular disease, asthma, cancer screening, child health, and flu and pneumococcal vaccinations. Moreover, Israel’s performance in terms of most of these measures appears to be good in comparison with that of other countries. Clearly, the health plans have taken the information generated by the project very seriously, and have introduced a variety of administrative and clinical changes that have produced the quality improvements.

At the same time, the project has identified numerous areas in need of improvement. These include the lag time in the availability of key outcome data (such as disease-specific mortality rates), and problems in accessing hospital discharge diagnoses (which are very important for building various registries).

One of the most impressive aspects of the project has been its ability to build and sustain cooperation among the four competing health plans, which need to agree on what areas of health care should be monitored and how performance in these areas should be defined and measured. They also need to adjust their data systems accordingly and submit their performance data to the central project team. There are anecdotal reports that the health plans have been sharing with one another various strategies, regarding not only how to measure, but also how to improve, performance. Cooperation has been built up and sustained through a variety of measures, including: involving health plan leaders in the design of the project from the very first stage; basing all major project decisions on consensus; and maintaining high scientific standards with regard to the choice of measures implemented and the data collection itself.
The project team publishes an annual report with its key findings. At the time of writing, the findings are published by age group and gender, as well as by a proxy for socioeconomic status. Within the next few years, the data are due to be published by region as well, once a methodology has been put in place to control for inter-regional differences in key sociodemographic characteristics. There continue to be differences of opinion on whether, and when, the data should be published by health plan. The arguments against publishing performance results by health plan include concerns that doing so will disrupt the cooperation that has formed the basis of the project and is also one of its greatest achievements. The arguments in favour include the concept that doing so will enable consumers to make more informed choices among health plans and that the resultant market forces will spur the health plans to invest even greater efforts to improve performance.

**Patient safety**

The Quality Assurance Unit of the Ministry of Health periodically checks the extent to which Israeli health care facilities meet various patient safety standards (see earlier). In addition, Israel has begun to explore a cooperative relationship with the Joint Commission to expand and upgrade these activities.

Israel does not have a formal procedure for identifying and reporting medical errors, aside from those which result in deaths in hospitals, or other very severe outcomes. However, patients – with the assistance of the media and personal injury lawyers – do identify and publicize many such cases each year, and the Ministry of Health does follow up on those cases.

### Hospital accreditation

Israel’s two big hospital chains (belonging to the Ministry of Health and Clalit) are working with Joint Commission International on accreditation of their hospitals. Several independent hospitals are also doing so.