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Coping with Health Inequalities: A roadmap for developing a national plan

The Israeli Experience

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Introduction

The reduction of inequalities in health is one of the great challenges confronting the international community in the past decades[1].

As of today, Western countries have accumulated rich experience in tackling disparities in health. Some countries have developed special national programs to reduce the gaps in this area. Much can be learned from international experience in this important sphere. International organizations have contributed to our understanding of the factors that impact health inequalities and to the ways of coping with them. A foremost report in this area was that of the WHO Commission on the Social Determinants of Health (WHO, 2008).

It has to be said, however, that many publications on measures taken around the world to reduce health inequalities describe a range of activities which in many cases ignore the philosophy that stands behind them. They lack the systematic comparative analysis that would allow conclusions to be drawn so as to establish foundations for a national policy.

A previous study (Horev, 2008) attempted to fill in part of this significant gap in our knowledge. The purpose of the study was to illuminate and analyze ways in which selected Western countries have coped so far with disparities in their healthcare systems, learn from their experience and create a framework for establishing a national policy containing specific macro-level levers. To this end, the researcher gathered copious materials that had been published in various countries and by diverse

[1] This study uses the term "inequality" generically to denote a relative and/or absolute disparity among population groups in individual and group states of health and risk factors. It should be emphasized, however, that the international literature also stresses the dimension of inequity, which reflects not only a value principle but also indicators of inequality that are unessential, unjust, and preventable. For more on the differences in definitions, see Whitehead and Dahlgren, 2006, and Kawachi, Subramanian, and Almeida-Filho, 2002.

international organizations. The study described differences among countries in their commitment to tackling health disparities and their strategic approaches in cases when such an explicit strategy exists. The study also presents the range of ways and means that were employed to combat health inequalities, including the choice of target populations, methods of monitoring and selection of indicators and objectives. After analyzing and processing this material, the author developed a model that tried to categorize and group the many disparate, and sometimes scattered, activities that have been undertaken, into a relatively small number of major macro-level levers.

The present study is based on the foundations of the previous one. The current paper will try to present an analytical model that will supply both a theoretical framework and a practical toolbox for governmental authorities to use in developing and implementing policy for tackling inequities in health.

The accepted approach today to reducing health inequalities is based upon social determinants of health (SDH). This framework was re-authorized recently at the World Conference on Social Determinants of Health which was held on October 2011 in Rio-De-Janeiro. The Rio Political Declaration that was adopted by representatives of 125 countries defined the main principles of gap-reduction activities, based mostly on collaboration between different sectors and actors in society.

Because the roots of inequalities of health are in principle socially rooted, it would seem that the focus of intervention needs to be within the relevant social systems such as welfare and education. Nonetheless, it is important not to neglect the contributing role of the health authorities in narrowing health disparities by using the tools it has and which are within its own locus of control. Policies that are located within the scope of responsibilities of the national health authorities include those which need cooperation with other national level authorities.

Based on the aforementioned foundations, the present study suggests a possible roadmap that can be used by the national health authority for establishing a strategic policy or an action

plan for combating health inequalities. A discussion regarding the various junctions on this roadmap and examples of how Israel has acted in forming its national policy are presented in the current paper as well.

Israel has not as yet accrued long-term experience in combating disparities in its healthcare system. Therefore, we humbly present our views and experiences and hope they will serve as a contribution to the body of knowledge that already exists in this field.

We also hope that this work will contribute to other members of the OECD in the struggle each faces against the expanding disparities in health. We hope it will facilitate, in countries that are still finding their way, the construction of a unique policy that will fit each one's characteristics and beliefs, and narrow socioeconomic inequality generally and health inequality in particular, for the welfare of members of the international community.

The Nexus of Socioeconomic Inequality and Health Inequality

The scholarly literature has been documenting health inequality for quite some time.[2] Back in 1978, the World Health Organization declared that health inequality between people in developed countries and those in developing countries, as well as among population groups within one country, is politically, socially and economically unacceptable (WHO, 1978). The declaration emphasized that health is a basic human right and that governments are responsible for the health of their populations. The implementation of this responsibility hinges, among other things, on the delivery of adequate healthcare and welfare services to all population groups. In 1986, the World Health Organization issued the Ottawa Charter (WHO, 1986), which called for action against health inequality. Pursuant to this appeal, many countries began to develop policies to tackle the problem. Subsequently, the WHO reemphasized this cause when its European Union released a statement concerning the recognition of health equality as one of the most basic values of health policy. Action against health inequality was one of twenty-one objectives set forth at the 51st World Health Assembly (WHO, 1998).

The cause acquired further momentum in the Treaty of Lisbon (EU, 2007), in which the member states of the European Union declared their resolve to fight the various manifestations of poverty and social exclusion on the basis of principles formulated in the Amsterdam Treaty (EU, 1997).[3] Subsequent documents defined the existing health disparities in the various European Union countries as a problem in need of attention and

[2] An example may be seen in a British report from the nineteenth century: Chadwick, 1842. See also an example of a debate that has taken place since the nineteenth century concerning the relationship between health and social issues: Hamlin, 1995.

[3] This treaty, to which the European Union countries are party, addresses a range of matters including public health. First formulated in 1997, it has gone through several updates (e.g. Nice, 2001).

stressed the preference that should be given to tackling health inequality within the framework of national programs (European Commission, 2008).

In 2008, a WHO committee published a report containing findings that constitute a milestone in stressing the effects of social factors on health disparities (WHO, 2008).

Another recent WHO initiative was the Rio Political Declaration on Social Determinants of Health that was adopted during the World Conference on Social Determinants of Health on 21 October 2011 in Brazil (WHO, 2011). The declaration expresses global political commitment to the implementation of a social-determinants-of-health approach to reduce health inequities and to achieve other global priorities. Its intention was to build momentum within countries for the development of dedicated national action plans and strategies.

Section 13 of that declaration calls "To further reorient the health sector towards reducing health inequities". That includes, among others steps, initiatives such as: to promote changes within the health sector, as appropriate; to provide the capacities and tools to act to reduce health inequities including through collaborative action; to integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programs; and to exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities".

As stated before, the purpose of the present paper is to share the Israeli experience and way of thinking. We hope to illustrate these by presenting a possible 'road map' that might assist a national health authority to find a way to construct its own unique strategy and policy. The main emphasis in this paper is to present specific policy tools that are under the purview of the health authorities which can be used in the struggle to narrow disparities in population health and in the healthcare system

Developing a national policy and action plan: Steps along the roadmap - The Israeli Way

Many countries, though differentiated by the extent of government involvement in their healthcare systems, have decided to act against health disparities for moral, social and economic reasons. The path to the attainment of their mutual goal differs from one country to the next as a function of social worldview. Some countries adopted tools and actions that lie outside the control of their healthcare systems, such as encouraging employment and education and changing the tax system in the belief that appropriate policies in these areas will reduce inequalities in health. Other countries chose to include their healthcare systems within the purview of their actions to narrow socio-economic disparities.

Many countries are already following clear and defined courses of action against health inequalities; others are still finding their way. In Israel**,** as in other countries, each with its unique societal values, political structure, socio-cultural characteristics and structure of the healthcare system, it was inappropriate to adopt another country's modus operandi *en bloc*, however successful this model may be. For that reason, a process has been initiated, led by the country's national health authority (the Ministry of Health or MOH), to develop and implement its own unique strategy for the mitigation of health disparities. The process considered the special characteristics of the Israeli healthcare system, but at the same time, was anchored in the cumulative experience and lessons learned from other countries. Its first step was to decide whether or not the government, through the MOH, should intervene in the health care market to 'correct' an undesirable social situation and if so, how.

1. Coping with inequality in health as one of the seven strategic goals of the Israeli Ministry of Health: the process

Although a first draft of a ministerial action plan to narrow disparities in health was presented already in 2009 (MOH, 2009), and partial implementation had already begun by then, it was not until the second half of 2010 that a comprehensive strategic policy planning process took place in the MOH. The process involved a preliminary study to evaluate attitudes of senior policy-makers in and outside the healthcare system, senior managers of the larger health organizations in Israel and various stakeholders and opinion leaders, on issues such as their perception regarding the role the MOH should play and what priority should be accorded to narrowing disparities. The Director General, along with senior managers of the MOH, participated in a two-day seminar during which seven principal goals for the years 2011-2014 were chosen (the "seven pillars of fire"). The first one was strengthening the public health sector and the second was eliminating health disparities. Other strategic goals were related to issues such as quality of care, public health and responsiveness of the MOH etc. (MOH, 2010a)

Based on these goals, The Health Economics and Insurance Division built an action plan for the MOH to narrow health disparities. The plan was evaluated and prioritized by senior colleagues in the ministry and was approved by the Director General of the Ministry. The result was an integrated policy that incorporates the responsibilities of all relevant divisions in the MOH to achieve maximum cooperation and commitment, which are necessary for implementation (a summary of the strategy is presented in Appendix A).

2. Steps on the road to establishing a national strategy and action plan

During the above mentioned process, a roadmap with decision-making stations was drawn up, on the basis of which a national strategy and action plan[4] have been developed in Israel. The current paper will present and describe these stations regarding which decision makers might want to take an *ab initio* stance, when preparing a national policy.

The presentation of the proposed path of decisions will be followed by a brief discussion regarding each of the choices to be made at each junction. In some cases, selected examples of Israel decisions and policy steps will be presented in order to illustrate possible solutions which fit the Israeli environment. (For a brief description of Israel's healthcare system and better understanding of the context of the Israeli steps see Appendix B).

Given the differences between countries in areas such as the structure and values that serve as the basis of their healthcare systems, it is our contention that each country will respond differently at the various proposed decision-making stations. The result should be a unique model that fits the needs and social values of the country. We hope that working with this roadmap will be of help to countries that are trying to develop an initial plan for narrowing health inequalities as well as for those reevaluating an existing one.

Following is an outline of the issues that might be raised at the relevant junctions on the roadmap to establishing a national action plan for combating health inequalities. Following that is a more in-depth discussion of these considerations and steps.

[4] In this paper, the concept of a national action plan and strategy includes the totality of written plans and strategic decisions that were taken by the MOH during the past two years and which have bearing on the struggle to reduce inequalities.

3. Considerations and decisions to be taken at the various junctions on the roadmap

A. Mapping the problem

1) Describe the extent of inequalities in health and whether they are acknowledged as a national problem

B. Strategic Decisions

1) Explore the level of commitment of actors and decision makers
2) Choose which strategic approach should be taken
3) Define the extent of acceptable government intervention in the healthcare system
4) Decide who will lead the action plan and what will be the role of the national health authority
5) Identify modes of strategic cooperation
6) Decide whether quantitative goals should be employed

C. Process and Methods

1) Define the target populations
2) Identify the main barriers to access (e.g. economic and cultural) and identify infrastructural imbalances
3) Analyze current incentives for desired behaviors of insurers (e.g. HMO's), providers and population groups
4) Consider who should be the agents of change and what incentives they should be offered
5) Determine the kind of assistance that national authorities can give each group of agents
6) Set goals and their method of measurement
7) Address information availability and transparency and IT systems
8) Identify methods to empower underserved populations
9) Choose the main entry points in the struggle to narrow gaps

D. Means

1) Determine the various means to reach goals such as structural changes, legislative changes, incentives and other regulatory tools
2) Define the budget and the sources of funding

E. Monitoring

1) Determine which follow-up indicators will be chosen and who will do the monitoring
2) Decide how the responsibilities for implementation will be shared and define a timetable
3) Prepare for implementation

F. Implementation

1) Adopt an implementation plan and a time schedule
2) Stick to the plan and timetable
3) Monitor progress and activities
4) Upgrade and correct the plan according to interim results and lessons learned
5) Report continually to the highest authority and to the public

Considerations and decisions: in-depth exploration

The discussion that follows elaborates upon the main issues that were raised with regards to decision-making junctions on the road to building an equitable health care system. Examples from the Israeli healthcare system will be given throughout this discussion in order to demonstrate the way a country might use this roadmap in its attempt to build a national policy.

A. Mapping the problem

"If you don't know where your destination is, each path will take you there (Alice in Wonderland)".

Mapping the problem should be the first step in trying to define goals and establish a national action plan. Sometimes missing data or the lack of ability to collect and analyze data on the national and local level are characteristics of an existing health system. In that case one should start with the existing data, with all of its limitations and include building a database as one of the highest priorities of its action plan.

The Israeli healthcare system lacks a solid base of data that would enable the preparation of long term goals for narrowing disparities in terms of health outcomes. Some of the data are missing and other data are anecdotal and without consistent methodology. For that reason the MOH included establishing the necessary data base as one of its first missions. It engaged a professional research institute (the Gertner Institute in Tel Ha'Shomer) as an out-sourced supplier for building and maintaining this database. Meanwhile, an initial action plan has been established and implemented based on existing data.

B. Strategic Decisions

1) Commitment

Acknowledgement, on the governmental level, of inequalities in health is a vital starting point for policy making on the reduction of health gaps and for establishing goals and action plans that will incorporate all actors inside and outside the healthcare system. The higher the level in the governmental hierarchy that expresses its obligation for coping with the problem, the wider will be the co-operation and commitment of ministries and organizations. However, sometimes a conflict exists within governments between the desires to cope with social problems and yet not to deviate from the 'right' extent of governmental involvement in the 'market'. Resolutions of this question cannot come from outside sources. It can only be resolved through an internal debate and the creation of a vector of political will that reflects the relative strength of each of the stakeholders in the cabinet and Parliament. This will result in the adoption by the government of a policy that specifies the areas that are considered justified for governmental intervention in the health market.

In Israel, following publication of extensive research findings that pointed to persistent gaps in numerous health indicators between sub-population groups, as well as inequalities in accessibility and availability of health services in peripheral regions of the country (Epstein et al. 2006, Epstein and Horev 2007), the issue of inequality in the health sector became one of the main objects of public and official discussion. In 2008 the President of Israel (Shimon Peres) established a task force to recommend ways to close social gaps in Israel, including in the health sector[5]. Recommendations were presented to him on September 2009 (Taub, Report of the President Workforce 2008).

[5] The main author of this work coordinated the entire project, and coauthored several chapters of the final report.

Recognition on the official level of inequalities in health was made by the MOH toward the second half of 2009. In 2010 the ministry published a statement in which it declared its obligation to deal with inequalities in health by including their reduction in the list of perennial targets of the MOH. A special unit was established in the MOH and a strategy was formulated for reducing inequalities in health. This was initially developed in the newly established Unit for Reducing Inequalities in Health in the Health Economics and Insurance Division in the MOH. During the end of 2010 the above mentioned process of selecting the MOH goals for the years 2011-2014 took place, in which the goal of narrowing health disparities was elected second among the seven goals. After it was approved by the Prime Minister (PM), the MOH plan to narrow health disparities was included in the annual Government Working Plan for 2011. The plan was presented both as part of the annual MOH working plan and as part of a governmental goal to narrow social disparities and cope with inequalities between geographical regions. The working plan specified several areas for intervention (e.g. expanding and upgrading the health workforce in peripheral areas; tightening up regulation of the private sector, among other things[6]).

2) Choosing the strategic approach

From the lessons that we have learned from other countries, it would seem that decision makers should decide to invest primarily in issues that make the highest impact on the root causes of health disparities. This might be accomplished through inter-ministerial coordination and by cooperation with players outside the healthcare system (from fields such as education, employment and social services) to narrow social gaps and prevent expanding social disparities that influence health disparities ("*upstream approach*"). Another possibility is focusing on activities within the 'locus of

[6] Although the National Health Insurance Law guaranteed universal coverage for 100% of the population (with no possibility to opt out), the private health sector and the share of private expenditure as a percent of total national expenditure on health is relatively high and growing. The concern is that it will affect the foundations of the public sector and will increase gaps between population groups.

control' of the national health authorities. This includes investment in health care infrastructures and in creating incentives that may influence healthcare processes that encourage investment in underserved populations ("*midstream approach"*). A third approach is to operate at the point of service and on the community level in areas where wide social disparities already exist, in an attempt to affect health outcomes and health behaviors of target populations, either by individual or group intervention plans (*"downstream approach"*).

The confrontation with health disparities in Israel has been recognized as one which should be based on an approach which addresses all segments of the "stream". In Israel, a decision was taken to act within the "upstream" approach, as for example, in the government's decision to institute a national plan (enacted as a cooperation of several ministries) for an active and healthy lifestyle (as will be discussed later in this paper). However, given the limited control the MOH has on policy outside its scope, it decided to limit its "upstream" involvement to a select number of actions that seek to narrow gaps in areas other than health and keep its main focus on impacting its own territory and increasing its involvement in areas under its own purview ("a midstream" approach). This includes ensuring the availability of critical healthcare-service infrastructures in peripheral areas; eliminating barriers that impede access to services among weak population groups, developing a set of incentives and imparting tools that will enable 'agents of change' to combat health disparities among target groups and establishing the necessary national database. The ministry also decided to expand its own intervention plans at a community level among weak populations and in the periphery and to encourage activities by the sick funds and local authorities that are aimed at impacting an individual's or community's health behaviors (a "downstream" component).

3) The acceptable extent of governmental intervention in the healthcare system

Due to a 'market failure' that exists in healthcare systems, all countries acknowledge the necessity for governments to intervene in the healthcare market. However, given differences in social values, macro-economic principles and health-systems' structures, countries differ greatly in their attitude towards the question of the 'right' extent of governmental involvement in the healthcare system.

From the perspective of both funding and delivery of health services, the public-private mix is one of the major sub-issues of the above question which might greatly affect inequalities in the healthcare system. A reevaluation of the current status of this mix is one of the first strategic decisions that might be considered. What is the share of private funding of the national expenditure on health and what are the principal components of this kind of funding? It is recommended that planners relate both to data on private funding as a whole and specifically to copayments for health services that are included in the public 'basket of services'. What is the effect of the public/private mix and the business sector on the public health services? What are the current trends in terms of this mix? Is it acceptable to have a relatively weak public healthcare system and a strong private one? How much room should be allowed for the growth of for-profit health organizations and health insurance companies? Does the existing situation (or expected future trends) call for intervention?

Some countries will see regulations such as those that are aimed at limiting the growth of the private health sector and private household spending, as legitimate steps towards strengthening the public sector and promoting equality in the healthcare system. Others will consider them as illegitimate interventions that might conflict with other values, such as free competition and freedom of choice.
In 2010 private funding reached 37% of Israel's national health expenditure. The penetration rate of supplementary health insurance provided by the sick funds reached three

quarters of the population. The penetration rate for private long-term care insurance reached 65% of the population and the rate for other types of supplemental private health insurance has exceeded 30% and is still growing. In recent years, there has also been significant growth in the number of private hospital beds, and private expenditure, as a percent of total health expenditure, reached 38%. In its national strategy, the MOH in Israel made a decision to strengthen the public healthcare system and tighten up regulations on the private sector, in order to slow down the growth of the private sector and decrease private spending. Some examples include its decision to be more active in its attempts to decrease spending on private health insurance; to regulate more extensively supplemental health insurance sold by the sick funds; to decrease sick funds' expenditures on services they buy from private hospitals; to limit the growth of private hospital beds; and to reduce the rate of household expenditure for health services.

4) Leadership and the role of the national health authority

Even though other social systems and factors do contribute to the development of health inequality, there is a consensus in the current professional literature about the role of healthcare systems and health professionals in the creation of inequality in health-related fields, and about their role in narrowing such gaps as already exist (WHO, 2011; Wanless, 2003; Whitehead, 1998). The elimination of economic and cultural barriers that impede access to healthcare services is only one example of the many possible interventions against disparities that fall within the healthcare system's purview (Gelormino, 2007). However, the conventional view has it that while an intervention confined exclusively to the healthcare system may have a salutary effect and is indispensable in some fields, its effect on inequality is limited in scope (WHO, 2011; WHO, 2008; Mackenbachet al., 2007).

Based on this, one possible suggestion is that the national health authorities focus on channels of intervention that correspond to the integrated strategic approach (upstream and midstream) presented above, with emphasis on the following:

a) ***Awareness and commitment:***

(1) Active involvement of the national health authority in maintaining awareness at the highest decision-making echelon of the importance of narrowing social gaps, and the high priority that should be given to this struggle. The health authority should emphasize the relationship between social disparities and health disparities and the need for a national endeavor to tackle them. It is recommended that the health authority leader should present the government with an annual update on progress in this arena.

(2) An assessment of the expected impact of each governmental decision on social gaps in general and health disparities in particular.

(3) Active participation in preparing a national action plan for the promotion of a multi-sectoral and multidisciplinary public policy. This should be reflected, among other things, in the setting by relevant departments, of quantitative targets to reduce social disparities and/or by taking the lead in promoting national policy in multi-sectoral areas (e.g. joint projects between the health and welfare authorities).

b) ***Availability, access, and incentives:***

(1) Enhancing access to healthcare services for target populations and eliminating structural and process barriers in the healthcare system, with reference both to economic and cultural barriers; and equipping healthcare-system workers with tools for the bridging of

language and cultural gaps, as explained in detail below.

(2) Improving the availability of physical infrastructures for critical healthcare services and of medical and paramedical staff in peripheral areas (including mapping of critical infrastructures, setting standards and establishing minimum thresholds and actions to correct deficiencies).

(3) Revision of the incentives to address health-endangering behaviors among members of weak groups, in cooperation with them and with municipal social-service and education officials, in a manner that is tailored to the specific needs of each geographic area.

Regarding raising the awareness of senior decision makers in the government and parliament (as in Section 1 above), the MOH in Israel publishes an annual review of the many aspects of health disparities (Averbuch, Kaidar and Horev 2010). It organizes an annual conference entitled 'The Israeli Healthcare System Copes with Inequality' and tries to keep the issue of health inequalities on the public agenda. An example for section (1) (c) is a national multi-ministry initiative for a healthy and active lifestyle. These initiatives and others that are concerned with section 2 will be discussed later in this paper.

It should be emphasized that finding a way to achieve a substantial impact of each governmental decision on social gaps in general and health disparities in particular (mentioned in section (1) (b)) is still a challenge in the Israeli system.

5) Strategic cooperation

Just as the key to successful treatment of socioeconomic disparities lies in cooperation among various government offices, so it is in regard to health disparities. A crucial part of a national plan should involve mapping potential areas of cooperation (horizontal and vertical) inside and outside the healthcare system.

In the term "horizontal cooperation", we imply cooperation among various government offices such as the Ministries of Finance, Health, Social Affairs, Education, and Employment. It is recommended that the national plan will define the central role of the national health authority and its intentions to establish strategic cooperation with other government offices in order to find partners for joint ventures that may affect the health of weak population groups. The plan should emphasize areas of possible vertical cooperation between the MOH and lower levels of organization in the hierarchy, such as sick funds and municipal authorities, in order to promote and assist in their actions that seek to narrow disparities.
The plan should strive for cooperation but at the same time uphold the ability of the MOH to define the extent of autonomy that would be given to the health organizations in carrying out their goals and action plans that are aimed at coping with health disparities.

Examples of possible areas of national and regional cooperation:

a) Active participation in preparing a national action plan for the promotion of a multidisciplinary public policy reflected, among other things, in the setting of quantitative targets for the relevant offices.

b) Broader cooperation with additional government offices, including the Ministry of Education and the local authorities; joint initiatives for the advancement of health; and expansion of multidisciplinary activities, with emphasis on the population of children.

c) Cooperation with other social ministries to enhance the ability of health organizations to identify weak populations and treat families and individuals through a multi-disciplinary approach (e.g. cooperation among social workers, educators and health workers).

d) Active involvement of the national health department with other departments in developing workplace medicine, as explained in greater detail below; encouraging labor-force participation among target population groups and developing employment and educational opportunities for persons with illness or disabilities.[7]

e) Interventions designed to influence the health implications of the work environment constitute an example of a possible model of strategic cooperation among the departments of health and labor and the healthcare organizations. Meaningful intervention in this field may lend the concept of "workplace medicine" a broader meaning than it has had thus far. The focal point of such an intervention program should relate to the organizational culture of the workplace so as to identify jobs that meet the definition of "high demand–low control" or "high cost–low gain". Workers in these jobs may require closer supervision by a workplace physician or other relevant medical professional in order to provide them with tools to cope with job-related stress. The intervention could also identify occupations that should be monitored by a professional in order to correct poor posture and other physical risk factors associated with the nature of the work.[8]

[7] Notably, the link between social disparities and health disparities act in both directions – social disparities affect health but faulty health exacerbates disparities. Therefore, there is room within the framework of the intervention programs to focus on the prevention of chronic morbidity as well as on rehabilitation of the disabled. This focus may help bring weak population groups into the labor force and thus help to narrow social disparities.

[8] As a first stage, a pilot program may be carried out with one of the large employers.

> Concurrently, it is recommended to place stronger emphasis on the need to raise primary care physicians' awareness of the importance of employment aspects of health, in the broad sense of the term--with an emphasis on occupations typically practiced by weak population groups.

In Israel, a governmental resolution (Government of Israel, 2011) recently approved a national multi-ministerial action-plan that encourages a healthy and active lifestyle, with a 180 million NIS budget for this purpose. The action-plan is being led by the MOH, the Ministry of Education and the Ministry of Culture and Sport. It will involve in its implementation another six Ministries (e.g. Finance and Internal Affairs) and have built-in incentives to invest in peripheral regions.

A regional cooperation program was established as a pilot in 2011, between the MOH and eight Israeli-Arab local authorities, with involvement of an NGO advocacy organization as a facilitator, to encourage health intervention plans and strengthen the health sector in those municipalities.

A 'round table' has been established in the MOH with representatives of voluntary NGOs to discuss a broad range of issues related to health inequalities.

Another new forum of high-level managers from different health organizations and insurers has been established by the MOH within the framework of an annual convention on inequality in the healthcare system. Its goal is to tighten up inter-organizational cooperation and to share and discuss successes and challenges in tackling inequalities in health. The forum includes representatives of the MOH, the sick funds, hospitals and local authorities. It seeks to strengthen vertical co-operation and establish a process of mutual learning, strengthen the commitment of organizations' senior managerial teams, encourage constructive competition and increase the effectiveness of the struggle to narrow health disparities.

6) Setting quantitative goals

A previous study (Horev, 2008) showed that different countries adopt different approaches to the question of setting goals. Some countries set quantitative goals; others deliberately chose to set non-quantitative goals while some did not set any goals at all. Apart from the administrative advantages, setting a quantitative goal might be meaningful for bringing about a consensus among the various players for coping with health disparities. A national strategy for narrowing gaps in the healthcare system should not ignore the process of selecting its goals. The goals, of course, must be rational and reasonably attainable. Irrational goals may discourage those involved in the effort, and induce frustration among health organizations' executives and decision-makers. Most of the countries that chose to establish quantitative goals, chose but one or two in the domains of mortality (relating to main causes of death or avoidable death rates), morbidity (relating to chronic morbidity from conditions that cause disability and/or that affect the quality of life of a large share of the population), and health-endangering behaviors. In some cases, a list of interim indicators was chosen; they should be linked to the main goals and monitored regularly for early detection of obstacles that may interfere with the attainment of the main goals.

As mentioned earlier, both the limitations of the current Israeli database and the fact that Israel's efforts to narrow health disparities are only in their initial stages, have prevented the establishment of short-term quantitative goals for health outcome indicators. An expert committee has been established by the MOH that will discuss and offer its recommendations for long term goals. In the meantime, quantitative goals were chosen using short- and medium-term structure and process indicators (such as workforce distribution, eliminating copayments for essential health services etc.).

Below are examples of quantitative targets that meet the above mentioned descriptions. These quantitative targets were presented in a draft to be discussed by the Expert Committee for Reducing Health Inequalities in Israel[9]: (1) narrowing by 15 percent the disparities in infant mortality between target populations and the countrywide average, by 2025[10]; (2) narrowing by 15 percent the disparities in mortality from cardiovascular conditions before age 75 between low-income persons and the population-wide average[11]; (3) narrowing by 10 percent the current disparity in rates of diabetes between low-income persons and the population-wide average (and the same in regard to the control of diabetes among those already diagnosed); (4) narrowing by 20 percent the current disparity in smoking rates between target populations and the countrywide average; (6) narrowing by 20 percent the disparity in obesity rates between low-income persons and the population-wide average.

[9] As mentioned, short term quantitative process goals have been defined. The above mentioned goals are still under discussion in the expert committee that has been established for this purpose.

[10] The point of departure should be defined as the disparity in infant mortality (and the other targets) that was measured in 2008 among the relevant population groups.

[11] The information would be based on a dispensation given to the health funds to gather information from their members, or on information that the National Insurance Institute already shares with them.

C. Process and Methods

Defining the modus operandi to be employed requires prior decisions on issues such as who the target populations should be, what are the main barriers for them to acquire proper health services and how the designated means should be implemented to address such issues.

1) The target population

Prior to defining the target population, a decision should be made as to whether in the struggle for increasing equality the goal is to affect the entire social gradient, or rather to improve the situation of specific target groups.

The implementation of a public policy that would benefit all population groups is advantageous from the standpoint of social solidarity. In such cases, people of medium and high income would feel that a large share of the taxes they pay is returned to them in the form of social services that they and their families may enjoy. This feeling is absent when the benefit is limited to low income deciles. It is true that, according to the principle of declining marginal utility, the utilities of a comprehensive policy with uniform benefits gravitate mainly to weak population groups because it is precisely among them that the chance of meaningful improvement resides. However, a policy geared to the entire population usually entails a larger allocation of public resources and bumps up against budget constraints. Accordingly, despite the drawbacks, the best course in a situation of budgetary limitations is to focus largely on weak population groups and to use macro-social policy tools such as legislation and incentives that will facilitate meaningful health promotion among members of these groups without prejudicing the situation of other groups.

In Israel, the national plan for reducing health inequalities includes both options. As mentioned earlier, it invests in interventions for the whole gradient but at the same time it also defines specific target populations upon which focused

interventions should be made. Two main weak populations have been chosen either by criteria of socio-economic status (using a proxy measure) or by 'geographic location' on the basis of the periphery index defined by the CBS (Israel Central Bureau of Statistics, 2008)[12]. This approach avoids legal barriers that forbid collecting data regarding income and education and make it possible to combine latitudinal intervention programs for socio-economically weak population groups wherever they live (in peripheral areas or in the center of the country), with other programs focusing on populations in a target peripheral location.

2) Main barriers to equitable accessibility for healthcare services:

a) ***Economic barriers*** – Significant economic barriers could include copayments for medications and services provided by the public healthcare system, or essential services that are not included in the basic basket of services that are publicly funded. Examples of other economic barriers include travelling costs and working hours lost, in cases where essential services are not sufficiently available.

Even though copayments have an important role in preventing over-utilization of health services and in cost containment, this kind of payment is regarded as a regressive one that can have a counter-effect on the health of low socio-economic groups. Therefore, countries are examining ways and mechanisms to protect weak groups from the negative impacts of copayments (e.g. exemptions, discounts, ceilings).

[12] The CBS publishes two different scales on local authorities; the first relates to the geographic location of the authority (five levels, from very peripheral to very central). The second uses a combined index that reflects the socio-economic status of the municipality (as well as of specific neighborhoods). The Israeli target populations include people who live in local authorities that are included in either the first two levels of the peripherality scale ('peripheral' and 'very peripheral'), or in the lowest four socio-economic groups on the latter scale.

Decisions should be made not only regarding which groups to protect but also regarding the kind of services for which to impose user-charges (e.g. prevention vs. other or according to the extent of the elasticity of demand).

It should be emphasized that in many cases these kinds of steps are controversial because of their possible impact on the incentive that people may have to join the labor market.

In Israel the national plan includes both the expansion of the number of groups that are exempt from payments or are eligible for discounts (e.g. medications for the elderly population) and also refers to the negative effect of copayments on the consumption of preventive services, especially among vulnerable populations (e.g. child and maternity care). It also includes expansion of the list of services that are included in the basic basket of services under the NHIL (National Health Insurance Law) and are publicly funded (e.g. dentistry for children), changing the way the reference price of medication is calculated and establishing two levels of copayments for a medication group (generic and patent drugs)[13]. All these steps have already been implemented in Israel. As for further expansion of discounts and exemptions from copayments which the plan has set as a long term goal, that is still one of the issues on which agreement with the Ministry of Finance has not yet been achieved.

[13] Establish different rates of copayment for patent drugs (15% of the citation price) and generic drugs (10% of the price).

b) ***Cultural barriers*** – countries differ in the heterogeneity and demographic characteristics of their populations. The more diversity exists in terms of the cultural background of population sub-groups, the more chances there are for the existence of cultural barriers that prevent certain subgroups from gaining adequate accessibility to essential healthcare services.

One of the decisions that should be made upon establishing a national policy and action plan is whether or not to set a binding standard for all healthcare organizations, requiring them to tailor their services and intervention programs as well as health-promotion information to the culture and language of the population in localities that are typified by cultural variance. Another decision is whether or not to require large service providers (e.g., sick funds and hospitals) to provide translation services, especially at clinics or hospitals that serve population groups of specific ethnic origin. A failure to establish norms in these matters might pose a significant barrier to caregiver-patient communication, prejudice the likelihood of successful medical care for the individual, and reduce the chances of success for health-promotion and intervention programs that address weak population groups.

Another aspect of a national plan should refer to the possibility of instituting courses and workshops on dealing with cultural variance as part of the training of all health professionals and having healthcare workers take part in these activities regularly.

Over the past century, Jews have immigrated to Israel from all over the world. In addition, approximately 20 percent of Israeli citizens are Israeli-Arabs. It is estimated that in Israel 33

languages are in use by Israeli citizens[14]. Under the framework of the Israeli plan, a directive of the Director General of the MOH was recently distributed among all health organizations in Israel (sick funds, hospitals etc.). It provides standards and norms that are expected to be implemented in the healthcare delivery system regarding translation services (four main languages) as well as other instruments to bridge cultural differences in the healthcare system with specific emphasis on patient-provider interactions (Appendix C). All major healthcare organizations were required to submit their plans for how they are going to implement the new standards and were asked to complete their preparations for full implementation by the beginning of 2013. Various organizations in the healthcare system have increased their activities in the translation of written materials (health promotion, patients' rights etc.) and in the training of cultural mediators and translators. Some of the sick funds have already initiated, on a pilot basis, call-centers with translation services to assist in bridging language barriers during health professional-patient contacts. The service is currently offered in several places in Amharic, Arabic and Russian. The ministry has prepared a circular with specific standards for such services. Steps for reducing cultural barriers are also being explored in the course of oversight visits to community sick fund clinics.

Starting in 2012, cultural competence (evaluated by a tool developed by the MOH) will be one of the issues that will be examined in the process of hospital accreditations in Israel. A reservoir of translated forms, primarily to be used in hospitals, is also being prepared.

[14] http://www.ethnologue.com/show_country.asp?name=IL

c) ***Infrastructural imbalances*** - A national action plan should also address imbalances in infrastructure which reveal impaired accessibility to healthcare services of weak populations and those who live in remote areas.

Such an evaluation might assess the availability of clinics in the community, the primary care workforce, as well as the secondary/referral system, hospital beds and emergency units: mapping their distribution in different areas of the country is an essential step.

It must be remembered, however, that in trying to reduce disparities, it would be inadvisable to necessarily strive for identical rates in each population. For example, higher rates of physicians -to -population in one area might reflect surplus physicians or higher needs for medical care and thus should not be necessarily replicated in another area. It is important to take into account the characteristics and needs of each region instead of striving for uniform rates between different regions of the country.

In Israel an expert committee appointed by the MOH mapped needs related to the distribution of physicians, nurses and beds. Under the current national plan, attempts are being made through the use of various incentives, to attract medical professionals to peripheral areas of the country.

An inter-ministerial expert committee has been established (on the initiative of the MOH) to explore effective incentives to attract health professionals to the periphery and to health specialty fields that are in short supply there, to suggest possible changes in wage and benefits policies for healthcare workers and to assess their likely effectiveness. The committee was chaired by a representative of the MOH and included several

representatives from different divisions of the Ministry of Finance and from the Prime Minister's Office. Many senior managers from a variety of health organizations and experts presented their experienced-based reports to the committee. The committee formulated its recommendations at the end of 2010 (MOH, 2010).

In early 2011 a physician strike and a labor dispute between the Israeli Medical Association and the Israeli Government broke out. After a long crisis in the public health sector a new agreement was signed, which included substantial incentives to physicians who are employed in peripheral areas (IMA, 2011). It is important to note that during the lengthy bargaining process the government representatives used the knowledge and data that was accumulated in the aforementioned committee. Salary increases will be implemented gradually so that by August 2013 physicians in peripheral areas will receive an increase of up to 25% in their salary compared to their colleagues who work in other parts of the country. Additionally, 37.5 million NIS in one-time grants will be distributed to residents and young specialists who commit to studying or working in a hospital or community in a peripheral region.

Special efforts have also been made to attract nurses to work in Israel's southern region. A first and modest attempt was not successful; a second one with increased grants and a successful campaign yielded positive results and all the nursing positions in the south were filled.

3) Incentives in the healthcare system

a) *Mapping the existing incentives and selecting which incentives might be used*

Well-planned incentives can make the difference between a health system that is organized effectively to cope with disparities and a health system that is full of good intentions but lacks the ability to implement its national plan. Many times incentives exist in healthcare systems unintentionally. For example, incentives can be manifested in the way funds are allocated among insurers which encourage them to 'cream skim'; they can be embedded in the way providers are remunerated and which encourage them to discriminate against certain patient groups; or they can be transmitted via copayments paid by insured parties that direct them to specific services. The latter may have negative effects on the accessibility of low socio-economic groups to important services or medications.

The developers of a national plan might consider including economic incentives as well as non-economic incentives. Setting specific quantitative goals for each organization and rewarding them for achieving these goals may serve as incentives for change in the desired direction and encourage the organizations to continue their gap reducing activities.

Examples of possible incentives follow.

Pay-for-performance in terms of outcomes (or even outputs) related to interventions might be considered. However, it should be emphasized that even in cases where budget constraints prevent allocations for this purpose, just setting the goals

and periodically publishing comparative results can in itself provide a strong incentive for action.

Another example of a non-economic incentive might be inspection visits and regular audit reports for organizations and clinics that include evaluations based on a set of indicators. The indicators might test activities in different areas such as the extent of outreach that the organization performs for health promotion in weak communities, or the extent of its investment in prevention, with special emphasis on health services in spearheading localities and the extent of empowerment they give to low SES groups. This set of indicators would affect the score that the clinic would receive in the audit report. By adjusting the scale used to assess the clinics and by performing audits at relatively high frequency in these specific localities, the organization may be encouraged to act in the desired direction, whether or not the results are made public.

There is a good chance that implementation of even a well-defined national policy would fail if the wrong incentives exist in the healthcare system. It should be emphasized that many times incentives have multiple targets as well as multiple consequences; therefore decision-makers have to consider all potential effects before changing incentives.

A discussion of all types of incentives in healthcare systems is beyond the scope of this work. However, decision makers should consider several groups of incentives in different aspects of the healthcare system: economic as well as non-economic incentives; incentives directed at insurers v. health providers v. consumers.

In Israel, a multi-dimensional system of incentives has been established to improve the ability to cope

successfully with health disparities. Regarding the allocation of resources between insurers (sick funds), in an attempt to encourage investment in remote areas and avoid cream skimming, a decision has been made by the MOH and the MOF to change the formula for budget allocation among sick funds (the "capitation formula"). Until recently only the age distribution of members in each health fund was considered. It was replaced by a formula that also considers the distance from the member's place of residence to highly populated urban centers. This step should contribute to the prevention of geographically-based cream skimming of populations and should encourage investments by the sick funds in the peripheral regions. It was accompanied by an additional allocation of 150 million NIS to the Health Insurance Law implementation budget.

The above mentioned prospective type of payment has been accompanied by a retrospective incentive. In the first stage, the retrospective incentive is to be applied for the next 3 years; during this period, a sum of 16.5 million NIS will be allocated annually to sick funds on a 'pay-for- performance' basis. Only sick funds that will annually prove that they comply with several indicators that reflect investment in infrastructures in remote areas and health promotion initiatives among underserved groups will be granted the money.

Other possible economic incentives are patient-level incentives to impact utilization behavior, including canceling copayments on specific preventive services to encourage their consumption.

One example of a non-economic incentive is comparing the activities and achievements in narrowing gaps among sick funds, through an annual report and an annual conference entitled 'The Israeli healthcare system copes with inequality". As

described earlier, it is led by the MOH, in cooperation with senior managers from the main public providers of health care services (sick funds, hospitals, municipalities etc.). This is an annual conference led by the MOH with participation of 200 top-level representatives from the Israeli healthcare system, the Ministry of Finance and other regulatory authorities, public organizations and academia. In this context, the main goals of this conference are: to discuss national policy and action plans that will enhance the system's ability to cope with health disparities; to achieve maximum agreement on the main targets; to map areas of potential cooperation between ministries, local authorities and health organizations; to promote the sharing of experiences and mutual learning; to serve as a booster to keep all actors motivated and to increase intra-organizational competition in terms of initiatives and activities to cope with health disparities. Attending the conference and reporting annually and publicly on activities, achievements and future intentions, present incentives for the sick funds to continue and even boost their actions in the realm of inequality reduction.

Transparency of comparative quality indicators among public providers in peripheral areas (for instance, waiting times for surgery) and among at-risk populations (for instance, control of hemoglobin levels among diabetics) is an important factor in encouraging intra-organizational improvements. In the 2011 conference, such data were presented by the MOH.

The annual publication of the activities and achievements of the various players, including the MOH, sick funds and local authorities are included in a new annual *Health Inequalities Report*, first published in 2010 by the MOH's Unit for Reducing Inequalities in Health.

It should be emphasized that the healthcare delivery organizations are not the only agents of change which should be motivated and encouraged. Action should be taken to ensure that the government in general, and the health authorities in particular, will encourage additional agents such as municipal authorities (in Israel they are minimally involved in healthcare delivery) and the educational system to invest in promoting the health of weak population groups and countering health disparities. Regular reporting to the head of a municipal authority about health disparities on the basis of selected indicators and the transparency of such information are examples of incentives geared towards agents of change outside the healthcare system.

4) MOH and the agents of change

It is important to identify those 'agents of change' within and outside of the healthcare delivery system which can contribute to the turnaround in the current trend of expanding disparities. The choice of change agents will depend on the structure of the healthcare system. Decision makers can choose between different actors or include most of them, each with a specific task according to the role it plays in the healthcare system. Even in cases where a national health authority limits its role in the struggle to narrow gaps to the boundaries of the healthcare system, there is a wide spectrum of choices to be made, in terms of what the role of the national health authority should be. It ranges from focusing on regulation and steering other 'actors' through increasing involvement in creating crucial infrastructure. The latter includes, for example, establishing physical resources (e.g. clinics, hospital beds) in peripheral areas and training the health workforce to improve its capacity to cope with cultural differences. The national health authority can expand its involvement even further to provide specific interventions among target populations. However, in cases when a national health authority limits its activities to the roles of regulator, facilitator and coordinator, one of the first steps in

establishing a policy might be to select the main stakeholders and actors which could promote and implement change, in addition to the national health authorities. Examples of such actors are sick funds, hospitals, medical and nursing associations and local authorities.

In Israel, all of the above were selected as 'agents', each in its relevant role. The MOH chose to focus mainly on macro-level activities; regulation, steering and establishing incentives. However, given the historic structure of the healthcare system in Israel, the MOH is also involved in the provision of health services (e.g. psychiatric care) and in health promotion services. In its national plan for narrowing health disparities, the MOH presented standards and norms, defined target groups and established incentives for stakeholders. However, actors have been given autonomy to select their own way to achieve targets and to gain financial incentives. For example, as mentioned earlier, a series of incentives have been established for the sick funds to encourage them to cope with disparities (as will be discussed later in detail). However, no specific interventions have been imposed on the sick funds and they have been given autonomy in choosing the programs best suited to their needs and to the characteristics of their members. They are also free to set specific goals for the reduction of inequalities, provided they attain the national targets or criteria assigned to them.

As mentioned before, specific incentives and frameworks of action can be tailored for each of the other agents, such as municipal authorities, schools, hospitals and medical unions and associations.

5) Assistance to agents of change

The role of the national health authority depends on the structure of the healthcare system. In countries where a national health service exists, it should be easier to establish and implement a policy through the different organs and hierarchies of the national health service and through its relationships with other social ministries in the government. In this case, assistance will be given to regions and providers according to their needs for implementing intervention plans among target groups.

In other systems, the national health authority plays the role of regulating, steering, and creating the right incentives to encourage health organizations to cope with disparities and act intensively among weaker groups. It also focuses on correcting infrastructural imbalances, as mentioned earlier, in terms of physical and human capital.

It may be necessary to exert special efforts to avoid dissonance between incentives aimed at achieving goals and the ability and readiness of the healthcare delivery organizations to achieve them. If, for example, expectations and incentives push toward narrowing cultural barriers but no training courses exist for providers, or if incentives are given to develop clinics in peripheral areas but governmental bureaucracy stands in the way, the results will be frustration and skepticism toward the leadership of the national health authority which may lead to negative results.

Other points of entry for the health authority include establishing a transparent and freely accessible center of information and knowledge regarding interventions to narrow health disparities as well as establishing cooperation with the higher professional-education system. The latter can ensure both the appropriate course of training that will give providers tools to cope in a multi-cultural society and also ensure that the number of health professionals that graduate in different specialties will correct shortages of supply in specific professions and regions of the country.

The national plan in Israel tried to address some of the above mentioned courses of action (i.e., expanding training capacity in the workforce, incentives to attract professionals to remote areas, pay-for-performance incentives, investments in the health infrastructure in the periphery etc.). Two examples that focus on training include a special course to train Bedouin women in nursing and an MOH initiative to train employees of different health organizations to become cultural-competence coordinators in their organizations.

6) Measuring

After addressing questions such as quantitative vs. non-quantitative goals, the method of measuring should be decided upon. As mentioned earlier, it is questionable whether reducing disparities between regions is an appropriate aim for issues such as hospital beds, physician rates and length of waiting times. In these realms it might be more suitable to measure deviation from a standard that has been determined by the national health authority or by an independent professional body.

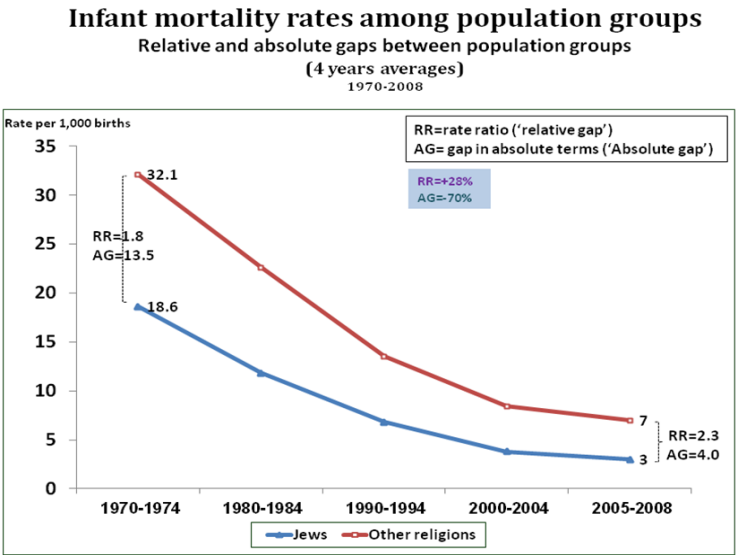
In terms of mortality and morbidity indicators, it is customary to measure gaps among groups. One important question is whether to measure disparities in absolute or in relative terms. The answer to this question depends on the social values and beliefs of each country (e.g. questions such as what is the acceptable gap in relative terms between the lowest and highest percentiles). From a practical perspective, it should be mentioned that the experience of countries that have been coping with health disparities for more than a decade suggests that it is much harder to mitigate disparities measured in relative terms than those measured in absolute terms. In many cases one can demonstrate a clear decrease in morbidity in absolute terms in the target group and even narrowed disparities between this group and the control group, yet still be frustrated in relative terms. The following graph, which shows infant mortality rates of Jews and other religions, demonstrates this phenomenon. A nice decline is

presented in both groups, and the gap between them, in absolute terms has narrowed. However in relative terms the gaps widened.

In a country that has a strong private healthcare sector alongside the public system, the stronger populations' states of health may be affected, among other factors, by lifestyle and by the services purchased in the private sector. Since these population groups' lifestyles and use of private healthcare services are beyond the control of the public healthcare system, establishing a target on the basis of relative concepts may be overly ambitious. Consequently, when quantitative targets are set, one might consider relating mainly to disparities in absolute terms— but to keep measuring and tracking the relative gaps as well.

The method to use in measuring disparities. In many cases there is a relationship between the strategy adopted and the constraints typical of a given country on the one hand, and the way the disparities are measured, on the other. Since some healthcare systems lack access to the public's educational and income data, it is presumed for methodological and topical reasons that concurrent interventions across the entire social gradient cannot be carried out. Hence the preference is usually to focus on weaker groups. Against the background described above, the indicators recommended for use are those that will reflect the disparity between the target groups and the population-wide average (and not between extreme percentiles); the use of more complex indicators such as SII[15] (Regidor, 2004) and RII ('Relative Index of Inequality') that reflects the situation along the whole social gradient could be considered as well, although their use is less common. (For a description of the index, see Sergeant and Firth, 2005).

[15] The SII is defined as the linear regression coefficient that describes the ratio/relation between the group's state of health and its socioeconomic standing.



7) Information availability and transparency

One of the main roles of the national health authority should be to verify that health delivery organizations that share in the effort to reduce disparities will have the data and information they need to enhance their ability to function effectively. For this purpose, the establishment of such a database should be considered.

The issue of a database relates mainly to three components of information: demographic data that enable all involved to concentrate their efforts and interventions on the target populations; epidemiologic data on morbidity and mortality for the relevant sub-groups of the population; and information regarding intervention programs (both national and international) that have already been implemented and have been proven effective. As mentioned earlier, it also might be reasonable to consider establishing criteria for 'good practice' that fit the nation's values and preferences, and to note those intervention programs that fit these criteria. Promoting the access of health organizations and public insurers to such

information might be an important part of a national plan for reducing health disparities.

Consideration should be given to establishing an online portal that will present the information for all comers, similar to the one that is being presented already in the DETERMINE (EU) portal as well as the British 'London Observatory'. A web site was established (London Observatory) that includes an instructional kit for intervention programs tailored to field conditions, with special emphasis on local-authority areas that were chosen as "spearheads," presenting the weaknesses and achievements of each area relative to the average of the others.[16] This database, accessible online, presents the characteristics of each district and its standing relative to the overall average, on thirty-one diverse indicators that are socioeconomic and health-related.

Such a portal, written in the local language and run by a dedicated unit at the national health authority, would serve as a working tool and a source of information on interventions that have been implemented and found to be effective in narrowing health disparities. The portal might include a "toolkit" with which users may construct intervention programs using parameters of their choosing. In presenting the data on morbidity, mortality, and health behaviors, parsed by population cross-sections and geographic area, use of the portal might emphasize disparities among municipal authorities and among sick funds and can show where each of these ranks against the population-wide average on each indicator.[17] Another point of emphasis is that the database should include information about patient rights in the healthcare system and comparative information about service providers that describes their activity among weak population groups and their success in narrowing disparities. The publicity attained in this manner may create incentives for positive behavioral change on the part of insurers, local authorities and service providers.

[16] http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx.
[17] Data that allow individuals to be identified would not be posted.

The national health authority also might consider reevaluation of current IT systems in order to ensure they are suitable to the task of monitoring the target population, not only for the purpose of data gathering but also for ensuring continuity of medical services provided to the target populations. This is especially necessary when referring from one provider to the other (e.g. from the community to hospital) and when transferring from one insurer to another.

In Israel, the task of establishing a national database regarding these last two components, is one of the defined responsibilities of the new unit in the MOH. It has also been decided to include regional data in a project that monitors quality of health services in the community setting, using various indicators.

As for establishing a national database for health disparities, a decision has recently been made by the DG of the Ministry of Health to include this project in an agreement that exists already between the MOH and the Gertner Institute for Health Research. The feasibility of the project and its framework will be examined during the first half of 2012.

As for expanding the component of demographic data that is available to the sick funds, it is currently under examination by the MOH and the National Insurance Institute, to identify possible legal and technical barriers that might prevent transferring this kind of data to public insurers in order to enable target intervention programs according to education, ethnic origin etc.

8) Empowerment of underserved populations

Empowering weak populations is a crucial part of a national plan that aims to narrow gaps. One related issue is how to ensure that people from low SES groups and immigrants from different cultures receive access to written information and consultation services in a way that helps them understand their rights in the healthcare system. They should be informed about the existence of an ombudsman, whose office should be able to handle applications in different languages. A similar effort should be made with written materials regarding health promotion and lifestyle, as discussed earlier (in the section of cultural barriers).

Another important way to empower weak population groups is by including their representatives in any planning sessions of intervention programs and evaluations of such programs. An additional consideration might be to establish a cadre of health professionals that consists of people who belong to minorities. The national health authority might consult with other relevant ministries and give priority to such applicants in programs for the training of healthcare professionals.

One example of this issue that was implemented in Israel is a training course for nurses from the Bedouin Arab sector. In addition, as mentioned earlier, a circular by the Director General to sick funds and hospitals established standards and norms in cultural competence of health organizations regarding translation requirements for written materials, phone information regarding patients' rights in four languages and interpreters in clinics that serve multi-cultural populations.

9) Choosing main entry points

A previous study (Horev, 2008) showed that confrontation with disparities relates to three levels of action: the national level, the level of activity in the healthcare system and community and intervention at the individual level. As stated previously, in many cases a national health authority will emphasize its involvement mainly in regulations, incentives and other macro-levers that will impact the will and activities of health delivery organizations and public insurers to narrow health disparities and achieve the targets set forth.

As for lower hierarchical levels of intervention to be enacted by sick funds, local authorities etc., when targets are set, consideration might be given to the foci of the interventions: some examples might include whether to focus on main causes of preventable death (e.g., cardiovascular disease) or on the main factors that contribute to functional disabilities at relatively early ages (e.g., diabetes) or perhaps on those diseases that have high incidence among the population and adversely affect quality of life (e.g., tooth decay in children[18]). Of course one can expand the list or select a combination of entry points. After prioritizing, health organizations or localities should be directed and encouraged to promote this mission by applying what has been defined in the above mentioned study (Horev, 2008).

[18] In this context, it was decided to include dental care in the basket of services provided under the National Health Insurance Law in Israel

D. Means

1) Which means should be used, and how?

It might be most effective to combine many types of means mentioned in this paper: structural changes, legislative tools, creating incentives and using 'agents of change', each in its proper context.

a) *Structural changes*

An efficient action plan for narrowing gaps should often start with structural changes needed in the health authority or in the way the public healthcare system operates as well as higher up in the hierarchy. Following are some examples of possible structural changes that can be implemented:

(1) Establishment of an overarching entity. Once a decision has been made to narrow social gaps, it can be accompanied by a decision whether or not to establish an independent authority or entity at the Prime Minister's Office to coordinate the actions of the diverse offices that will be involved. This entity would make sure that each office set targets for the mitigation of inequalities in its purview. In matters that entail a multidisciplinary approach, this function would set joint targets for the offices involved[19] and would be in charge of examining the socioeconomic implications of social inequality over time and of the regular release of information about socioeconomic disparities in all fields. Each office active in the matter should establish a unit to centralize action to reduce social gaps in the context

[19] In narrowing disparities in rates of smoking, for example, a joint target should be set for the Ministry of Health, the Ministry of Education, and the Center for Local Government (at the Ministry of the Interior), which is in charge of enforcement of smoking bans in public places. The target relating to the narrowing of disparities in physical activity would be shared by the Ministries of Culture and Sports, Education, and Health.

of its activity and to interact with the overarching entity.

In cases when such a comprehensive approach is impossible to implement it might be wise to consider establishing such a position in lower-level entities, either in the MOH or in local authorities.

In the Israeli case, the current government set up societal goals for reducing inequalities. Each of the ministries had to respond to the goals. The action plan of the MOH, including the chapter on 'narrowing health disparities' is part of the government action plan. It is supervised and coordinated by the Prime Minister's Office (Division for Socio-Economic Policy). In the MOH, the Deputy Director General of Health Economics and Insurance bears the responsibility for developing recommendations and coordinating the struggle to cope with health inequalities. In his division a special unit has been created for this task[20]. The main functions of the unit are consulting about policy recommendations, coordinating and monitoring the activities aimed to decrease health inequalities, identifying barriers, defining incentives to different actors, building data infrastructure and supervising implementation of policy decisions in the area of narrowing disparities.

(2) Strengthening the public healthcare system and the national health authorities. In addition to positioning the national health authority as a key player in tackling health inequalities, it is necessary to build the national health authority's capacity to cope with this important task. As mentioned earlier, one possible step is to expand the department's infrastructure by establishing a unit that would take the lead in the struggle against the trend of

[20] Currently it includes one position that is occupied by an employer with a PhD degree in Sociology, who specialized in the healthcare system. An additional full-time employee has been already approved for this unit to be implemented in 2012.

increased disparities in the healthcare system. It also means assuring the necessary legal infrastructure and broadening the MOH's powers. The latter refers first of all to its activity vis-à-vis local authorities and other government ministries so that it may initiate change in an array of incentives and enforce action against disparities wherever necessary. These activities, under the purview of the health system and outside of it, should prevent further exacerbation of disparities and bring about strengthening of the public system.

As for other parts of the public healthcare system, a decision should be made whether or not to allow further development of the private sector (e.g. private hospitals beds, commercial health insurance companies etc.), at the expense of narrowing the power and attraction of the public sector. If the decision is to tighten up regulation of the private sector, specific steps should be selected accordingly after a clear vision is established about the desired structure of the whole healthcare system, in terms of public/private mix, distribution of health services etc.

Two examples will be presented of steps that were taken to strengthen the public sector in the Israeli healthcare system. The first is a new collective labor agreement that was concluded recently between the Government of Israel and the IMA[21] (IMA, 2011). It deals with physicians who work in the public sector and includes financial incentives for 'full-timers' in the public sector; for residents who are studying specialties that are in shortage in the public sector; and for residents and specialists who are employed or study in public hospitals in peripheral areas[22]. The MOH was a leading partner in this agreement and, as mentioned earlier, initiated

[21] Israeli Medical Association
[22] This will also be implemented later with community doctors

and chaired an inter-ministerial committee that preceded the negotiation and whose recommendations pointed out several implementable solutions that were adopted during the negotiations. A second example is the fact that in 2011 an extensive effort was put forward to allocate additional hospital beds and expand funds to the public hospitals (especially in remote areas). Initiated by the MOH, a governmental resolution was accepted to add 540 hospital beds during the next three years and 420 more in the three years afterwards. Half of the new beds will be allocated to hospitals in peripheral areas. Additionally, about 1,000 new physician positions have been added, with hospitals in the periphery being given first priority.

As for the role of the private health sector, an extensive attempt is in progress to establish, in cooperation with the MOF, an agreed upon, mutual policy that will tighten up the regulations of commercial health insurance plans[23] and more strongly regulate the private sector with the aim of decreasing private spending as a share of the national expenditure on health.

(3) The construction and maintenance of a national database. Establishing such a database, under the auspices of the national health authority or the National Bureau of Statistics will reflect trends in disparities in health status, health behavior and accessibility to healthcare systems. The body which will maintain this database will be responsible also

[23] In Israel, although the basic basket of services is wide and universal (100% of the population is covered), 75% of the population purchased an additional voluntary supplemental health insurance offered by one of the sick funds, and 30% purchased a health insurance policy (collective or individual) from a commercial insurance company.

for monitoring and evaluating intervention plans for the reduction of health disparities[24].

b) *Legislative changes*

The effort to counter health inequalities will evidently require legislative changes. A national policy that aims to tackle health disparities should map the desired changes in the current legislation framework that will increase the capacity to narrow gaps in the healthcare system. Examples of this pertain to the powers of the health authorities (federal and local) including: revision of copayments for public health services; giving healthcare organizations better access to their members' educational and/or employment data (so that they can prepare appropriate intervention programs) and requiring health organizations to provide translation services in hospitals and community clinics where relevant.

Moreover, any proposed legislative changes that might impact upon the health system should be assessed with regard to its potential impact on health disparities[25].

One example of recent, significant legislative change in the Israeli healthcare system is a new reform in dental care which provides for comprehensive dental care to children. This reform, aimed (among its other goals) to narrow health disparities and improve accessibility to dental care for children, required significant changes in the National Health Insurance Law. When initiated on July 1, 2010 it covered children up to age 8 years; currently it covers children up to 10 year olds, and it will be expanded gradually in the next 2 years to children up to 14 years old. Preventive services are free of charge; surgical procedures require a symbolic copayment (up to a designated ceiling).

[24] It could be out-sourced outside the government on the condition that responsibility remains within the national health authority under its tight supervision (the option that was adopted in Israel).

[25] This should be one of the ongoing duties of the special unit for narrowing health disparities

The services are now part of the universal basket of health services under the auspices of the National Health Insurance Law.

Another example of a legislative step to narrow disparities is the cancellation of copayments to public preventive health services (e.g. vaccinations and consultations) for pregnant women and newborns provided at maternity and infant care centers ("Tipot Halav"). Another legislative change enabled a 15% reduction in copayments for medications for people 75 years and over.

A current legislative effort, initiated by the MOH, seeks to expand accessibility to long-term community and institutional care for those in need.

c) *Other regulatory tools*

A crucial part of a national policy should be mapping the current incentives that exist in the healthcare system, identifying those that are counterproductive to narrowing disparities and adjusting them to be in accordance with the national struggle against disparities in health. Regulatory tools might be aimed at decreasing private spending on health or on verifying a suitable distribution of healthcare services. Other examples might include limitations on commercial health insurance plans, in an attempt to avoid a multi-tiered system in which a thin layer of basic public services exists alongside a thick one that depends on the patient's ability to pay. Other tools include those which aim to establish mechanisms to encourage health organizations and health providers to strengthen the availability of essential health services in remote areas and among underserved populations. Several examples of these tools have been presented earlier in this paper.

2) Budget and the sources of funding

Success in defining a specific budget (out of the national public budget) that is designated for the purpose of coping with health disparities is proof of how serious the government is in its commitment to this goal. Political limitations may play a role in the extent of financial resources, as well as in the way they are allocated and defined. They may be allocated as a global sum, accompanied by the government's declaration of its determination to cope with disparities and thus permit the national health authority maximum freedom of movement, or, they can be allocated as a designated budget for specific interventions and incentives without declarations about a national strategy. The latter is easier to achieve. A gradual approach, one step at a time, is sometimes the preferred way to overcome resistance and obtain financial resources to get a national plan going, without bombastic declarations. This is acceptable as long as the leaders operate according to a long term plan (even if it was not approved as 'one piece' and recognized as the national plan by the parliament).

A national health authority might also consider the method of distributing the approved budget among service providers. This could be done in either a prospective or a retrospective manner (with a clearer relationship to achievements) or any combination of the above.

Another issue is the source of funding: the generation of public resources from within the ministry's budget, getting additional budget from the national budget, earmarked taxes or social contributions, or expanding employers' contributions, are some of the possibilities for additional funding. They all depend on political will and on the values that lead the society as a whole as well as that of the Ministry of Finance, as the patron of the government's budget. One could also consider the possibility of combining public sources with funds from philanthropic sources.

In Israel so far no 'declaration' has been made by the PM regarding a national policy to cope specifically with health disparities, however, it did declare its general commitment to narrowing social gaps and to investing in the periphery. As mentioned before, the Deputy Minister and the Director General of the MOH did make such a declaration regarding disparities in health and are very active in this regard. Its plan is part of the government's working plan. Through this plan, and under a series of ministerial decisions, specific budgets have been earmarked for each purpose – e.g. incentives for investing in health intervention plans among underserved groups, for establishing and strengthening healthcare infrastructures in the periphery and for increased accessibility of low SES groups to specific services.

Examples of such allocations in the 2010 budget were: 65 million NIS for including dental health services for children in the public basket of services under the National Health Insurance Law (to be expanded gradually to 240 million NIS in the coming 3 years); 60 million NIS for the development of hospitals in the periphery; and 40 million NIS for cancelling copayments for services in infant and maternity care centers.

In 2011, 160 million NIS have been added to the budget as a prospective payment due to the launching of a new indicator - geographical peripherality- to be used in the capitation formula (through which allocation of resources to the sick funds is calculated); 16.5 million NIS have been allocated (annually for the next 3 years) as incentives for sick funds to invest in health promotion and in establishing infrastructures among low SES groups and in peripheral areas of the country (retrospective conditional payment). Increasing the number of hospital beds and physicians, allocating incentives to attract healthcare workers to peripheral areas and establishing a fifth Medical school in Israel in the northern part of Israel - all bring with them budgetary implications. (For additional examples of policy tools and decisions that the Israeli government and/or the MOH have taken in 2011 and 2012 with implications for reducing health inequalities and for preliminary estimates of financial investments - see Appendix D).

Some of the budget is population-group earmarked. Other parts are left open with maximum autonomy given to sick funds to operate under specific rules to narrow disparities. An example of the first is 13.6 million NIS that was allocated to the MOH for Bedouins in the Negev (the southern part of Israel) within the framework of a five-year intervention plan to improve their health and health services. An example of the second kind is the allocation of an annual sum of 16.5 million NIS to the sick funds as mentioned earlier.

In the Israeli case, several such decisions have been approved during the last year (to be implemented in 2011-2013) including investments that were allocated individually to attract specialists and nurses to peripheral areas.

E. Monitoring

1) Follow-up indicators and monitoring

After setting up the goals, consideration should be given to which follow-up indicators should be used employed. Given the long term aspects of this struggle, one might not expect short term achievements in terms of outcome indicators. For this reason, follow up indicators can concentrate in the first few years on process indicators. The latter will help in establishing the framework that hopefully will result, in the long run, in the expected health outcomes that reflect narrowed health disparities. Monitoring and tracking quantitative goals and upgrading the plan (and even the goals) accordingly, are an important part of any national plan. A national health authority might want to clearly define the unit or person who will monitor the disparities and selected indicators and the pattern of reporting.

At the current stage the Israeli MOH has defined process indicators and goals for the next three years (e.g. in terms of infrastructure ratio- to -population in peripheral areas, the standard and norms for bridging cultural disparities and the timeframe for implementation). It is working together with partners within the healthcare system to establish the necessary database-infrastructure and to define, together with an expert team, medium and long term outcome indicators.

2) Responsibilities and timetable

The national health authority might consider a clear statement, to be included in the national action plan, regarding how responsibilities should be apportioned among the partners in the healthcare system. It should emphasize its own responsibilities as well as others', such as municipal authorities, health insurers, healthcare delivery organizations, providers and individuals. As in other public plans, a detailed timetable, both for the process and outcome targets should be included as well.

Currently the Israeli plan divides responsibilities among different sectors in the MOH and the senior managers of the major health providers. Pilot initiatives have recently been started, that are focused on struggling with health disparities, in cooperation with local authorities (e.g. a partnership between MOH and eight Israeli-Arab local authorities).

Examples of timetables that were determined by the Israeli health system include that of the "seven pillars of fire" for the years 2011-14 and the five-year-plan for improving health and health services to the Bedouin population, for years 2012-2016.

3) Preparation for implementation

A successful implementation phase depends on preparations in earlier stages. Given that the healthcare system is only a part, and usually not a powerful part of the government, health policy decisions are in many cases the subject of political debate. The national health authority might consider including in the planning phase general principals and techniques to:

a) Verify the cooperation of main stakeholders: In Israel, cooperation was mainly established with the sick funds and several NGO's. Few examples exist of cooperation with professional unions. One

such example is of negotiations between the Israeli Medical Association, the Ministry of Finance and other ministries on salary incentives for attracting physicians to peripheral areas.

b) Identify possible political resistance and prepare plans for overcoming it or ways to bypass it. One example in Israel was the negotiation with the Israeli Dental Association during the process of getting governmental approval for the dental health reform for children.

F. Implementation

1) Adopt an implementation plan and a time schedule
2) Stick to the plan and timetable
3) Monitor progress and activities continually.
   Be prepared for unexpected circumstances that might force you to change the master-plan (be persistent but flexible)
4) Upgrade and correct according to interim results and lessons learned.
5) Report continually to the highest authority and to the public about activities undertaken and on achievements and challenges; keep the information transparent.

Summary and Conclusions

The extent and nature of the investment in narrowing healthcare disparities are linked to the strength of the national commitment to the narrowing of social disparities in general and health disparities in particular.

The well-known sociologist Sol Levine (Levine, 1994) has long argued that health policy should not be separated from national social and economic policy and that in order to impact health disparities, decision-makers in the health field should also consider themselves involved in policy questions in other domains, e.g., tax policy and the encouragement of employment. This approach is supported and reinforced by publications of foremost international organizations such as the European Union and the WHO. The experience amassed in various countries shows that, indeed, the issue of health disparities links many social systems and that most countries are adopting integrated solutions. Defining action against health disparities as a national target contributes to the sense of social cohesion and makes the attainment of the target more likely.

Writers of the current paper are aware of the need for broad national commitment and cooperation in the struggle for narrowing health disparities. However, the main emphasis of this work is on opportunities for tackling health disparities that exist within the 'locus of control' of the national health authority using tools and power that exist within it. The writers point out some of the interfaces between the health authorities and other governmental bodies.

The purpose of this work is neither to recommend a specific national policy nor to draw a detailed national plan for narrowing disparities in health. Rather, the main goal is to offer a suggested roadmap or framework for establishing a new national plan for reducing inequality in the healthcare system, or for revaluating an old one. The suggested stations of decision-taking

are based on a previous analysis of how countries combat health disparities, and also upon a systematic analysis of the Israeli experience.

There is no 'right way' in tackling health disparities. In the process of defining its own way of struggling with inequality in health, each country can follow these suggested steps, skip some of them or add a few of its own. Usually this will be dictated by a combination of the nation's values, beliefs, political agenda and the structure of each country's healthcare system. Examples that were given in this work from the Israeli experience were intended for the purpose of demonstrating possible principles and considerations raised at each junction in the process.

It is too soon to analyze the results or outcomes of any steps that have been taken in the past two years in Israel. However, we hope that the current paper will add another perspective to the wide range of activities and research on health disparities that are being conducted around the world and that it will serve as an applicable tool to be used when preparing a strategic national plan to combat disparities in the healthcare system.

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Appendix A

Citation[26] *from: "Ministry of Health Goals for the Years 2011-2014"*

GOAL No. 2

REDUCTION OF HEALTHCARE INEQUALITY

Background and Main Challenges

Inequality in the health field is, to a large degree, the result of the existing socio-economic disparities in Israeli society. On the one hand, the health system needs to confront the health ramifications of these inequalities while on the other, to act in such a way so as not to contribute to widening these already existing gaps but rather, strive to bring to their narrowing, both in terms of actual health and accessibility to health services.

Reducing the inequality in Israel is not just a moral imperative but also a necessity for the maintenance of a strong and united society, capable of standing as one in the face of the challenges facing the country.

The disparities in the state of Israel's citizens' health are due to the following factors: education, income, residential location, employment, sector of population, ethnic origin and religion. There are also disparities in infrastructures: distribution of medical personnel, hospital beds, use of preventative health services, availability of services, expenditure on health services, and those forced to dispense with health services due to financial difficulties.

[26] Text only (not including graphs)

In addition, the information existing today regarding inequality is incomplete and random and the need therefore exists to expand the current information infrastructures relating to health disparities in Israel both as a tool for decision making in the field and as a means of aiding the directors of the health system. This is the case both for relevant epidemiological data and in the context of intervention programs found to be efficient among the relevant target populations in reducing disparity.

Action to reduce the disparity in the health field must be undertaken on a national social level, the regional level, and also via the operations of the Ministry of Health.

Target Objectives

1. Reducing the disparity in financial access to health services

2. Reducing the influence of cultural differences in the utilization and quality of health services

3. Providing sufficient quality and professional healthcare personnel to the periphery

4. Improving the physical infrastructures in the peripheral regions

5. Providing incentives to the health funds for undertaking activities to reduce disparity

6. Establishing a database for information relating to morbidity, accessibility to and availability of services, and relating to intervention activities effective in reducing disparity in the health sector

Objective 1: Reducing the disparity in financial access in financial access to health services

What does the Ministry of Health seek to achieve?

- The reduction in the proportion of the population dispensing with medicine or necessary medical treatment due to financial difficulties

In order to achieve this objective, the Ministry of Health will:

- Reduce the levels of cost participation in medicines and vital health services for underprivileged sectors of the population
- Include necessary services in the public basket of health services without cost participation or with a low level of participation
- Include those medicines and services characterized by a high usage level among underprivileged sectors of the population in the public services basket

Objective 2: Reducing the influence of cultural differences on the utilization and quality of health services

What does the Ministry of Health seek to achieve?

- A reduction in morbidity resulting from cultural and lifestyle differences
- Expanded access to health services for sectors of the population with language difficulties
- Confrontation with personnel difficulties in providing quality care due to language and cultural differences

In order to achieve these objectives, the Ministry of Health will:

- Direct and obligate service suppliers in the health system to a standard of language and cultural accessibility
- Train caregivers and mediators in the subject of "cultural congruity"
- Act to produce explanatory material on issues relating to health, rights, surgery consent forms etc. in a wide range of languages with cultural compatibility

Objective 3: Providing sufficient quality and professional quality and professional healthcare personnel to the periphery

What does the Ministry of Health seek to achieve?

- An increased ratio of nurses per 1,000 people in the South
- An increased ratio of specialist doctors per 1,000 people in the periphery
- An increased number of physician residents in hospitals located in the periphery

In order to achieve these objectives, the Ministry of Health will:

- Act to increase nursing training programs in the South
- Promote the transition of doctors and nurses to the periphery for specialization and permanent employment

Objective 4: Improving the physical infrastructures in the peripheral regions

What does the Ministry of Health seek to achieve?

- An increased number of hospital beds in the periphery
- Opening of additional professional units in the periphery
- Increased technological infrastructures in the periphery

In order to achieve these objectives, the Ministry of Health will:

- Expand infrastructures in the periphery in all fields: hospital beds, emergency
- departments, operating theaters, deployment of rescue services and more
- Prioritize allocation of sophisticated technologies to the periphery
- Allocate professional units with preference to the periphery

Objective 5: Providing incentives to the health funds for undertaking activities to reduce disparity

What does the Ministry of Health seek to achieve?

- An increased scope of financial investment by the health funds in infrastructures and activities to advance health in the periphery

In order to achieve this objective, the Ministry of Health will:

- Determine incentives for the health funds totaling approximately NIS 20 million for each of the years 2011-2013, earmarked for improving infrastructures in the periphery
- Examine means for including the social-demographic variable in the formula for allocating resources to the health funds

Objective 6: Establishing a database for information relating to morbidity, accessibility to and availability of services, and relating to intervention activities effective in reducing disparity in the health sector

What does the Ministry of Health seek to achieve?

- The establishment of a central database including a range of information relating to health disparities and the means for combating them, the utilization of which is to be used as a base for decision making

In order to achieve this objective, the Ministry of Health will:

- Create a central base of information and expand the existing information regarding disparities in indices of morbidity, mortality and availability of health services
- Create an accessible online database for managers in the health system and local authorities, on intervention programs effective in reducing disparity

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Appendix B

Characteristics of the 'Modus Operandi' of Israel's Healthcare System

In early 1995, Israel reformed its healthcare system by enacting a National Health Insurance Law (NHIL). Since then, all persons with resident status in Israel have had health insurance. Several studies have described the principles of the reform and the processes that led to its maturation [1–4].

The main goals of the reform were to provide universal health coverage; spell out residents' entitlement to a basic package of health services (a "health basket"); promote increased equity; assure the solvency of the healthcare system; give residents greater freedom of choice among sick funds[27]; and absolve the Ministry of Health (MOH) of operational responsibility for the provision of health services, thereby allowing MOH to devote more effort to regulating supervising and monitoring the system [3].

The law itemized the "basket" of services (i.e., the services to which all insured persons would be entitled under the NHIL). Delivery of service was entrusted to four sick funds, apart from specific exceptions that would remain in the hands of the MOH, and the legislator expressed its intention to assign responsibility to the sick funds for these services as well at some future time. The cost of the "basket" of services was defined and the state undertook to provide supplemental funding to cover it fully. The NHIL based the funding of the healthcare system mainly on earmarked taxes collected by the National Insurance Institute—a compulsory progressive/ 'ear marked' tax ('health tax') paid by each adult resident and a 'parallel tax' paid by employers. The law was changed in 1997 and since then employers' contributions are no longer a source of funding for the healthcare system. Currently, the main sources of funding for the basket of

[27] A sick fund is a public nonprofit healthcare provider, similar to an American HMO.

services supplied by the sick funds under the NHIL are: the 'health tax' (53.4%), governmental budget (40.2%) and cost sharing paid by the consumers for services and medicines (6.5%). Supplemental sources set forth in the NHIL were budgets given to MOH for the funding of services that MOH would provide directly (e.g., mental healthcare, inpatient nursing services, and preventive maternal and neonatal services). Allocation of the budget between sick funds is based on a capitation formula which takes into account the distribution of insured members by age, gender and geographical peripherality. The formula does not contain other variables, such as socio-economic factors or chronic morbidity. The sick funds were allowed to provide additional healthcare services beyond the basic "basket" defined in the law, via supplemental voluntary health-insurance plans. Furthermore, commercial insurance companies offer health insurance plans (through individual and collective insurance policies) that compete with those of the sick funds in order—the companies claim—to complement the "basket" and, in part, to complement the sick funds' supplemental insurance plans (a three-tiered system). 100% of the residents are covered under the NHIL. 74% of the population is covered also by the supplemental health programs offered by the sick funds. 32% of the population has both a supplemental health policy (purchased in their sick fund) and a private health insurance and 3% of the population hold a private health insurance policy but did not join the supplemental health insurance scheme. (Approximately 80% of the population has some kind of health insurance that covers services above and beyond the basic basket of services offered by the NHIL).

Although the NHIL contains a declaration that "…this law is based upon principles of equity, social-justice and social-solidarity", nonetheless social disparities as well as disparities in health and in access to health care services have been described in several studies [5,6,7]. These gaps are widening and Israel stands before a real challenge in confronting this situation.

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Appendix C

A Circular Distributed by the Director General of the Ministry of Health

Circular of the Managing Director **Ministry of Health**
29 Shvat 5771
03 February 2011
No. 7/11

Re: Cultural and Lingual Adaptation and Accessibility within the Health System

1. **Background:**

The Israeli population is a heterogeneous population composed of several groups distinct in religion, culture and language. Each group maintains a unique traditional character and lifestyle, as well as perceptions of sickness and health conditions, health-related behaviors, patterns of health services utilization, morbidity and various health indexes.

The health system's challenge of dealing with cultural diversity requires the application of humanistic values, and of legal aspects related to standards of care.

The State National Insurance Law determines that all Israeli residents are universally eligible for health services, regardless of individual background.

There exists a lawful and legal obligation to provide the public with information and documentation, pertaining to various contexts, in languages other than Hebrew (especially Arabic, but also in other languages as the context requires), in accordance with applicable legislation, regulations, government resolutions and court rulings.

The Patients' Rights Law determines, inter alia, that patients are entitled to provide their informed consent to medical treatment, whereas caregivers are required to provide information in a manner that is comprehensible to the patient. The Law also emphasizes maintaining human dignity during the course of medical treatment.

Clearly, dealing with cultural and lingual diversity comprises one of today's most important challenges faced by Israel's health services providers. In order to realize these goals, health organizations are required to invest in the cultural accessibility of health services provided by them to various cultural populations, so that all Israeli citizens may receive adequate service.

This document shall present the Ministry of Health's objectives and standards in this area.

The Ministry of Health views these objectives as part of its core responsibilities – responsibilities that are by definition independent of budget expansion.

The Circular was compiled in accordance with the primary objective led by the Ministry of Health, namely, the mitigation of inequality in Israel, and in light of the recommendations mentioned, inter alia, in the IMA's Position Paper published in 2008.

2. <u>Objectives</u>:

A. Improving the cultural and lingual accessibility of the Israeli health system, and adapting it for all Israeli citizens, while strengthening its capacity to provide medical services to citizens of all cultures.

B. Formulating standards for cultural and lingual adaptation and accessibility applicable for health organizations.

C. Reducing health disparities within Israel's various subgroups, while empowering those most at risk.

3. <u>Cultural Accessibility Standards in Health Organizations</u>:

Following are standards and norms for creating cultural and lingual accessibility in Israeli health organizations. Some are mandatory guidelines, whereas others are only recommendations for possible courses of action.

These standards are founded upon five basic principles:

- Developing organizational infrastructures within professional organizations (hospitals, sick funds, public health services, emergency services) so as to provide ongoing support for cultural accessibility matters and to consolidate supporting intra-organizational policies.

- Translating documents, regulations, forms and websites intended for patient use, into other languages, as well as maintaining translation services via telephone.

- Instructing medical staff and administrators in hospitals and clinics, in accordance with their expertise, in the matter of cultural accessibility.

- Developing suitable physical infrastructures by way of signposting, directing, adequate equipment, etc.

- It is recommended that health organizations' cultural accessibility be provided based on lingual and cultural mapping of target audiences within the health organization's various levels, wherever possible: beginning with the entire organization and culminating with the target audience in every service provision location – hospitals, clinics, and so on – so as to adapt target audience services in an optimal manner, in light of the principles set forth in this document.

3.1 Patient Information

A. Forms requiring patient signatures (informed consent forms, admission forms, payment/financial liability forms) must be available in four languages: Hebrew, Arabic, Russian and English28. The IMA website contains many such consent forms available in these four languages, as specified in Circulars (Managing Director) 20/96, 13/97.

B. Caregivers are obligated to ensure that their patients comprehend everything related to the medical treatment provided or due to be provided to them, including their right not to accept the proposed treatment. For this purpose, various means are to be employed, such as: written translated material, translation services via telephone or via language-speaking "mediators" and interpreters, whether these are employed by the medical institution or whether they are provided by a third party.

C. Insured people and patients will receive written administrative material (such as that pertaining to their rights to health services, clinic deployment and working hours, visitor reception hours in admission centers, payment methods, etc.) in four languages: Hebrew, Arabic, Russian and English.

D. It is recommended that further materials and documents providing vital information to patients will be published in four languages, per the discretion of the medical institution's director.

E. It is mandatory to promulgate existing information pertaining to health care promotion, preventative medicine, domestic violence, etc. in the following languages: Hebrew, Arabic, Russian and English. The material must be culturally compatible and suitable for the institution's target audience.

[28] The English language is used in many cases as an intermediate language for immigrants who speak neither Hebrew nor any of the languages specified in this document.

F. Signs in health care institutions must be adapted to the lingual composition of the major groups receiving service in them. Signs should present information, as applicable, in three languages: Hebrew, Arabic and English.

G. Public Complaints Units: these must be capable of providing support via telephone in each of the following languages- Hebrew, Arabic, Russian, Amharic and English within a reasonable time frame, and in any event, within 24 hours of contact (per institutional operating hours).
Written applications must be made in Hebrew. An applicant who contacts a Unit, for any reason, e.g. lack of Hebrew language skills, in Arabic, Russian or English, shall nevertheless have their application processed. Applicants shall be informed that their application may require additional processing time compared with applications in Hebrew, and that they must submit any further applications in the Hebrew language, unless the Public Complaints Unit chose to respond in the applicant's language.

H. Telephone service centers in public health care institutions, whose purpose is to manage doctor appointments and provide information on medical treatments and patient rights, are required to provide service in five languages: Hebrew, Arabic, Russian, English and Amharic. Each medical institution will choose the manner by which such service is given, provided that the patient will receive service in a language comprehensible to them within 24 hours, at most.

I. Emergency- service call centers (such as MDA, sick fund emergency centers, etc.) must provide for immediate response in Hebrew, Arabic, Russian, English and Amharic, so as to realize the citizen's right to emergency services.

J. The websites of health organizations and institutions must be accessible to Arabic, Russian and English readers, and must include, in these languages, such vital information as basic rights, core services and contact addresses.

3.2 Interpretation Services during Treatment

A. All organizations and institutions within the health system (including primary care services, admission systems, emergency services, preventative services, health bureaus, etc.) are required to provide available interpretation services when such are needed in the course of medical treatment/counseling. For this purpose, one or more of the following may apply:

   1. Providing professional interpretation services via telephone, by way of designated call centers for each language.

   2. Employing language-speaking cultural mediator within the institution.

   3. Employing language-speaking staff.

B. Call center representatives must receive basic training in the field, including that which relates to cultural and lingual compatibility; interpretation services will be carefully and professionally inspected.

C. Receiving assistance from family members and non-relatives:

   1. As much as possible, the use of patient family members as interpreters must be avoided, unless the patient expressly requests this of their own volition.

2. In any event, family members who are minors must not be used as interpreters, unless an emergency situation presents itself or whenever simple information must be relayed, the relay of which is suitable to the minor's age.

3. Mental health services will not be provided using family members as interpreters, to the exclusion of emergencies or whenever the patient expressly requests this of their own volition.

4. Passers-by or strangers may not be employed as interpreters, except asexpressly requested by the patient. (Should the employment of a stranger necessary, they are to be informed of their obligation to maintain confidentiality of personal and medical information disclosed to them).

3.3 Education and Training of Medical Teams

A. It is recommended that all health organization staff undergo cultural competence courses, especially those staff members whose function is to deal with populations of various or diverse cultural backgrounds.

B. Directors of organizations (such as sick funds, hospitals, emergency services) must appoint a senior administrator who will, in addition to their other functions, oversee matters of "Cultural Competence". This functionary will be responsible for applying organizational policy pertaining to this domain; they are to oversee any issues arising during ongoing operations, coordinate activities for health promotion amongst various lingual and

cultural minorities and are to coordinate pertinent employee training.

3.4 Manpower Recruiting

It is recommended, as much as possible, that personnel (medical, paramedical, administrative) recruited to the organization shall also include cultural and lingual minorities.

3.5 Health-Promoting Activities

A. Efforts should be invested in promulgating information, in executing intervention and planned health promotion programs, among groups distinct for their religious practices or culture, particularly in those areas that help mitigate treatment non-compliance issues or health-compromising behaviors.

B. Collaboration with local leadership (religious, social, etc.) is recommended in executing the intervention programs.

3.6 Adapting Institutions' Physical Conditions

Organizations must endeavor to adapt their physical and environmental conditions (signposting, directions, relay of medical information, privacy regulations) to the cultural background of the subgroups served by the clinic, so as to allow accessibility and utilization of all medical services provided by it in an optimal fashion, and so that the population shall not be deprived of receiving vital services due to cultural, lingual, social or any other difficulty.

3.7 Further Recommendations

A. Efforts must be invested in studying the morbidity, use of health services, behavioral patterns and special needs of various cultural subgroups to which insured organization members/patients belong, so as to adapt services and health-promoting activities efficiently and in a manner pertinent to the subgroup.

B. The organization must endeavor to increase staff and health system awareness in all matters concerning cultural diversity and its implications on inter-personal communication, treatment responsiveness and healthy behavioral patterns.

3.8 Further Recommendations

A. Efforts must be invested in studying the morbidity, use of health services, behavioral patterns and special needs of various cultural subgroups to which insured organization members/patients belong, so as to adapt services and health-promoting activities efficiently and in a manner pertinent to the subgroup.

B. The organization must endeavor to increase staff and health system awareness in all matters concerning cultural diversity and its implications on inter-personal communication, treatment responsiveness and healthy behavioral patterns.

4. Implementation and Incorporation Process

A. Sick funds, hospitals and other health care providers for which this document is intended shall submit an organizational program for the implementation of this letter to the Health Economics and Insurance Division, Unit for Reducing Inequalities in Health, Ministry of Health. Program submission shall not occur later than 30 July, 2011.

B. Target date for implementing the organizational program in full: two years as of this circular's publication. The Ministry recommends gradual implementation of the circular.

C. Implementation of accessibility regulations per this circular shall be overseen as part of the control inspections carried out by the Ministry of Health within the various organizations. The Ministry of Health also recommends the execution of internal inspections pertaining to this matter.

Dr. Roni Gamzo
Managing Director

Cc: MK Rabbi Yaakov Litzman, Deputy-Minister of Health.

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Appendix D

Examples of policy tools and decisions that the Israeli government and/or the MOH have taken in 2011 and 2012 with implications for reducing health inequalities and promoting accessibility of healthcare services to low SES groups and populations in the periphery

Subject	Comments
Incentives for the sick funds	
Adding a peripherality indicator to the capitation (allocation) formula	
A special budget allocation due to the additional peripheral indicator in the capitation formula	
Implementing a retrospective economic incentive to the sick funds, to encourage investments in peripheral areas and health promotion among low SES groups	Will be paid according to criteria that measure performance
Health workforce	
Allocating 340 new positions for physicians to work in peripheral areas (in 2011, 2012). Total of 1039 new positions in the next 9 years	
Substantial increase in salaries of physicians who work in peripheral hospitals (included in the new collective agreement with the Israeli Medical Association (IMA)	
Grants to residents who study for one of the specialties in medicine, in the periphery (increased grants for those who study specialties that are in shortage)	
Establishing a new unit in the Ministry of Health that is responsible for the collaboration of activities to cope with health inequalities	1st position was allocated in 2009; an additional position has been approved in 2012
Approving 55 new positions for physicians in the periphery	Due to the approved additional hospital beds
Approving 320 new positions for nurses in the periphery	Due to the approved additional hospital beds

Subject	Comments
Approving 260 new positions for other health professions	Due to the approved additional hospital beds
Allocation of economic incentives to nurses who are employed in the Bedouin sector	
A training course for students of nursing from the Bedouin sector	
Increased accessibility to health services and health promotion interventions	
Inclusion of dental care for children up to 12 years old in the basic basket of services under the NHIL (eligibility will be increased gradually up to age 14)	Intervention targeted on the whole social gradient
Reduction of copayments for low SES – elderly Holocaust survivors	
Reduction of copayments for generic drugs	Intervention targeted on the whole social gradient
5 year- plan to promote healthcare services for the Bedouins in the Negev	Investments in establishing 3 new *'Mother and Child'* centers and in reducing infant mortality rates, promoting health education and health promotion intervention programs
National multi-ministerial plan to promote a healthy and active lifestyle	Intervention targeted on the whole social gradient
Physical infrastructure	
Emergency units/clinics in peripheral areas	Frontal emergency rooms that will be built in peripheral areas
Financial investment in hospitals in peripheral areas (5 medical centers)	
5 new MRI units for peripheral areas	
Establishing a new medical school in the northern part of Israel (Zafat)	Opening of the new faculty - 2011
Upgrading hospitals in the northern part of the country	Affiliated/associated with the new medical school
Approving allocation for additional 167 hospital beds in the periphery (for	

Subject	Comments
internal medicine, intensive care, obstetrics, intensive neonatal care), and the needed allocation needed for constructions	
Purchasing new ambulances for the periphery	
Information and Databases	
Developing a national database regarding inequality in health and in the health care system	Has already been decided (to be located in the Gertner Institute) – currently in the planning stage
Establishing a national database on intervention programs for health promotion and reducing disparities in health	
MOH's annual conference on *'Israel HCS copes with inequalities*'	2 conferences (2010, 2011). The next will be in- 11/2012
Bridging language-related and cultural barriers:	
Distributing a circular from the Director General of the MOH on reducing cultural and language barriers in health organizations	
Translation of the MOH website to four languages	
Establishing a call center for simultaneous translation services in the Healthcare system	In the planning stage of a pilot to be implemented in 2012
Training course for professionals who are responsible for cultural competence of health organizations	

The overall preliminary estimate of the annual investment for 2011 and 2012 (excluding investments such as the new medical school in the north) is - 1.2 billion NIS (390 million dollars). The estimate for 2013 is - 1.6 billion NIS.

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