**From Public vs. Private to Public/Private Mix in Healthcare: Lessons from the Israeli and the Spanish Cases**

Dani Filc Md PhD: Department of Politics and Government, Ben-Gurion University, dfilc@bgu.ac.il, phone number: 97286477240, fax number: 97286477242

Alon Rasooly MHA MPH: School of Public Health, Ben-Gurion University, rasooly@post.bgu.ac.il, phone number 97286477419, fax number:97286477634

Nadav Davidovitch MD, MPH, PhD, School of Public Health, Ben-Gurion University, nadavd@bgu.ac.il, phone number 97286477421, fax number:97286477634

Corresponding author: Dani Filc

**Abstract**:

Background: Different forms of public/private mix have became a central mode of privatization of health care, both in financing and provision.The present paper compares processes of public/private mix in health care in Spain and Israel in order to better understand current processes of privatization of health care.

Main Text: While both in Spain and Israel combinations between the public and the private sectors have become a main form of privatization, the concrete institutional forms differ. In Spain, the different forms of public/private mix maintain relatively clear boundaries between the private and the public sectors. In Israel, the main forms of public/private mix have been forms that blur the boundaries between the public and the private system: private insurance sold by the non-profit health funds, private for-profit hospitals owned by the public non-profit health funds and public hospitals selling private services.

Conclusions: The comparison of the processes of privatization in health care in Spain and Israel, shows the variegated character of these processes. It shows the active role played by national and regional state apparatuses as initiators and supporters of healthcare reforms that adopted different forms of public/private mix. While in Israel until recently these processes have been perceived as mainly technical, in Spain they created deep political rifts, both within the medical community and the public. There are lessons each country can learn from each other, to be adopted in its local context.

Keywords: private/public mix, neo-liberalism, privatization, Israel, Spain

**Background**

Since the late 1970s health care systems all around the world have been undergoing processes of reform, and public and academic discussion on health care system transformations have become ubiquitous (Watson 2014). There are several reasons for these reforms, such as changing therapeutic paradigms and technological developments, professional demands from medical associations or users' changing demands. Demographic and epidemiological changes, mainly aging population, had also important influence. However, a central reason is the transition to a global, neo-liberal socio-economic model (Jessop 2003, Harvey 2005, Lee 2004). During the last decade leading medical and public health figures have been raising concerns about the growing influence of neo-liberalism on healh care. This influence was expressed in economic policies such as privatization, austerity, deregulation, free trade and reductions in government spending on health and welfare systems. This increase in the role of the private sector in the economy and society, leads to an ongoing process of privatization of welfare services, among them health care, thus leading to growing health inequalities (Pickett & Wilkinson, 2017; Modi, Clarke and McKee, 2018).

As suggested by proponents of convergence theories, the tendency to the partial privatization of health care is common to most reforms.Hhowever, a comparative examination of those processes in different countries shows that the situation is more complex than claimed by convergence theories. While neo-liberalism is pervasive, there are significant differences among countries, leaving substantial space for the local context, politics and constestation. As Brenner, Peck and Theodor (2010) argue, reform processes are simultaneously patterned by global assumptions and conditions, therefore interconnected; and locally specific, modulated by the institutional, historical and political characteristics of the different countries. Understanding the tensions between the global processes and local implementation is crucial for policy makers when dealing with consequences of recent health reforms, and their influences on both efficiency and equity – two main challenges of current healthcare systems.

The present paper compares processes of privatization in health care in Spain and Israel, focusing mainly on forms of public/private mix, to evaluate concretely the 'variegated' character of neoliberalization processes. Following Brenner, Peck and Theodor's theoretical approach, we compare the Spanish and Israeli cases as examples of the ways in which the globalization of the neo-liberal socio-economic model puts constraints on individual countries and supports processes of privatization – in the present case of health care - while simultaneously increasing the uneven development of regulatory and institutional forms, an uneven development related to each country’s institutional specificities (Brenner, Peck and Theodor, 2010).

Thus, while aware of the role played by global transnational processes, this approach is also attentive to the active role played by national and regional state apparatuses as initiators and supporters of neoliberal reforms, and the role of pre-existing institutional forms.

Within the health care sector, privatization can be present in three, interconnected, main forms. The first one is the privatization of financing, meaning that an increasing share of the national expenditure in health is financed either by private insurance or out-of-pocket (as co-payments or wholly private expenditure). The second one is the privatization of health care provision, mostly in the form of development of privately owned services contracting with the public system, or services financed by private insurance. The third form is the "enterprization" of the public healthcare system, i.e., adoption of a business managerial culture by public system institutions, which blurrs the limits between the public and the private, for-profit sectors (Gastaldo 1997). Related to all these aspects, the concept of managed (or regulated) competition was introduced a several decades ago, where one of the objectives was to create a balance between private and public modes of operation.

Almost by definition, the privatization of finance ties the right to health services with the ability to pay for them. Studies have consistently shown that, when compared with countries with publicly funded universal health coverage (i.e. UK and Netherlands), in health-systems where private insurance dominates (i.e. USA and Switzerland) equitable access to healthcare is severely harmed (Schoen et al, 2010; Schoen et al 2013; Osborn et al, 2016; Dickman et al, 2017). In a survey that compared insurance-related experiences among adults in 11 countries during 2010 (Schoen et al, 2010), 39% of USA citizens with below average income and 20% of those with above average income have experienced at least one access barrier due to cost. In the UK on the other hand, only 4% experienced one or more access barriers due to cost, regardless of their income level. In a similar study among respondents who requested emergency care during 2016 (Osborn et al, 2016), 33% of USA and 22% of Swiss citizens reported experiencing cost-related access problems whereas only 7% and 8% had such an experience in the UK and in the Netherlands respectively.

In support for private provision of healthcare, some researchers (Barnea et al, 2019) claim that private provision allows for a more efficient utilization of resources. For example, operating room utilization in the private healthcare system is more efficient compared to the public healthcare system. However, numberous studies have shown that the patients’ composition is entirely different (Grotle et al, 2014; Schizas et al, 2019; Mia et al 2019; Cheng et al, 2015). Compared with their counterparts in the public sector, patients receiving private elective surgeries are younger, have less comoribidities and are from a higher socio-economical class. This widespread difference has led researchers to claim that the apparent efficiency advantage of private provision is related to “cream skimming” patients according to their risk (Freisner et al, 2009; Berta et al, 2010; Cheng et al, 2015; Cowley et al, 2019; Chard et al, 2015).

Beyond the adverse outcomes on equity and the doubtful gains in efficiency, private provision and finance of healthcare can result in unnecessary, and sometimes harmful, cases of overtreatment. In a systematic review of 21 studies (Hoxha et al, 2017), the odds of a caesarean section (c-section) to be performed in privately insured women was significantly higher compared with women using public health insurance coverage. In Chile for example, three out of four publicly insured women who opt to give birth in a private hospital will have a c-section, while in public hospitals only one out of four women will undergo this procedure (Borrescio-Higa et al, 2018; Murray, 2000). Mixed-methods studies suggest that private obstericians bring women to undergo non-medical cessareian sections, since this procedure is more lucrative for the private practitioner and allows the “programing” (scheduling) of births (Murray, 2000; Long et al, 2018).

Evidence from Spain and Israel show that mixed provision of private and public services does not necessary lead to better performance while equitable access and provision of health services are harmed. In Spain, the highly praised Alzira private public partnership model was shown to perform worse than the benchmark in 15 out of 26 indicators (Comendeiro Maaloe et al. 2019). Furthermore, studies have shown that in Spain private medical insurance allows high-income individuals to avoid waiting lists and receive fast-track consultations (Alvarez et al. 2009, Cantareo-Prieto et al. 2017). Similar implication on equitable access to health services were found in Israel. According to the Central Bureau of Statistics (2019), 31% of Israel’s Jewish population had private insurance plans that allow access to surgical procedures in the private sector while only 5% of the arab population had such an access in 2017. Similarly, 42% of high-income individuals had access to private specialist consultations versus 6% of low-income individuals (Central Bureau of Statistics 2019). This data emphasize how in a private-public mixed health system the ability to pay for private insurance determines ones access to medical consultations.

In terms of healthcare provision, within hospitals that provide both public and private medical services (Sharap) in Israel a patient may be informed that a specific treatment is available through the public system in three months, but within a few days if he chooses to pay for it using private insurance or out of pocket payments. A study conducted in two such hospitals in Jerusalem (Hadassah Hospital and Shaare Zedek Hospital) found that average waiting times for a range of specialist appointments were 14 times longer for patients seeking a public rather than private consultation at Hadassah Hospital (Ministry of Health, 2014, p. 36). At Shaare Zedek Hospital, the waiting time was five times longer for patients seeking care through the public- in comparison to the private-pathway (Axelrod et al 2013). Also, private patients in hospitals with a private-public mix (Sharap) have an advantage over public patients in terms of the seniority of the lead surgeon (Ofer et al, 2006). In summary, the above studies suggest that patients receiving care through the public system in a mixed system are de-prioritzed in terms of access, waiting times and seniority of the attending specialist. This implicates both dimensions of social inequity as well as efficiency of resources within private-public mixed systems, since those with a more severe medical condition are less likely to receive timely care by expert specialists unless they can pay for it.

In the present paper, we seek to investigate: (a) what are the main processes of privatization in health care in Spain and Israel, both in financing and provision of services; (b) how they relate to budget constraints and to neo-liberal reforms; and (c) what the comparison between the Spanish and the Israeli case can teach us about the ways to cope with both budget constrains and the effects of privatization of health care services? We will focus especially on the development of models of private public mix as a central form of privatization in countries with a single-payer system.

In order to cope with growing health care expenditures and the increasing budget constraints, many countries have adopted various models of public-private partnerships. Those models have been proposed by their supporters as the best answer to shrinking public capital investments in health (Barlow, Roehrich & Wright 2013; Coelho et al. 2009; Rechel et al. 2009; Liebe & Pollock 2009; Economic Commission for Europe Committee on Economic Cooperation and Integration, 2012; Sanchez et al. 2013; Acerete et al. 2011). Different forms of public-private partnerships have been implemented in order to design, finance, build and maintain hospitals and other health-care infrastructures (McPake & Hanson 2016). In some cases, even, public-private partnerships also provide health care, whether by outsourcing or by privatizing specific services (Barlow et al. 2013; Acerete et al. 2011). While global changes in the political economy of health induced the adoption of different forms of private-public mix in almost every country, their specific forms, the ways in which different countries adopt specific forms of public/private mix, depend on the local context.

**Main Text:** The comparison between Spain and Israel

Comparing the process of partial privatization of health care in Spain and Israel provides a good case study for evaluating neo-liberal reforms, and assessing the validity of the theoretical approach presented above. . Health care reforms in Spain and Israel share common similarities in context, including the level of economic development, the characteristics of the welfare system, and, more specifically, the development of the health care system. According to OECD 2016 data, Israel’s GDP per capita stands at 31822$ PPP, while Spain’s stands at 32764$ PPP. According to the UNDP, the 2016 human development index values are very close (0.899 for Israel and 0.884 for Spain). Concerning the welfare regime, Spain and Israel are considered as belonging to the extended Mediterranean welfare regime (Gal, 2010). This extended family of Mediterranean welfare states includes Cyprus, Greece, Israel, Italy, Malta, Spain, Portugal and Turkey. The aforementioned welfare regime is characterized by relatively late industrialization, labor market rigidity and segmentation, significant shadow economies, with implications for the protection of workers and for state revenues. Social spending in these countries, while higher than in countries with liberal welfare regimes, is lower than in social-democratic and corporatist countries, and the ability on the part of the welfare state to overcome socio-economic gaps is limited (Gal 2010). Among the characteristics of the Mediterranean regime are the centrality of family and religion for welfare and the the existence of universal (or near universal) health provision by the state alongside a flourishing private health market (Ferrera 1996, Gal 2010). Concerning specifically the health care system, both Spain and Israel passed from a Bismarckian, social security health care system, to a universal one, in which residency granted access to health care, and in both countries we can assess significative trends of privatization of health care (Filc and Davidovich 2016, Bernal-Delgado et al. 2018, Epsten and Jimenez-Rubio 2018, IDIS 2018).

Table 1: Comparison between Spain and Israel

Albeit these significant similarities that make comparison relevant, there are also differences that are important in explaining the dissimilarities in the forms of private/public mix. Among those, the different character of the state (central state with devolution of power and responsibilities to regional autonomies in the Spanish case, a unitary and very centralized state in the case of Israel), different parliamentarian and electoral systems (bi-cameral in Spain, uni-cameral in Israel; 52 provincial circumscriptions in Spain, a single circumscription in Israel), different structures of citizenship (universal but challenged by national segregationist movements in Spain, ethno-national in Israel), and different medical professional culture (more European and identified with the welfare system in Spain, more Americanized and supporting private medicine in Israel). Thus, the combination of structural similarities – similar economic development, similar welfare regime and similar health care system – with political and cultural differences make the comparison very useful in understanding variegated pathways of privatization.

The Spanish case

During the last period of the Franco dictatorship, the Spanish health care system begun to be organized following a Bismarckian model (Vilar-Rodriguez and Pons-Pons 2017). Following the Transition, the 1978 constitution, article 43.1, recognized the right of all Spaniards to health protection (Garcia Armesto 2010). However, it was only in 1986, with the legislation of the Health Care General Act (Ley General de Sanidad), that it was legally implemented within a universal health care system (Ponte 2009).

The 1986 act recognized the right to health care as a fundamental right, underlying the importance of equal access. Article 3.2 specifically established effective equality in access to health care services (Acosta Gallo 2012).

The 1986 Act gave birth to a national health system (Sistema Nacional de Salud- SNS) with a progressive transition from payroll contributions to general taxation as the main source of financing (Menendez Rexach 2008, Garcia Armesto 2010, Vilar-Rodriguez and Pons-Pons 2017, Bernal-Delgado et al. 2018). The SNS integrated all the functions and infrastructures which are responsibility of the public sector (Menendez Rexach 2008, Bernal-Delgado et al. 2018). The new system covered all Spanish residents, with the exceptions of civil servants, the only group who could opt out of the national service. Civil servants are organized in three mutual funds (MUFACE- Mutualidad General de Empleados Civiles del Estado, MUGEJU- Mutual General Judicial and ISFAS- Instituto Social del las Fuerzas Armadas) and may choose fully private provision (Garcia Armesto 2010, Bernal-Delgado et al. 2018). Further modifications devolved responsibility to regional authorities in a two-tiered mode. The first one, a fast-track for regions with strong regional identity (the Basque country, Navarra, Catalonia Galicia, Valencia, Andalucia and the Canary Islands), some of them with self-governing traditions. The second tier, including 10 other regions, reached autonomy in 2002 (Garcia Armesto 2010, Avanzas et al. 2017). The 2001 reform made funding not earmarked but as part of the general sum transferred to the regions, which were responsible for decisions on how much funds they allocate to the health budget (provided that expenditure does not fall bellow the 1999 sum) (Garcia Armesto 2010, Fernandez Cuesta Valcarce 2013). The reform also established a new allocation formula, based on weighted capitation, taking into account population dispersion, extension and insularity of the territory In Spain, thus, the development of the public health care system and its relations with the private sector are function of the interaction between the national and regional level, with interregional differences in the degree and forms of privatization.

As a result of the crisis, in 2012 the Spanish government passed a royal decree (16/2012) that in a certain way rolled back the universal model, including in it certain characteristics of a Bismarckian, social security one (Fernandez Cuesta-Valcarce 2013, Bernal-Delgado et al. 2018, Picatoste et al. 2018). The system remained universal for urgencies, pregnancy, delivery and post-partum care, under age 18 and severe disabilities. For all other cases, the SNS provided services for those considered as insured (Royal Decree 16/2012). According to Article 3, in order to be considered as insured a person has to fulfill one of the following conditions: being a worker affiliated to the Social Security, being a pensionist affiliated with the Social Security, receiving payments from the Social Security (as unemployment subside), being a Spanish or EU citizen with an income under a limit fixed by the rules (Royal Decree 16/2012). The decree also increased the scope of co-payments, and made them relative to income (Picatoste et al. 2018). While de facto the Royal Decree did not modify coverage for most of the population, it made a de jure significant change, since the right to health care was not anymore the basic assumption for the functioning of the system (Lema Anon 2014). The decree excluded immigrants and people 26 years and over that are not part of the labor force and therefore did not pay direct taxes (Picatoste et al. 2018). The Royal decree linked entitlement to the legal and working status of individuals (Bernal-Delgado et al. 2018). In July 2017, a new Royal Decree revoked the 2012 reform and based access on residency (Boletin Oficial del Estado, 2018).

While the 1986 Act instituted a national service financed through taxation, there was still a relatively significant private sector, with around 30% of the national health expenditure privately financed (higher than the European average) (IDIS 2018). This private sector included, initially, mostly the abovementioned civil servants' mutual funds (Civil servants insured in the MUFACE, MUGEJU and ISFAS), as they may opt to receive private provision of health care or remain within the SSN. Some 85% of them choose the private sector (pwc 2012. IDIS 2018).

Concerning the private share of health care provision, the public system has traditionally contracted out specialized care provision to private (mostly non-profit-making) hospital providers, especially technologically sophisticated diagnostic services or outpatient surgical procedures, many times in order to shorten waiting times (Garcia Armesto 2010, Bernal-Delgado 20118, IDIS 2018). In 2014, contracts with private providers represented 12% of public health expenditure (Bernal-Delgado et al. 2018). Currently, the private hospital sector represents 53% of all hospitals and 33% of all beds (IDIS 2018). In 2015 private hospitals performed 29% of surgical procedures, discharged 23% of patients and provided 23% of emergency, figures that indicate growth in most areas of the private sector (IDIS 2018).

The private sector provides some 29% of the national health expenditure. A special case is that of Catalonia, where due to historical reasons, two thirds of the hospital services in the SNS are provided by private non-profit hospitals (Garcia Armesto 2010, Bernal-Delgado et al. 2018).

During the 2000s, emerged in Spain several hospital groups, mostly financed by the private insurance sector (60% of their income comes from private insurance, 30% from selling services to the SNS and 10% private out-of-pocket (Acosta Gallo 2012)). These groups are partly related to trans-national firms (for example the purchase of the Quiron group by the German Helios), and show a continuous tendency to concentration in large hospital groups (IDIS 2018). Among the most important, the Capio group (owning 14 hospitals), USP United Surgical Partners (owning 35 centers in Spain), the Vithas group, and the Hospiten group, active in the field of medical tourism (Ponte 2009, IDIS 2018). In the last years, the volume of private medicine in Spain reached 28.5 billion euro, representing 3.3% of the GDP in 2018 (IDIS, 2019).

Today 30% of the workers in the health sector are employed in the private sector. Fifty thousand physicians (slightly more than a third of all physicians) practice private medicine, with a third of them working both within the public system and privately (Ponte 2009).

Since the 1990s and until the late 2010s, Spain has undergone a slow and partial process of privatization of health care. The private share of the national health expenditure has increased form 22% in 1991 to 29%in 2015 (Garcia Armesto 2010, OECD 2014, Bernal-Delgado et al. 2018). This is related mostly to the growth in co-payments for drug prescriptions for people under 65 years, dental care, over-the-counter drugs and optical items (Garcia Armesto 2010). A second source is the increase in private insurance (though the percentage of insured population is still low in comparative terms). For-profit insurance companies provide insurance for the three abovementioned mutual funds; and are very slowly increasing their market share among people covered by the SNS, reaching to 13.4% of the population in 2011 and to 16.3 in 2017 (OECD 2013, Ministerio de Salud 2018), with significant regional variation (in Catalonia and Madrid over 20%) (Garcia Armesto 2010). If we add those insured by the Mutuals that choose private insurance, the percentage of people holding private insurance schemes reached 22.9% in 2015 (Bernal-Delgado et al. 2018). Voluntary private health insurance is unrelated to the statutory public system, and it is mostly a duplicate kind of insurance, providing coverage for the same goods and services offered by the public sector. This duplicate insurance provides greater choice, faster access to procedures and specialists, and improved amenities (Garcia Armesto 2010). There are also private insurance schemes that cover services not included in the SNS, such as adult dental care. In the mid-1990s, the state implemented several reforms aimed to expand private health care insurance, such as a 15% tax break applied to all private health care payments, replaced in 1999 by deductions for employer-purchased private insurance (Garcia Armesto 2010). The role of private insurers has increased, though slowly, as a result of the 2008 crisis. In 2007 services provided by private insurance companies represented 7.8% of the public health-care budget, and in 2012 it reached 8.8% (Adeslas, 2015).

However, the main way of privatization of health care has been the development of different forms of public/private mix, a mix that “is highly relevant for explaining policy outcomes in the [Spanish] health policy sector” (Gallego et al. 2017:26).

We already mentioned above that the public system sub-contracts with the private sector. Since the 1990s several forms of public-private mix have developed (Sanchez Bayle 2014, Ponte 2009). Firstly, the submission of publicly-owned foundations or institutions to civil –private –law, in such a way that public insitutions adopt organizational criteria imported from the business sector (Menendez Rexach 2008, Sanchez Bayle 2014). Secondly, beginning in 1996 especially in Catalonia, the development of the "associatively based entities" (EBAs), associations of a group of physicians managing a health center (form of group practices selling services to the public system) (Sanchez Bayle 2014, Bernal-Delgado et al. 2018). Thirdly, development of PFIs (private-financed initiatives). This model begun in Madrid in 2007 and extended to other regions such as the Balear Islands, Castilla y Leon and Galicia. Fourth, contracting with a private provider for the coverage of all services within an area (the "Alzira model") (Sanchez Bayle 2014).

The first form, the enterprization of public health care institutions begun with the legislation in 1997 of a law that allowed for institutions within the SNS to function as private enterprises (Acosta Gallo 2012). The "enterprization" of public institutions takes place at all levels: competition between public institutions, forms of management, role of the health professions, budget responsibilities, labor relationsips ("flexibilization" of labor relationships, outsourcing of ancillary work) (Sanchez et al.). Thus, appeared a constellation of new public institutions with different legal characteristics: public entities, consortia, foundations, public commercial societies, autononomous organisms and public enterprizes (Sanchez et al. 2013).

A particular form of the enterprization of the public system (that exists also in Israel, as we will show below) that completely blurs the boundaries between public and private, is the provision of private services within public hospitals. In this model (exemplified by the "Barna Clinic" developed within the Hospital Clinico de Barcelona), the public hospital receives private patients, generating two queues, and two levels of provision (Ponte 2009).

Second, the EBA model, adopted since 1996 in Catalonia, aimed to promote the passage of physicians from the public system to the private sector (Ledesma and Iruela Lopez 2014, Sanchez et al. 2013, Ledesma 2005). The EBAs are for-profit entities - mostly societies with limited responsibilities but some of them cooperatives – owned mostly by physicians, which sell services to the SNS. Physicians must own at least 51% of the firm, and no single proprietor may own more than 25% of the shares (making most firms composed by at least three or four physicians). Physicians' income is therefore a function of the EBA's profits. Today there are 13 EBAs in Catalonia, providing services to 260,000 people (Aceba, 2019)

The third mode of private/public mix in Spain are the privately financed initiatives (PFI). This model, including thirtheen hospitals in five Autonomous Communities, implies the development of services (mainly hospitals, but also laboratories), financed and sustained by the private sector, who perceives an annual payment from the public sector for a relatively long period (20 to 30 years) (Barlow et al. 2013, Bernal-Delgado et al. 2018). Among the services thus developed in Spain, hospitals in Madrid, Castilla y Leon (Burgos, Salamanca) and Barcelona, and a radiotherapy unity in the Canary Islands (pwc 2013, Ponte 2009, Moreno Munoz 2013).

Finally, the Alzira model, by which the SNS pays a capitated sum to a private for-profit firm in order to develop and manage all health care services within a certain area, providing the residents of that area with all the services guaranteed by the SNS. The implementation of this model begun in Alzira in 1997 and extended to include five areas in Valencia and three in Madrid (Bernal-Delgado et al. 2017). In the Alzira region, the community of Valencia contracted with a private group, UTE-Ribera headed by the private insurance company Adeslas, owned by the Bank Sabadell and the Centene Corporation, and financed by public, regional banks (Bancaja and Cam) (Acerete et al. 2011, Comendeiro Maaloe et al. 2019). The group was to provide a full range of services for the 250,000 inhabitants of the Alzira district. The integrated system included a university hospital, four health centers and forty-six primary care units. The original contract was signed for 15 years, extensible to 20, and the profit rate was capped at 7.5% (Garcia Calvo 2013). The contract was redesigned some years after with higher capping. Similar concessions were given in other four areas, including 19% of the Autonomic Community’s population (Olivas Arroyo et al. 2018, Comendeiro Maaloe et al. 2019). In 2018, a new autonomic government in the Valencia community did not renew the contract with Ribera salud in Alzira. Concessions were given in other four areas Manises, Denia, Elche-Vinalopó and Torrevieja (Comendeiro Maaloe et al. 2019). It should be noted that the decision was based on principled motives and on difficulties in regulation, since evidence about results in terms of efficiency or access is contradictory (Comendeiro Maaloe et al. 2019). A report by the comptroller of the Valencia community on the 2013-2016 period in the Torrevieja area, found that the model was more efficient than the public system (Sindicatura de Comptes 2018). However, a thorough new study did not show conclusive differences between the model in the Alzira area, and the public sector. The authors’ conclusion was “this archetypical PPP has not generally outperformed public-tenured providers, although in some areas of care its developments have been outstanding” (Comenderio-Maaloe et al. 2018).

The Israeli Case

The Israeli healthcare system has always been fragmentary and complex, due to the context of the emergence of several health care institutions before the establishment of the Israeli State. The Ministry of Health is in charge of planning and supervision, but it also runs hospitals and is in charge of public health services delivered by the Israeli Public Health Services, leading to conflicts of interests and difficulties in fulfilling planning and oversight duties of the Ministry. The health funds, most of all established before the establishment of the state, are non-profit health maintenance organizations (HMOs) responsible for the provision of health services – the "health care basket" as defined by law – to their members. Until the legislation of the National Health Insurance law (NHIL) in 1994, they provided health care services within a Bismarkcian/social security framework. The health funds administer and provide primary and secondary care, and finance (and sometimes provide) hospitalization services. Historically, voluntary non-profit organizations established before the state, run some of the hospitals and provide emergency care. Municipalities are in charge of some of the preventive care and public health services, and some even run hospitals.

The analysis of the Israeli case provides us with an example of both a systemic transformation (from corporatist to universal) aimed to increase equality in access, and the paradoxically rapid privatization of financing. The process of privatization of health care financing begun in the early 1980s, with the decrease in government funding and the increase in out-of-pocket expenditure and members' fees during the 1980s and early 1990s.

As Spain, also Israel underwent a transformation from a social security health care system to a universal one. In 1994 the Parliament passed the NHIL, which organized healthcare into a universal, state-funded, system[[1]](#endnote-1). As in the Spanish case, the new law recognized healthcare as a right, underlined the importance of equality in access to healthcare, and guaranteed a universal basket of services to every Israeli resident[[2]](#endnote-2). The system was to be financed by an earmarked “health tax” (4.8% of income), by the (already existent) earmarked employers tax, and by the government's general budget. The National Insurance Institute (NII) collected both the health tax and the employers' tax, and distributed the monies among the health funds, according to a weighted capitation formula. This weighted capitation takes into account the number of members in each health fund and their age mix (in 2010, the formula was modified in order to include gender and living in the periphery. The inclusion of other indicators such as socio-economic status and or disease severity are currently under analysis of an expert governmental committee). A key aspect of the NHIL was that the government would cover any difference between the funds collected by the NII and the the cost of the basket of services.

The passage of a law that transformed the Israeli health care system into a universal single-payer, run against Israel's shift to a neo-liberal socio-economic model, a shift that begun in the mid 1980s. Thus, although the law increased significantly both equality of access and progressivity of financing, it did not took long before the process of partial privatization of health care which begun in the mid 1980s was resumed. In 1997, only two years after the passage of the NHIL, the government passed a Budget Reconciliation Bill that eliminated employers' contribution to healthcare. In 1998, the government passed another Budget Reconciliation Bill that replaced the government's commitment to bridge the gap between the cost of the health basket and the funds distributed by the NII, with the provision of a significantly lower sum to be established yearly. In order to cover for diminishing public budget, the bill introduced significant increases in co-payments.

Since 1998, the government's share of the national health expenditure has declined gradually, shifting costs to the public in the form of "out-of-pocket" payments or private insurance. Between 1995 and 2010, public financing of health care services grew 11.7%, while the private share grew 51.6% (Chernichovsky 2013). By 2013, public financing of national health expenditure had reached an unprecedented low of about 60%, while private spending represented 36.8% of national health expenditure (see Table 2) (CBS 2015, Bin Nun 2014). The decrease in government financing was reflected in the growth of the share of health expenditure for households. In 1997, healthcare expenditure represented 3.8% of total household expenditure. By 2001, this expenditure had risen to 4.9%, and in 2009, it reached 5.1%. This rise in private healthcare expenditure has influenced equality in access to services. Household expenditure on health was significantly higher for the more affluent 20% of the population than for the poorer 20% of the population—by 2.9 times in 1997, increasing to 3.5 times in 2001, and 3.6 times in 2008 (Horev and Keidar, 2010). Compared to OECD (Organization for Economic Cooperation and Development) countries, Israel has a high share of private expenditure and a low share of public expenditure (Chernichovsky 2013). Out-of-pocket payments represent some two thirds of the private expenditure (co-payments, dental care and oral treatment, private doctors and private insurance, prescription drugs not included in the health basket, long-term private care). The other third goes to private insurance (roughly half of it in commercial insurance policies and the other half in private policies sold by the non-profit health funds) (Bank of Israel 2015).

 While the bulk of private expenditure is in out-of-pocket payements, the increase in private expenditure is mostly an increase in the bulk of private insurance. Between 2000 and 2011, the revenues of private insurance grew more than fourfold, from 700 million NIS (New Israeli Shekel) to 3.1 billion NIS (Bin Nun, 2013). Israel has now one of the highest private health insurance ownership rates in the world, reaching 80% of the population (Bin Nun 2013). In 2013 the public spent 1.5 billion euros in private insurance (Bank of Israel 2015).

Concerning ownership, private healthcare participation in national health expenditure rose from 18.9% in 1984 to 31% in 2013 (CBS 2014, Bank of Israel 2015). The number of private healthcare centers increased from 57 in 1980 to 185 in 2013 (CBS 2014), and their share increased from 30% in 1980 to almost 50% in 2013. In areas such as nursing care, privatization has been the preferred trend, and plans for construction of new units were – and still are – focused mostly on the private sector.

As in Spain, the central way of privatization of health care was the expansion of different forms of public/private mix, which in the Israeli case is characterized by the blurring of the boundaries between the public and the private sectors. Since the 2000s, budget constrains pushed hospitals and health funds to find alternative, market-related, sources of income. In order to alleviate pressure on the state budget, governments allowed the public health funds to sell private supplementary and duplicate insurance, providing for services not included in the public health basket. Hospitals developed different arrays of private initiatives in order to replace insufficient funding.

As we saw above, the private share of Israel's health expenditures has grown mainly due to the impressive expansion of supplementary insurance sold by the non-profit health funds, from 49% of the population in 1999 to 75% in 2011(Bin Nun 2013, Horev and Keidar 2011), rates that remained steady during the last decade. Supplementary insurance covers services not included within the public “health basket”, such as certain diagnostic procedures and pharmaceuticals. It also covers alternative and cosmetic medicine. However, the main reason drawing people to buy this kind of insurance policy is to allow for choosing specialist and skipping queues (Filc and Davidovitch, 2016). These programs allow choosing surgeons for surgical procedures performed in private (and in some public) hospitals and thus, although not their original intention, they are used to shorten waiting times[[3]](#endnote-3). Moreover, the public sick funds own private for-profit hospitals, medical imaging and laboratory facilities.

During the 2000s, many of the government-owned facilities were transformed into trusts, i.e., into business-like institutions. Government-owned public hospitals were required to behave as business firms and "sell" their "products" at full market price. Moreover, public hospitals use the existing infrastructure apart from the regular activities in order to expand services. Public hospitals run private services, such as institutes for plastic surgery. They also provide services not included in the public health basket to patients insured by commercial insurance companies ("check-ups", laboratory tests not included in the public service, "personalized medicine", etc). This transformation of government-owned public hospitals into "market producers" (as defined by the Central Bureau of Statistics 2004) has been a process that has taken place over the last fifteen years. As estimated by a former Deputy General Director of the Ministry of Health, by the late 1990s, 90% of hospital activities were determined by the health basket and 10% were activities "sold" by hospitals (Bin Nun, 1999). Between 1994 and 1996, the Ministry of Health has allowed public hospitals to sell private services of up to 20% of their income (Shirom and Amit, 1996). Even though this process had started already before the enactment of the NHIL, during the last two decades its scope has expanded, from private lodging for women giving birth to medical tourism. (Committee for Strengthening the Public Health System, 2014)

The hospitals incorporated these private and semi-private initiatives into their routine activities via three main instruments: Sharap (Hebrew acronym for Private Medical Services), Sharan (Hebrew acronym for Additional Medical Services) and the operating of private facilities within the public hospitals. Sharap is a system by which patients may choose their physician in a public hospital by paying an additional fee. It was implemented at the Hadassah Medical Center already in the 1950s, but forbidden in government owned hospitals by the Attorney General in 2002, a decision refrained by the Supreme Court in 2009 (Kyriati ruling, see also Gross, 2014) . Sharan is a system by which public hospitals sell services not covered by the National Insurance to the health funds, either to private insurers or to individuals. Even the main example of PFI in Israel is characterized by the blurred boundaries between private and public. A new hospital built in the city of Ashdod by Assuta Medical Centers, a private for-profit corporation owned by the non-profit Maccabi health fund. Assuta and the state will jointly finance the costs, and the new hospital was planed to dedicate 25% of its activity to private patients (using the Sharap arrangement), an agreement that was finally cancelled (Bin Nun 2013).

 The ongoing reforms have created a tiered system, that differentiates between those that have only public insurance, those holding insurance schemes sold by the public health funds, and those holding private insurance (Ilan-Schwartz et al.2011). Furthermore, most of the new private services within the public system are provided in the country's central area (around Tel Aviv and Jerusalem), increasing existing inequalities in service provision between the center and the periphery (MOH 2012). Thirdly, the public/private mix is less efficient, as shown by the higher loss- ratio and the increase in the shopping for third and fourth opinions (Simon-Tuval et a. 2015). Finally, another consequence of the tiered system has been the erosion of citizens’ trust in the public sector (Cohen and Filc 2015, Filc et al. 2019).

Public/private mix in Spain and Israel

We can see that the Spanish and the Israeli case have some salient similarities, and some significant differences. Firstly, both countries underwent a transition from a Bismarckian model to a universal health system in a period in which neo-liberal globalization had already begun, and in which both countries had already initiated their transition to neo-liberalism. In both countries, the relevant legislation (in Spain in 1986 and in Israel in 1994) recognized health care as a right and stressed the centrality of equality in access to health care. Secondly, and in apparent contradiction with the universalization of the system, both countries underwent processes of partial privatization of health care at three different levels: privatization of financing, privatization of ownership and the "enterprization" of the public system. Moreover, in both countries the public/private mix represented a central, if not the central form of privatization, and experts see it as a main threat to the future of the public health care system (Ponte 2009, Sanchez Bayle 2014, Committee for Strengthening the Public Health System, 2014, Gallego et al. 2017).

While these similarities are striking, there are some significant differences. From the beginning, the way in which the universal system was implemented was different. In Spain there was a combination of a national organization with progressive devolution to the autonomous regions. In Israel, universalization was implemented through the health funds that were the central institutions of the Bismarckian model. These different institutional forms, as showed below, result in different forms of privatization, and mainly in different forms of private/public mixes.

The partial privatization of finance is greater in the Israeli case than in the Spanish one. Figure 1 shows that in Spain public health expenditure as percentage of the GDP is clearly higher than in Israel. Moreover, while in Spain the public's share of national health expenditure went down from 75% in 1995 to 71% in 2012, in Israel it went down from 70% in 1995, to 60.4% in 2012 (Garcia Armesto 2010, OECD 2014, CBS 2015). In both countries, the number of people owning private health care insurance grew. However, in Spain figures are still low (13.4%), while in Israel growth was exponential, and today 80% of the Israeli population owns private insurance (OECD 2013). This, even though in Spain there are economic incentives for purchasing private insurance (in the form of tax exemptions), and in Israel not. While the effect of these incentives may be small in terms of size and target group, one would expect at least a smaller difference in ownership of private insurance between Israel and Spain.

Figure 1: Health expenditure in Israel and Spain as percent of GDP (1995-2017)

Regarding privatization of ownership, in both countries there has been an increase in private ownership of health care facilities, but in Spain the penetration of trans-national firms has been much more significant, while in Israel private groups are local, and there are no significant inverstments of foreign capital in the health care sector. Finally, even though forms of private/public mix are central to the processes of privatization in both countries, the concrete institutional forms differ. In the Spanish case, there have been three main forms for the public/private mix: out-sourcing of services (as in Catalonia), PFIs as in Madrid, and the "Alzira model" in the Valencia region. In Spain the mix has taken place in different forms in the different autonomic regions, but in general without blurring the boundaries between the private and the public health care sectors (with some exceptions, as the abovementioned hospital in Barcelona). In Spain the blurring of boundaries between private and public has taken place outside the health care system, for example public regional banks providing financing for the private consortium running the Alzira project. In Israel, there is a certain amount of out-sourcing of services, but the main forms of private/public mix blurr the boundaries between the public and the private system: private insurance sold by the public health funds, private for-profit hospitals owned by the public non-profit health funds, public hospitals selling private services.

The comparison of the processes of privatization in health care in Spain and Israel, shows the variegated character of neoliberalization processes, the ways in which the global transition to a neo-liberal model does not result in convergence, but in the "systemic production of geoinstitutional differentiation" (Brenner, Peck and Theodor 2010). From this perspective, procceses are "polymorphic, interscalar *constructions* – born of transnational, national and (newly devolved) subnational institutional reform frameworks" (ibid:196). Moreover, these processes are not linear and unidirectional, they create "hybrid" institutional forms and policies "in which commodifying *and* market-constraining logics commingle and co-evolve." (ibid:189). In comparing the Spanish and the Israeli cases, we can see how global processes (modifications in the modes of production, capital mobility, deregulation, the strength of the neo-liberal paradigm), combine with specific transnational processes (the EU and the euro constrains in the Spanish case, the consequences of a prolonged conflict in the Israeli one), and national and sub-national institutional and cultural characteristics. The latter are important, because they explain the differences in the ways privatization takes place in both countries. In Spain, the dynamics between the national government and the regional autonomies is central, with different regions adopting different ways of public/private mix (the abovementioned differences between Madrid, Catalonia and Valencia, or the differences between Catalonia and Andalucia showed by Gallego et al. (2017)). Moreover, the firm opposition to privatization of the health professions working in the public sector (Picatoste et al. 2018), did not allow for the blurring of the boundaries between private and public.

In Israel, the historical role of the health funds, and the institutional strength and relative independence of the public hospitals, are the reason that the main forms of private/public mix took place within those institutions (private insurance schemes owned by the public health funds, private services provided by public hospitals). Moreover, increasing support for public/private modles of health care delivery among physicians working within the public sector (combined with the general public opposition to the privatization of health care), made forms of private/public mix that blurred the boundaries between the public and private sectors, an easier – thus preferable – path. While in Israel these processes were quite consensual among the medical profession, perceived as mainly technical, in Spain privatization in healthcare is perceived as a much more political issues and resistance emerged from some parts of the medical profession, as well from the public.

**Conclusions:**

The comparison between the Spanish and the Israeli cases confirm Brenner et als. claim that reforms are the uneven and unstable result of the influence of trans-national and national forces on pre-existing institutional forms that provide fields of opportunity, and spaces of realization for the neoliberazation processes (Brenner et al. 2010). On one side, we see the penetration of market forces, the partial privatization of finance, the 'enterprization' of the public system; all local responses to constraints imposed by the global neo-liberal model. On the other side, the institutional differences between both countries show that processes of neo-liberalization are constitutively uneven (concerning both institutions and forms of regulation).

The comparison shows that those processes are not only non-linear (as exemplified by the institutionalization in both countries of an equal right to health care already in the neo-liberal age), but also not uni-directional (from the global level to the national one). The analysis of the Spanish and the Israeli cases shows the active role played by national and regional state apparatuses as initiators and supporters of neoliberal reforms. In the Spanish case the modifications in legislation that allowed for the 'enterprization' of the public system, the adoption of PFIs by the Madrid community, the adoption of the Alzira model at the regional level, the symbolic abandonment of the universal model as a response to the economic crisis (the 2012 Royal decree). Spain coped with budget constraints resulting from neoliberal policies, medical advances and demographic changes by restricting scope of coverage and allowing Autonomies to engage in different forms of public/private mix. Israel coped by decreasing the public share of the national health expenditure, while blurring the boundaries between public and private (for example the provision of private insurance schemes by the public funds). In Israel, the 'enterprization' of the public system as local responses to budget constraints, the complete blurring of the boundaries between private and public, the exponential growth in private insurance due to its marketing by the public health funds.

Albeit the rapid growth of privatization in healthcare provision, models of mixed-provision are being scrutinized by the health-policy community in both countries. This has resulted, in some cases, in acts of resistance towards several private public partnerships or in the rejection of elements that increase inequity in care within those partnerships. For example, as numerous administrative and financial doubts emerged regarding Spain’s Alzira model of private-public partnership, in 2018 the Valencia's Health Authority decided to terminate the concession and to revert to direct public provision of healthcare (Comendeiro Maaloe et al. 2019). At the national level, the socialist government approved in 2018 a new Royal decree that made access to health care universal once more, including undocumented migrants, thus abolishing the 2012 decree.

In Israel, the Ministries of Finance and Health implemented measures aimed to limit the blurring of boundaries between the public and the private sectors. In 2014 the MOH Committee for the Strengthening the Public Healthcare System decided not to expand the Sharap system to public hospitals outside Jerusalem (Israel MOH, 2014). Moreover, the state reverted previous decisions that resulted in the blurring of boundaries between public and private. For example, the Assuta Hospital network (Israel’s biggest private hospitals network) built in the city of Ashdod a hospital that would provide both private and public services. In 2016 the Ministry of Health decided to compensate the network in exchange that it cancel the provision of private services. (Kropski, 2016). This agreement was reached following several years of judicial petititions against the expansion of the “Sharap” private provision model to additional hospitals in Israel. The MOH also aims to limit the ways in which physicians blurr the frontiers between public and private, for example, establishing that physicians will not be able to treat privately patients they saw at the public sector during the last six months.

The examples show that in Spain revisions of previous policies took place mostly at the macro level, while in Israel they take place at the meso, or even micro level. While these different approaches may be related to the fact that in Israel there is payer competition between the funds, and in Spain not; still each country may learn from the other, since a combination of macro, meso and micro level policies should be the best strategy to strengthen the public health care system. Any such strategy, though, as policy makers in both countries recognize, requires increasing public funding. Hence, the socialist government in Spain commited to rise public spending in health from 6% to 7% of GDP, and the Israeli health community demands of 15 billion NIS in order to maintain the quality of the public health care system.

A comparative perspective is important since countries can learn from each other. The Spanish case offers Israel health care policy makers, planners and managers, two main teachings. The first is that the failure of the Alzira model - the gap between the initial proposal and real costs (Olivas Arroyo et al. 2018), lower performance when compared with public tenures (Comendeiro-Maaloe et al. 2019) and difficulties in supervising services (Olivas Arroyo et al. ibid) – warns us of the problems of for-profit HMOs. The warning is of importance, since the idea of allowing the opening of a for-profit HMO in Israel to compete with the current four public ones has been seriously considered by both the MOF and the MOH. The second teaching concerns the importance of cultural factors, and not only economic considerations, in citizens’ decisions concerning health care. While Spain provided economic incentives for the acquisition of private insurance packages through tax exemptions, Israel did not. However, as shown above, the percentage of the population having private insurance schemes is much higher in Israel than in Spain. The low cost of those schemes in Israel may partially explain this fact. However, in order to fully understand it we have to take into account cultural issues such as confidence in the public system or attitudes toward uncertainty (Filc et al. 2019). The Israeli case offers the Spanish health care policy makers, planners and managers, three main teachings. First, private/public mix solutions risk to erode trust in the public system, thus reinforcing market failures and inneficient medical systems (for example, by shopping for third and fourth opinions) (Ministry of Health, 2014, p. 49). Second, growing privatization in the form of supplementary insurances creates less efficient systems. This is expressed in greater loss ratios, and in the fact that the sick funds’ private insurance schemes create a way to bypass the efficient public healthcare basket decision making process (Simon-Tuval et al. 2015). Finally, public/private mix forms such as SHARAP show that in fact the public system subsidies private users, as in the case of the Hadassah hospital, were private surgical interventions were performed the whole day long. Thus, public facilities served private patients at the expense of those in the public sector (Ministry of Health, 2014).

The shared experience of Israel and Spain with privatization of health services shows that members from the health-policy community as well as civil society activists can lead to a re-evaluation of models of private-public mix, and in some cases change the trajectory from private towards public provision of services.

**Abbreviations**

EBA Entidades de Base Asociativas

HMO Health Maintenance Organization

ISFAS Instituto Social del las Fuerzas Armadas

MOH Ministry of Health

MOF Ministry of Finance

MUFACE Mutualidad General de Empleados Civiles del Estado

MUGEJU Mutual General Judicial

NHIL National Health Insurance law

NII National Insurance Institute

NIS New Israeli Shekel

OECD Organization for Economic Cooperation and Development

PFI Privately Financed Initiatives

SHARAN Additional Medical Services

SHARAP Private Medical Services

SNS Sistema nacional de Salud

USP United Surgical Partners

**Declarations section**

- Ethical Approval and Consent to participate: Not applicable

- Consent for publication: Not applicable

- Availability of supporting data: Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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1. Addressing the reasons for the apparently paradoxical transition to a universal system during a period of neo-liberal reforms exceeds the scope of the present paper. For possible explanations, see Filc 2004. [↑](#endnote-ref-1)
2. However, not as in Spain, the system is open only for 'legally' recognized residents. [↑](#endnote-ref-2)
3. It should be noted that supplementary insurance schemes sold by the public sick funds are community rated and have no underwriting, see Chernichovsky 2013). [↑](#endnote-ref-3)