Health Economics, Policy and Law (2016), **11**, 223–225 © Cambridge University Press 2015
doi:10.1017/S1744133115000377 First published online 21 October 2015

Response

If it looks like a duck, swims like a duck, and quacks like a duck, it probably is a duck: black market medicine and privatization in Israel

DANI FILC*
Department of Politics and Government, Ben-Gurion University, Beer Sheva, Israel
NISSIM COHEN
Department of Politics and Government, Ben-Gurion University, Beer Sheva, Israel

Gregory Bateson began his 1972 seminal 'Steps to an Ecology of Mind' with several imaginary dialogs on science and epistemology between a girl and her father. We quote from one of them – "Why do Things have Outlines?" – because it addresses the problems of approaches that favor shades of gray and the blurring of boundaries brilliantly:

> 'Daughter: Daddy, why do things have outlines?
>
> … Father: …Do you mean 'Why do we give things outlines when we draw them?' or do you mean that the things have outlines whether we draw them or not? (...) William Blake … was mad angry about some artists who painted pictures as though things didn't have borders. He called them 'the slobbering school'.
>
> D: He wasn't very tolerant, was he, Daddy?
>
> F: No, Blake was not very tolerant. He didn't even think tolerance was a good thing. It was just more slobbering. He thought it blurred all the outlines and muddled everything- that it made all cats gray. So that nobody would be able to see anything clearly and sharply…
>
> D: …and getting things clear is what Science was about.' (Bateson, 1972: 37–40).

To try to get things clear, let us examine Chinitz and Israeli's criticque. They make four main claims: (1) We overstate the degree of privatization of the Israeli health care system. (2) We overstate the degree to which the blurring of the public/private distinction reflects privatization. (3) Our definition of black market medicine (BM) overestimates its dimensions. (4) We wrongly consider lack of

*Correspondence to: Dani Filc, Department of Politics and Government, Ben-Gurion University POB 653, Beer Sheva 841051, Israel. Email: dfilc@bgu.ac.il

trust as explaining the persistence of BM in Israel instead of culture or poor regulation:

(1) The commentators are right in claiming that a significative percentage of private expenditures on health is spent on dental care and long care term. However, that was also true in 1995, the first year of the NHI Law. Back then, Israel's private expenditures on health were close to the OECD average. Today, they are the fourth highest, not because of the increase in the cost of dental care, but because of the significant increase in private insurance and copayments. Countering their claim, the percentage of household expenditures on dental care did not grow between 1997 and 2008, but the expenditures on drugs increased 30%, and the expenditures on private health insurance 400% (Bin Nun, 2013). Moreover, the commentators compare 2014 with 1998, and not with 1995, obscuring the fact that between 1995 and 2013, private expenditures increased from 31.4 to 39.7% (CBS, 2015).

(2) The commentators do not offer any evidence supporting their claim that we overstated the degree to which the blurring of the public/private distinction reflects privatization. The facts speak differently. As we indicated, the Central Bureau of Statistics changed its estimation of private vs public provision, because many of the public providers are in fact 'market producers'. The State Comptroller clearly defined insurance packages sold by the public sick funds as private insurance and criticized the fact that the public hospitals' private activities represent 40% of their budget. The Ministry of Health itself considers the growth in private insurance sold by the sick-funds as one of the problems of the Israeli healthcare system.

(3) The commentators rightly claim that a positive answer to question four in our survey does not point to BM. Indeed, we agree that some of the cases in this statement may be understood as 'gratitude payments'. Yet, this statement also includes cases in which patients give presents before and during treatment to receive better treatment – as the qualitative evidence we collected reveals. Given the fact we asked about illegal activities, one can equally argue that some would not report these activities. However, even if we agree with their claim that BM is less than our figures, they are still high in international terms, particularly where there is no reason for 'inxit'. To prove that the situation improved, they quote Lachman and Noi's 1998 figures, which were higher than ours. However, their survey did not cover the whole population; it was done in hospitals, surely making the figures higher and comparisons irrelevant.

(4) In arguing that we 'seek to dismiss other elements, such as culture and lack of good regulation as causes of BM,' the commentators clearly misread or misrepresent our argument. We unmistakably state, '[C]ultural characteristics and poor regulation partly explain the persistence of the phenomenon. The phenomenon of "alternative politics" proposed by one of us partly explain BM in Israel… Poor regulation also contributes to the persistence of the phenomenon… Indeed, our qualitative and quantitative findings led us to believe that regulation, indeed, is a key factor for reducing the phenomena of BM' (page 15). While the commentators did not empirically support their claim

about the 'obvious' role of culture and regulation, we propose 'a complementary explanation.' Our qualitative evidence supports the claim that blurring the lines between private and public erodes trust in the healthcare system, which is not high in Israel. Erosion of trust is positively related to the use of BM.

Finally, we agree with the commentators that increasing public financing for mental health, long-term care and dental care are central goals for the Israeli health care system. We also agree with their emphasis on health promotion and disease prevention (we would add, addressing the social determinants of health). However, our paper was not about the priorities of the Israeli health care system. It discussed the dimensions of BM in Israel and its possible explanations (and decision makers should ask themselves what they did or can do to decrease this phenomenon). While future research is necessary, we showed that blurring the boundaries between private and public strengthens an undesirable phenomenon.

References

Bateson, G. (1972), *Steps to an ecology of the mind*, New Jersey: Jason Aronson.

Bin-Nun, G. (2013), 'Private health insurance policies in Israel: a report on the 2012 Dead Sea Conference', *Israel Journal of Health Policy Research*, **2**: 25. http://www/ijhpr.org/content/2/1/25 [7 July 2015].

Central Bureau of Statistics (2015), *Statistical Yearbook (Hebrew)*, Jerusalem: CBS.

https://doi.org/10.1017/S1744133115000377 Published online by Cambridge University Press