Health Economics, Policy and Law (2016), **11**, 215–221 © Cambridge University Press 2015
doi:10.1017/S1744133115000365 First published online 3 September 2015

Commentary

Not everything is black or white: commentary on Filc D and Cohen N, blurring the boundaries between public and private health care services as an alternative explanation for the emergence of black medicine: the Israeli case

DAVID CHINITZ*

Department of Health Policy and Management, School of Public Health, Hebrew University-Hadassah, Jerusalem, Israel

AVI ISRAELI

Department of Health Policy and Management, School of Public Health, Hebrew University-Hadassah, Jerusalem, Israel

Health systems are challenged "amid the hard, austerian times that now beset Western economies" (Brown and Chinitz, 2015). Richard Saltman, a staunch supporter of public financing of health care (Saltman, 1994), has, in some of his recent writings, suggested that current conditions warrant new and creative ways of admitting increasing private finance into public health systems (Saltman, 2013, 2015). Indeed, financial sustainability of health systems challenges the various strait jackets put by Western health systems on private medicine, and would appear to call for "blurring" of the boundaries between public and private (Flood, 2010).

It is thus surprising to read a paper based in a country with National Health Insurance (NHI) that implies that such blurring is problematic to the point of contributing to the emergence of black medicine in that country's health care system. The article by Filc and Cohen (2015) on which we comment here, appears to be issuing a warning that when boundaries blur mischief is likely to be afoot. Given the relevance to many health systems, and the illustrative value of the Israeli case, we have decided to review briefly the contents of that article, and comment on the main components of its analysis. Overall, it seems to us that seeing black in the blur, as opposed to the gray one might expect, flies in the face of the facts regarding the Israeli system, as well as the exigencies faced by all universalist health care systems.

*Correspondence to: David Chinitz, Department of Health Policy and Management, School of Public Health, Hebrew University-Hadassah Jerusalem, POB 12272, Jerusalem 91120, Israel. Email: chinitz@cc.huji.ac.il

Conceptualizing black medicine and its causes

The theoretical agenda of the authors is to explain the emergence of black medicine in systems where extensive legal alternatives to the public system exist. In order to do so, they are compelled to exclude from black medicine any types of gray medicine, such as legal, regulated use of private insurance to exercise choice of physician. As we will point out in the next section, according to this very exclusive definition, little of what takes place in Israel qualifies as black medicine.

However, the point raises conceptual conundrums. If the idea is to show that 'blurred boundaries' lead to black medicine, this is exactly what one would expect as long as the level of black medicine is quite low. There is no reason for *inxit,* the term used by McKee and Gaal to describe informal payments in systems with no private outlets, because the willingness to pay extra is channeled through formalized gray medicine (Gaal and McKee, 2004). The blurring of public private boundaries will increase resort to blurred payments, and constrain actual black, illegal payments to a minimum. And, despite their apparent intentions, this is what the authors demonstrate in their paper.

The public private context in Israel

NHI in Israel mandates provision of a standard basket of health services (commonly said to be comprehensive and up to date in international perspective) by four non-profit health plans that cover the entire population. Citizens are entitled to enroll in the plan of their choice with no limitations. Providers include salaried and independent physicians and nurses, as well as government, non-profit and private general and chronic care hospitals. The health plans are financed by an ear-marked tax paid by residents to the government together with general government revenues. The budgets so provided to the health plans are meant to equal the anticipated cost of providing the standard basket of health services. Provisions are made to increase the budget according to an index (discussed below) that is linked to price increases and additional funds for absorption of new technologies.

Filc and Cohen rightly present their analysis in light of the evolving public/private mix in the finance and delivery of health care in Israel. They state that "by 2012 public financing of national health expenditure had fallen to an unprecedented low of 61.3%." This makes it look like there has been a significant decline in public finance of medical care, but private financing of the national health expenditure has risen by only 6% between 1998 and 2013 (Plotnik and Keidar, 2015). Moreover, the 61.3% figure is misleading, because the vast majority of private finance is spent on long term care, dental care, and mental health care, services not included in the medical care basket provided by Israeli health plans. Whereas about 6% of the cost of providing the standard basket of services is paid for privately, ~42% of nursing/long-term care is privately financed

https://doi.org/10.1017/S1744133115000365 Published online by Cambridge University Press

(Horev *et al.*, 2011; Plotnik and Keidar, 2015). For mental and dental health care, due to underfunding of public mental health clinics and widespread private consumption of mental and dental health care, the figure is probably even higher. Using the 61.3% public finance figure in international comparisons is distorting, since in most OECD countries, services such as long-term care, mental health and dental care are funded publicly to a greater extent. For example, long-term care in Germany is financed by an earmarked tax.

Moreover, as the authors point out, the largest increase in private spending for the health basket has been for supplemental insurance provided by the health plans. Such insurance covers items not included in the standard basket mandated by law. As mentioned by the authors, entrance to supplemental insurance, as opposed to commercial private insurance, is guaranteed issue and community rated, showing clear publicly mandated solidaristic qualities. As a result, nearly 80% of the Israeli population holds such insurance. Research shows that about 30% of the supplemental insurance payouts are for choice of physician for services included in the standard basket, as choice is not guaranteed by the latter (Chinitz and Grau, 2015). In other words, most of the increase in private expenditure in the Israeli health system since 1995 has been for items not included in the mandated health basket and/or paid for by quasi public supplemental insurance held by most of the population. A smaller increment in private finance is due to co-payments, which rose from 5% of health plan revenues in 1995 to about 9% in 2013. The equity and health impacts of co-payments have fluctuated over time, and are beyond this discussion, but, in any case, they have nothing to with black medicine.

It is worth pointing out that over the last decade, while Israel has been governed, arguably, by a neo liberal orientation and austere policies toward social services, health care has seen the least reduction of public funding of any sector. Moreover, in absolute terms, the government has increased funding to the standard basket of services budget in order to include new technologies (Chinitz and Grau, 2015). Arguments are made that the index by which the overall budget for the standard basket of services is not adequately adjusted to demographic changes and health sector price inflation (Plotnik and Keidar, 2015). Per capita public expenditure on health has risen by about 1% annually on average over the last seven years (OECD, 2014), while total expenditure per capita has risen over the same period by about 2.4% annually (Central Bureau of Statistics, 2014). Health expenditure as a percentage of GDP has remained level at about 7.5% (Plotnik and Keidar, 2015), including since 2008, a period of continued economic growth in Israel despite the economic crisis that has slowed or halted growth in most of the Western economies. Overall, the article by Filc and Cohen, arguably, overstates the decline in public finance to the health sector and the main areas of private expenditure are on services not related to the standard basket of services and likely not related to resort to black medicine.

On the provision side, the authors describe correctly the increased activity of private medical organizations, such as hospitals and diagnostic centers, as well as

private subsidiaries of the health plans and public hospitals, dealing mainly with items not included in the national basket of services. Their point seems to be that an atmosphere of commercialism is pervading the system. But, again, the relationship to the emergence of black medicine is unclear. The authors themselves describe all of these activities as at most 'legal forms of *inxit*.'

The author's reading of the public/private mix picture in Israel seems to be that there is increased blurring of the distinction. We agree with this assessment, but observe that the authors have exaggerated the degree to which the blurring reflects privatization. The next question is whether this blurring has led to greater resort to black medicine, to which we now turn.

Estimating the prevalence of black medicine in Israel

The first problem with the authors' attempt to measure the extent of black medicine in Israel is their method of asking about the phenomenon. They use four questions given to a representative sample of Israeli citizens:

1. Have you, or anyone of your family ever made an informal payment, discreetly, in order to receive preferential health care services?
2. Have you ever made an informal payment for private care in a public hospital that does not provide private medical service?
3. Have you ever donated money or equipment to a hospital or a research fund in order to move up an appointment, receive better care or choose your treating doctor/attending physician?
4. Have you ever given gifts to the/a medical team prior or during treatment, receive by you or a family member?

The authors defined a positive answer to any of these questions as indication of black medicine. There are several problems with this. First, at least one of the items, number 4, to which 8% answered affirmatively, is not clearly black medicine. It cannot be assumed that gift giving initiated by the patient is any more than a sign of appreciation for the provider, and there is no proof that the gift influenced care relative to other patients, and such gift giving is not illegal.

Regarding the other three items, the authors do not reflect on how well, especially in the blurred environment they themselves go to such great lengths to describe, respondents understand these questions. If the physician encourages me to use my supplemental insurance, could that be construed as an informal payment? This could especially be the case if the patient sees the physician in a government hospital and is encouraged to have treatment given at a private facility. Patients may not be able to distinguish use of their supplemental insurance, including the accompanying co-payment, from the type of informal payment the authors have in mind, which is actual cash under the table. The most likely suspect to be black medicine is item number 3, to which only 2% answered in the affirmative.

Seven percent of the respondents answered yes to item 1 and 5% to item 2. Beyond the fact that both of these items cannot be definitively labeled as black medicine, the authors go on to *add the results together* and say that 12% of Israelis have made informal payments that are illegal.[1] Even if we accept the blackness of these items, the authors provide no comment on whether the answers are mutually exclusive. It appears that the real figure is that somewhere between 5 and 12% have made such payments, even if we dismiss our doubts about how well the respondents understood the questions. Indeed, the only unquestioned evidence of black medicine provided in the paper is one qualitative response of an individual who claimed to have paid $600 for a visit to a physician's private clinic that resulted in the patient being moved up in the queue.

Even if we take the 12% as accurate, the authors fail to compare it with past studies. While they mention studies of the phenomenon from 1988, they do not reveal that that source uncovered prevalence of black medicine nearing 30% (Resnick, 2009). So has the Israeli health system, with the blurring of boundaries, evolved in a way that has reduced and constrained black medicine, or is the latter on the increase? From the data presented, we cannot know, but the authors assert that black medicine is re-emerging when, clearly, the real picture is that gray, legal forms of *inxit*, are not only available (as the authors show) but also the main avenue for health care consumption and provision that are not totally publicly financed and provided.

Trust and the emergence of black medicine

The authors appear intent to trace the (very small) amount of black medicine they discovered to an overall lack of trust in the public system derived from increasing privatization. Thus, they seek to dismiss other elements, such as culture and lack of good regulation as causes of black medicine. Apparently, they want to support their theory that it is the blurring of boundaries between public and private that causes the phenomenon. We will not argue the point here, but when the authors say that it is not clear why physicians in one culture would be greedier than in another, or why one health system context would feature weak regulation more than others, readers in any country, not least Israel, would be likely to raise an eyebrow.

1 Another study puts the number of people who have, or know someone who has, ever made an 'under the table payment' to a physician at 14% (see "Public Attitudes Towards the Health System," Israel Democracy Institute December 2013). The use of the word 'ever' poses problems of validity and recall bias, because we do not know to what period the respondent is relating. It likely inflates these numbers, since the respondent could be referring to a time before the expanded access to supplemental insurance. We would have expected the authors to ask regarding the last one or two years. One could also argue with the reference to 'anyone in your family' or 'anyone you know,' which could lead to what legalists might call 'circumstantial evidence' at best. In general, what respondents understand by 'under the table' is, as mentioned, problematic and the number has clearly gone down by at least half since the advent of NHI in 1995.

https://doi.org/10.1017/S1744133115000365 Published online by Cambridge University Press

Instead, the authors turn to the question of trust in the health system. Polling the respondents with a reasonable questionnaire regarding their trust in their health plan and anticipation of being able to access care when needed, they characterize the trust of respondents in the health system. These are then correlated with resort to black medicine as measured by the authors.

While other studies demonstrate higher levels of citizen trust in general in the Israeli health care system (Chinitz *et al.*, 2009), the analysis presented by the authors of their data demonstrating that levels of trust are inversely related to resort to what they call black medicine is convincing. However, as we pointed out, are citizens with lower trust more likely to resort to black medicine, or to gray medicine? We would argue that the blurring of boundaries between public and private has perhaps enabled physicians to play on lack of trust to increase resort to gray medicine.

From a theoretical standpoint, the authors do not discuss the intricate and recursive relationship that exists between culture, regulation and trust. They rush to assume to that trust is exogenous, but, clearly, whatever the level of trust, if physicians and citizens are culturally averse to breaking the law, or if they are being well regulated, the phenomenon of black medicine will be mitigated. An alternative theoretical model would reasonably suggest that regulatory behavior in Israel is inchoate,[2] and that not enough is being done to monitor the behavior of physicians who might be encouraging patients to resort to gray (mostly) and black (very little) medicine.

Conclusion: misplaced emphasis

There is no doubt that better regulation would improve the Israeli health system. However, this would be aimed at fine-tuning gray medicine, better managing the blur by monitoring the use of supplemental insurance, as opposed to tracking down the small amount, if any, of actual illegal black medicine. Whether lack of good governance creates lack of trust or vice versa, efforts to nurture both of these important features of the policy setting are unlikely to benefit from exaggerations of the privatization tendency in the Israeli health system and the level of black medicine. To focus on informal payments that are marginal and on the relatively small decline, if at all, of public expenditure on the standard basket of services mandated by NHI appears misplaced. If there is to be an increase in public finance to the health sector, it should be in the areas of mental health (which is about to be added to the standard basket), long-term care and dental care, which are typically covered to a much greater extent in other OECD health systems. Moreover, with

2 Indeed, recent research on legally sanctioned private practice in quasi public hospitals in Jerusalem, while suggesting large gaps in waiting times between private and public frameworks, argues that the evidence shows that better monitoring and enforcement of rules regarding private practice in one of the hospitals mitigates such disparities (personal communication with Professors Mayer Brezis and Amnon Lahad who conducted the as yet unpublished research).

high levels of patient satisfaction, and good health indicators, the Israeli system ought to be turning its attention to health promotion and disease prevention (Schmidt *et al.*, 2015). Hopefully, these will be the future directions of the Israeli health system, rather than an emphasis on exaggerated assessments of the degree of private finance of the standard basket now provided under NHI.

References

Brown, L. D. and D. P. Chinitz (2015), 'Saltman on solidarity', *Israel Journal of Health Policy Research*, **4**: 27–34.

Central Bureau of Statistics (2014), *Statistical Annual: Health* (Table 6.2), Jerusalem: Central Bureau of Statistics.

Chinitz, D. and I. Grau (2015), 'Privatization in the Israeli health system', in I. Galnoor and A. Paz Fuchs (eds) *Privatization and the Boundaries of the State*, Jerusalem: Kibbutz Seminar Press and Van Leer Institute, 238–264.

Chinitz, D. P. I., R. S. Meislin and I. C. Grau (2009), 'Values, institutions and shifting policy paradigms', *Health Policy*, **90**(37–44): 1.550.

Filc, D. and N. Cohen (2015), 'Blurring the boundaries between public and private health care services as an alternative explanation for the emergence of black medicine: the Israeli case', *Health Economics, Policy and Law*, **10**(3): 293–310.

Flood, C. M. and A. Haugan (2010), 'Health Economics Policy and Law', **5**(3): 319–341.

Resnik, R. (2009), 'Cash on the Table: A Complete Guide to Black Medicine', *Yediot Aharonot*.

Gaal, P. and M. McKee (2004), 'Informal payment for health care and the theory of 'INXIT'', *The International Journal of Health Planning and Management*, **19**(2): 163–178.

Horev, T., N. Keidar and I. Hershkovitz (2011), *Public Insurance for Nursing Care*, Jerusalem: Ministry of Health.

OECD (2014), 'Public expenditure on health per capita'. Health: Key Tables from OECD, No. 4. doi: http://dx.doi.org/10.1787/pubexhltcap-table-2014-1-en.

Plotnik, R. and N. Keidar (2015), *The National Health Insurance Law after 20 Years: Statistics* Jerusalem: Ministry of Health.

Saltman, R. (2015), 'Health sector solidarity: a core European value but with broadly varying content', *Israel Journal of Health Policy Research*, **4**: 5.

Saltman, R. B. (1994), 'A conceptual overview of recent health care reforms', *European Journal of Public Health*, **4**: 287–293.

Saltman, R. B. and Z. Cahn (2013), 'Restructuring health systems for an era of prolonged austerity', *British Medical Journal*, 346–350.

Schmidt, H., L. O. Gostin and E. J. Emanuel (2015), Public health, universal health coverage, and Sustainable Development Goals: can they coexist? *TheLancet*,-d-15-00297r1 s0140-6736(15)60244-6.