

## **National Health Insurance Plans and “Health-Care Citizenship”: Canada and Israel**

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### **Introduction**

All health-care systems are imperfect in the sense that they cannot ensure full coverage for all people for all medical situations without delays. This invites system reform, especially in welfare states which have a vested interest in maintaining health-care standards. But how can we evaluate a health-care system and determine whether it requires reform? Using the concept of “health-care citizenship”, I present several criteria for evaluating relations between individuals and health-care systems.

Evaluating health-care systems can be difficult. The number of models of health-care systems equals the number of health-care systems, as each welfare state develops unique institutional arrangements for funding, regulating, and delivering medical services (Hatzopoulos, 2005). This multiplicity of systems has not prevented the development of typologies based on macro-level variables as funding rules (Flood, Stabile, and Tuohy, 2002; Hacker, 2004) or on the interactions of political actors and political institutions (Andrain, 1998), as key variables for explaining variation and dynamics. But by focusing on society-level institutional arrangements, these typologies miss the target of health-care systems – individuals. Sadly, individuals’ contributions to health-care systems do not necessarily guarantee their access to services, nor do they ensure a concomitant influence on reforms. “Health-care citizenship” adds citizens to the analysis of a health-care system.

Drawing on T.H. Marshall’s institutional approach to citizenship, “health-care citizenship” is multidimensional, containing social, political, and civil elements. The social element considers to what extent one’s access to medical services depends on one’s ability to pay. The political element evaluates whether citizens can influence health-care decisions. The civil element examines whether individuals can choose between public and private insurance plans. Multidimensionality suggests that access to medical services is not only a social right. However, it also suggests that if one element is limited (i.e., access), others may compensate for it, at least in some cases.

The civil element proposed in this article may infuriate some, as choice between public and private alternatives is generally perceived as dangerous for the sustainability of public health-care systems. In Canada and Israel, just such a debate on the sustainability of the public health-care system is taking place as re-commodification of medical services is increasing. This paper looks at the state of “health-care citizenship” in Canada and Israel.<sup>1</sup> Their histories and structure,

discussed in the third section, differ.<sup>2</sup> But their health-care systems (see Table 1) share similar values – access to health-care should be based on medical need, not ability to pay – that “compete” with such ideals as the “free market” and civil liberties, as both nations are influenced by their relations with the United States (Geva-May and Maslove, 2000). Furthermore, in both “national health insurance” systems, citizens perceive access to adequate health-care services as a duty of the political community (Asiskovitch, 2007; Johnson-Redden, 2002), even though medical services have never been completely de-commodified in either state.

*Table 1 here*

Canada’s and Israel’s “national health insurance” systems are constructed on decision-making processes characterised by political fragmentation, albeit different types of fragmentation. In Canada, power is shared by the federal and provincial governments and the medical profession. Since the federal and provincial governments are frequently controlled by different political parties, the conflict over health-care, a central political issue in Canada, is exacerbated. Nor does Canada’s fragmented political process yield “more” rights. For one thing, it allows differences between provinces. And while federalism opens more opportunities for Canadians to influence decision-making (public pressure was a primary factor leading to increased federal funding in recent years), it also allows blame avoidance politics on the part of both federal and provincial governments. Finally, the declared commitment to publicly-funded health-care upheld by the federal government has led (or forced) provinces to greatly reduce individual choice.

In Israel, meanwhile, the ministries of finance and health and non-state not-for-profit sick funds (the primary insurers and service providers)<sup>3</sup> struggle for power. As health-care is not a central issue on the political agenda, coalition governments, common in Israel, do not seek to intensify the conflict. Furthermore, the structure of multiple insurers combined with limited state control over the sick funds has led to variations in the level of access and has increased the amount of choice between public and private insurance plans, thereby empowering the civil element while harming the social element. The Israeli case is also characterised by limited opportunities for participation in policymaking.

The empirical arguments of the paper are the following: (1) within the “national health insurance” system type, Canada and Israel exemplify different models in each dimension because of their unique institutional arrangements; (2) in both countries, the scope of “health-care citizenship” is limited in all three dimensions; and (3) external pressures lead to “path dependence” changes in “health-care citizenship,” as shown in the specific institutional contexts of Canada and Israel. The paper has four sections. The first links Marshall’s citizenship to “health-care citizenship”. The second section describes the social, political, and civil elements of “health-care citizenship”, while the third analyzes these elements in Canada and Israel. The final section presents conclusions.

**From citizenship to “health-care citizenship”**

T.H. Marshall's (1965) rights-based conceptualization of citizenship elaborates three dimensions of the relations between citizens and political communities: a civil element, which stands for autonomy from oppression; a political element, which equates to participation in public decisions; and a social element, which refers to citizens as beneficiaries of public goods and resources. Social rights are central in Marshall's thought, as the realization of civil and political liberties depends on personal resources and/or public services.<sup>4</sup>

The understanding of the gradual development of citizenship by expanding rights from one realm to another and from the elite to the entire population indicates that the enhanced "equality of status" is a criterion for belonging in a democratic political community. However, Marshall does not look for "equality of outcomes" or call for the complete altering of market economy; rather, he argues that economic forces threatening to dismantle solidarity and democracy should be restrained.

Following Marshall, Michael Moran (1991: 35) defines "health-care citizenship" as a social right: "'Health-care citizenship' might ... be summarily defined as a right to health care for all citizens free at the point of treatment". The right to health-care is generally considered essential for overcoming economic obstacles to health-care access and preventing catastrophic economic outcomes related to access to modern medicine (Hatzopoulos, 2005; Toebes, 2001; WHO, 2000). The concept of "health-care citizenship" in this paper considers different aspects of citizenship in modern democratic societies – enjoying common goods and influencing decision-making while allowing one's autonomy, at least to some degree.

In political sociology, citizenship refers to a social belonging to a political community that provides "persons with rights and obligations, as well as roles and identities" (Ferrera, 2005: 13; Kivisto and Faist, 2007). As studies of citizenship demonstrate, different individuals enjoy different levels of rights (and duties) as they belong to different social groups (Shafir and Peled, 2002; Shklar, 1991). Today, rights and obligations in health-care re-define the boundaries of national political communities, differentiating between insiders and outsiders, "deserving" citizens and "undeserving" foreigners (Culic, 2006; Filc and Davidovich, 2005; Hatzopoulos, 2005). Clearly, citizenship defined as belonging to a political community is approaching some tough tests in the realm of access to health care. As medical costs are rising, access to health-care is first and foremost about making (hard) decisions about who will enjoy the collective resources and who will not. And by extension, who will live and who will die?

As sympathizers of Marshall's theory claim, its importance remains in its moral arguments for expanding social rights to the entire populations of political communities (Dwyer, 2000; Lister, 2005). Yet the plausibility of Marshall's approach is questioned in an era of globalization, political integration (as the EU), and mass migration blurring the boundaries between insiders and outsiders (Ferrera, 2005). In an era when costs of the welfare state increase faster than economic growth in most democratic nations, some question the contemporary relevance of Marshall's theory (Johnson-Redden, 2002). The need to re-examine Marshall's categories is

especially pressing in the light of increased national expenditures to health-care. In the next section I will examine this issue.

### **“Health-care citizenship”: social, political, and civil elements**

Health-care is one area where the solidarity of the relationship between the individual and the political community can be evaluated. All democratic nations must make decisions regarding the distribution of limited resources among individuals (Wright, 2005). In making these decisions, governments use their political powers to shape the rights and duties of individuals with respect to health-care systems. The question is whether different individuals experience different relations with their political community’s health-care systems. The relevant social, political, and civil elements of this dilemma are discussed below and summarised in Table 2.

*Table 2 here*

**Social element.** The social element of “health-care citizenship” expands if medical services are taken out of the market (“de-commodification”), and access to health-care services is dependent on need, not ability to pay. Moran considers “health-care citizenship” according to three main criteria: what share of the population is insured in public health insurance plan(s) for hospital and ambulatory care, how much countries expand on health-care out of the GDP, and what the shares of public/private expenditures for health-care are (Moran, 1991; see also OECD, 2007). However, if we use these criteria, we need to evaluate the resulting figures. In an era when developed democratic nations face the cross-pressures of aging societies, medical innovations, and rising expectations balanced against lesser economic growth, reluctance to pay higher taxes, and the spread of neo-liberal ideologies, governments have to decide which services to list in public insurance plans and which not. Rationing decisions determine which individuals are included as full members of society, enjoying its resources in times of need – and which individuals are not.<sup>5</sup>

The social element cannot be based only on traditional aggregate indicators. The trend towards diminished public funding replaced by growing private funding is common in most welfare states (OECD, 2007). This “economic” gap is triggered by the rising number of new technologies and political reluctance to raise taxes for public funding of insurance. Many nations now encourage private solutions (Twaddle, 2002). Even more problematic, the relations between macro-level institutional arrangements of funding and health-care de-commodification may be more complicated than a country’s statistics reveal (Flood, Tuohy, and Stabile, 2002; Tuohy, Flood, and Stabile, 2004). For example, in some countries, public insurance plans treat the wealthiest and the rest of society differently.

What should be included in the social element of “health-care citizenship”? One should start by considering whether the entire population is insured in public plan(s) and whether different individuals have different legal rights and duties. As immigration challenges welfare states, one can accept the OECD’s claim (2007) that in most developed countries all citizens are insured to some degree. Even so, we should look at the boundaries – whether non-citizens are insured and

under what terms (Hatzopoulos, 2005).

Next, one should evaluate the range of listed services in public plans and the principle of their listing (Andrain, 1998; Hatzopoulos, 2005). As demands outgrow resources, not all medical services are fully publicly funded. Equity – whether an individual’s access to medical services is based on need, within society’s economic constraints (Aday, Andersen, and Fleming, 1980; Aday et al, 1993; Daniels, 1982; Mooney, 1983; Stoddart and Labelle, 1985: 6) – seems the most appropriate criterion for evaluating imperfect (in other words, all) public health-care insurance plans. Yet Alanzweig et al. (1986) point out:

Equity in medicine does not mean equality. Equity does not mean that all individuals would receive the same amount of medical services. Equity directs to the optimum, not the maximum, and calculates not only the will and aspirations of individuals but also the general circumstances: the benefit a patient would receive out of a certain treatment, economic constraints, the need of the individual, and more. Thus, equity in medicine is the level of access of individuals to adequate medical services. (Alanzweig et al, 1986: 7)

Flood, Stabile, and Tuohy (2006) elaborate on the difficult choices this principle creates:

Take health-care delivery options created by technological advancement. How does one decide which delivery option to choose – on cost alone? Should a treatment that costs \$150,000 but offers only a 5 per-cent chance of success be publicly funded? Or should a new drug that is equally effective but with fewer side effects be funded as opposed to an existing drug that costs 20 per-cent less? In theory, the choices should be made on the basis of combination of information about relative costs and health benefits, the values that we hold about preventing and/or curing specific illnesses or disabilities, the values that we have with regard to equality and fairness, the resources available, and, of course, opportunity costs. Money spent on one thing cannot be spent on another; trade-offs must always be made. (Flood, Stabile, and Tuohy, 2006: 16)

No existing definition of equity enables us to judge whether one decision advances the social element of access to health-care better than another (not all decisions are as easy as choosing between life-prolonging medications and cosmetic surgery).<sup>6</sup>

Equity can be determined at two levels: which groups of individuals and which medical services are partially or completely removed from the market; and equality of access and distribution according to health (Culyer and Wagstaff, 1993). Thus, some suggest we consider (1) whether individuals belonging to different social groups face different economic and other (as geographical) burdens when attempting access to health-care services (Aday, Andersen, and Fleming, 1980; Aday et al, 1993; Braveman, 2006), and (2) whether certain services are required to overcome impairments that excessively limit individuals from integrating in society (Aday et

al, 1993; Daniels, 1982).<sup>7</sup> The concept of equity varies between nations and across time and is a product of political processes involving interests, ideologies, and economic constraints interacting with medical needs of members of society, cultural values regarding solidarity, and socio-economic stratification (Daniels, 1982; Evans, 1997; Mooney, 1983). Nevertheless, political communities should be judged on whether access to medical services is based on equity, even if these communities cannot completely achieve it and/or prioritize other principles.

Public health-care insurance plans include mechanisms for rationing as a way to balance economic constraints, political interests, medical considerations, and social needs (Ham and Coulter, 2001). In an economically limited environment, rationing is required to satisfy the needs of as many individuals as possible. Rationing is explicit when certain medical services are listed with or without imposing conditions on delivery, while other services are not insured. The goal is to prevent a (hypothetical) situation where one patient consumes all resources allocated to health-care. Where rationing is implicit, health-care providers limit the amount of services delivered because of financial constraints. Equity-based rationing is non-discriminatory and aims to extend rights to individuals without excessively harming the rights of others (Von Tigerstrom, 2002).

Every health-care system contains a private sector which handles both funding and delivery of services (Burke and Silver, 2006). In all mature welfare states, excluding the United States, the private sector is small and primarily designed to complement the public sector (Evans, 2005). The shortcomings of public systems encourage private solutions, including long wait times for certain diagnostic and surgical procedures (Maynard, 2005; Wright, 1998, 2005). Since the 1990s, a process of privatization has characterized most health-care systems as services “drift” from public to market coverage, and new (and expensive) technologies find private “solutions” (Hacker, 2004: 714; Tuohy, 1999; Twaddle, 2002).

The part of private funding in total expenditure for health-care is an indicator of inequality in access, as the “have-nots” lack financial resources needed for higher quality care and quicker access to medical services (WHO, 2000). It is important to ask whether privately-funded services threaten patient equality, considering the scope of private funding and private insurance (does a two-tiered system exist?), what services are privately insured and their quality compared to the public sector, and whether public resources (money, manpower, and infrastructure) are diverted to the private sector (Flood, Stabile, and Tuohy 2002; Tuohy, Flood, and Stabile, 2004).

We also need to consider the explicit and implicit obligations of individuals within their political communities. Adequate medical services require contributions from individuals, and the nature of these contributions should be as progressive as possible (WHO, 2000). Welfare states acknowledge that vulnerable groups should be partially or fully exempted from such duty: the poor, elderly, and chronically ill. The poor should not be expected to proportionally contribute more than the rich, because the health-care system is also a re-distributive mechanism. Individuals’ contributions can take several forms varying in progressivity. General revenue

taxation is the most progressive, followed by payroll taxes (Achdut, 1999; Andrain, 1998; Myles, 2006). More regressive are private insurance premiums and direct out-of-pocket payments (Evans, 1997; WHO, 2000).

As for private insurance premiums, levels of contributions define the levels of access to care and are decoupled from individuals' incomes, but in situations of need, benefits exceed costs. Out-of-pocket payments (co-payments, deductibles) are imposed only on those in need of services and may cover the entire cost of treatment.<sup>8</sup> As a link between ability to pay and access to adequate medical services exists to some degree in all health-care systems, there is an implicit obligation to work in order to pay contributions for the health-care system. Inclusion in the labour market entitles some individuals access to private health-care insurance that they would not otherwise have been able to purchase. Another implicit obligation is living a healthy life to limit the burden on health-care systems.<sup>9</sup>

**Political element.** As limited resources collide with increasing needs and expectations, decisions must be made as to who should pay for health-care, what share of public resources should be devoted to it, and how resources are to be allocated amongst competing needs. By making such decisions, political communities shape the relations between the state and the medical profession (health-care policymaking involves governments and service providers) and between public and private health-care sectors (Tuohy, 1999). As political force can be used to temper market forces, several questions arise: how decisions are made, by whom, and to what extent these decisions are democratic (Flood, Stabile, and Tuohy, 2006). In "democratic decision-making" I refer to citizens' participation in, or strong influence on, decision-making regarding the scope of public health-care insurance. I also consider such principles as transparency and accountability.

Several things shape health-care decision-making, including medical knowledge, economic constraints, interests (of politicians, state bureaucracies, physician interest groups), and ideas on the place of the state in the economy (Andrain, 1998). Health-care is a central government activity, and democratic input into decision-making is essential for two reasons (Flood, Stabile, and Tuohy, 2006; Johnson-Redden, 2002; Litva et al, 2002). First, health-care policies should not give physicians or state bureaucrats a monopoly on making decisions which involve values. Second, popular participation improves decision-making, as policymakers become more aware of needs. Moreover, in theory, democratic decision-making prevents decision-makers from favouring their own interests.

The influence of citizens on health-care decisions can range from non-participation (including suppression), through modest involvement where citizenry views do not constrain policymaking, to "forms of participatory activity in which the public has increasing power and where there is a commitment to an ongoing integration of the views of the participants fully within wider decision-making process" (Litva et al, 2002: 1826). Health-care decision-making takes place at different levels, with varying degrees of democratic participation (Litva et al, 2002). Elections and the use of the media can generate public demands into macro-level decisions regarding

health-care funding. Although governments may be reluctant to share power with the public, public outcry can put pressure on them, especially near elections. Which services/populations are to be publicly insured could be determined at forums which include representatives of the general public, the state, and service providers. Legal appeals might force decision-makers to change policies (Flood, Stabile, and Tuohy, 2006; Woodhouse, 1998). As for micro-level decisions (i.e., delivery of services to specific populations), more participatory frameworks are needed (Litva et al, 2002).

When considering political elements, two difficulties become apparent. First, too much democracy can be harmful; decision-making processes may turn into popularity contests (in which the majority ignores the minority's needs) or into tyranny (where powerful small groups use public resources to promote their own interests). Second, there is a difference between public and client (health-care patients) participation. The public is more involved when the issue is the nature of the health-care system, and a problem shared by many individuals is at stake, whereas clients may push for particular interests (i.e., the medical needs of certain groups of patients with a similar illness). When public and client participation collide, the determination of which form better protects democratic decision-making is an empirical matter. In the name of general interest, vulnerable groups of clients may be neglected, while in order to protect some groups' interests, meeting the diverse needs of the entire population may be at risk.

**Civil element.** Individual autonomy to choose health-care insurers raises substantial concerns in democratic political communities. In democratic societies, citizens make decisions affecting their lives with only partial information (voting without complete knowledge of the issues), and they are free to pursue dangerous life-styles (smoking or extreme sports). By the same token, individuals should be allowed to make choices regarding their health-care – how to spend their money and what kind of insurance is right for them, if any. Allowing individuals to choose not to insure themselves might ultimately prove destructive for both them and their society, and this, of course, is not desirable. In many cases a “choice” not to be insured is related to a lack of means. Thus, the civil element primarily refers to whether individuals can choose to opt-out of public insurance plan,<sup>10</sup> where it exists, and select private alternatives.

Marshall's notion of the civil element of citizenship is liberty: civil rights protect individuals from state oppression.<sup>11</sup> The right to health-care, as other social rights, is not attached solely to duties imposed on states to provide resources and/or services. As Eide (2001: 23-24) points out, this is a “narrow understanding of the nature” of social rights:

States must, at the primary level, respect the resources owned by the individual, her or his freedom to find a job of preference and the freedom to take the necessary actions and use the necessary resources – alone or in association with others – to satisfy his or her own needs.

It is assumed that states act for the individuals who lack the resources needed to realize access to health-care.<sup>12</sup>



Following Marshall, we should ask ourselves which individuals can actually choose to opt-out of public health-care systems. If this applies only to wealthy and healthy individuals, the civil element is crippled. If choosing between public and private insurance alternatives is possible but is conditioned on income or previous medical condition,<sup>13</sup> state power should be used to regulate the health-care market to realize the civil element for as many as possible (Gress, 2005). The fear is that privatization of funding and delivery will be accompanied by “privatization” of the political process governing regulation of insurers and providers and allocation of resources among competing needs and populations (Gildiner, 2006).

There are three main reasons for the use of state power to limit individuals’ freedom in health-care. First, limiting choices advances cost-containment control (Tuohy, 1999). Second, limiting the number of insurance plans creates larger pool(s) of resources better dealing with increasing costs of medicine (WHO, 2000). Third, if only the wealthiest can choose, resources will be concentrated in the private health-care sector while public systems deteriorate (Maynard, 2005). In essence, limitations on freedom of choice of health-care insurance plans are designed to overcome inequalities and to protect the economically less fortunate (Evans, 1997; Flood, Stabile, and Kontic, 2005).

It seems that realization of the civil element includes an adequate public plan accompanied by more than one private insurer, supplying a minimum number of services and complying with state regulations on excluding applicants and insurance fees.<sup>14</sup> Hence, I do not propose complete freedom of choice. Limitations should be enforced for the sake of the rights of other individuals and the entire political community.

**Conflicts between elements.** As in Marshall’s definition of citizenship, the social and civil elements of “health-care citizenship” seem to collide. While civil rights are liberties from “government oppression”, social entitlements call for state power to temper the “free market”. Marshall’s account presents a scheme whereby social rights are needed by many (probably most) individuals to realize civil rights. In the case of “health-care citizenship”, where health is considered a social right, the existence of a large private health-care sector is seen as a threat to the public health-care sector, as both sectors compete for financial resources, professional manpower, and political support (Bin-Nun, Berlovitz, and Shani, 2005; Flood, Stabile, and Tuohy, 2002; Maynard, 2005; Tuohy, Flood, and Stabile, 2004).

Lister (2005) considers Marshall’s account an analysis of the complexity of citizenship in democratic political communities: in some areas of life the civil element is dominant, while in other areas, the social element takes priority. I suggest adding another interpretation, namely, that in some areas, one finds the three elements together. Relations between the elements can be quite complicated, however. A perfect health-care system would integrate all three elements for all individuals in such a way that each person would enjoy a portion of each element without harming the interests of others. In real world, however, we should ask about the combination of elements in specific health-care systems and consider whether these health-care systems yield

different combinations for different individuals.

### **“Health-care citizenship” in Canada and Israel<sup>15</sup>**

Canada and Israel’s health-care systems are “national health insurance”, single-payer systems, based on a public-private mixed ownership of facilities (Chernichovsky, 1995; Hacker, 2004). Canada’s health-care insurance program, known as Medicare, is composed of 13 plans run by the 13 provincial/territorial governments (Maioni, 2002). The Canada Health Act [CHA] of 1984 does not impose a constitutional or legal duty on the federal or provincial governments to supply public medical services (Choudhry, 2002; Lahey, 2007).<sup>16</sup> In Israel, the National Health Insurance Act [NHIA] came into force in 1995. It set a legal, yet not constitutional, right for access to health-care services for all residents within the limitations of available resources, and it imposed legal duties on the government and the sick funds to finance a basic package of services and to deliver them, respectively (Gross, 2004; Shalev, 2003). In this section, I begin by analyzing the social element, estimating the boundaries of de-commodification in each country. I then discuss the political element and decision-making regarding funding and coverage. Last, I look at the role of the civil element.

**Social element.** The scope of the social element of “health-care citizenship” in both Canada and Israel is the outcome of previously shaped institutional arrangements of insurance and external pressures, yet they offer different models for the de-commodification of medical services. In Canada, some sectors are fully publicly funded (“core services”), others are partially publicly funded, and the remainder are almost entirely privately funded. In Israel, most sectors of health care are included in the national health insurance plan; however, no sector is entirely publicly funded. Economic and political pressures in both countries threaten to weaken equity by tying access to medical services to one’s ability to pay rather than one’s needs. The exact nature of the changes is linked to the characteristics of de-commodification in each case.

In recent years, Canada and Israel have pursued different paths (see table 3). Whereas Canada bridled its previous course of liberalization, while not overriding it, Israel continued to restrain public funding for access to health-care. These trends are part of the general course of change in social policy spending in both countries since the end of the 1990s (Doron, 1999; Prince, 1999).

*Table 3 here*

As discussed in the previous section, to understand the relations between health-care systems and individuals, one has to look beyond aggregate indicators and analyze institutional arrangements. A summary of the comparative assessment of the social element on Canada and Israel, discussed below, is presented in Table 4.

*Table 4 here*

Focusing on the formal range of insured services in both countries, one finds two generous yet

imperfect methods for public funding of medical services. At the heart of Canada's Medicare, two sectors are publicly first-dollar covered – hospital and physician services, if considered medically necessary. In previous times, these two service areas drew the largest expenditures, and Canadian governments looked to overcome the economic burdens on individuals (Taylor, 1987; Tuohy, 1999). In 2004, the public sector funded 98% of hospital services and 93% of physician services (CIHI, 2005).<sup>17</sup> Core sectors are included in the CHA, and all provinces supply them to residents free of charge. Since 1984, physicians and hospitals are prohibited from extra-billing/user-charging patients if they wish to be reimbursed by the provincial public plan (Choudhry, 2002; Lahey, 2007). All provinces extend their plans to include additional services (i.e., drugs) in exchange for cost-sharing (deductibles, co-payments) for vulnerable groups, such as senior citizens, the poor, and (in some provinces) individuals unable to obtain private solutions (CIHI, 2000, 2007; Coombes et al, 2004; Gagnon, 2002).

Israel offers a different model. The basic package of services in the NHIA, identical to these of the sick funds prior to the law, includes two lists of services (Chinitz and Israeli, 1997; Shalev, 2003). One includes services other than pharmaceuticals; it ranges from hospital and physician services to psychological treatments, diagnostics services, and dental care for children under six. Listed services, however, are vaguely defined, leaving room for some discretion in their delivery. Another list is formulary, in which entitlements are explicitly defined for drugs. Not all publicly-insured services are free of charge, and co-payments for some services (i.e., drugs) are required. In 2004, 33% of total costs of listed drugs were directly paid by households (Bank of Israel, 2007: 307). In 2003, private expenditure on pharmaceuticals in Canada and Israel was 62% and 52% of the total expenditure on pharmaceuticals, respectively (Bank of Israel, 2007: 307; OECD, 2007).

Implementation of these “national health insurance” plans reveals a more limited social element than one might expect, given the rhetoric. Canada and Israel's public plans are universal, but several vulnerable groups are partially or fully excluded. In Canada, newcomer access to health-care services varies by provinces and immigration class (Gagnon, 2002). However, Canada is more generous than Israel. In Israel, permanent residents are covered by NHIA but other groups, including most non-Israeli Palestinians and labour migrants and their dependents, are excluded (Filc, 2006; Flic and Davidovitch, 2005).

In both countries there is a gap between the ideal and reality. In Canada, hospital and physician services are not fixed and vary across provinces (Caulfield, 1996; Lahey, 2007). Furthermore, some Canadians, mainly in rural areas, find access limited because of a lack of available providers (Lahey, 2007). Thus, the scope of the social element of “health-care citizenship” depends on where one lives and to which social group one belongs (CIHI, 2005). Furthermore, studies in several provinces have found variation in access to services based on wealth (Gilmore and Zowall, 2002). In Israel, meanwhile, capping expenditures on drugs and physician visits for senior citizens and the chronically ill has not eliminated these as obstacles to access. According to a 2005 survey, 16% and 8% of senior citizens “chose” not to purchase a medicine or consult a

specialist, respectively. The figures for the chronically ill were 19% and 3%, respectively (Gross, Bramli-Greenberg, and Matzliach, 2007: 22-23). In 2005 2.4% of households in Israel spent over 20% of their incomes on health-care (Chernichovsky, 2007: 11). Furthermore, soon after NHIA improved access to medical services for the most vulnerable segments in the Israeli society, the poor, Arabs, elderly, and the chronically ill (Filc, 2004),<sup>18</sup> the not-for-profit sick funds adopted a for-profit behaviour; as their economic pressures increased, they began looking for new members among younger, wealthier, and healthier individuals (Gross, 2003; Gross and Harrsion, 2001).

Canadians and Israelis are expected to contribute to the funding of health-care systems.<sup>19</sup> Public funding of the Canadian health-care system is done through the progressive general tax systems of the federal and provincial governments (Lahey, 2007). For the provincial plans' non-core services, such as pharmaceuticals, individuals are expected to cost-share. In Israel, the NHIA has introduced a payroll tax, called the "health tax", of 5% (paid to a ceiling of up to four times the mean income). The law lists several categories of individuals (including senior citizens and the unemployed) who pay lower rates. It also adopts co-payment for some services, primarily pharmaceuticals and services still delivered by the Ministry of Health (Shalev, 2003). In 1998, in order to handle with sick funds' debts and reduce public funding, co-payments for medications were increased and cost-sharing for services as specialist visits were introduced (Bin-Nun, 2003).

In both countries the private sector fulfils certain essential roles. The sources of private funding vary: in Israel out-of-pocket contributions play greater role than in Canada (see Table 5).

*Table 5 here*

In Canada, private insurance is restricted to non-core services to prevent the development of a two-tiered system (CIHI, 2005). Most individuals are expected to privately finance, through out-of-pocket spending or private insurance, services as pharmaceuticals, long-term care, psychological treatments, visual care, and dental care. For example, in 2003 only 79% of Canadians aged 12 or older reported having public or private drug insurance (CIHI, 2005: 64),<sup>20</sup> and access to private insurance varies by income and education (CIHI, 2000: 21). In Israel, private funding complements public funding of listed services in the form of individuals' co-payment and out-of-pocket spending; supplementary/private insurance covers services not covered in NHIA, such as some expensive drugs and dental care (Chernichovsky, 2007).<sup>21</sup> The share of Israelis obtaining supplementary insurance has been growing since the mid 1990s, reaching 72% in 2006 (Bin-Nun and Kaidar, 2007a: 27).<sup>22</sup> Not surprisingly, most of those who lack supplementary/private insurance belong to vulnerable groups (the poor, elderly, Arabs, and Russian immigrants) (Gross, Bramli-Greenberg, and Matzliach, 2007: 19). The expansion of supplementary insurance is primarily the result of inadequate updating of the basic package of services in the NHIA since its enactment (Asiskovitch, 2006).

In both counties, as an outcome of cuts in public funding, services have "drifted" from the public to the private sector. In Canada, this has led to "passive privatization" (Andrain, 1998; Tuohy,

1999). In 1975, hospital and physician services amounted to 59.8% of total health expenditure; in 2004, it was only 43.4% (CIHI, 2006: 98). During the same period, the share of prescribed drugs, as some pharmaceuticals are used to replace hospital care, increased from 6.3% to 13.7% (CIHI, 2006: 99). While the share of public funding for prescribed drugs increased from 20.6% in 1975 to 46.6% in 2004 (CIHI, 2006: 101, 112), one must remember that access to prescribed drugs is not a universal entitlement under Medicare.<sup>23</sup> Thus, in Canada, one's ability to enjoy health-care services increasingly depends on one's access to private insurance or ability to pay out-of-pocket. In Israel, many new medical technologies are drifting to supplementary insurance. The ratio between expenditures on supplementary insurance and sick funds expenditures on the basic package of services in 2001 was 1:19.8; by 2005, it had dropped to 1:13.9 (Havusha and Schiff, 2003; Waldman-Asherov and Hilman, 2007).

Both countries ration medical services because of the growing gap between social demands and economic constraints. In Canada, core sectors are explicitly and implicitly rationed, as the methods are interlinked. Decisions concerning listing (and, to a lesser extent, de-listing) take place in the provinces (Caulfield, 1996; Flood, Stabile, and Tuohy, 2006; Lahey, 2007).<sup>24</sup> However, declaring a service or technology "medically necessary" does not mean it is available. The availability of listed services depends on the existence of sufficient resources (Sullivan et al, 2005; Taylor, 1990). For example, a hospital will not introduce a new technology unless funds can be allocated for this purpose. Moreover, while services exist, patients may need to wait a long time for certain treatments in some areas of the country. Long waiting times have become one of the problems troubling individuals and governments in Canada (Sanmartin, Pierre, and Tremblay, 2006; Sullivan et al, 2005).<sup>25</sup> In Israel, explicit rationing methods have become central since the introduction of NHIA, although implicit methods remain substantial as well (Asiskovitch, 2006; Chinitz and Shmueli, 1997; Shalev, 2003; Shmueli and Chinitz, 2001). The primary goal of including a package of services in NHIA is cost-containment of public expenditures. Other methods are implicit. Within the lists of services, sick funds can use discretion and impose bureaucratic obstacles on consumption. In some cases, because of poor government clinical control, they can illegally limit access to expensive listed services (Asiskovith, 2006, 2007). In addition, some areas have long wait times for specialist visits and hospital services because of a lack of medical professionals (Levy, 2008; Shay, 2003).

Rationing access to health-care systems may be seen by policymakers and analysts as cost-containment, an economic problem and a policymaking matter. Governments may pursue structural changes to improve the economic efficiency of service delivery (Twaddle, 2002). For individuals, evidence of this widening gap, juxtaposed with their stable or growing contributions to the system, presents a worrying call for action.

**Political element.** The scope of the political element of "health-care citizenship" is limited in Canada and Israel. Even though the place of health-care in politics differs, in both countries the primary role of the citizenry is to set boundaries for legitimate policies and reforms. Otherwise, the citizenry plays a marginal role in policymaking compared to other political actors.

Health-care has different status in the two polities. In Canada, Medicare is perceived as a central component of the national identity, and proposals for reform are publicly debated (Maioni, 2002; Tuohy, 1999).<sup>26</sup> In Israel, NHIA is a marginal political issue. This explains some differences discussed below (see summary of comparative assessment of Canada and Israel in Table 6). The general public is an essential factor in the politics of Canadian Medicare funding, and public opinion is strongly opposed to a two-tiered system. Client groups are also involved in provincial decision-making on service listing, albeit, in this instance, with limited success. In Israel, client groups are involved in the politics of funding and listing services, but meet with only partial success; the general public remains silent.

*Table 6 here*

In both countries, other political players dominate health-care policymaking. In Canada, the political process of funding, the main issue of the 1990s, takes place at the national level between the federal and provincial governments, and at the provincial level between governments and service providers (Andrain, 1998; Geva-May and Maslove, 2000; Tuohy, 1999).<sup>27</sup> In Israel, the introduction of NHIA has shaped a political process which focuses on the struggle between the Ministry of Finance and the sick funds (the Ministry of Health tends to adopt the position of the sick funds) on funding (Asiskovitch, 2006).

During the 1980s and the first half of the 1990s, the federal government in Canada cut its share in Medicare by moving from cost-sharing individual programs to block-funding several programs and de-indexing cost increases. The share of direct federal funding in public health expenditure increased from 1979 to 1996, jumping from \$57 to \$109 per capita, while the provincial governments' per capita share increased from \$1527 to \$2045 (CIHI, 2006: 95).<sup>28</sup> As the economic burden of health-care continued to grow in period of economic recession, provincial governments adjusted their health-care plans to meet shrinking federal contributions and their own growing deficits. Solutions included structural reforms: hospitals were closed, merged or restructured; some services were de-listed from provincial plans; and rules for the eligibility of publicly-funded non-core sectors were tightened (Andrain, 1998; CIHI, 2000; Geva-May and Maslove, 2000; Maioni, 2002; Woodward and Charles, 2002). Provincial governments shifted the pressure to service providers (Tuohy, 1999).<sup>29</sup> The public was affected, as access to publicly-funded services narrowed.

At first, Canadians did not oppose cuts in health-care, but once these cuts jeopardized access to services, citizens began to speak out (Woodward and Charles, 2002). The public voice was directed towards the provincial governments, and then used by the provinces to shift the blame to the federal government, claiming the latter's unilateral moves were solely responsible (Deber, 2000; Maioni, 2002). The federal government, in response, accepted the provinces' demands for greater funding (Lahey, 2007) and increased its direct share in funding Medicare, from \$109 per capita in 1997 to \$182 per capita in 2006; at the same time, provincial governments' share rose from \$2045 to \$2864 per capita (CIHI, 2006: 95). Such decisions preceded elections (Prince,

1999), demonstrating that the federal political parties used this method to signal their loyalty to a public system (Maioni, 2002). The public's criticism of long wait times led the federal and provincial governments to agree in 2004 to increase funding in a bid to eliminate the problem (Lahey, 2007; Sullivan et al, 2005). Public pressure can partially explain these changes, but that pressure was certainly channelled by sophisticated and powerful actors. Increased federal funding also resulted from the improved performance of the Canadian economy and the availability of federal surpluses (Lahey, 2007; Prince, 1999).

Public influence on health-care insurance policymaking concerning which services should be listed/de-listed in provincial plans seems even more limited. For example, with respect to listing/de-listing physician services in Ontario, the "public participation is at present given little weight in the decision-making regarding what to fund publicly" (Flood, Stabile, and Tuohy, 2006: 34). Also in Ontario, neither public debate nor democratic input took place in the privatization of the rehabilitation sector during the 1990s (Gildiner, 2006, 2007). In British Columbia, an interest group's demand to list costly treatments to autism failed. At the same time, pressure from other interest groups led to the inclusion of some expensive, yet marginally effective, pharmaceuticals in most provincial formularies (Wright, 2005).

In Israel, distributional issues replaced partisan politics as the primary political conflict of the health-care system after NHIA. The Ministry of Finance and the sick funds (together with the Ministry of Health) have dominated policymaking, and are involved in a continued blame-avoidance politics; the Ministry of Finance blames the sick funds for being inefficient and the sick funds accuse the Ministry of Finance of risking the lives of Israelis. Since 1995, the politicians' involvement in policymaking has been limited even though few radical amendments promoted by the Ministry of Finance to limit egalitarian access to health-care were blocked by opposing politicians mobilized by the sick funds and patient groups (Asiskovitch, 2006). Filc (2004: 429) argues that the wide support of Israelis for public-funded health-care is a primary reason. However, in general, the public has been passive.

The major issues in NHIA politics include adjusting the cost of the basic package of services and listing new technologies (Asiskovitch, 2006). Israel has moved from a "Bismarck model" of funding based on contributions to a tax-based "Beveridge model". Until 1996, employers (and the self-employed) paid a mandatory payroll tax on behalf of their employees; this accounted for 40.3% of total NHIA revenues in 1996. Since 1997, these contributions were replaced by general revenue taxation. From 1997 to 2006, the share of general revenue taxation in total NHIA revenues decreased from 48% to 43.1%,<sup>30</sup> while the share of "health tax" increased from 46.6% to 51.5% (Bin-Nun and Kaidar, 2007a: 28).<sup>31</sup> As a result, expenditure per capita increased during this period by only 1.7%. These changes demonstrate the increasing power of the Ministry of Finance and its ability to lower government's share in funding.

Patients and their organizations have also played a key role, acting in a coalition of non-governmental organizations criticizing the government for neglecting its responsibilities.<sup>32</sup> In the

three years after its enactment, NHIA lacked mechanisms for listing/de-listing services, and the Ministry of Finance apparently expected sick funds to find the needed resources. But patients protested the lack of funding for listing new and expensive drugs. For example, petitions in labour courts pressured the government to list new drugs for Multiple Sclerosis. The national television appearance of a 17-year-old girl begging for her life led politicians to order the Ministries of Finance and Health to find a solution. Thus, the “technology index” and the “public committee for listing new technologies” were formed at the end of 1998 (Shalev, 2003).

This has become an important, albeit limited, victory for patients. Annual increases in the cost of the basic package of services are still controlled by the Ministry of Finance and are lower than the demands of rival actors. Since 2005, politicians have become more involved in response to protests by patients and physicians. In May 2006, cancer patients held a hunger strike for 16 days until the government accepted some of their demands. The public committee for updating the basic package of services and the process of listing/de-listing are not “democratic”. Most committee members represent the interests of the Ministries of Health and Finance and the sick funds; physicians are represented, but not patients; nor can patients argue their case in front of the tribunal; until recently the tribunal’s discussions were confidential, and even now, they are far from open; and the criteria guiding decisions have been criticized by the courts and others for ignoring equity and pursuing economic and other interests (Asiskovitch, 2006; Ramon, 2003).

Citizens in Canada and Israel are not satisfied with the various review mechanisms currently in place. According to Choudhry (2002), the federal Ministry of Health has failed to protect the interests of Canadians. The federal government has been unaware of the extent of provincial non-compliance with CHA’s principles, including extra-billing and user-charges. When the federal government was aware of problems, it preferred its own interests over those of Canadians. The situation in Israel is similar: the Ministry of Health lacks the legal means and financial resources to gather information, supervise sick funds’ clinical compliance with NHIA, or penalize sick funds for denying access to publicly-inured services (Asiskovitch, 2006).<sup>33</sup>

In Canada and Israel, citizens appeal to the courts in an attempt to force governments to expand public health-care. Although in both countries petitions are based on legal rights (Sections 7 and 15 of the Canadian Charter of Rights and Freedoms and Article 3 of the NHIA), success has been limited. Courts in both countries are reluctant to review health policies; expanding entitlement has a heavy financial outcome and is considered the prerogative of parliaments and executives. Several studies argue that Canadian courts have generally been deferential to overturn decisions made by health authorities and order provincial plans authorities to list new services (Flood, Stabile, and Tuohy 2006; Greschner, 2004; Von Tigerstrom, 2002). Courts in Israel are more accessible.<sup>34</sup> The sick funds and the government oppose any reading of the law to include the extension of entitlement for financial reasons. However, in cases of life-prolonging drugs, the courts order the sick funds to supply the drugs before giving a final decision (Asiskovitch, 2007).

Why is the political element weak in Canada and Israel? In both countries, the power of



decision-making is shared by governments and service providers, while the public tends to react. The public's "position" on health-care and its power are diffused, as the "public" is composed of diverse groups with conflicting interests. Even interest groups of patients wishing to influence policymaking have limited power compared to governments and insurers/service providers. Different mechanisms limit democratic influence in the two countries. In Canada, health-care is a central issue and may determine election outcomes. Even so, the federal system restrains the citizenry and enables federal and provincial governments to avoid blame. Moreover, by decentralizing health-care system, a stronger popular resistance to reforms is difficult to form. In Israel, health-care is not a central political issue, only patients struggle to expand public coverage, and politicians rarely resort to blame-avoidance mechanisms.

**Civil element.** The civil element is more limited in Canada than Israel (see summary of comparative assessment of Canada and Israel in Table 7). In Canada, individuals' ability to opt for private health-care insurance plans for core services is eliminated because of the institutional arrangements of Medicare and the structure of the polity. In Israel, NHIA was originally intended to marginalize the need for private insurance for most needed services. But the law and its politics of inadequately updating the basic package of services have shaped the behaviour of sick funds and individuals alike, favouring greater reliance on private solutions.

*Table 7 here*

In Canada, delivery of physician and hospital services outside Medicare is not illegal, but most provinces assume that private insurance for core services should be eliminated. Flood and Archibald (2001: 829) find that provincial legislation is primarily aimed to "prevent the development of a private sector that depends on subsidy from the public sector". Six of the 10 provinces ban private insurance for core sectors. Even where private insurance is not explicitly illegal, regulations limit the entrepreneurial autonomy of opt-out physicians. All provinces outlaw or sanction direct billing, extra-charging, and public subsidizing of private medicine (Flood and Archibald, 2001).

When the public health-care system satisfies individual needs, opting for private insurance plans is not essential and may well endanger the sustainability of the public system. Wait times for medically necessary services which prolong life or ease suffering, are followed by dissatisfaction with the poor performance of the public system and translate to pleas for private solutions. In the 2005 Chaoulli case, the Supreme Court of Canada acknowledged the failure of the public system in Quebec to meet legitimate demands for timely access to core services. The decision stated that a ban on private health-care insurance is illegal if the public health-care system of Quebec cannot guarantee timely access to core services (Dickens, 2005; Russell, 2005). Chaoulli proves that support for two-tiered health-care system has gone beyond medical associations (CMA 2006; Maioni, 2002) to include other groups and political actors, such as the Conservative Party and the Supreme Court of Canada (Andrain, 1998; Choudhry, 2005; Hutchinson, 2005; Sossin, 2005; Premont, 2007). However, the Chaoulli decision has not changed the ban on private insurance in

Quebec (Premont, 2007)<sup>35</sup> or other provinces. Thus, “choice” in Canada is made in one of two ways: by moving to another province seeking a publicly-funded solution, or looking for a privately-funded solution in the United States (CIHI, 2000). In both cases, costs are high, and few are able to make such choices.

In Canada, private health-care insurance for employees and their dependents is the most important work-related benefit (CIHI, 2000; Dyck, 2006: 172; Gilmore and Zowall, 2002). However, the choice is given to employers, not employees, and insurance schemes vary according to the services insured. Others who can afford it purchase private insurance.

In Israel, NHIA requires mandatory affiliation with one of the four not-for-profit sick funds and bans opting-out. The promise of the freedom to switch between sick funds was a major reason for the NHIA legislation (Barzilai, 1996; Shalev, 2003; Shuval and Anson, 2000).<sup>36</sup> The original intention of the law was to secure the same basic, yet generous, package of services for all, no matter which sick fund they belonged to. Beyond this basic package of services, there was an expectation that such managed competition would lead the sick funds to include other services free of extra fees (Shalev, 2003). Thus, the NHIA aimed to favour consumer rights over quality of services and to empower individuals vis-à-vis sick funds, not to enhance the civil element.

Considering the possible negative outcomes of an expanded civil element in health-care, the Israeli “consumer rights” solution could have served as a substitute for a restricted civil element. However, as 72% of Israelis obtained supplementary insurance in 2006 (see above), their ability to switch between sick funds is greatly limited. Supplementary insurance circumvents the free transition between sick funds by attaching a qualification period of 6-24 months prior to eligibility for services as expensive drugs, operations in private facilities, or organ transplants abroad. If an individual chooses to switch between sick funds, she cannot “take” her rights from the old supplementary insurance to the new insurance plan. Thus, patients remain powerless in their relations with the sick funds.

As the gap between medical innovation and the scope of NHIA coverage increases, supplementary and private insurance becomes more essential. The overlap between mostly-public funded basic packages of services and supplementary/private insurance is quite narrow. Israelis can choose whether to purchase supplementary insurance, and the sick funds cannot refuse applicants (insurance firms can exclude applicants from private schemes based on a previous medical condition). Supplementary/private insurance includes services not covered or partially covered by NHIA, such as drugs and several two-tiered system services (Chernichovsky, 2004; Bramli-Greenberg, and Matzliach, 2007). Two-tiered services include surgery in for-profit facilities and the ability to choose a physician in a few public hospitals. Since 2006, the sick funds have presented “second generation” supplementary insurance, including expensive life-prolonging drugs for cancer. But supplementary insurance for such drugs was prohibited in December 2007, and the legal ban was not replaced by adequate public funding.<sup>37</sup> Thus, many patients face a “choice” to fund life-prolonging treatment out-of-pocket.

A comparison of Canada and Israel highlights different paths of development in the civil element of “health-care citizenship” according to different institutional logics. In Canada, opting-out of the public system for core services is practically impossible, while in Israel, the growing private number of alternatives offers the mirage of freedom. Both paths of development weaken citizens vis-à-vis their governments by shaping their daily behaviour in the health-care market. In Canada, no competition presses the public plan to improve; in Israel, private solutions seem to satisfy middle and upper class demands while taking pressure off the public plan.

## **Discussion**

The health-care arena in Canada and Israel is dominated by national health insurance programs. Analyzing the institutional settings of the two health-care systems from a “health-care citizenship” perspective, one reaches the conclusion that Canada and Israel present similar types of solidarity albeit via different mechanisms.

In the legal and social sciences literature, the right to health-care is perceived as a social right. Canada and Israel present different models for health-care de-commodification within the “national health insurance” type. In Canada, hospital and physician services are fully funded by public sources. Other services, such as pharmaceuticals, are publicly-funded for vulnerable groups. In Israel, most sectors of medical services are publicly-funded. De-commodification is not complete, as individuals are expected to cost-share for some services, such as pharmaceuticals or visits to specialists.

In both countries, one can trace the evolution of the scope of public insurance to the needs of individuals – and to the interests of the state and most service providers. In Canada, hospital and physician services cause the largest economic burdens for individuals, but the public-funding of these services also serves the interests of the federal government and most physicians (Tuohy, 1999). In Israel, the basic package of services of the largest sick fund is enacted in law, as the government looks to restrain public expenditures while re-distributing resources between sick funds to meet the needs of their insured members (Asiskovitch, 2006).

Public health-care systems face growing external pressures, and their capabilities to de-commodify medical services are being questioned. The pressures and their outcomes – how services are explicitly and implicitly rationed – are shaped in relation to the institutional arrangements of public plans in each political community. I wish to emphasize two conclusions. First, the scope of de-commodification in Canada and Israel is decreasing, even if governments introduce new mechanisms and ad-hoc solutions to specific needs. It seems that the phrase “universal coverage means coverage for all, not coverage of everything” (Von Tigerstrom, 2002: 166) is more true than ever. Second, the scope of relations between individuals and imperfect health-care systems goes far beyond the social element of access.

The concept of “health-care citizenship” developed in this article evaluates interactions between individuals and their national political communities in the area of health-care and is composed of three elements: social, political, and civil. Acknowledging that these interactions are a complex

reality is important, as individuals and governments face imperfect public health-care insurance programs and limited resources to satisfy all needs. Canada and Israel present limited scopes of political and civil elements. In both countries, democratic input for health-care policymaking is limited as is the ability of most individuals to make choices.

Using the perspective of “health-care citizenship”, we can evaluate phenomena like the liberalizing of health-care systems. Such reforms yield diverse and conflicting outcomes. On the one hand, governments declare that the good of individuals and their active participation in decision-making is essential and that this directs their policies. On the other hand, in the case studies of Canada and Israel, governments have used their powers to advance neo-liberal ideologies that limit public debate and opposition.

In a perfect health-care system, political and civil elements might be considered redundant, as the social aspect would be fulfilled. In real-world imperfect health-care systems, individuals should be allowed to make decisions that influence their own fate. This is not to suggest that under scarce resources, the civil element in “health-care citizenship” should dominate. Rather, a balance between elements, or rights, should be the goal. In health-care, it is reasonable to limit the civil element more than the other two elements, as attempts to realize the civil element are usually limited to the wealthiest stratum.

My use of the term “health-care citizenship” could be criticized, as it seems to “reverse” Marshall’s argument in its suggestion that a central area of the original social element includes a civil aspect and that collective efforts should make room for individual interests, at least to some degree. However, I follow Michael Lister’s (2005) interpretation of Marshall, arguing that citizenship is a complicated enterprise of complementing and conflicting rights, and that such relations between rights exist in a number of areas of human life. Citizenship consists of various ingredients, benefits (social element), influences (political element), and autonomy (civil element), and different individuals pursue different goals. The important thing is balance – and this lesson is equally important for health-care systems.

## **Conclusion**

The paper has proposed a framework for a rights-based analysis of health-care systems, following T.H. Marshall’s theory of citizenship and focusing on the relations of individuals and political communities in health-care. It argues that such relations do not revolve around social access to medical services alone, but include political and civil dimensions. Canada and Israel, two countries with national health insurance systems, present different models of social, political, and civil elements. In response to the growing gap between public resources and social needs, both countries have increasingly turned to private solutions. Political and civil dimensions in both countries have changed according to “path dependence” logic. Yet, in both cases the scope of these dimensions is rather limited.

Canada and Israel can learn from each other’s experiences, even if political, structural and

historical circumstances limit the ability to “transplant” models. From Canada, Israel can learn that the path of private-public mix in funding is not irreversible; Israel should also note the passionate commitment of Canadians to Medicare and their ability to pressure governments to defend access to health-care as a human right. From Israel, Canada can learn different models for the coverage of medical services and for choice within the public system.

Future research could employ a rights-based approach to other health-care systems, especially those which do not offer “national health insurance” (Hacker, 2004: 696). Such research may yield a different typology and centre on the individual in the political community. Future research could also develop the framework and its components using aggregate measures, institutional analysis, and methodological individualism, and combine a rights-based perspective with a group-based perspective.

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Table 1: Canada and Israel’s health-care systems: Main indicators (in 2005)<sup>38</sup>

	(in 2004/5)	Canada	Israel
<i>Inputs</i>			
Population (in millions)		32.271	6.930
GDP per capita (PPP\$)		34,057	26,051
% of senior citizens (65 years-old and above)		13.1	9.9
Expenditure for health as % of GDP		9.8	7.8
Expenditure for health per capita (PPP\$)		3,326	2,069
% of private expenditure for health		29.7	32.2
<i>Process</i>			
Hospital beds (per 1000)		3.4	6.1
% of employees in the health-care sector		8.1	6.6
Physicians (per 1000)		2.2	3.6
Nurses (per 1000)		10.0	5.9
Physician visits per capita		6.0	8.4
<i>Outputs</i>			
Life expectancy at birth – women		82.6	81.6
Life expectancy at birth – men		77.8	77.4
Infant mortality (per 1000)		4.5	5.3

Table 2: Elements of “health-care citizenship”

Element of citizenship	Criterion	Content
Social element	Population covered	The existence of one or more public health-care insurance plan. Whether all citizens insured in public insurance(s). Whether groups of foreigners/immigrants are included.
	Equity	Whether the range of services listed in public plans and de-commodified is extensive. Whether the principle of equity determined listing/de-listing technologies in public plans, or other principles as the interests of the state/service providers rule. Aggregate measures of national economic expenditure for health-care, the shares of public and private sources, and trends of changes. Whether individuals belonging to different groups enjoy different insurance coverage – whether under formal rules and/or in actual implementation of formal rules.
	Rationing	Use of explicit methods in different health-care sectors. Use of implicit methods in different health-care sectors.
	Private sector	The scope of private funding and private insurances and whether there is a two-tier system. A comparison of quality of services where there is an overlap between public and private insurance plans. The nature and scope of “drift” of services and resources from public-funded sector to the private-funded sector.
	Obligations	Methods of individual participation in funding of public health-care systems/insurance plans and their level of progressivity. Economically-weak groups (poor, elderly, chronically ill, ethnic minorities) that are partially or fully exempted from contributions. The role for private funding – out-of-pocket payments and private insurances.
Political element	Citizen participation	Whether decision-making regarding public health-care systems/insurances include mechanisms for absorbing citizens’ demands in policymaking process. Participation and influence of the general public in decision-making. Participation and influence of patient interest groups (clients) in decision-making.
	Legal inspection	Public influence on decision-making through appealing the courts and/or the impact of inspection bodies.
Civil element	Insurance plans	Possibility to opt-out from public health-care system/insurance plan to private alternatives. Restrictions on entitlements in the private health-care insurance market.
	Service providers	Ability to freely “contract” with various physicians, hospitals, and other services providers.

Table 3: Aggregate indicators: Canada and Israel (%)<sup>39</sup>

	Private sector share of funding		Total health expenditures as % of GDP		Private sector expenditures per capita increase		Public sector expenditures per capita increase	
	Canada	Israel	Canada	Israel	Canada	Israel	Canada	Israel
1983	23.8		8.3					
1995		24.0		7.9				
2001				8.4				
2002	30.4		10.0		5.7 (1983-2002)		2.4 (1983-2002)	
2006	29.7	33.2	10.3	7.8	3.0 (2002-2006)	4.5 (1995-2006)	4.0 (2002-2006)	-0.2 (1995-2006)

Table 4: “Health-care Citizenship” in Canada and Israel: Summary of social elements

Dimension	Criterion	Canada	Israel
Social element	Existence of public plan(s)	***	***
Social element	All citizens insured	***	***
Social element	Coverage for non-citizens	**	*
Social element	Range of services insured	**	***
Social element	Listing new technologies based on the principle of equity	**	**
Social element	Low share of private funding in national expenditure	**	*
Social element	Variation in access of different social groups	**	**
Social element	Use of explicit methods for rationing	**	***
Social element	Use of implicit methods for rationing	***	**
Social element	Existence of two-tier system	*	***
Social element	Higher quality of privately-funded services	-	-
Social element	“Drift” of services from the public system to the market	**	**
Social element	Progressivity of health-care payments <sup>40</sup>	**	*
Social element	Exemption from obligations for economically-weak groups	***	**
Social element	Limited role for private funding	*	**

Comments: [1] for the meaning of the criteria see table 2; [2] (-) not compared; (\*) low level in comparison; (\*\*) medium level in comparison and/or varying within a case-study; (\*\*\*) high level in comparison.

Table 5: Private funding in Canada and Israel (in 2005)<sup>41</sup>

	Canada	Israel
Share of private sources out of total expenditure for health-care	29.7	32.2
Share of out-of-pocket payments of total expenditure for health-care	14.5	23.7
<i>% of private funding</i>	53	74
Share of private insurances of total expenditure for health-care	12.9	8.5
<i>% of private funding</i>	47	26

Comment: Canadian estimate of share of total private funding includes non-consumption revenues.

Table 6: Health-care Citizenship” in Canada and Israel: Summary of political elements

Dimension	Criterion	Canada	Israel
Political element	Formal mechanisms for including citizens’ demands	*	*
Political element	Influence of the general public	**	*
Political element	Influence of patient interest groups	*	**
Political element	Legal inspection	*	**

Comments: [1] for the meaning of the criterions see table 2; [2] (-) not compared; (\*) low level in comparison; (\*\*) medium level in comparison and/or varying within a case-study; (\*\*\*) high level in comparison.

Table 7: Health-care Citizenship” in Canada and Israel: Summary of civil elements

Dimension	Criterion	Canada	Israel
Civil element	Ability to opt-out of the public system for private insurances	*	**
Civil element	Freedom to enrol into private health-care insurance plans	-	-
Civil element	Freely “contract” with service providers	***	***

Comments: [1] for the meaning of the criterions see table 2; [2] (-) not compared; (\*) low level in comparison; (\*\*) medium level in comparison and/or varying within a case-study; (\*\*\*) high level in comparison.

## Notes

<sup>1</sup> According to a World Health Organization report (WHO, 2000), Canada and Israel are ranked 30 and 28<sup>th</sup>, respectively, and close to the top of the ranking of most indicators for efficiency, effectiveness, and equity.

<sup>2</sup> For both countries, see Geva-May and Maslove, 2000. For Canada see: CIHI, 2005; Lahey, 2007; Maioni, 2002; Tuohy, 1999. For Israel see: Gross, 2003; Gross and Anson, 2002; Gross and Harrison, 2001; Gross, Rosen, and Shirom, 2001. More comprehensive discussions on Israel can be found in Hebrew: Asiskovitch, 2006; Bin-Nun, Berlovitz, and Shani, 2005; Shalev, 2003.

<sup>3</sup> About sick funds in Israel, see: Gross, 2003; Gross and Anson, 2002. About the development of the health-care system in Israel, see: Shuval and Anson, 2000; Zalmanovitch, 2002.

<sup>4</sup> Marshall’s approach was criticized by many for its empirical and theoretical arguments. A review of these critiques can be found in: Dwyer, 2000; Ferrera, 2005; Johnson-Redden, 2002; Kivisto and Faist, 2007; Lister, 2005; Rees, 1996; Turner, 1993. Some critics are more relevant to “health-care citizenship” as discussed in the paper.

<sup>5</sup> Moreover, if equity considers unique medical situations of distinguished groups, the health-care system can be taken as an instrument for granting full citizenship (in health-care) to marginalized groups.

<sup>6</sup> See, for example, the definition proposed by Kelly et al (2002: 270): “Equity has been defined in terms of both clinical equity – priority being given to those with more severe symptoms – and social equity – the absence of any effects of gender, age, marital status, education or other nonmedical conditions on waiting times.”

<sup>7</sup> Thus, expensive treatments that are not effective or whose effectiveness is negligible are inequitable (Culyer and Wagstaff, 1993).

<sup>8</sup> Studies in the United States show that imposing cost sharing leads to prudent use and avoidance of discretionary, yet vital, medical services among the poor, elderly, and chronically ill (Trivedi, Rakowski, and Ayanian, 2008).

<sup>9</sup> Imposing co-payments for some services such as physician visits and pharmaceuticals are aimed to prevent “moral hazard” of clients and direct them to a rational behaviour. Yet the primary function is substituting private funding of

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health-care systems for public expenditures (Maynard, 2005).

<sup>10</sup> In various health-care systems individuals can “contract” with a certain physician/hospital as personal trust is required for successful treatment (WHO, 2000). By deciding whether to use new and/or expensive technologies, physicians function as grass-roots bureaucrats in other welfare state programs (Lipsky, 1980) and daily challenge the boundaries of health-care insurance plans. Ability to select between physicians and other service providers – a consumer right – can achieve similar effects as freedom of choice between health insurance plans (Aday et al, 1993).

<sup>11</sup> By civil element, I refer to the capabilities of individuals to act as autonomous agents; not to physicians who pursue entrepreneurial and clinical autonomy.

<sup>12</sup> For neo-liberals/neo-conservatives, “freedom” in health-care is considered most important, and political interference seems intolerable (Engelhardt, 1997).

<sup>13</sup> Furthermore, one’s ability to select between not-for-profit and for-profit service providers might be limited, as in some fields of medicine, the choice of public or private options is not available. For-profit medicine focuses on a limited range of profitable services (Maynard, 2005), and as discussed above, growing shares of medicine are left out of public insurance plans and “drift” to the private sector.

<sup>14</sup> I tend to agree that in most cases such private insurance plans offer better coverage in exchange for higher premiums compared to public plans. Furthermore, the insured in these private insurance plans would be the wealthier and healthier due to the plans’ rules, even if regulated, and to the insured’s will to receive better services and/or to differentiate him/herself from the lower strata (Gal, 1998). However, this does not necessarily lead to lack of support of the higher strata in most Western countries in funding public plans. The wealthiest still profit from the health of their employees or public servants, such as police officers protecting their safety, or municipal employees keeping their environment clean.

<sup>15</sup> Before turning to the analysis, an important methodological warning is in order. Thoroughly analyzing Canada’s Medicare requires an analysis of 13 different public health-care insurance plans according to the same criteria. When the discussion is based on previous analysis of one or more but not all provinces/territories of Canada, I explicitly mention it.

<sup>16</sup> The CHA states that if the provinces and territories wish to enjoy federal cost-sharing for their medical services, they should meet five principles: public administration, comprehensiveness, universality, portability, and equal access (including prohibition on extra-billing by physicians and user-charges by medical facilities), to ensure equity (Wright, 2005).

<sup>17</sup> In core sectors, private sources (out-of-pocket or private insurance) pay for “extras,” such private rooms in hospitals or cosmetic surgery.

<sup>18</sup> The NHIA set a formula for allocating public funds among the sick funds based on the number of insured individuals and their ages, not their economic status (Shmueli and Chinitz, 2001). Thus, the sick funds expanded their services and facilities to include new groups.

<sup>19</sup> According to a World Health Organization (WHO, 2000) report on the quality of health systems, Canada was ranked slightly higher than Israel according to level of fairness in funding – 17-19 (0.974) compared with 38-40 (0.964) out of 191 countries. Such measuring cannot encompass the subtle changes which the funding of medical services brings about on the very poor. As these changes affect ability to pay, access to health-care of growing sections in society is infringed upon. If individuals cannot pay for services, the WHO index misses this critical phenomenon.

<sup>20</sup> As public insurance plans vary across provinces, the rate of the uninsured in 2001 went as high as 35% in Newfoundland (Lahey, 2007: 22).

<sup>21</sup> The content of these insurance plans varies. See more below, in the discussion on the civil element in Israel. According to the NHIA, fees for supplementary insurances are set according to individuals’ ages, not their incomes; thus, older people pay more. Private insurance premiums are adjusted to risks.

<sup>22</sup> 34% had private insurance, according to a 2005 survey (Gross, Bramli-Greenberg, and Matzliach, 2007: 18).

<sup>23</sup> Gildiner (2006, 2007) points to a different kind of drift, in which inadequate update of non-core publicly-funded rehabilitation services can lead to the growth of an alternative private market.



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- <sup>24</sup> Explicit rationing is also used for other services, such as drugs, which provinces decide to insure.
- <sup>25</sup> Several studies focusing on wait times suggest that an individual's access to health-care in Canada is not affected by socioeconomic determinants (Kelly et al, 2002; Sanmartin, Pierre, and Tremblay, 2006; Shortt and Shaw, 2003).
- <sup>26</sup> According to a 2005 survey, 85% of Canadians feel that "eliminating public health care would alter the fundamental nature of Canada" (Dyck, 2006: 255).
- <sup>27</sup> Health-care is the responsibility of the provinces. The federal government is constitutionally prohibited from running health-care insurance plans or delivering medical services, except for First Nations and a few other groups. However, the federal government is allowed to offer financial cost-sharing and to condition its transfers. This is known as the "spending power" (Lahey, 2007; Maioni, 2002).
- <sup>28</sup> These figures ignore federal contributions as part of the "tax points" system, included in the provincial governments' share. However, these data are not available.
- <sup>29</sup> The scope of services and funding in a given province are set by deliberations between provincial governments and service providers (hospitals via regional health boards) or representative organizations (provincial medical associations) (Flood, Stabile, and Tuohy, 2006; Lahey, 2007; Taylor, 1990; Woodward and Charles, 2002).
- <sup>30</sup> In 1995 and 1996, the share of general revenue taxation in financing the basic package of services was 17.5% and 9.9%, respectively.
- <sup>31</sup> Co-payments remained at a steady level of 5.4% during this period.
- <sup>32</sup> These interest groups organized during the legislation of NHIA to advance patients' interests (Asiskovitch, 2006).
- <sup>33</sup> Other critics argue that the committee gives equity far greater priority than economic efficiency consideration due to pressure by patients groups (see Bank of Israel, 2007: 304).
- <sup>34</sup> NHIA assigns Labour Courts authority in lawsuits against sick funds. Access to these courts is easier than to regular courts. These courts are also assigned authority over social security and income support matters.
- <sup>35</sup> Since the judicial ruling, for-profit insurance and delivery are allowed in Quebec for a few non-emergency procedures, such as hip and knee replacement and cataract surgery.
- <sup>36</sup> It is complemented by a duty imposed on the sick funds not to exclude applicants and "cream-skimming." The available data shows that since 1998, when transitions between sick funds were regularized, the annual transitions amounted to 0.9%-1.8% of the entire population (Bin-Nun and Kaidar, 2007a: 19).
- <sup>37</sup> In exchange for the prohibition, the Ministry of Finance agreed to increase the "technological update" to include new pharmaceuticals during 2008-2010. The additional funding cannot cover all recommended drugs by committees of experts.
- <sup>38</sup> Source: Bin-Nun and Kaidar (2007b).
- <sup>39</sup> Sources: for Canada see CIHI (2006: 89, 93, 106-107); for Israel see Bin-Nun and Kaidar (2007a: 50-51).
- <sup>40</sup> One cannot escape the conclusion that progressivity of health-care funding in both countries is limited when compared to most OECD countries.
- <sup>41</sup> Sources: see Bin-Nun and Kaidar (2007a: 39-41); CIHI (2006: 19).