

**HEALTH CARE DELIVERY TO FOREIGN WORKERS IN ISRAEL**

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## ABSTRACT

In 1995, Israel implemented a National Health Insurance law, which entitles all of its permanent residents to a comprehensive package of health care services. However, the estimated 250,000 foreigners who work in Israel are not covered by this law. Although they are required to have private health insurance, problems have been reported involving acquisition of insurance, extent of coverage and access to care. Various proposals have been suggested for improving health care delivery to this population. This paper examines problems engendered by the current situation, proposals for change and possible strategies for their implementation.

## INTRODUCTION

Israel's National Health Insurance (NHI) law went into effect January 1, 1995. Under its provisions, every permanent resident must select enrollment in one of the four non-profit Sick Funds. Each Fund is required to provide an identical defined comprehensive package of health care services. The primary source of funding for the NHI is the health insurance premium, which is paid by each individual, in proportion to his/her income, to the National Insurance Institute (NII). Employees have this premium deducted by their employers. NHI revenues are allocated to the Sick Funds on the basis of a capitation formula which adjusts for age of the enrollee and his/her distance from population centers. Private insurers are permitted to offer supplementary insurance (Government of Israel [GOI], 1994).

Because they are not considered residents, foreign (non-Israeli, non-Palestinian) workers in Israel are not covered by the NHI law. The number of these workers is estimated at 200,000-300,000 (*The Jerusalem Report*, 1997:4), which is equivalent to 3.5-5% of the population and 10-15% of the labor force. Almost 60% work in construction, approximately 15% each in agriculture and home care, with the remainder employed in other services or industry. Approximately 80% are male and most are without dependents in Israel. There are an estimated one

thousand children of foreign workers, the majority of whom live in Tel Aviv. Countries of origin include Romania, Ukraine, Bulgaria, Turkey, Philippines, Thailand, China, India, Colombia, Ecuador, Chile, Nigeria and Ghana. Foreign workers are located throughout the country, with the largest concentration (approximately 30%) residing in Tel Aviv (Kav L'Oved, 1997b:1).

An estimated 120,000 of these workers are in Israel legally, having received one year work permits, which are usually arranged by personnel agencies who have recruited them from abroad. A condition for the granting of work permits is passing a physical examination in the country of origin. The majority of illegal workers are former legal workers whose permits have expired. However, there is a growing phenomenon of agencies bringing in workers as tourists and passing them on to employers without obtaining the necessary permits (*The Jerusalem Report*, 1997:5; Kav L'Oved, 1997b:1).

By law, employers of legal foreign workers are required to obtain for them private health insurance coverage equivalent to the comprehensive benefits package defined in the NHI law for Israelis. In practice, however, many of the policies provided by the private insurers are much more limited in scope than the services offered to Israelis under NHI. Specifically, most of the private policies do not cover chronic disease or other medical conditions which existed prior to the issuance of the policy. Similarly, private insurers may refuse to renew policies of foreign workers who become ill during their period of employment (Physicians for Human Rights [PHR] - Israel, 1997a:1).

Cost of this private health insurance for foreign workers is typically one dollar per day, whereas Israelis earning the equivalent laborer's salary would pay a NHI premium of approximately 75 cents. Often, employers of foreign workers are offered discounts by the private insurers, based on the number of insured and their utilization of services. Thus, the more foreign workers insured and the less they utilize health services, the less the employers pay to the insurer. Given that employers usually deduct the full sum of one dollar per day from the workers' wages, they stand to make a profit by this arrangement. This utilization discount has a significant potential for abuse, by creating a financial incentive for employers to limit the workers' use of services. Regardless of any discount involved,

employers of foreign workers serve as gatekeepers, regulating access to services. Workers may not be aware of their right to health care, and this may be compounded by language barriers. All of these factors result in limited access to care for foreign workers (Kav L'Oved, 1996:3; PHR, 1997a:3).

While the problems cited above are typical for foreign workers in the construction sector, the agricultural sector, in contrast, presents a better situation for reasons worthy of note. The majority of foreign farm workers are employed by "moshavim," cooperative agricultural settlements located throughout the country. The Moshav Movement purchases foreign worker health insurance centrally on behalf of its members. It uses this purchasing power to ensure both favorable policy terms and favorable adjudication of individual cases. Furthermore, the insurance premiums are paid by the employers, and not deducted from worker salaries as is the norm in the building sector (Rosen, 1998).

Problems also have been reported with payment by private insurers to hospitals that treat foreign workers. Cases of delayed or non-payment by insurers have caused some hospitals to limit their services to foreign workers to life-threatening emergencies only, as required by the Patient's Rights Law. Other hospitals have continued to provide uncompensated care to foreign workers, but report increasing losses (PHR, 1997c:4; Rosen, 1998).

Illegal foreign workers are permitted to acquire private health insurance, but they rarely do so. They may be unaware of this option, unable to arrange it or fearful of disclosure. Without private insurance they have almost no access to health care, other than treatment for life threatening emergencies and work-related accidents (PHR, 1997a:1).

All foreign workers, whether legal or illegal, are covered by National Insurance (NI) for treatment of work-related accidents. Employers are required to report all such accidents, but don't always do so. In cases where the employer refuses to file a claim, the worker is entitled to submit one directly. However, this is long and complicated process and delays in treatment may ensue. Illegal workers often forfeit this right altogether, fearing disclosure.

Furthermore, NI law provides that follow-up treatment be performed within the framework of the Sick Funds, to which foreign workers have no access, thus leaving them with no way of realizing this right to follow-up care (Kav L'Oved, 1995:2, 1997a:3; PHR, 1997c:3).

Data from the National Insurance Institute show that in 1997, foreign worker claims represented 1.7% of the total (Pri-Or, 1997). Given that foreign workers comprise 10-15% of the labor force and are found primarily in the most dangerous occupations (construction and agriculture), it would be expected that they would account for at least 10-15% of all National Insurance claims. Yet the observed percentage is only 1.7. The ratio of observed to expected claims (11-17%) may be seen as a crude proxy indicator for health care access/utilization of foreign workers.

Special problems exist concerning the small, but growing population of foreign worker children. The majority, an estimated one thousand, live in Tel Aviv (Nechama, 1997). Acquisition of health insurance for them is highly problematic. Many private insurers refuse coverage outright, others limit the extent of new policies and may deny renewal. By a decision of the Tel Aviv municipality, all children residing in the city receive full free primary and preventive health services, but this issue has yet to be addressed at the national level (Nechama, 1997; PHR, 1997c:3; Yanai and Borowski, 1998:16).

## BACKGROUND

### *Foreign Workers in Israel*

Founded on principles of Jewish labor, Israel evolved rapidly from an agricultural economy to an industrialized one. Although currently classified by the United Nations as a developing country, it is recognized by the World Bank as a high-income nation with a per capita GDP of \$17,200 (GOI, 1997a:1). A significant shift in labor patterns occurred following the 1967 Six Day War, when Palestinians from the West Bank and Gaza began to work as day laborers in Israel. As their numbers grew, the General Labor Federation insisted on their being paid equal wages, in order to protect its own members' salaries. This led to the phenomenon of illegal underpaid Palestinian workers, who accounted for at least one third of the estimated peak total of 150,000 Palestinian laborers in the 1980's (Sachar, 1996:960).

1987 saw the beginning of the intifada, a prolonged uprising of Palestinians in the West Bank and Gaza, and a new cycle of terrorist acts, which led to repeated border closures and thus a labor shortage. After unsuccessful attempts to induce Israelis to fill these vacancies, in 1993, the then Labor government began issuing tens of thousands of short-term permits to foreign workers (Yanai and Borowski, 1998:17). Also in 1993, the Oslo accords were signed leading to the establishment in 1994 of the Palestinian Authority, which assumed administrative responsibility for the West Bank and Gaza, including all health services. Thus, health care for the 45,000 Palestinian day laborers who currently work in Israel is within the purview of the Palestinian Authority.

The present Likud government has declared its intention to drastically reduce the number of foreign workers by issuing fewer permits, increasing deportation orders against illegal workers and fining their employers. It has stated its desire to replace the majority of foreign workers with Palestinian day laborers, believing this will

reduce social problems because Palestinian laborers return every night to their homes in the West Bank and Gaza. Employment of Palestinians is also believed to reduce their motivation to engage in terrorism (*The Jerusalem Report*, 1997:3). Furthermore, with an increase in unemployment from 6.4% in 1996 to 8.0% in 1997, the government simultaneously claims that there are many Israelis who would now be willing to fill jobs presently held by foreign workers (GOI, 1998:7).

In practice, however, under pressure from strong construction and agriculture lobbies, the government has done little to change the status quo (Yanai and Borowski, 1998:17). According to the Ministry of Labor, legal workers were reduced from 107,000 in 1996 to 92,000 by mid-1997 (*The Jerusalem Report*, 1997:4). However, Ministry of Finance current economic indicators show average monthly work permits as 119,000 in 1996 and 125,000 by mid-1997 (GOI, 1998:3). The Ministry of Labor further reported 4,000 deportations of illegal foreign workers in 1997 (Yanai and Borowski, 1998:20), which represents only 2-5% of their estimated number. The inertia of the government has been matched by that of the General Labor Federation which once championed equal pay for Palestinian workers, but has not substantively addressed the issues involving foreign workers.

### *Health Care in Israel*

Israel's tradition of health care pre-dates the state. In 1912, a group of 150 immigrant workers formed a mutual aid health care association, which evolved into the Sick Fund of the General Labor Federation, the largest of the four Sick Funds which continue to dominate health care today. This fund alone currently operates 1250 primary care clinics and eight hospitals throughout the country. Also in 1912, the first maternal and child health (MCH) care stations were established. This network today includes almost 600 clinics. Following statehood in 1948, the newly-created Ministry of Health (MOH) established its own hospitals and assumed responsibility for preventive care (including MCH stations) and regulation of health services (Tulchinsky, 1998b).

One of the founding principles of the new nation was the absorption of Jewish immigrants, who are guaranteed automatic citizenship under the Law of Return. In the decade following statehood, the population doubled with the arrival of approximately 1,000,000 immigrants and refugees from post-Holocaust Europe and the

Middle East. Nearly all were integrated into the health system, receiving preventive services from the MOH, and insurance and curative services from the Sick Funds. Despite the enormous health problems created by this massive immigration, rapid improvement in national health status indicators was achieved. More recently, the arrival of approximately 750,000 immigrants from the former Soviet Union during the last decade, and 15,000 immigrants from Ethiopia during a 48 hour airlift in 1991, created new challenges to the health system, which have been met with a large measure of success (Berger, 1989:117; Michaeli, 1997:87, Tulchinsky, 1998b). In total, Israel has absorbed some 2.5 million immigrants from over 100 countries during its 50 years of statehood, providing virtually all with health care services, most with Hebrew language instruction, and many with housing and vocational training.

Even before implementation of the NHI law in 1995, 96% of the population was covered by the health insurance and services of one of the four Sick Funds. Of these, 65% were enrolled in the Sick Fund affiliated with the General Labor Federation, a major inducement for obtaining union membership (Sachar, 1996:1016). The government was spending 8.4% of GDP on health care. Childhood immunization rates were uniformly high (>90%); infant mortality low (7/1000). Life expectancy was 75 years for men and 79 years for women (Tulchinsky, 1998b).

Thus, neither health care coverage nor health status indicators were driving forces for enactment of the NHI law. Rather, continued operating deficits the General Labor Federation affiliated Sick Fund provided an impetus for restructuring of the health care system. The NHI law, which went into effect January 1, 1995 severed the ties of the General Labor Federation to the largest Sick Fund and created a system of public financing for all four Sick Funds, which now operate as non-profit health maintenance organizations (Sachar, 1996: 1017; Tulchinsky, 1998b).

The effects of this restructuring of health care are still being assessed. Large deficits (\$300-400 million) were recorded in the first years of operation and were underwritten by the Ministry of Finance (GOI, 1997a:8). Many amendments to the NHI law were under consideration in 1997. In December of that year, legislation permitting co-payments under certain conditions was passed. These co-payments are not expected to cover deficits,



but rather to discourage over utilization. Among the amendments rejected were those allowing Sick Funds to eliminate benefits from the comprehensive package, permitting for-profit Sick Funds to enter the market, and transferring responsibility for preventive care from the MOH to the Sick Funds (GOI, 1997b). The health care system is still in a state of flux as it confronts issues of cost containment, equity and quality of care.

## POLICY PROPOSALS

All of the proposals for improving health care delivery for foreign workers involve bringing them into the framework of the Sick Funds that serve the Israeli population. The most far-reaching suggestion, advocated by one prominent member of the medical establishment (Michaeli, 1998), is to grant Israeli resident status to all foreign workers, whether legal or illegal. Recognizing that the problems of foreign workers are multiple and complex, this proposal would involve full taxation in return for full social entitlements of health (i.e., NHI coverage), education and welfare. The proponent of this approach foresees practical benefits for the society at large. He believes that access to these services would provide an incentive to acquire resident status and would thus largely eliminate the phenomenon of illegal workers. He further argues that “upgrading” the status of foreign workers to Israeli residents would result in wage increases, which could make Israeli labor more attractive to employers. This, in turn, would both decrease the influx of foreign workers and reduce the economic gap between the poor (both foreign worker and Israeli) and the rest of society. The problem of health care delivery for foreign workers would be solved by their inclusion in NHI, guaranteeing equal coverage and equal access.

Others (Yanai and Borowski, 1998) have advocated a similar full taxation for full social entitlement approach, without going so far as to suggest a formal change in the status of foreign workers. They also cite among the expected benefits increased wages for foreign workers, thus reducing their attractiveness to employers. The Ministry of Finance has argued that increased salaries are needed within the construction industry in order to stimulate conversion from the current labor-intensive methods to the capital-intensive methods necessary to promote long overdue modernization in this sector (GOI, 1998:7). Thus, improved building production may be another

indirect benefit of this approach.

These proposals, however, have little chance of success in the current political climate. The ruling conservative coalition is too ideologically opposed, the construction and agriculture lobbies too strong, and the General Labor Federation too weak for these to be viable options in the foreseeable future.

Another proposal is to extend NHI coverage to the foreign worker population. This would entail taxation in the form of the NHI premium in return for health entitlement, without changing the legal status of foreign workers. This approach has been advocated by the non-governmental organizations (NGO'S) that have been active on behalf of foreign workers (Kav L'Oved, 1996:3; PHR, 1997a:5). Specifically, they recommend that the Minister of Health extend NHI coverage to all legal foreign workers. Further, they propose that illegal workers also be allowed to pay NHI insurance premiums in return for health care. They also advocate NHI coverage for all children of foreign workers, regardless of their parents' status. Their motivations are primarily humanitarian. They feel that only insurance through well-established health service providers, such as the established Sick Funds, would secure the realization of the foreign workers' medical rights. However, they are also pragmatic. Foreign workers are mostly young, male, healthy and temporary. These factors are all associated with low utilization of health services. Rather than pay one dollar per day to private health insurers, they would pay the NHI premium of approximately 75 cents per day. This, they believe, would be to the mutual benefit of both the workers, who would pay less and receive better care, and the NHI system, which would receive total added revenues of tens of millions of dollars per year, an amount in excess of expected costs for this population of low utilizers. So convinced are they of this point that they have already proposed a plan whereby this assumed excess would be used to cover uncompensated care costs incurred by uninsured foreign workers (PHR, 1997a:6). In order to avoid unexpected high costs, which would undermine this argument, this proposal includes provisions for medical screening of foreign workers prior to and/or at the time of their arrival in Israel, at the employers' expense. Extending NHI to foreign workers, they argue, would also eliminate the problem of non-payment by private insurers to hospitals.

Extension of the NHI law to uninsured non-residents is within the mandate of the Minister of Health.

However, since this is a cabinet position, it is unlikely that the current Minister or others appointed by the present government will take this step, for reasons cited in reference to the previous proposals. In addition to the ideological opposition of the ruling coalition, MOH officials have expressed fears that extension of NHI coverage would lead to an influx of foreign workers for the express purpose of seeking medical treatment, a reaction which ignores the provisions for medical screening suggested in the proposals.

An alternative approach to that of extending the NHI law has recently been suggested (Tulchinsky, 1998a). This would allow the Sick Funds to offer insurance directly to employers of foreign workers and thus compete with the private insurers for coverage of this population. In this case, the Sick Funds would function as both insurers and providers. Under this plan, the foreign workers would enjoy the benefits of mainstream coverage and the Sick Funds would benefit from additional revenues for a low utilizing population. These advantages are similar to those cited above for NHI coverage. However, this plan does not entail a politically-laden conceptual change in the NHI law and might therefore meet with less resistance, insofar as an equitable premium could be agreed upon by all parties.

## INTERIM PROPOSALS

Given the current political climate, any change in health care delivery to foreign workers will be difficult to initiate. Yet, there is a growing awareness of the problems engendered by the present situation and a realization that the issue must be addressed. At a recent Knesset (Parliament) meeting convened to discuss health care of foreign workers, the Director-General of the MOH acknowledged problems with the current arrangements and reported on an inter-agency committee that has been established to recommend new legislation for regulation of private insurance for foreign workers (Rosen, 1998).

While the NGO's are confident that NHI insurance premiums would more than cover costs of care to

foreign worker, others are not so sanguine. At the same Knesset meeting mentioned above, Sick Fund representatives expressed concern that low premiums paid by low-wage earning foreign workers would not cover true costs of care, which would then be subsidized indirectly by higher-wage earning Israelis, who pay higher NHI premiums. To prevent such a situation from occurring, the Labor Knesset member who convened the meeting suggested a higher premium to be paid by jointly by both the foreign worker and his/her employer (Rosen, 1998). Similar suggestions involving employer-paid premiums have been made by others who believe employers of foreign workers bear responsibility to cover true actuarial costs.

Rough estimates of projected costs have been made and were presented to the Knesset meeting (Rosen, 1998). These are in the range of what foreign workers are currently paying for private insurance. Clearly, more work needs to be done to determine the projected costs of care, in order to convince both proponents and opponents of the viability of the proposed changes.

As a practical first step to change, I suggest an experiment in direct contracting, the least ideological of the proposed policy options. Two logical partners for this study are the Moshav Movement and Kupat Holim Clalit (KHC), the Sick Fund which was affiliated with the General Labor Federation prior to the enactment of the NHI law. As described above, the Moshav Movement already negotiates collectively for private insurance on behalf of the foreign workers employed by its members, and furthermore, moshav employers already pay the premiums. KHC has the advantage of being the largest, most diverse and experienced of the Sick Funds, and also of having clinics in or near most agricultural settlements. Even a small scale experiment in direct contracting between these two parties could have several positive effects. It would yield important data regarding the health status of foreign workers, their utilization of services and costs of care. It could demonstrate the viability of both direct contracting and integration of foreign workers into the framework of the Sick Funds. Also, it might stimulate competition among the Sick Funds for foreign workers as potential enrollees.

The extent of deficits caused to the health system by the current state situation should also be addressed. This could include a survey of uncompensated care costs incurred by hospitals treating foreign workers, whether due to non-payment or late payment by private insurers or by lack of any coverage in the case of illegal workers. Here, I

would like to suggest a possible source of funds to cover these uncompensated care costs. Officials of the MOL have spoken of imposing stiff fines on employers of illegal foreign workers (*The Jerusalem Report*, 1997:4). If, in addition to deportation of the foreign workers, these fines were to be enforced, they might provide an appropriate and potentially lucrative source to help cover the costs of uncompensated care.

## CONCLUSIONS

There are moral, medical, social and economic reasons for trying to improve current health care delivery to foreign workers. In a country with a long tradition of near universal health insurance, many see health care as a basic right that should be extended to this population. The fact that legal foreign workers are required (and illegal workers permitted) to have private health insurance may be viewed as a tacit acknowledgment of this right.

There are significant problems with the current system of health care for foreign workers involving acquisition of insurance, extent of coverage, access to care, and payments by insurers to providers. To overcome these problems various proposals have been suggested. All involve bringing foreign workers into the framework of the Sick Funds, which serve the rest of the Israeli population under the NHI law. These Funds have provided ample precedent for the successful and rapid integration of diverse populations into the health care system. There seems to be a consensus within the medical establishment that they could repeat this experience with the foreign workers, providing a higher standard of care than currently available.

These proposals all have an implicit egalitarian basis, which could expect support from labor and other liberal parties. Perhaps, in order to preempt opposition by the current conservative government, advocates of these proposals have stressed the financial incentives involved. These include increased revenues for the health system and decreased uncompensated care costs. These economic arguments need to be more fully developed and detailed to make the case convincingly. This may be particularly difficult because the economic effects of implementation of the NHI law are only just beginning to be analyzed. In the present political climate, ideological opposition to

recognition of foreign worker rights appears to be stronger than the attraction of economic incentives. Therefore, the recently suggested proposal to allow Sick Funds to offer insurance directly seems to have the best chance of acceptance and should be developed and pursued accordingly.

Potential supporters of these proposals should be mobilized. These include the Sick Funds, which can expect increased revenues, and hospitals, which can expect a decrease in uncompensated care. The Municipality of Tel Aviv could also expect a decrease in uncompensated care costs. Although foreign workers are not entitled to vote in any elections, opposition parties should find this issue ideologically attractive. This is also true of the General Labor Federation, which has thus far abrogated its traditional mandate. Professional medical associations should also be natural advocates for improving health care delivery to this population. Foreign workers, themselves, have recently begun to organize (Yanai and Borowski, 1998:20), and they should play an integral role in the process of change.

From a public health perspective, it is important to have the best possible surveillance, prevention and treatment programs in place for all segments of the population. This is true even when the likelihood of disease transmission from one segment to another is low (Gellert, 1993:1491). Recent experience with Soviet and Ethiopian immigrants in Israel provides a positive example of what can be accomplished. Rapid detection and treatment of communicable diseases was achieved through the concerted joint efforts of the Ministry of Health and the Sick Funds (Michaeli, 1997:87). Currently, neither is involved in the care of foreign workers, which can only be to the detriment of public health in Israel.

Bringing foreign workers into the mainstream of Israeli health care may also focus attention of the medical establishment on factors causing morbidity and mortality in this group and generate new programs for prevention (e.g., adult immunization, work-place safety). Such a process might have positive ramifications for the health of the society at large.

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