Community Pediatrics in Israel: Time for Change?

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Since the publication by Robert Haggerty of his vision of a "New Morbidity" in pediatrics nearly 50 years ago, increasing attention has been paid to the breadth of health needs of children. Haggerty and his co-workers in Rochester, New York, saw the need for pediatrics to move beyond the acute health care needs of children, and to include in clinical practice the following: preventive health care, behavioral and developmental problems, chronic disease, and family-related problems [1-3]. Over the years the American Academy of Pediatrics has issued position statements regarding the role of the pediatrician in the public health needs of the community, and the pediatrician as an advocate for children [4]. This paper poses the question whether, and how, Israel should follow these trends for improving child health.

A focus on the total health needs of the child will require better integration of preventive and curative pediatrics, with coordination of care assisted by trained nurses working in pediatric offices

BACKGROUND

PREVENTIVE CARE

Standard measures of child health such as infant and childhood mortality place Israel in a leading position among countries in the world. Although gaps still exist between population groups, infant mortality has fallen steadily for all population groups over the years, reaching 3.8/1000 for the Jewish population and 8.8/1000 for the Muslim population in 2004 [5]. In addition, immunization rates have consistently been high [5], which until recently could be attributed to a network of maternal and child health clinics that provide the immunization schedule to the entire population, with families paying a minimal charge. Following implementation of the National Health Insurance Law in 1995, the area of preventive care remained under the control of the Ministry of Health. In a review of preventive MCH services in 2006 by Palti [6], approximately 50% of the MCH centers were run by the Ministry of Health, 36% by Clalit Health Services (the largest of four health funds), 9% by the other health funds, and 5% belonged to the municipalities of Tel Aviv and Jerusalem [6]. Though the number of these MCH clinics within the health funds is still relatively small, they are seen as an important channel for recruiting young families. However, within the health funds that operate MCH services, preventive and curative care is frequently given by a different pediatrician and nurses, creating further segregation of care.

The ability to develop high-quality comprehensive preventive care has been further compromised by the steadily decreasing funding of new positions in MCH clinics despite the increase in population size. The relatively poorer salaries of nurses and lower qualifications of physicians in the MCH sector have further contributed to the difficulties in providing high-quality preventive care. Despite numerous debates at governmental and professional levels regarding the pros and cons of integrating preventive and curative pediatric services, and a decision to transfer the preventive services to the health funds within the framework of the National Health Insurance Law, preventive and curative services remain separate at this time.

COMMUNITY PEDIATRICS PRACTICE

The community pediatrician is employed by one or more of the four health funds. Due to the improved remuneration for community-based pediatricians, many hospital-based pediatricians today work in a community clinic in addition to their hospital position as an important source of supplemental income, though in many cases they give relatively few hours to primary care. The limited involvement of the Israeli pediatrician in issues related to the "New Morbidity" was demonstrated in a recent study by Oren et al. [7], with both certified pediatricians and pediatric residents showing limited confidence in managing issues out-

MCH = maternal and child health

side the realm of classical acute disease-oriented pediatrics. In another part of the same study [8], the amount of time devoted to issues other than acute disease or administrative issues by a pediatrician was small, with less than 1% of diagnoses related to problems of the New Morbidity. A recent finding that some 200,000 children in Israel suffered from a chronic disease or some disability that significantly influenced their daily activity [9] supports the need for an expanded role for the pediatrician. This is probably a conservative estimate of a domain where the community-based pediatrician has a central role. In recent years Clalit Health Services has spearheaded the creation of a network of Pediatric Centers aimed at upgrading community-based pediatrics, enabling the full range of primary care and specialty pediatric services to be provided under one roof. At the same time, the role of independent pediatricians working on a modified fee-for-service basis for one or a number of health funds is still a prevalent service model, including many working in solo practice. The remuneration system is based on the volume of children seen, thus acting as a "disincentive" for more in-depth management of non-acute problems. The role of nurses in the health funds is still limited to the traditional model, and the widely accepted nurse practitioner model, which has existed in the United States for over 40 years, is still not found in the Israeli context for a variety of political reasons [10].

Incentives must be provided to ensure that pediatricians with the special skills required for community pediatrics will take the leadership in improving child health services in peripheral areas

The issue of care coordination is another issue that is receiving increasing attention in the literature [11] and is a major issue in pediatric care in Israel. If a child is being seen by a number of specialists, often the pediatrician is not aware of all the visits, or does not see his or her role as the coordinator of the input from different sources. Thus, it often occurs that the child with a chronic disease, or a child undergoing assessment and treatment in a Child Development Center, will not have a pediatrician as coordinator and advisor to the family. The common reason cited for the failure of the primary care pediatrician to function as the coordinator of a child's care is lack of time, where a short visit for an upper respiratory infection or otitis media will receive the same remuneration as for trying to attend to the complexities of a child with a chronic disease or developmental problem. In addition, the study by Porter and colleagues [8] showed that despite high levels of satisfaction with their pediatrician, parents do not expect the pediatrician to deal with issues other than acute problems. The result is an ever-increasing number of visits for children to various subspecialists – the pulmonologist for mild asthma, the allergist for a mild eczema, or a Child Development Center for a mild motor coordination problem or suspected attention deficit hyperactivity disorder. The increased referrals generate longer waiting lists for subspecialists who are called on to see a range of mild problems that could be managed in the primary care setting, thereby leaving the subspecialist free to deal with the more severe problems.

PEDIATRIC TRAINING

Israeli pediatrics has developed as a two-track system. Residency training involves five and a half years of in-hospital training, with much of the time spent in the emergency room, the newborn nursery and the newborn intensive care nursery, and dealing with complex pathology on the inpatient ward. While residency training is the same for all, most graduates will practice in the community after completing their training, with a smaller percentage remaining in the hospital. However, a projected deficit in the number of pediatricians, and of doctors in general, in Israel may result in more graduates of pediatric residencies being absorbed into hospital positions. Subspecialization is the rule for the majority of hospital-based pediatricians, with most hospitals developing subspecialty units in cardiology, pulmonology, infectious diseases, allergy and immunology, neurology and child development, and child psychiatry. Community-based pediatricians do not manage their patients in hospital, and any contact with the hospital staff depends on specific relationships being developed between the community pediatrician and the specific hospital. The development of the professional Pediatric Societies also reflects the separation between hospital and community. Thus under the umbrella organization, the Israel Pediatric Association, there exist two societies: the Israel Clinical Pediatrics Association that caters mainly to hospital-based pediatricians, and the Israel Ambulatory Pediatrics Association that caters to the community-based pediatricians.

Over the years efforts have been made to better synchronize the work of the community clinic and the hospital regarding child health. More than 40 years ago, the small newly established hospital in Ashkelon pioneered a model of integrating preventive services within the hospital, with MCH clinics intimately linked with the hospital pediatric ward through the involvement of the pediatric staff in the MCH clinics, and the encouraging of community pediatricians employed by the health funds to follow their patients within the hospital. The opening of the community-oriented medical school in Beer Sheva in the 1970s also produced an innovative attempt at integrating a community clinic in nearby Ofakim (a small development town) with the pediatrics department [12]. More recently, the pediatrics department at Sheba Hospital in central Israel has established a model of community involvement of the academic pediatric department in a community clinic in Or Yehuda, a neighboring town. However, efforts to better integrate inpatient and community pediatrics have been sporadic and often frus-

trating, with no policy being dictated regarding the desired model, or the requisite accompanying funding.

Until relatively recently, community pediatricians were isolated from the academic centers. With the increasing demand for medical students and pediatric and family practice residents to have experience in community pediatrics, several community pediatricians have received academic appointments, though the number is still insignificant. The creation of a network for research in community pediatrics is helping foster the development of a cadre of pediatricians doing community-based research [13].

WHERE CAN WE GO?

While some dissatisfaction has been voiced with the system of pediatric care in the community over many years, consensus is growing regarding the need for changes in the system along the following lines:

- **A focus on the total health and well-being of the child**

A perspective is needed whereby child health care is seen as a broad area including the management of acute health problems, chronic disease, preventive health care, needs of the adolescent, behavioral and developmental issues, and family and societal issues including child abuse and family dysfunction.

- **Changes in the mode of service delivery for children**

The issue of integration of preventive and curative services, as planned within the National Health Insurance Law of 1995, must be resolved. There are strong arguments regarding the danger of preventive services being neglected if integrated into current busy practices, as shown by the study of Palti et al. [14], where mothers in an integrated service received less instruction about both giving iron supplements to their babies and laying the babies on their backs, compared with a control group. The challenge is to ensure a pediatric team that guarantees the maintenance and improvement of preventive services. The recognition of well-trained nurses as an important cost-effective resource for inclusion in the child health team could facilitate the development of an expanded model of child health delivery. Clearly, expanding the role of the pediatrician must ensure that increasing time devoted to patients does not result in a penalizing of income, i.e., improved quality of care must replace quantity of patients as a criterion for remuneration.

Pediatric residency training must be able to provide the required knowledge and experience for pediatricians who will be spending their future careers in community settings

- **Coordination of care**

The need for a coordinator of the multiple health care needs of certain groups of children has gained increasing attention in the pediatric literature [11]. This role can be filled by nurses, secretaries or family members, with improved satisfaction and outcomes for the child, the family and the health team.

- **Attention to the needs of the periphery**

Lack of professionals, limited accessibility to hospitals, and population groups with greater health needs (poverty, immigrants) are some of the problems encountered in peripheral areas. Incentives are needed to ensure that young pediatricians, residents, nurses and other professionals will be attracted to work in outlying areas. While Israel is a small country geographically, the use of well-trained pediatric teams in the community could do much to limit unnecessary travel to emergency rooms and specialist clinics.

- **Pediatric training**

It is essential that pediatricians who will practice in the community receive appropriate training for their future role, a topic that is receiving growing emphasis in the pediatric literature [15-17]. Despite residency requirements, which include an optional period of work in the community, the shortage of manpower in pediatric departments has essentially prevented this option from being realized in almost all training programs, even where the department leadership is supportive of rotation in the community. Thus, most pediatric residency graduates today will enter practice in the community with little or no experience in managing common pediatric problems or preventive care.

A community pediatric training model involving theoretical and practical elements of practice in the community as a compulsory part of residency training will only be accomplished if funding is provided for additional senior and training positions in pediatric departments, enabling the inclusion of a community pediatrics rotation, without affecting the needs of the inpatient pediatric department. The inclusion of community pediatricians in inpatient activity and encouraging their input regarding the care of their patients will lead to an improvement in the perceived inferior status of the community pediatrician.

Developing a subspecialty of Community Pediatrics could help ensure high-quality training and improved remuneration for community-based pediatricians. The awarding of academic rank is crucial for upgrading the status of the community pediatrician.

- **Integration of the child health role in the community**

The community pediatrician, in addition to taking on an expanded clinical role, is expected to be an active child advocate, providing professional expertise on the health and well-being of children to other organizations relating to children,

such as educational frameworks, child welfare, families, and any organization that relates to the needs of children. Recently, Halfon and Hochstein [18] issued a challenge to the U.S. to follow the lead of European countries, Canada and Australia in developing nationwide child health support through an enhanced model based on Life Course Health Development, with an emphasis on a comprehensive program for identifying and intervening in areas relating to the total health and well-being of the child.

The above list seems to be a formidable task for reform. However, the pediatric community should learn from many western countries that have recognized the need to integrate issues of child health into a larger picture of society's role regarding the child. Thus the UK initiative, "Every Child Counts," which has placed the welfare of the child under a special government ministry, and the community outreach model of Oberklaid et al. [19] in Melbourne are just two examples of changing service models to serve the needs of child health. The scientific research regarding the cost-effectiveness of early intervention as described by Nobel Laureate economist Heckman should help child health advocates in Israel to persuade both the professional and political leadership of the importance of improving community child health services [20].

A recent initiative of leaders of the Israel pediatric societies, together with the Hadassah Medical Organization leadership and the Community Pediatric Center at Royal Childrens' Hospital in Melbourne to create a cadre of future leadership in community pediatrics and to improve the training for community pediatrics, holds promise for initiating serious future change in the practice of and training for community pediatrics in Israel. At the same time a coalition – representing pediatric training programs, management of the health funds, the ministries of health, education and welfare, the pediatric professional societies, and families – is needed to develop a relevant model of comprehensive child care for today's needs.

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"I love my country too much to be a nationalist"

Albert Camus (1913-1960), French Algerian author, philosopher and journalist. A key philosopher of the 20th-century, his most famous work is the novel *The Stranger*

"I love mankind. It's the people I can't stand"

Charles Schultz (1922-2000), American cartoonist, whose comic strip *Peanuts* proved one of the most popular and influential in the history of the medium, and is still widely reprinted on a daily basis