The Development of Primary Care in Israel

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Community-based primary care services have been a key concern in Israeli health since the period of the pre-state pioneers, who included mutual aid and healthcare as a basic tenet of their unionized power. The powerful labor union body (the *Histadrut*) controlled the largest health services provider organization, Kupat Holim Clalit (The General Sick Fund), until the late 1990s, when the health arm of the labor union was split from the main body as part of the National Health Insurance policy. Three other health funds were later established, all with variations of the basic policy of capitated healthcare, with individuals and employers sharing in the provision of basic health insurance. Membership in the funds was voluntary, with different criteria for accepting members among the four funds.

Preventive services were first established following World War I and were known as *Tipat Halav* stations, meaning literally "A drop of milk." This service developed into a national network of mother-child clinics. This service included monitoring the health of mothers throughout their pregnancy, nutritional counseling and provision of immunizations for the infants following birth, and home visits (as required) for infants and families viewed as being at risk for health problems. The role of this service has expanded to include services for the school-aged child and wider support services for the whole family.

Following the establishment of the State of Israel in 1948, the Ministry of Health assumed control for all health affairs in the country. In addition to controlling health policy and budgeting for health services, the Ministry has maintained responsibility for running most of the hospitals in Israel, preventive services for mothers and infants, school health, and mental health. Primary care health services in the community remained in the hands of the largest sick fund, Kupat Holim Clalit, which was the dominant primary care provider, with the three smaller health funds – Maccabi, Meuhedet and Leumi – serving smaller segments of the population. Clalit established the first family practice training programs in 1963, which emphasized the commitment to high quality primary care as the basis of the health system. At the time of the International Conference on Primary Health Care held in Alma Ata in 1978, Israel could already pride itself on having a national primary care system with high accessibility and competence. Preventive services were available to all citizens, with primary care capitated services provided by four health service provider organizations serving more than 90% of the population. The four provider organizations could define their inclusion and exclusion criteria, with the majority of the chronically ill, the aged, and new immigrants belonging to the large Clalit fund, which demonstrated the largest degree of equity in its membership policy, linked to its traditional political affiliation with the socialist political parties. There are fundamental differences in the service model of the four health funds. In Clalit and Leumi, most physicians work as salaried employers in neighborhood clinics, whereas in Maccabi and Meuhedet the dominant model has been that of the independent physician, frequently working alone in a private clinic.

The waves of immigration from the former Soviet Union included large numbers of physicians, with widely varying professional expertise, who were trained in a system vastly different from that of western countries, including Israel. These immigrants were required to pass a basic qualifying examination to assess their competence to practice medicine in Israel. Many of these physicians subsequently found employment in primary care, without additional specialization in one of the primary care fields. These physicians are an important asset in areas of the country where Russian-speaking physicians are in demand to deal with the large numbers of Russian immigrants.

Israel's healthcare system promises timely access to high quality health services for all its citizens

Despite the small size of the country, regional variation in primary care services does exist. A study of health services in the south of the country in 2000 [1] showed persisting gaps in physician and nursing manpower, together with a greater patient burden on physicians in primary care clinics. The waves of Russian immigration, which included a high percentage of elderly sick patients, together with the low hospital bed-to-population ratio and the relatively greater geographic dispersion in the south, have also contributed to the regional service gap in the region.

Medical education has also influenced primary care develop-

ment. While only one medical school existed in the early years of statehood – the Hadassah School of Medicine in Jerusalem, today there are four schools, the most recently established being the Ben-Gurion University Faculty of Health Sciences established in Beer Sheva in the southern part of the country in 1974. Academic medicine has thrived in Israel, with almost every hospital in the country having some affiliation with a tertiary care academic center. At the time of the establishment of the medical school in Beer Sheva there was much debate as to the need for a fourth school in a country of five million people. The decision was made on the basis of a perceived need for a school that would produce graduates with a more community-oriented approach to healthcare; a number of appointed committees had already pointed to the discrepancy between the heavy emphasis on tertiary hospital-centered specialty medical care, with primary care being a low priority. The school provided an innovative curriculum with intensive community exposure from the first year of studies, and encouraged graduates to spend a year in community-based clinics following their internship [2]. While the new community-oriented medical school provided a significant thrust for improving education towards primary care, it reflected many of the difficulties involved in trying to change the status quo of health systems delivery.

Training in primary care professions

Approximately 5,000 of the 25,000 physicians in the country are in primary care practice. In 2000 there were approximately 750 certified specialists in family medicine, 850 in pediatrics and 480 in internal medicine [3], with the number of specialists in family medicine rising to 1,100 by 2002 (Ministry of Health records). Family Practice training was started in the 1960s, together with the establishment of the first teaching practices, and today residencies run by the HMOs are linked to all four medical schools [4]. An obligation for graduates of pediatric residencies to spend 6 months of their training in the community was recently rescinded, and the majority of graduates of pediatric training programs find themselves working in primary care situations with negligible prior experience [5]. Preliminary data from a national study of pediatric practice in community settings indicate a high level of dissatisfaction among these pediatricians regarding their preparation for practice in primary care settings [Porter et al., unpublished data]. Internal Medicine residency graduates have no formal primary care exposure.

The National Health Insurance Law of 1995

In the early 1990s, concerns about financial stability, cream-skimming, growing inequality in the health system, and the lack of legal entitlement to a defined benefits package led to a consensus on the need for major change. The Netanyahu Commission called for the introduction of a National Health Insurance Law to address these issues [6]. In 1995 the National Health Insurance Law came into effect. The law ensured equitable access to health services for the entire population and stated that all citizens of the country will be insured through one of the four existing healthcare organizations [7]. The organizations were required to accept all applicants irrespective of age or health status, and to supply the same basic package of services based on the services provided by the Clalit health service at that time, including hospitalization. The funding for this law included health insurance premiums to be paid by each citizen, according to his/her income. In addition, the Ministry of Health would budget the health funds through a capitated formula, which recognized differences on the basis of age and geographic residence. The health funds were required to ensure the provision of accessible primary care services 20 hours a day. Certain co-payments by the consumer for drugs and visits were also allowed, subject to the approval of the ministry. Under the new law, the government could augment, but not diminish medical services, unless authorized to do so by a special government committee. The health funds could offer supplementary insurance to cover medical services not included in the basic "basket of services." The Ministry of Health was to be responsible for monitoring the equality and availability of services provided by the provider organizations, and financial statements of the providers were required. A public complaints office was also established in the Ministry of Health. A percentage of the budget of the National Health Insurance Law was earmarked for research specifically aimed at issues relating to the enactment of the law. The law also established a number of advisory committees to aid the Ministry of Health in policy development and implementation.

Training of specialists in primary care areas still lags behind needs, particularly in pediatrics and internal medicine

One of these committees was devoted to the future planning of community health services, which during its deliberations defined a number of key issues for the Israeli health system following the National Health Insurance Law. Firstly, it reiterated the country's commitment to primary care services as the backbone of health services. Secondly, it recommended the concept of a "personal physician" for every resident of the country, with the eventual aim that this personal physician would be a specialist in family medicine, internal medicine or pediatrics. The role of this personal physician was defined as a "case manager" and not a "gatekeeper," stressing the importance of a competent primary physician to coordinate and optimize patient care [8].

Shortly after the passing of the NHI law a Patients' Rights Law was enacted [7], which emphasized the right of the patient to participate in all decisions relating to his healthcare, including access to all medical records, the right to a second opinion, and other issues – all decreasing the omnipotent role of the physician in decision-making.

HMO = health management organizations

NHI = National Health Insurance

The development of health systems to meet changing health policy

The National Health Insurance Law of 1995 created a number of new realities in the health system, with far-reaching effects on primary care provision. While some questioned the need for such a law in a country with health indicators among the best in the western world, today – 9 years later – it is possible to define a number of significant improvements in primary care resulting from the law:

Patient empowerment

The Patients' Rights Law [7] has resulted in a strong trend for members of the health funds to demand increased say regarding decisions related to their health. Physicians are required to explain decisions and offer options to suggested treatments. In addition, all four health funds have an office dealing with patient complaints relating to their care, in addition to a patient complaint office attached to the Ministry of Health that can be called on to represent the patient in grievances against the health funds. While many complaints relate to administrative issues regarding payment or access to services, and some relate to questions regarding the quality of healthcare, a considerable number concerns issues of doctor-patient communication. This is forcing physicians and managers in the system to direct educational interventions to physicians to improve their communication skills.

Health system accountability

Increasing budget restraints, together with the demand that all the health funds provide equitable, high quality care has resulted in a dramatic improvement in methods for measuring processes and outcomes. The different provider organizations provide healthcare in the community through mixtures of salaried and independent physicians, solo and group practices, and direct or referral-based access to specialists. The fixed budget allocation system and the demand for a unified basket of services have forced the providers to examine the cost-effectiveness of these methods. The adoption of the personal physician model and support for group practices are seen as important ways to achieve cost-effective primary care delivery. Guidelines are being used increasingly to improve compliance with evidence-based medicine regarding management of chronic disease, such as diabetes and asthma, and appropriate drug usage in accordance with professional and administrative preferred standards.

Computerized information systems

The NHI Law of 1995 demanded new levels of accountability from the health funds. The Ministry of Finance closely monitors their budgets, while the Ministry of Health monitors adherence of the funds to supplying the basket of services. Computerized systems have rapidly developed to monitor financial, administrative and clinical quality issues. Today, these information systems are being used by all the health funds to monitor appropriateness of clinical behavior, such as appropriateness of drug prescribing and disease-management programs.

Chronic disease management

Initially, programs for improved management of chronic disease such as asthma and diabetes involved the creation of registries of patients with the disease, and monitoring of treatment guidelines for those diseases. For example, the monitoring included supplying specific physicians with profiles of their patients (hemoglobin A1c levels, eye examinations, lipid profiles), in addition to providing managers with comparison regional and national profiles. These data have helped increase dissemination of the Chronic Disease Model [9], with managers, physicians, paramedical professionals and patients working to improve the care of diabetes. Evidence-based guidelines are being used as educational tools, and are also being embedded in the computerized medical record as a system of prompts to ensure adherence.

Increasing efforts are being made to include more comprehensive quality indices into community primary care [10,11]. One of the health funds, Maccabi Health Services, has recently developed a Health Value Added model [12]. This model attempts to integrate four interrelated levels of the system. The first level is the mission of the organization – provision of comprehensive healthcare. This is followed by the goals, including quality of care, member satisfaction and fiscal responsibility. The next level relates to the systems for achieving the goals, including delivery of services, information systems, incentives and decision-making mechanisms. At the base of the model are the resources – the physicians, employees and technologies. The Health Value Added system is seen as a new way to stimulate the whole organization to improve performance.

Making community and hospital services more cost-effective is a major challenge for the Israeli health system today

Accessibility to health care

Under the NHI law, round the clock accessibility to health services was clearly defined. Thus even in remote areas, the funds must supply a primary care service, either through their own resources or through outsourcing. This demand resulted in the development of a number of alternatives for after-hour service. These include private agencies, special centers run by the health funds themselves, or services of private physicians. A study of these services in 2001 showed an overall high level of satisfaction, suggesting that accessibility is a key issue for fund members, even if some compromise of continuity of care is involved [13].

In addition to the strict demands for accessibility, the law declared intent to limit unnecessary duplication of services. In many small towns with a population of less than 5,000 people, all four health funds might set up clinics as part of the competition to recruit new members in the capitated system. During the regular budget crises of the health system, attempts have been made to ensure that the number of funds serving such areas be restricted, though this has not happened to date.

An additional factor influencing the type and availability of health services has been the attempt of the health funds to limit access to hospital services and to provide services within their organization. This trend has resulted in recruitment of hospital-based specialists to work in community-based clinics in addition to their hospital bases, the establishment of home-care teams, and the establishment of day hospital services in community clinics. These changes have created new issues relating to primary care. Initially, direct access was allowed to specialists in the community, but the pendulum has swung back, with increasing pressure today to limit unnecessary utilization of specialist services through the use of primary care case managers.

Home care has become a major focus for limiting the length of hospitalization, particularly for patients with chronic disease or geriatric problems. While the service seems to be cost-effective, the role of the primary care physician is not always clearly defined, with a tendency for the busy practitioner to leave home visits to homebound patients for the home-care team.

The reality of primary care in Israel in 2003

The history of healthcare in Israel has always placed a priority on the ability of all citizens to have access to healthcare services, including basic preventive care for infants and pregnant women. The National Health Insurance Law of 1995 expanded the principles of universal accessibility and equity. The ratio of physicians per population was generally perceived to be high even prior to the wave of immigrant physicians in the 1990s, with some thoughts at the time to reduce applicants to medical schools. However, the Israel Medical Association predicts a possible physician shortage in the next 15 years [7]. Health status indicators such as life expectancy and infant mortality compare favorably with those of OECD countries. Life expectancy at birth in Israel increased between 1980 and 1996 by 4.2 years for both men and women, and infant mortality rates have declined by 70% over the past 25 years [14].

New challenges for primary care services

- *Increasing costs of health services, including new technologies and drugs*
  While one of the aims of the National Health Insurance Law was to reduce the budget deficits of the health funds, spiraling costs of new technologies and costs of hospitalization have perpetuated budget deficits. Inadequate financing of the health funds has forced additional financial burdens on patients. During the 1980s, private payments for health increased from about 20% to 31% of national health spending, while government financing decreased from 45% to 21%. The primary care system is at the front line of the demand for curtailing health expenses through more efficient use of consultations, investigations, drug purchasing and hospital referrals. The need for accountability to the patient and to the employer is placing an increasing burden on the primary care physician, who frequently resents the role of budget manager as well as clinician.

  Between 1987 and 1999 there was a 119% increase in household expenditure on drugs, with households in the bottom decile of the population spending more than 5% of their income on medications [15]. Expenditure on drugs constitutes approximately 20% of the health funds budget, creating demands on administrators and physicians to closely monitor both quantity and type of prescribing, with accompanying consumer perception that the funds are restricting necessary drugs at the expense of their health.
- *The increasing burden of chronic disease*
  Chronic disease is becoming a dominant feature with regard to morbidity and costs for the health system. Age-adjusted diabetes mortality rates are higher in Israel than in the United States, Canada and Western Europe. Models of disease management are being increasingly adopted, with documented overall improvement of outcome measures, such as a steady decrease in the average hemoglobin A1c level in all diabetic patients [16]. More work is required to create a true chronic disease model, as pioneered by Wagner [9].
- *Competition between the hospital and community health system for funding*
  Instead of a "seamless" connection between community and hospital-based services, primary care services frequently find themselves in a confrontational role with hospital services. While severely budget-strapped hospitals struggle to maintain their role as centers of excellence, the health funds are increasingly using community-based alternatives for specialist consultation, day hospital services and some emergency services as a less expensive alternative to the hospital. In most areas, primary care physicians have little contact with the hospital, resulting in duplication and inefficiency of healthcare.
- *Keeping up with the need for primary care specialists in the community*
  Despite the fact that numerous national committees have placed primary care as the cornerstone for the healthcare system, there is still no national coordinated plan to achieve this goal. The number of specialists in the primary care fields of family medicine, pediatrics and internal medicine is determined on an ad hoc basis by the health funds. A national committee reviewing the status of community health since the NHI law has suggested declaring a target year when all primary care physicians must either be specialists or have undergone an upgrading course to establish core proficiency in primary care. While the number of specialists in family medicine is steadily growing, the appropriate training of specialists in pediatrics and internal medicine lags behind due to the demands of the hospital to keep these professions within the hospital setting during training. Growing numbers of internists and pediatricians subsequently find themselves having to practice in the community, but many feel inadequately prepared for the task from their exclusively hospital-based training.

Summary

Primary care today in Israel is in a state of transition. Following many years of its being the second best alternative for patients and practitioners, economic constraints and lessons from other

countries are ever more driving the need to establish primary care as the cornerstone of healthcare. The transition is complex, involving educational, political and economic issues. Raising the number of trainees in primary care specialties is a key goal. Efforts are underway to increase not only the number but also the quality of the training to ensure that specialists are better equipped to practice in primary care. Studies on the efficiency and effectiveness of services are being used as a basis for policy and manpower planning in the health services. The era of information technology in health services, together with acceptance by all of the need for accountability, is allowing more appropriate planning of primary care services – based on needs as well as demands. The interface of health with social well being is being moved close to the patient's home in the community through the appropriate use of primary care resources. More attention is being placed in Israel on the need for primary care workers with managerial skills, as well as the need for all primary care clinicians to have a basic understanding of the economic and administrative constraints in all healthcare systems.

References

1. Nirel N, Pilpel D, Rosen B, Zmora I, Greenstein M, Zalcberg S. The Accessibility and Availability of Health Services in the South of Israel in the Wake of the National Health Insurance Law. Jerusalem: Brookdale Institute, March 2000.
2. Porter B, Seidelman W. The Politics of Reform in Medical Education and Health Services. New York: Springer Publishing, 1992.
3. Shemesh A, Pilpel D, Smetannikov E, Dor M. The Primary Care Physician in Israel. Jerusalem: Brookdale Institute, March 2000
4. Weingarten MA, Lederer J. The development of family medicine in Israel. *Fam Med* 1995;27(9):599–604.
5. Israel Scientific Council. Requirements for Pediatric Specialization. Revised 2002.
6. State Commission of Inquiry into the Functioning and Efficiency of the Israeli Health Care System. Jerusalem, Government Printing Office, 1990 (Hebrew).
7. Rosen B. Health care reforms. In: Thomson S, Mossialos E, eds. Health Care Systems in Transition: Israel. Copenhagen: European Observatory on Health Care Systems, 20035(1):109–35.
8. Shani M. Primary care in Israel: recommendations of the National Council for Health in the Community. *IMAJ* 2001;3(12):881–2.
9. Wagner EH, Glasgow RE, Davis C, et al. Quality improvement in chronic illness care: a collaborative approach. *Joint Commis J Qual Improve* 2001;27:63–80.
10. Elhayany A. The use of medical quality indices as a performance enhancement tool for community clinics. *IMAJ* 2001;(12):947–51.
11. Reis S, Hermoni D, Borkan JM, Biderman A, Tabenkin C, Porat A. A new look at low back complaints in primary care: a RAMBAM Israeli Family Practice Research Network study. *J Fam Pract* 1999;48(4):299–303.
12. Friedman NL, Kokia E, Shemer S. Health Value Added (HVA): linking strategy, performance and measurement in healthcare organizations. *IMAJ* 2003;5:3–8.
13. Greenstein M, Tarragin M. Night Services: A New Sick Fund Service Mandated by the National Health Insurance Law. Jerusalem: Brookdale Institute, April 2001.
14. Israel Center for Disease Control (ICDC). Health Status in Israel 1999. Publication 209, Ministry of Health.
15. Brammli S, Rosen B, Wood F. Households, Health Plans and Pharmaceutical Expenditures. The Israel National Institute for Health Policy and Health Services Research, Annual Research Report 2000-2001. December 2002.
16. Goldfracht M, Porat A. Nationwide program for improving the care of diabetic patients in Israeli primary care centers. *Diabetes Care* 2000;23(4):495–9.

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A psychiatrist is a man who goes to the Follies Bergere and looks at the audience

Dr. Mervyn Stockwood (1913-), Anglican bishop

Capsule

Effect of terror attacks on driving behavior in Israel

Terror attacks have consequences that extend beyond the immediate victims of the violence. G. Stecklov from the Hebrew University and J. Goldstein from Princeton assessed the impact of terror attacks on driving behavior and accident outcomes in Israel. Covering the period January 2001 until June 2002, the study was based on data of the Interdisciplinary Center of Herzliya, which were checked against a list kept by the Israel Ministry of Foreign Affairs. The terror attacks were categorized as more than one casualty and more than 10 casualties. Altogether 63 attacks were recorded. Traffic volume stayed stable on the day of the attack and the day after, but declined significantly on the third day – a decline of 4.7% during peak hours and 2.7% during off-peak hours. With regard to the impact on accidents, there was no effect during the day of the attack but a 6% decline the next day. This may be explained by more cautious driving or more policemen on the roads, and there may also be a tendency not to report minor accidents after a terror attack. Regarding accidents with casualties, no effect was observed until 3 days after an attack when an increase of 35% was noted; and after a major attack with more than 10 fatalities there was an increase of 60%. The additional number of people killed over the usual number in road accidents was 28 during the period of the study. By day 4, no influence was observed.

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