A New Stage in the Renaissance of Primary Care in Israel

Second Dead Sea Conference: Aspects in Community Medicine

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In Israel, as in many other countries, high quality and efficient primary care is an essential component of the health-care system. The last 30 years have witnessed a process of renaissance of primary care in Israel, which developed on two main tracks: medical education throughout all its stages, and the organization of medical care in its various aspects.

The Israel National Institute for Health Policy and Health Services Research considers the subject of primary care to be of high priority. It thus decided to assign to this subject one of the three teams that worked on the preparations and discussions of the Second Dead Sea Conference, which took place on 9–10 May 2001 [1]. For all practical purposes, the conference considered family medicine, primary pediatrics and primary internal medicine as the three specialties that come under the definition of primary care.

The team recommended the adoption of a wide scope of primary medicine [2]: the treatment of acute and chronic patients, health promotion and disease prevention, rehabilitation, and palliative care. The group noted two additional elements that were included in the definition of primary care devised by the Institute of Medicine in the United States in 1994 [3]: the patient's role, and the relationship with family and community. The changes that have occurred in the healthcare system have created a new situation of conflict that emerges from patients' expectations, the needs of the system, and professional ethics. From this point of view, there is a need for a new definition of both the physician's and the system's authority and accountability, as well as an adaptation of the education of physicians, their training, and the work environment. The conference underlined the need for the Ministry of Health to allocate a very high priority to primary care from a strategic, planning and supervisory point of view. The need for increased development of research in primary care is an additional challenge that was also highlighted.

Today, there is a general consensus on the significant influence of social factors on the health of the population. From this standpoint, cooperation with public health professions and social services could provide the necessary background information to the health-care system. In the current era of chronic community diseases, in addition to primary prevention, it is necessary to stress two other important functions of primary care: improvement of the quality of life of the chronically sick, and secondary prevention through therapeutic means – particularly in the cardiovascular sphere.

Several factors have contributed to the increasing discrepancy between the needs and the resources of the health-care system. These include demographic changes, the steady growth of the old and the very old segment of the population, impressive technological developments, and increased awareness of the population to health needs. This situation requires the primary physician's knowledge and awareness of the different kinds of health services and their cost-effectiveness.

The team was aware of the different models [4] of "primary-oriented" care and "specialty-oriented" care, based on the different kinds of access to specialists. Nevertheless, the team avoided initiating a theoretical discussion on the subject, assuming that the ongoing improvement of the quality of primary care would contribute to the strengthening of "primary-oriented" care [5], which has contributed to the health of the population, to the level of satisfaction with the system, and to the reduction of medical care costs in different countries.

The main subjects the team and the conference considered were:

- The content of primary care in our times
- Residencies, training programs and postgraduate education
- The nurse and other health professions in primary care
- Factors in the work environment of the primary care physician

The content of primary care in our times

In addition to the mandatory clinical knowledge, several areas of knowledge are crucial today. These are: the influence on health and disease of the

patient's socioeconomic, ethnic and occupational background; different social problems, such as family aggression and addictions; mental health problems, like depression; health education; prevention and early detection; and the responsibility for the care of chronic diseases. In addition, the primary physician must take into consideration health economics factors, such as the cost-effectiveness of technologies in the field of prevention, diagnosis and treatment. He or she must be aware of the need for quality assurance and clinical guidelines for different diseases.

It is important to note that one of the basic conditions for quality assurance in the work of the primary physician is the continuity of care and coordination of the various special branches of the healthcare system. This implies a complete view of "case management." The primary physician is in charge of all stages of the patient's health: prevention, diagnosis and treatment – even when it is handled in part by specialists or through hospitalization – by following his or her patients. The primary physician has to centralize information on night care, the content of hospitalization, follow-up of patients after discharge, and the care of patients with chronic diseases, including periodic home visits to the disabled. However, the primary physician cannot carry out all these functions alone. There is an important part to be played by the community nurse and other health professionals.

High quality primary healthcare is the suitable answer to the breakdown of medicine, which is the result of over-specialization on the one hand, and the growing gap between the needs and the resources of the system on the other.

Residencies, training programs, and continuing primary medical education

These educational measures are necessary for preparing the primary physician to fulfill the abovementioned functions. With regard to residency programs in primary care, the committee's first recommendation was that the healthcare system should determine a date, after which the only physicians who would be appointed in primary care would be either specialists in one of the three primary care specialties, those completing residency programs, or new residents. A similar recommendation was made in the past by the Ministry of Health's Council of Community Health, but it has not yet been implemented.

The establishment of family medicine residency programs was one of the most important steps taken in Israel in the process of the renaissance of family medicine since the early 1970s. Their contribution to this process is outstanding. It was emphasized that residency programs in primary medicine (family medicine, internal primary care and primary pediatrics) must be adapted to the abovementioned content of the work of the new primary care physician. Their development on a national basis must be considered a priority by the Ministry of Health and the health maintenance organizations. The various available budgets within the governmental ministries, health maintenance organizations, hospitals, etc., have to be coordinated in accordance with the needs of the process of upgrading primary care in Israel.

The committee recommended that the remaining primary care physicians who do not qualify as specialists in these fields should undertake a complementary training program, or participate in a plan to complete primary care specialization. In addition, the team recommended a permanent program of continuing medical education for all physicians in primary care.

All the specified educational programs need to be reorganized, including the components of clinical knowledge that were not sufficiently emphasized in the past (e.g., geriatrics), as well as other disciplines of information and management beyond clinical practice. It was recognized that programs of frontal teaching are insufficient, and that there is a need for interactive and interdisciplinary methods. The relationship between continuing education and salary incentives was stressed.

A recommendation was adopted for the professional associations and the Scientific Council of the Israel Medical Association to especially consider the tracks of professional and academic progress of specialists in primary healthcare.

The role of nurses in primary care

The role of the nurse was the subject of a very special discussion. Historically, primary care in Israel was once considered a "solo practice," while nurses were limited to traditional nursing functions carried out according to the physician's instructions. The era of chronic diseases and the overcrowded primary care practices, particularly in new immigrant centers and development areas, prompted the Clalit Health Services in the late 1960s to introduce the physician-nurse team. According to this model, the access to the physician's room was through the nurse's room. The nurse then dealt with functions such as the categorization of patients, prevention and health promotion, early detection of chronic disease (like hypertension) and the follow-up of the chronically sick in the clinics and at home. This work was done by the nurses according to the physician's guidance. Different surveys have demonstrated that this system resulted in a significant decrease in the number of visits to the physician, and an increase in the early detection of chronic disease.

The conference agreed unanimously that the nursing services in primary care should return to this concept, including health promotion, prevention and health education, triage (categorization and direction of patients to physicians), care management of the chronically sick, care of home-bound disabled patients, follow-up of patients discharged from hospital, and rehabilitation. Two models were discussed in this regard: the physician-nurse team, and the model where the nurse has an independent function as a case manager of the chronically sick in various primary care practices.

The integration of a medical social worker as part of a primary healthcare team was also considered. It was agreed that this is an important component of the primary healthcare team. Cooperation with other health professionals, like dieticians, health educators, physiotherapists, occupational therapists and others was also discussed.

The work environment

This topic relates to the time available for the doctor/patient encounter, the information and the use of computers, quality assurance, the use of new technologies, and the interface with the services provided outside the primary care clinic.

An increase of the available time for the primary physician/patient encounter was considered a first priority. In this respect, the doctor/nurse team and the change in the reward system of physicians was viewed as important.

With regard to information, it was recommended that while the health insurance system has to provide the physician with all relevant information on the patient, utilization of health services and clinical guidance, the Minister of Health should provide demographic and epidemiological information about the respective community, and other agencies must provide relevant information on social problems.

Conclusion

The main recommendations of the Dead Sea Conference in the field of primary care education, the role of nurses and the work environment were specified. They were considered during a joint meeting of the Ministry of Health, the Director General of the Ministry and his deputy, together with representatives of the National Institute for Health Policy and Health Services Research. The implementation of these recommendations will augur a new era of impetus in the process of the renaissance of primary care in Israel.

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