Planning Community-Oriented Primary Care in Israel

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Synopsis

The concept of primary care in the Kupat Holim Health Insurance Institution encompasses all the stages of health: the promotion of health, personal preventive care, curative care, and rehabilitation in the community. Primary care is, thus, the foundation of this nationwide comprehensive health insurance and health care delivery system; Kupat Holim covers 3.2 million people, close to 80 percent of Israel's total population in 1983. Primary care clinics in the community are the main focus of care and have undergone changes in the types of health care providers and functions as population characteristics change. In this system, the planning process allows constant review of changing needs and demands and the introduction of new functions.

The main approaches to planning primary care that are presented deal with team members and the division of work in the community clinic, manpower training at undergraduate and postgraduate levels, and the content of primary care. Current trends include the extension of services provided to the patient in his home as well as the clinic and greater emphasis on preventive care.

The interrelationship between policy and planning for primary care is strengthened by the linkage between financer, provider, and consumer in Kupat Holim. The planning process must make optimal use of this linkage to guide those responsible for health policy in implementing effective change.

PRIMARY CARE IS THE VERY FOUNDATION of the Kupat Holim Health Insurance Institution, the nationwide comprehensive health insurance and health care delivery system in Israel. In Kupat Holim, we see planning as the process that constantly enables us to review changing needs and demands for care and to introduce new functions that make optimal use of resources—manpower, facilities, and finances. Let us go deeper into the basic premises of both primary care and planning before examining their interrelationship in the Kupat Holim system.

First, primary care encompasses all stages of health: the promotion of health, personal preventive care, curative care in the community—in the clinic and the patient's home—and rehabilitation.

Second, in the spectrum of care, the primary care team cares for the patient before and after hospitalization. There is special importance to the two-way and sound relationship between the primary care provider and hospital care provider. This relationship should ensure continuity in the responsibility for the patient's care and for transfer of information.

A third integral part of the primary care spectrum is mental health. Consideration of the psychosocial factors that may affect the patient, such as those in his family, work, and community environment, will determine the extent to which the family medicine concept can be effectively integrated into the overall primary care structure.

Then we should consider the economic basis for primary care. It is well recognized that, by shifting care from the expensive hospital environment to the community clinic and the patient's home, considerable savings can be realized. This may be true for simple specialist consultations and for more complex procedures, such as home renal dialysis. Here we have to consider the indirect costs of hospital services to the patient and to society related to travel costs and loss of productivity.

We also have to consider the shift in costs to primary care systems when modern concepts of medical care are applied. In recent years, health insurance has been extended to preventive services and rehabilitative services. The main reasons for extending coverage were obviously medical, but they also made sound economic sense.

Another cost issue is when payment is made. In systems in which the consumer is faced with a significant payment at the time of service, we must guarantee that (*a*) the reimbursement is made with minimal delay and bureaucratic procedure, (*b*) the provider does not charge the patient more than the set tariff, and (*c*) the payment itself does not constitute a barrier to seeking care, and, in particular, preventive care. It is extremely difficult to guarantee these conditions in systems that do not recog-

nize the basic functions of primary care, but rely on the patient to determine the appropriate time and level in seeking medical care, with the decision often involving a financial consideration. The fee-for-service system has become a major health policy topic, and here, too, we find extreme differences of opinion.

The planning process is vital to achieve the basic objectives of delivering comprehensive, high-quality care with equal availability and accessibility for the entire population served. Today, persons involved in health policy question the necessity for round-the-clock availability and unlimited accessibility. Equity, however, cannot be compromised, and care must be given within the economic constraints of the system. The nature of the planning required is a process that begins with the formulation of policy based on data, particularly epidemiologic data. Planners define the objectives and the resources available and then determine how to develop and operate the service. Evaluation constantly provides information to modify programs and policy.

Kupat Holim

A brief description of Kupat Holim will be useful for our American colleagues. The system integrates two basic concepts: prepaid health insurance and the nationwide delivery of comprehensive health services. Kupat Holim currently covers a population of almost 3.2 million, close to 80 percent of Israel's total population in 1983. Beneficiaries are labor federation workers and their dependents, as well as self-employed persons and their families. The same coverage is also given to Israel's welfare recipients according to a global agreement with the government.

Health insurance in Israel is voluntary. Currently 96 percent of the population is insured in one of the four Sick Funds, with Kupat Holim covering 83 percent of the insured. The insurance is based on a social security system in which the individual worker and employer participate. Our insurance system has no deductibles or coinsurance, with minor exceptions such as a nominal fee for each prescription drug dispensed in the clinic pharmacy. The decision to introduce this payment in 1977 was not a simple one. Even this nominal form of cost-sharing was strongly opposed for deeply rooted ideological reasons.

The original principles on which Kupat Holim was founded in 1911 called for a strong primary care base. Services were to be provided directly by the Sick Fund's doctors and nurses in community clinics built and maintained in every settlement. This principle is still the backbone of Kupat Holim, which now provides primary care in some 1,260 clinics in agricultural settlements, villages, and urban neighborhoods.

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Kupat Holim owns approximately one-third of the general hospital beds in Israel, in eight hospitals across the country, and uses government or voluntary hospitals in other areas. Routine laboratory and X-ray diagnostic services are generally provided in ambulatory facilities in the community or district hospital. Prescription drugs are dispensed by the pharmacies of the community clinics and hospital outpatient departments.

In addition to general hospitals, Kupat Holim operates three long-term rehabilitation and chronic disease hospitals and three psychiatric hospitals, all with day-care and outpatient services. Mental health centers have been developed in the community, and recently Kupat Holim opened several geriatric day-care centers. Dental clinics have been established in 66 areas across the country, with preference given to development or "new" towns, which have mainly immigrant populations and 5,000–25,000 inhabitants. Although dental care is not an insurance benefit, it is provided at cost to Kupat Holim members.

Today some 22,000 full-time positions in Kupat Holim are held by close to 30,000 physicians, nurses, and paramedical, administrative, teaching, and research staff members. The vast majority of these salaried employees work on a full-time basis. With this background, let us look more closely at the community primary care clinic, bearing in mind the implications for planning.

Community Clinics

Three-quarters of the community clinics serve populations of fewer than 5,000 persons; half of these clinics are in small agricultural settlements with a single doctor. Fifteen percent of the clinics, all in urban areas, serve 5,000–10,000 members, and the remaining 10 percent serve larger populations.

In urban areas, the average list size of the family doctor is 1,500 insured persons; the primary pediatrician has a smaller load of about 1,000 children. The rural doctor generally has a list of 1,200 persons and serves a small village or a number of agricultural settlements.

The dynamics of demographic change are important to planning primary care when a publicly owned community clinic is seen as the main provider of primary care. The increase in population has not been uniform all over

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the country. In some suburbs and towns the population increased in 2 years by several thousand families, requiring a new community clinic for primary care.

Another demographic change is the aging of the population. In 1976, slightly more than 6 percent of the population was older than age 65. Today this age group is almost 11 percent of the population. The trend is paralleled by the tendency of young families to move to the suburbs. Today, in the inner city clinics, up to 45 percent of the members are age 65 and older, while, in the newer suburban clinics, even less than 5 percent of the members are in that age group. A major national policy issue is how the burden of caring for the aged should be shared by health insurance, social welfare, and the public health agencies.

On the average, a Kupat Holim member visits his primary care physicians 7.2 times annually. From the registry of patients on a regular drug regimen for chronic diseases, we know that 9 percent of the insured population is on such a therapy.

Analysis of the daily diaries of 18 urban general practitioner practices in Israel has given us interesting information for more than 28,000 visits during October and November 1982. On a pilot basis, all of the practices had used in the diaries a modified code of the World Organization of National Colleges and Academies of Family Medicine-General Practice (WONCA).

For all the practices, respiratory illnesses accounted for the largest proportion of visits—31 percent, ranging from 12 to 52 percent among physicians. The next largest group was diseases of the circulatory system, including heart disease and blood pressure problems. These diseases accounted for 19 percent of all visits, ranging from 5 to 37 percent among the physicians' practices. The next groups constituted much smaller proportions. Musculoskeletal problems accounted for 9 percent of all visits, and symptoms, signs, and ill-defined conditions were recorded for 6.2 percent. The groups of diseases of the digestive system, endocrine and metabolic disorders (including diabetes), nervous system and sense organs, and the genito-urinary system each accounted for between 3 and 4 percent of all visits. Accidents and injuries accounted for 2 percent of all visits. The same diaries also give information on the distribution of visits by age of the patients.

These data reflect reasons for visits to the primary care physicians and are not a distribution of the prevalence of the diseases among the patients. However, the data are a clear indication of what the primary care physician is confronted with in his daily work. The data become essential in the planning process for issues such as the division of tasks among primary care team members, the organization of the clinic day, and design of the clinic.

To plan primary care, some of the main approaches we have taken are based on the continual analysis of changes in demography, disease patterns, and basic concepts of providing primary care. The approaches we will review deal with development of teamwork in the clinic, manpower, and the introduction of new functions in primary care.

Teamwork in Primary Care Clinics

Teamwork in the primary care clinic is a concept that has developed in several directions. In Kupat Holim's very first rural practices, the family doctor and nurse worked together, dividing their tasks between them, without anyone having to define functions and coordinate their activities. In urban clinics with several doctors, the prevailing pattern was to have the doctors work alone, with a smaller number of nurses doing their clinic work in a nurses' room. Over the last 15 years we have been reinstating the doctor-nurse unit as the basic team.

Today we see new kinds of primary care providers in the clinic on a routine basis. They may be social workers, health educators, or dietitians, generally assisting more than one basic team and playing a clear and significant role in the broad spectrum of primary medical care.

Analysis of the staff structure in the urban clinics indicates the existence of a peer group of physicians. We have to find ways to make this group of professionals work as close associates, although they have indeed not chosen their colleagues in the clinic and are not bound by a hierarchical structure as in the hospital.

The implementation of this peer concept is not easy, particularly with the different backgrounds of the physicians in Israel. One way of dealing with it is by developing another team concept. This broad, total clinic team includes the doctors and nurses, the clinic pharmacist, laboratory technician, and newer kinds of primary care providers. With the complexity of this broad team, leadership is in the hands of a designated "area physician," who is responsible for achieving the overall objectives of the clinic. Establishment of this broader team spirit also permits flexibility in practice arrangements, use of equipment, and taking care of a colleague's patients when necessary.

From the medical administration point of view, the broad clinic team concept is essential to the development of standards and medical audit. Furthermore, this ap-

proach promotes more sensitive clinic planning to meet the specific community needs.

Manpower Development

Education has been the main thrust of health manpower planning by Kupat Holim. The basic premise is that through education the graduates, immigrants, and those already working in the system may be guided to the kinds of services and practice concepts needed by Kupat Holim to continue reaching its objectives for the delivery of comprehensive services to a changing population. This approach has proved itself.

Involvement in education relates to all levels—undergraduate, graduate, and postgraduate. At the undergraduate level, Kupat Holim and the Faculty of Health Sciences of Ben Gurion University are jointly establishing the Medical School in the Negev, which combines under the same authority the delivery of services, education, and research. The major objective of this endeavor is to educate a different kind of doctor, one who will find his main interest in community and primary health care. To do this, many changes have been made, beginning with the system of selection of applicants in order to accept those with the most suitable motivation and background. Also, a new curriculum was developed, oriented toward family and community practice rather than the classic methods of teaching medical education.

At the graduate level, Kupat Holim has actively promoted the residency program in family medicine and has assumed responsibility for providing residency positions in family medicine for young doctors in its community clinics and hospitals. The Scientific Council of the Israel Medical Association has approved a specialization syllabus of 4½ years, with half the time for rotation in hospitals and the other half for supervised practice in family health clinics in the community. Academic courses in community and family medicine in the university and clinic complete the training of the young doctor destined to family medicine. Currently there are about 240 doctors in this residency program, and the number of new residents is increasing significantly each year.

The continuing education of physicians in the ambulatory care network is of special importance, both as a means of upgrading the knowledge of physicians working in small and sometimes isolated settings and as an integral part of their employment benefits. As a result of an agreement with the association of Kupat Holim physicians, all the primary care and specialist physicians in ambulatory care clinics are entitled to 24 days of postgraduate education a year. This encompasses close to 3,000 physicians. Some spend this time attending a weekly round and discussion in a designated department in the nearest hospital; others use the days in block time to attend courses on such subjects as health education, geriatrics, pharmacology, psychiatry, or clinical subjects of choice. These programs are planned and supervised by the Institute for Post-Graduate Medical Education, which was set up by Kupat Holim and the Hebrew University Medical School in Jerusalem.

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In the nursing school curriculum, substantial changes directed toward the needs of community medicine have been made over the years. The schools have remained attached to hospitals, but, with the academization of the nursing profession, more teaching is done in the community. The inservice training programs in community health deal with the prevention, detection, and treatment of the chronically ill in the community. Another recent development is the establishment of the School for Allied Health Professions at the bachelor's level in the Faculty of Health Sciences, Ben Gurion University, in Beer-sheba.

Involvement in education is an important and a feasible approach to primary care manpower planning. It obviously cannot solve all manpower problems, but the basic commitment to and readiness to undertake training, at whatever level required, is a significant basis for responding to changing needs through primary care planning.

Planning Primary Care's Content

Health education, prevention, and home care are today basic and integral elements of primary care. The combined effects of changes in all three concepts at the primary care level can be significant. Let me briefly describe recent activities in these fields.

Kupat Holim's Department for Health Education has developed and tested programs on a number of subjects relevant to Israel's population and associated with common primary care problems. For example, there are programs on food hygiene and liquid intake during the hot summer months, drug prescription and compliance, smoking, obesity, and heart disease. Clinic doctors and nurses may attend courses on the nature of effective communications and how to use those programs and deal with different audiences. These tools give team members the necessary knowledge and confidence to take on other

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forms of patient counseling, as well as giving them an understanding of the value of health education. Other types of counseling may be spontaneous and unstructured, such as dealing with the individual patient, or may be more formal programs given to groups in community facilities. Kupat Holim is currently putting more and more effort into patient education on self care.

The concept of prevention as an integral part of primary care is not new, yet its application must change significantly as the disease pattern changes. In our system, the family doctor, with his defined population list, has a continued relationship with his patients at risk of developing chronic illnesses as they grow older. The family doctor can play an important role in promoting good health behavior, in dealing with risk factors as they arise, and in detecting problems early. In almost all of these preventive measures, the doctor can and indeed must involve other members of the primary care team, from the nurse who takes regular blood pressure measurements to the dietitian who advises appropriate diets.

Home care is another old concept undergoing redevelopment. New concepts of primary care, addressing current disease patterns, may require more home visits than have been common in the last few decades and may be carried out by paramedical health workers, not only the family doctor. These concepts recognize the benefits of home care in keeping the chronically ill at home as long as possible and in providing support for the terminally ill.

Home care must be planned. The tasks are now divided between the basic team—the patient's regular clinic doctor and nurse—and the district home care team. The basic team carries out regular examinations and treatment and, within limits, nursing duties. The role of the primary care nurse has been expanded to comprise "nurse-initiated" visits, including followup of patients who have known chronic illnesses and whose attendance at the clinic has dropped.

For patients who need more complex care that includes personal hygiene and housekeeping, the basic team calls on the district home care team. The district team uses its resources to provide paramedical services, such as physiotherapy and occupational and speech therapy, as well as nursing and personal care.

To accommodate all these new functions, changes in the clinic workday and workweek had to be introduced. Until recently, the vast majority of our clinics had worked on a walk-in basis during the weekly six morning sessions and four late afternoon sessions. The new system, introduced a year ago, divides the clinic's day and week according to newly defined concepts of clinic practice: short question periods for patients, walk-in and appointment times, and, at the end of the day, doctor-initiated visits. In these visits, patients are invited to come in to their regular family doctors for more thorough examinations as part of an early detection program, or for an opportunity to discuss a stressful situation mentioned during a previous visit. A weekly staff conference covers local clinic issues and current interests or problems, such as new drugs or preventive programs.

Introduction of these changes in the organization of primary care had to be planned, implemented, and evaluated, step by step, with due time for each stage. The changes after the first year of the new system are encouraging, not only in dealing with current objectives, but in the development of planning methods to meet changing needs in a large and nationwide health care system.

Conclusion

We are still far from having enough epidemiologic data for all aspects of planning primary care. However, Kupat Holim does have a strong commitment to primary care per se, as well as to the concept of providing this care in community clinics. The community clinic, with its multidisciplinary primary care team and services, plays an essential role in maintaining the patient in his home to the extent possible.

The information we do have allows us to follow trends in the population's age structure, movement, and basic socioeconomic characteristics. We have a fair estimate of the total volume of visits and more detailed information on reasons for primary care doctor visits in practices that were sampled. The linkage between the individual doctor and population list permits the calculation of rates of visits by population group and allows comparisons.

Planning approaches linked to these kinds of information bases in several fields explored here dealt with planning team development, manpower, introduction of new functions in the primary care clinic, and, finally, practice organization. Clinic design, in terms of space allocation, is another field in which the planning process has led to changes. All of these examples, however, represent significant policy issues in the overall objectives of providing primary care.

The relationship between primary care policy and planning is strengthened by the combination of health insurance and health care delivery in a single organiza-

tion. We at Kupat Holim believe that the ability to initiate changes in the system comes from a unique linkage between financer, provider, and consumer. These three groups share common aims of quality and equity in the care provided.

The ability to succeed in the implementation of change goes beyond this relationship within the organization. Here we are dependent on planning, a process that begins with the study of changing needs and demands and ends with evaluation. Effective change must reflect our ability to link epidemiology and health policy through the planning method.

Epidemiology, Health Policy, and Resource Allocation: the Israeli Perspective

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Synopsis

Israel represents a developed country as far as demand and consumption of health services are concerned. The analysis of the Israeli health system reveals a significant trend of expansion in the intensity and the utilization of health services as well as an accelerated development of sophisticated technology, while the percentage of Gross National Product used for health expenditure remained constant and even decreased. Competing needs, reflecting population growth, a rapid aging process, new areas of treatment, and changes in use of health services, illustrate the aggravating issue of setting priorities.

The permanent dilemma of the health system is oscillation between opposite trends:

- *enlargement of public eligibility and technological capabilities and*
- *economic reduction and budget limitations.*

Is there a possibility that the insufficiencies of the system are built into patterns of thinking of those in the system, into its structure, and into its organization of health services delivery? Does the formulation of health policy influence, in terms of the outcomes of the system, priorities and allocation of resources? Does the process of decisionmaking reflect in an appropriate manner the epidemiologic data?

Under the objective constraints, decisionmaking and health policy formulation become critical determinants of the ability to cope more efficiently and effectively with growing and changing needs. The authors suggest an alternative strategy of health decisionmaking that is more instrumental in order to prevent setbacks and to open new horizons for the future.

We would like to discuss the process of making health decisions in a country that has very special problems, many of them unique. The process of decisionmaking at the national level is always multifaceted and multidimensional. In addition to the usual factors to consider, decisionmaking in Israel is subordinated to security priorities as well as immigration considerations and possible influences on the continuing social, cultural, and ethnic integration—all essential components in the national priorities. When decisions involve allocation of resources, one must also bear in mind the continuous inflation, an unstable economic situation, and unpredicted cuts in the national budget for health care. These factors contribute to the difficulties of trying to plan under pressure and in uncertainty.

While a permanent social and cultural laboratory, Israel has developed rapidly. In many ways, it can be considered a developed country; health care and health services are but one example. We can, indeed, point to many impressive achievements in the organization,