

Innovations in Primary Care in Israel
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Good morning,

I am glad to have the opportunity to meet with you and talk about some interesting developments in the primary care system in Israel. I would like to first thank Sophia Schlette and Prof. Amelung for inviting me and organizing this meeting.

Many things are going on in Israel and in the short time we have I'll try to touch upon several – to share some directions/ideas which we then can continue to discuss over lunch.

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I'll begin with a few words describing the context and present the main features of the primary care system in Israel.

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Israel is a small country with a relatively young population (compared to the OECD average of 14.2%). We have relatively good health outcomes – long life expectancy for men and average for women (OECD average: 81.2/75.5) and low infant mortality (OECD average: 5.5%). We have high rates of physician visits (OECD average: 7.0), short hospitalization stays (OECD average: 6.8) and relatively low overall expenses on health (OECD average: 9% of GDP, 2,759 \$PPP).

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Health care is provided by four competing not for profit sick funds that are managed care organizations. They provide comprehensive health care to all residents – primary, secondary and tertiary care. Clalit has the largest market share insuring 53% of the population and Maccabi 25%.

The ministry of health has a central role in the system. It regulates but also owns hospitals and is responsible for provision of some services (psychiatric care, preventive care and long term care).

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Primary care

- Israel has a very strong primary care system, established before statehood in the 1920s. All residents insured in a sick fund of their choice
- The National Health Insurance (NHI) law enacted in 2005 defines the overall budget and a uniform basket of services sick funds provide (updated annually for new medications and technologies).
- Prospective payments are transferred from government to sick funds using an age adjusted capitation formula taking into account the number of members and their age.

- Nationwide network of clinics and independent physician's offices; high access in rural areas
- Primary care physicians (PCP) are salaried or have a contract (prospective, per listed patient); no fee for service
- The PCP has a central role; over 90% of population have a regular PCP
- The PCP –is the physician of first contact and gatekeeper; direct access only to common used specialties

With all this in mind, I will now talk about two innovative programs to improving quality of primary care. The first is a national program and the second is implemented in one of the sick funds.

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NATIONAL PRIMARY CARE QUALITY MEASUREMENT SYSTEM

The national primary care quality measurement system is a unique example of a system-wide voluntary cooperative effort to improve quality of primary care.

The tool for improvement is measurement of medical indicators and feedback to the sick funds. The indicators are based on the HEDIS system developed in the US to provide information to employers about quality of different HMOs .

The system is implemented since 2004 with the goal of measuring medical indicators and thus motivating internal quality improvement efforts in the sick funds. However there were doubts regarding the effect as data on each SF were not published separately (as in HEDIS).

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The measurement system began as a research project (2001) in Ben Gurion University in which sick funds participated voluntarily.

The research team with the sick funds, the Ministry of Health (MOH), Israel Medical Association and academic experts select the measures. The project begun with a set of about 13 measures and has expanded over time to about 50.

In 2004 it was endorsed by the MOH which provides funds for the continuation and enhancement of the project, and publishes annual reports.

The annual reports are published (also in English) on the MOH website and are easily accessible. The reports present national trends in the indicators measured, and to date do not compare between sick funds due to their objection (given the competitive environment in which they act). However each sick fund receives a confidential report comparing it's performance with the average score.

Since 2007 the sick funds are reimbursed for participating in the program and providing the data, as this requires time and adjustment to a uniform format.

Despite the confidential reporting, we have noticed that sick funds put in a lot of effort in internal programs aimed to improve their scores in these measures. These include systematic monitoring of physicians, training of staff, direct contact with patients and patient education.

Overtime, the data show significant improvements in many of the indicators measured – which can be attributed to sick funds' efforts to improve what is measured as they

foresee the possibility of future publication. It demonstrates that measurement in itself (even without publication) is an incentive for improvement.

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All sick funds use a uniform methodology to construct the measures based on data from their computerized medical records. A lot of effort was put into generating comparable data. There is an annual audit of the data-collection procedures in each sick fund.

The measurements address the following conditions (examples of data from the 2007 report are presented in brackets):

Asthma – prevalence (1%), % taking preventive drugs (78.4%)

Breast cancer screening – mammography performance (60%)

Screening for **colorectal cancer** – fecal occult blood testing rates (22%)

Flu vaccine – rates (59% among 65+)

Pneumococcal vaccine (36.5% among 65+)

Diabetes – prevalence (4.2%) rates of HgA1c testing (91.6%); good control of blood sugar level < 7 (49.4%); LDL testing (90.9%) LDL<100 mg/dl (61%); urine micro albumin testing (70.7%); eye exams (62.7%) flu vaccines (49.7%) pneumococcal vaccines (24.8%); documentation of BMI (72.9%) blood pressure measurements (89.3%) control of blood pressure (130/80) (66.8%)

Cardio vascular diseases - cholesterol level testing (76% adjusted for age), BMI documentation (60% of 65+; 41% of 20-64), blood pressure documentation (71% of young and 77% of old), beta blockers (68% purchased among patients with atherosclerosis who have undergone therapeutic coronary angiography or bypass)

Children – BMI documentation (41.9%) and hemoglobin values of babies (66.3%)

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The measures can be classified into five types:

Morbidity indicators (prevalence of diabetes, hypertension)

Prevention indicators (screening, vaccinations)

Performance indicators (medication to diabetics, beta blockers; measuring BP, BMI)

Outcome indicators (achieving a recommended control value – HmgA1c <7 ; BP <140/90)

Documentation indicators (vital information is recorded – BMI)

Data is presented by age group, low socio-economic group, changes over time. In the future the plan is to present the data also by geographical region and sick fund.

Examples of Improvements between the years 2005 and 2007:

Mammography screening rates (50-74) – 56% in 2005 and 60% in 2007

Screening for **colorectal cancer** (50-75) – 9% in 2005 to 22% in 2007

Pneumococcal vaccine – (65+) 26% in 2005 to 36% in 2007

Diabetes – Hga1c<7 30% in 2005 to 33% in 2007

Hga1c >9 from 16% in 2005 to 13% in 2007

Microalbumin test 58% in 2005 to 71% in 2007

Cardio vascular risk factors – documenting BMI annual (55-74) 20% in 2005 to 55% in 2007

Documenting blood pressure annual (55-74) 62% in 2005 to 77% in 2007

Children – Hemoglobin measurement from 59% in 2005 to 66% in 2007

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To conclude:

This is a remarkable project on a national scale to monitor and thus improve quality of primary care – with documented improvements. **The main advantage** is the inherent incentive for SFs to improve quality of care and equity (as measures are reported by SES). However, the project may have **undesired effects** if SFs concentrate only on measured activities and neglect other aspects of quality such as inter-personal communication, or treatment of other conditions.

I would also note that physicians feel pressure to improve regardless of the effect of patient compliance on the outcome measures (e.g. control of blood pressure or sugar level). Physician organizations are beginning to object to these measures fearing that in the future sick funds will use the quality measurement data against them.

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REDESIGNING PRIMARY CARE SERVICES IN MACCABI

I will now present another program carried out in Maccabi sick fund which is the second largest, and insures about 25% of the population. This program too has the objective of improving quality of care. The tool for improvement in this program is redesign of primary care services – a structural change.

Traditionally, primary care services in Maccabi were provided by a solo practitioner, in the German tradition as it was founded by German physicians who emigrated to Israel in the 1930s. The redesign concept was based on the "chronic care model" in which treatment is provided by a physician-nurse dyad responsible for proactive prevention, life style counseling, treatment and regular follow up of patients (i.e. providing managed integrated care). Since 2007 the model is implemented in 50 clinics, and if successful the plan is to implement it widely.

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The new model is based on five principles:

1) **Care is provided by a multi-disciplinary team** responsible for ongoing aspects of their patients' health. The team is led by the physician-nurse dyad, and includes other healthcare professionals as well (e.g. social workers).

2) In this model, **physicians have a defined community of members** they are responsible for, and are expected to proactively invite patients for health promotion, preventive care and follow-up on chronic conditions. These services are provided in cooperation with the nurse, who functions as a 'care coordinator'.

3) The encounter is **used for comprehensive management of patients' health** (e.g. life style counseling, periodic tests for chronic patients, identification of emotional distress etc); Planned visits with sufficient amount of time are allocated for these activities; nurses manage encounters that are dedicated to the follow-up and maintenance of chronic care.

4) **One-stop-shopping for preventive care** by offering all routine check up procedures at the clinic, or another location, during one visit which is very convenient for the patient.

5) **Care is "patient-centered"**, i.e. care that takes into account patients' values and wishes as part of the clinical decisions, and provides patients with tools for self-management of chronic conditions as well as for maintaining their health on a regular basis .

Maccabi had developed a manual with clear protocols and working processes. There is an internal evaluation of the program and initial results are expected at the end of 2008.

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The incentives for physicians to adopt the new model include: 1) A opportunity to improve the health of their patients, as well as their performance in a set of 25 clinical performance measures monitored continuously by Maccabi; 2) The teamwork will provide the physicians with more time for the clinical tasks that are sometimes abandoned because of time limitations and now are performed by nurses. This is expected to increase their job satisfaction 3) Physicians joining the new model receive funding for hiring a nurse practitioner, who is trained to work in the new model.

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The **model is new in Maccabi, but is known in the literature**. Some aspects of the model (multidisciplinary team responsible for a defined community of members) can be found in the "primary care clinic" model which is the prevalent model of care in Clalit Health Care services, the largest sick fund in Israel. The other aspects are an innovative development of Maccabi, based on the "chronic care model" (see Bodenheimer et al. 2002 – Improving primary care for patients with chronic illness – the chronic care model. JAMA 288 1775-1779).

Based on the literature, implementing this model is expected to improve quality of care (outcome measures) as well as equity (outreach to vulnerable populations that do not come in for care). Cost efficiency is also expected as improved control of chronic diseases will reduce future costs related to deterioration and complications.

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CONCLUSION

I would like to conclude with a general observation on quality initiatives in the Israeli health care system.

The sick funds operate within tight budgetary constraints. The Ministry of Finance approves the annual budget which does not fully compensate for population growth, ageing and technological advancements. Sick funds are audited and not allowed to accrue deficits.

So, overtime sick funds are pressured to become more efficient and reduce costs.

At the same time, there is a growing realization among managers that appropriate high quality care (especially for chronic disease) contributes to cost containment.

Consequently, in the last years we have seen many programs to improve the care for chronic conditions. (Of course, sick funds are trying to reduce costs in other ways too such as better contracts with providers, restrictions on excess use of services, salary cuts etc.).

For example, there have been a lot of **training programs** for primary care staff to improve their ability to identify and treat depression and anxiety disorders. This will improve quality of care as well as save costs related to untreated conditions and somatization of symptoms. Staff also undergo **training in treatment of chronic conditions** – diabetes, hypertension. They receive **guidelines** and participate in workshops to increase adherence to the guidelines.

Sick funds in Israel also initiate many **health promotion programs**. These too have the potential to save costs if members adhere to a healthy life style. They also contribute to the image of the sick fund as caring for your health. For example, consultations with dieticians, encouraging physical activity, smoking cessation. These programs not only **improve care but are also a source of revenue** as patients pay a special fee for participating in the program.

You can find more detailed information on these and other innovations in the Israeli system on the Bertelsmann HPM website.

Thank you.

Sources

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