ג'וינט-מכון ברוקדייל

תפיסותיהם של ערבים ושל יהודים את מערכת הבריאות שנתיים וחצי לאחר יישום חוק ביטוח בריאות ממלכתי

ממצאים מסקר באוכלוסייה הכללית

מרק פרפל • דן יובל

המחקר מומן בחלקו על-ידי המכון הלאומי
לחקר שירותי הבריאות ומדיניות הבריאות

ד ו ח מ ח ק ר

דמ-99-351

ג'וינט–מכון ברוקדייל מהו?

מרכז ארצי למחקר בתחומי הזיקנה, התפתחות האדם ורווחה חברתית בישראל, שהוקם ב–1974.

ארגון עצמאי ללא כוונת רווח, הפועל בשיתוף עם הג'וינט העולמי (AJJDC) וממשלת ישראל.

צוות של אנשי מקצוע המקדישים עצמם למחקר יישומי בסוגיות חברתיות בעלות קדימות עליונה בסדר היום הלאומי.

קבוצת חשיבה שנטלה על עצמה מחויבות לסייע לקובעי המדיניות ולספקי השירותים בתכנון וביישום תכניות רווחה.

המחקר במכון מתבסס על גישה בין–תחומית. במכון חמש יחידות עיקריות:

- **זיקנה**
- **מדיניות בריאות**
- **קליטת עלייה**
- **מוגבלות**
- **המרכז לילדים ולנוער**

תפיסותיהם של ערבים ושל יהודים את מערכת הבריאות שנתיים וחצי לאחר יישום חוק ביטוח בריאות ממלכתי

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נובמבר 1999 ירושלים כסלו תש"ס

ג'וינט-מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה
ת"ד 13087
ירושלים 91130

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פקס: 02-5612391
דואר אלקטרוני: www.jdc.org.il/brookdale

פרסומים נוספים של ג'וינט-מכון ברוקדייל העוסקים בנושא זה

פרפל, מ.; רוזן, ב.; ברג, א.; גרוס, ר. 1997. **תפיסת מערכת הבריאות והשימוש בה בקרב ערבים ויהודים לאחר יישומו של חוק ביטוח בריאות ממלכתי: ממצאים מסקר באוכלוסייה הכללית.** דמ-274-97. (אנגלית)

ברג, א.; גרוס, ר.; רוזן, ב.; חיניץ, ד. 1997. **מערכת הבריאות בעיני הציבור בעקבות החלת חוק ביטוח בריאות ממלכתי: ממצאים מסקר באוכלוסייה הכללית.** דמ284-97. (עברית)

גרוס, ר.; גרינשטיין, מ.; דובני, א.; יובל, ד.; רוזן, ב. 1998. **רמת השירות בקופות החולים בעקבות חוק ביטוח הבריאות הממלכתי: לקט ממצאים ראשוניים מסקר מבוטחים 1997 והשוואה לסקר 1995.** תמ-17-98. (עברית)

להזמנת פרסומים ניתן לפנות לג'וינט-מכון ברוקדייל, גבעת הג'וינט, ת"ד 13087, ירושלים 91130, טל': 02-6557400, פקס: 02-5612391.

תקציר

הערבים המתגוררים בישראל מהווים אוכלוסייה פגיעה, המתמודדת עם מכשולים גיאוגרפיים, כלכליים, חברתיים ותרבותיים לקבלת שירותי בריאות. לכן הם היו עשויים להפיק תועלת מחוק ביטוח בריאות ממלכתי, אשר יושם ב-1 בינואר 1995. לפני החלת החוק היו הבדלים משמעותיים במצב הבריאות ובשירותי הבריאות בין ערבים ליהודים, בד בבד עם שיפור הולך וגדל במצב הבריאות ושירותי הבריאות באוכלוסייה הערבית. על-פי הספרות, לפני יישום החוק היה מצב הבריאות של הערבים פחות טוב מזה של היהודים; שיעור החברים בקופות חולים היה נמוך יותר; נגישות בעלי מקצוע או מתקנים של שירותי בריאות לערבים היתה מוגבלת יותר; ושיעורים נמוכים יותר מהם ביקרו אצל רופאים (רופאי משפחה, רופאים מומחים, רופאי שיניים). נמצאה סבירות גבוהה יותר שלערבים תהיינה הוצאות על שירותי רפואה פרטיים – הדבר משקף ככל הנראה את נגישותם הנמוכה של שירותי קופות החולים. ב-1993 הוועדה לקידום שירותי בריאות לערביי ישראל של משרד הבריאות ראתה בהחלת חוק ביטוח בריאות ממלכתי רכיב חיוני בקידום שירותי הבריאות לאוכלוסייה הערבית ולצמצום הפערים בין ערבים ליהודים באשר לשירותי בריאות.

חוק ביטוח בריאות ממלכתי קובע כיסוי ביטוח בריאות אוניברסלי, ובכך ביטל היבט אחד באי-השוויון בין ערבים ליהודים בשירותי הבריאות. שנית, החוק השתית את התגמול לקופות החולים לפי שיטת הקפיטציה, שבה כל קופת חולים ממומנת על-פי מספר חבריה ועל-פי גילם, במקום מימון על-פי רמת ההכנסה של חבריה, כפי שהיה נהוג לפני החוק. שינוי זה אמור היה להפוך את האוכלוסייה הערבית ליותר אטרקטיבית מבחינה פיננסית לקופות החולים, וזה, בתורו היה צפוי להגביר את התחרות, להעלות את רמת שירותי הבריאות ומכאן, לקדם את שירותי בריאות ואת מצב הבריאות במגזר הערבי.

אכן, בהתבסס על הסקר שערך ג'וינט-מכון ברוקדייל בשנת 1995 בקרב האוכלוסייה הכללית, שמונה חודשים לאחר יישום החוק, ערבים, יותר מיהודים, נטו במובהק לדווח על עלייה ברמת השירותים של קופת החולים. המחקר של 1995 חשף גם צמצום של חלק מהפערים בין ערבים ליהודים, כולל הבדלים בשכיחות הביטוח המסחרי ובהוצאות למשק בית על רופאים פרטיים. מדיווחים בעל-פה של פאנל של אנשי מקצוע ערבים שהגיבו על סקר 1995 עולה שבעקבות יישום החוק, קצב הקמת המרפאות ביישובים הערביים על-ידי קופות החולים הלך וגבר. אולם, ההבדלים בין ערבים ליהודים שכבר תועדו בעבר, כגון שימוש נמוך יותר בשירותי מומחים בקרב הערבים, נמצאו תקפים. המחקר גם חשף הבדלים שלא זוהו קודם, כולל סבירות נמוכה יותר שיהיה לערבים רופא משפחה קבוע וידע מוגבל בקרב הערבים על מדיניות ביטוח משלים או בעלות על ביטוח. המחקר גם חשף חוסר שביעות רצון באשר לסבירות זמני הנסיעה לרופא הראשוני.

דוח זה עורך השוואה בין תגובותיהם של 233 ערבים לבין תגובותיהם של 972 יהודים לסקר מעקב ארצי בקרב האוכלוסייה הכללית, שבוצע באמצעות ראיון טלפוני על-ידי ג'וינט-מכון ברוקדייל בשנת 1997, שנתיים וחצי לערך לאחר יישום החוק (סה"כ שיעורי היענות 85%). הסקר העריך את השינויים בתפיסות

הציבור, את השינויים ברמת שירותי הבריאות ואת ההוצאות על בריאות, את נגישות שירותי הבריאות הראשוניים ושירותי המומחים ושכיחותם, את קבלתם של שירותי מניעה נבחרים ושל שירותי חירום, את שביעות הרצון מהשירותים, ואת נושא רכישת ביטוחי בריאות משלימים ומסחריים. מימון מהמכון הלאומי לחקר מדיניות בריאות ושירותי בריאות אפשר לנו להוסיף שאלות בנושאים חשובים במיוחד לערבים הישראליים (כלומר, גישה לשירותי מומחים ולשירותי חירום, שימוש בשרותי רופאים פרטיים); להכפיל את מספר הערבים בסקר הטלפוני; ולקיים ראיונות פנים-אל-פנים (תוך שימוש בשאלון דומה) ב-237 משקי בית ערביים ללא טלפונים בכפרים ובערים בצפון ובי"משולש הקטן". הדבר אפשר לנו להשוות בין תת-קבוצות ערביות שונות, כמו ערבים החיים בכפרים לא-מוכרים. הסיכום להלן מתייחס לממצאים מהסקר הטלפוני, אלא אם כן מצוין אחרת.

יחסית למרואיינים היהודים, המרואיינים הערבים עם טלפון בביתם או בלעדיו היו צעירים, היו להם משקי בית גדולים, רמות ההשכלה וההכנסה שלהם היו נמוכות, ובדרך כלל הם התגוררו בקהילות כפריות קטנות בצפון הארץ. שיעור קטן יותר של מרואיינים ערבים עבדו מחוץ לבית בהשוואה למרואיינים יהודים; ממצא זה נבע בעיקר מן השכיחות הגבוהה יחסית של עקרות-הבית באוכלוסייה הערבית. לגבי מרבית הנושאים נמצאו הבדלים בעלי מובהקות סטטיסטית גם לאחר ניתוחים אלו (כלומר, מצב רפואי על-פי דיווח עצמי, שיפור ברמת השירותים של קופת החולים, ויתור על טיפול בשל המרחק, קבלת סוגים נבחרים של טיפולי מניעה ושכיחות ביטוחים מסחריים). ניתוחים רב-משתניים בוצעו כדי לנטרל את ההבדלים הדמוגרפיים בין ערבים ליהודים.

הממצאים מסקר המעקב הטלפוני של שנת 1997 הראו שמשנת 1995, הבריאות ושירותי הבריאות בקרב האוכלוסייה הערבית המשיכו להשתפר; אולם, בעוד שחלק מהפערים בשירותי הבריאות בין ערבים ליהודים צומצמו, אחרים נותרו בעינם. לדוגמה, חל שיפור בנגישות רופאי המשפחה של קופת החולים בעבור הערבים; הופחתו הוצאות של משקי בית על רופאים פרטיים, וכך גם ההוצאות על רופאים פרטיים בשירותי חירום לאחר שעות העבודה; והערבים דיווחו על שיפור במצב הבריאות. יש לציין שכמעט כל המרואיינים הערבים דיווחו שיש להם רופא משפחה קבוע בקופת החולים שלהם; לרובם היה אותו רופא בשלוש השנים האחרונות; יש להניח שהדבר ישפר את המשכיות הטיפול לאוכלוסייה הערבית.

השפה המדוברת על-ידי רופאי המשפחה של קופת החולים לא נמצאה כמכשול לקבלת טיפול לגבי רוב המרואיינים הערבים. שבעת האחוזים מן הערבים שדיווחו שלא הרגישו בנוח עם השפה שרופא המשפחה שלהם דיבר, ציינו בדרך כלל שהוא דיבר עברית. זמני המתנה לטיפול שגרתי ולטיפול מומחים צומצמו במגזר הערבי. יחסית לתגובות שלהם בשנת 1995 ולתגובות היהודים בשנת 1997, דיווחו הערבים על המתנה קצרה יותר לרופא המשפחה, ועל זמן קצר יותר בין בקשת ההפניה למומחה לבין הביקור אצלו בפועל; הדבר נכון לגבי חמשת סוגי המומחים השכיחים ביותר. בנוסף, יחסית ל-1995, אחוז גדול יותר של ערבים דיווחו ששעות הקבלה של הרופא המומחה היו נוחות או נוחות מאוד. לבסוף, שיעור קטן יותר של ערבים מיהודים דיווחו על כך שהוצאותיהם על בריאות גרמו להם לקשיים כלכליים ניכרים.

נמצא כי 71% מהמרואיינים הערבים, בהשוואה ל-34% מהמרואיינים היהודים, דיווחו על שיפור כללי ברמת שירותי קופת החולים, והדבר תואם את השיפורים שצוינו לעיל. יתר על כן, הפער בין תפיסת

השיפור בקרב הערבים לבין התפיסה בקרב היהודים גדל מאז 1995. הבנה מעמיקה יותר של שינויים ברמת השירותים לערבים וליהודים דורשת מידע על הקצאת המשאבים של קופות החולים לקבוצות ולתת-קבוצות אוכלוסייה שונות, ועל שינויים באיכות הטיפול.

שיעור גדול יותר של ערבים מיהודים דיווחו שמצב הבריאות שלהם היה טוב או טוב מאוד, יחסית ל-1995. שינוי זה יכול להיות תוצאה של הנגישות המשופרת של שירותי הבריאות במגזר הערבי, ושל התחושה החזקה יותר בקרב הערבים של שיפור ברמת השירותים.

בהתבסס על השיפור הנרחב ברמת שירותי קופת החולים בקרב האוכלוסייה הערבית (מ-30% ב-1995 ל-71% ב-1997), ניתן היה לצפות לעלייה מקבילה בשביעות הרצון הכללית משירותי קופת החולים. אולם, השיפור בשביעות הרצון הכללית בקרב המרואיינים הערבים בין 1995 ל-1997 היה קטן יחסית, והוא נמוך מהשיפור בשביעות הרצון הכללית שדווחה על-ידי היהודים בשנת 1997. שיפור קטן אך מובהק סטטיסטית בשביעות הרצון של הערבים נמצא לגבי כל רכיבי הטיפול מלבד שניים. אפשר שהמרואיינים לא ראו את השיפור באותם רכיבי הטיפול אשר נבדקו בסקר כמכריע בשביעות הרצון הכללית שלהם. לכן, התייחסות לבעיות אחרות, שיפורטו להלן, יכולה להיות מכריעה יותר לגבי שביעות הרצון הכוללת של הערבים משירותי קופת החולים.

בהתאם לממצא שהנגישות של שירותים מסוימים של קופת החולים במגזר הערבי השתפרה, נמצא כי הערבים פחות תלויים בשירותי רופאים פרטיים מאשר היו בשנת 1995. ראשית, ערבים מעטים דיווחו כי המטפל הראשוני הקבוע שלהם הוא רופא פרטי. שנית, שיעור המרואיינים הערבים שדיווחו על הוצאות על רופאים פרטיים (מלבד רופאי שיניים) היה נמוך באופן משמעותי ב-1997 מהשיעור ב-1995, ועתה הוא דומה לשיעור בקרב היהודים. שלישית, בניגוד למצב ב-1995, ב-1997 אף אחד מהמרואיינים הערבים לא דיווח על שימוש לאחר שעות העבודה בשירותי רופא פרטי שאינו שייך לשירות מאורגן לטיפולי חירום. הדבר יכול לנבוע בחלקו מהשימוש המדווח בשירותי "חייאת", המהווים מקור גדל והולך של שירותי חירום פרטיים במספר ערים וכפרים ערביים. ערבים גם דיווחו על הרחבת השימוש בחדרי מיון בבתי חולים, במוקדים לטיפולי חירום בקהילה (המופעלים על-ידי קופות החולים) ובשירותי מד"א לטיפול חירום לאחר שעות העבודה.

שינויים אלה משקפים את הנגישות המוגברת של סוגים שונים של שירותי חירום לאחר שעות העבודה בעבור האוכלוסייה הערבית. ייתכן שיש בכך גם שיפור באיכותם של טיפולי החירום לערבים, שכן אנו מניחים שלרופאים הפרטיים שעליהם הם נסמכו בעבר היתה פחות גישה לציוד ולמומחים מאשר לבתי החולים ולמתקני החירום הקהילתיים. אולם, על-פי דיווחיהם, השימוש של הערבים במוקדי החירום בקהילה היה פחות מהשימוש של היהודים, ככל הנראה בשל הזמינות הנמוכה יותר של שירותים אלה ביישובים הערביים. שיעורי השימוש הגבוהים בקרב הערבים בחדרי המיון של בתי החולים לצורך קבלת טיפול לאחר שעות העבודה מצביעים על כך שעדיין יש מקום לשיפורים בתחום זה, במיוחד לאור העובדה שערבים מתגוררים בדרך כלל במרחק רב יותר מבית החולים הקרוב ביותר מאשר יהודים.

עדיין קיימים הבדלים בין ערבים ליהודים ביחס לשימוש בשירותים של מומחים, של רופאים בעלי תת-התמחות ושל בעלי מקצוע בתחום בריאות הנפש; ביחס להספקת שירותי מניעה (כגון בדיקות לחץ דם); ביחס לשכיחות ביטוחי הבריאות המסחריים; ובאשר לידע על ביטוח משלים. מספר בעיות נבעו ככל הנראה מהמיקום הפריפרי של כפרים ערביים רבים, ומכאן גם זמן הנסיעה הארוך לצורך ביקור בבית חולים, במרפאות החוץ של בית החולים, במרכזים שלישוניים לטיפול רפואי, במוקדי חירום בקהילה ובמעבדות.

לדוגמה, ערבים יותר מיהודים נטו לדווח על ויתור על שירותי בריאות, במיוחד על שירותי מומחים, בשל המרחק של השירות מביתם. יתר על כן, למרחק לבית החולים הקרוב או למוקד החירום בקהילה הקרוב יש השפעה מכרעת באשר לוויתור על טיפול הן בקרב הערבים והן בקרב היהודים; לכן חשוב לציין שבממוצע רוב הערבים חיים רחוק יותר מאשר יהודים מבתי חולים וממוקדי חירום. משום שערבים נטו פי שניים מיהודים לצרוך שירותי מומחים במרפאות חוץ של בתי חולים, המרחק הגדול יותר מבית החולים הקרוב מייצג לכל הפחות אי-נוחות, וקרוב לוודאי -- מכשול בדרך לקבלת טיפול; זה גם יכול להסביר את תת-השימוש בשירות ואת העיכוב בקבלת טיפול בקרב הערבים.

הערבים גם נטו יותר מיהודים לדווח על כך שזמני ההפניה למומחים וזמני הנסיעה לרופא המשפחה של קופת החולים אינם סבירים, ולהביע פחות שביעות רצון משירותי החירום. משום שאחת ממטרות חוק ביטוח בריאות ממלכתי היא לספק לכל שכבות האוכלוסייה שירותי בריאות זמינים, נוחים ובאיכות סבירה, יש להעניק את תשומת הלב הראויה לממצאים אלה. יש לציין **שזמני** הנסיעה שדווחו על ידי הערבים והיהודים היו דומים למדי. הבדלים בין תפיסות הערבים לתפיסות היהודים לגבי מה שנחשב זמן נסיעה סביר למרפאת קופת החולים עשויים לנבוע מההבדלים בשיעורים של בעלי מכוניות; מהנגישות המוגבלת של התחבורה הציבורית בערים ובכפרים הערביים; מן המצב הירוד של הדרכים לערים ולכפרים הערביים; ומההוצאה היחסית, הזמן, המרחק ואי-הנוחות שערבים מייחסים לנסיעה. יותר מכך, יש ערבים שצריכים לנסוע מחוץ לכפר כדי לבקר אצל רופא המשפחה שלהם - ממצא שדווח לאחרונה על-ידי אדלר ולוטן (1997). הן ערבים והן יהודים דיווחו על שביעות רצון מרכיבים רבים של הטיפול והדבר מדגיש את חשיבות ההבדלים בתפיסת זמן הנסיעה לרופא המשפחה שלהם.

ייתכן שהערכת הערבים שלוקח להם זמן בלתי סביר לקבל שירותי מומחים (למרות שהערבים דיווחו על **זמני** המתנה קצרים יותר מהיהודים) נובע מן הצורך הדחוף יותר שלהם לקבל טיפול, אשר מקורו בתת-השימוש שלהם בשירותים בשל המרחק מבתי חולים, ממרפאה וממוקדי החירום, כפי שצוין לעיל. הערכה זו יכולה גם לעלות מתוך תחושה סובייקטיבית שהצורך בטיפול הוא דחוף, מן הקשיים להגיע למומחים או מתהליך ההפניה המסורבל. ערבים שדיווחו על גישה ישירה למומחים חשו כי זמן ההמתנה שלהם פחות סביר מאשר אלה שהופנו לשירותי מומחים על-ידי רופא המשפחה שלהם, ונמוך משל יהודים בעלי גישה ישירה לשירותי מומחים.

יחסית ליהודים, ערבים אשר סבלו מבעיות נפשיות נטו פחות לפנות לפסיכולוגים או לפסיכיאטרים מאשר לרופאי המשפחה. ייתכן שזו תוצאה הן של ההבדלים בזמינות בעלי המקצוע בבריאות הנפש בין המגזר הערבי למגזר היהודי, והן בשל הבדלים תרבותיים בין ערבים ליהודים. בשנת 1993, דיווחה

הוועדה לקידום שירותי בריאות לערביי ישראל של משרד הבריאות על הצורך להפחית את הפער הגדול יחסית בזמינות שירותי בריאות הנפש במגזר הערבי על-ידי הגדלת כוח האדם המקצועי דוברי הערבית והכשרה יותר אינטנסיבית שלהם.

בעת ניתוח הנתונים, התעוררה השאלה האם ממצאי המחקר היו שונים אילו היינו מתרכזים רק בתושבים ערבים ויהודים המתגוררים ביישובים קטנים באזורי הפריפריה. כדי לענות על שאלה זו, נערכה השוואה בין התגובות לסקר הטלפוני של יהודים וערבים החיים ביישובים קטנים (פחות מ-50,000 תושבים) שאינם סמוכים לערים גדולות (כמו חיפה, תל אביב-יפו, ירושלים). ניתוח זה העלה ממצאים דומים לאלה של הסקר המרכזי. הדבר מעיד כי נותרו הבדלים בין ערבים ליהודים ביחס להיבטים רבים של שירותי הבריאות, גם לאחר פיקוח על גודל היישוב ועל הקירבה לעיר הגדולה. יוצא מן הכלל חשוב אחד היה שביישובים הקטנים היה שיעור דומה של ערבים (12%) ושל יהודים (10%) שדיווחו כי ויתרו על סוגים מסוימים של טיפול רפואי הממומנים בידי קופת חולים בשנה החולפת משום שהשירות לא היה קרוב מספיק לביתם.

נמצאו הבדלים מסוימים בין ערבים ללא טלפון לבין ערבים עם טלפון, המעידים על כך שבפני הראשונים עומדים מכשולים נוספים בדרך לקבלת שירותי קופת חולים. לדוגמה, נמצאה שכיחות גבוהה יותר בקרב ערבים ללא טלפון של הוצאות למשק בית על רופא פרטי. בנוסף, לשיעור נמוך יותר מקרב הערבים ללא טלפון היה רופא משפחה קבוע, שיעור קטן יותר עברו בין קופות החולים, ואחוז המדווחים על שיפור בשירותי קופת החולים היה קטן יותר, מאשר ערבים עם טלפון. נמצא כי ערבים בכפרים לא-מוכרים המרוחקים מבחינה גיאוגרפית מהווים תת-קבוצה פגיעה במיוחד, המתמודדת עם בעיות קשות בקבלת שירותי בריאות, בשל מחסור בשירותים מקומיים. שיעור המסתמכים על תחבורה ציבורית כדי לבקר את רופא המשפחה שלהם קטן מהערבים האחרים; הם דיווחו על זמני נסיעה ארוכים יותר לרופא המשפחה שלהם (לעתים קרובות על יותר משעה); ערבים סברו כי זמני הנסיעה לרופא המשפחה הם בלתי סבירים וכי שעות הקבלה של רופא המשפחה ושל הרופא המומחה בלתי נוחות. אף אחד מהם לא דיווח על הגעה רגלית לרופא או על מעבר בין קופות החולים מאז יישום החוק. שיעור המדווחים על שיפור בשירותי קופת חולים היה קטן יותר מאשר מרואיינים ערבים אחרים. יתר על כן, הסיכויים שידווחו על הוצאות למשק בית על רופא פרטי, או על ויתור על טיפול בשל המרחק בין השירות לביתם היו גבוהים יותר.

הסקר פניה-אל-פנים כלל סידרת שאלות נוספת, שבאמצעותן נתגלו הבדלים בידע של המרואיינים לגבי זכויותיהם בחוק (לדוגמה, ידע מועט לגבי זכותם לגבי ביקור בחדר מיון או ביקורי בית של רופא). נושא זה דורש בדיקה נוספת. שאלה פתוחה לגבי תפיסת המרואיינים את הבעיות העיקריות הקשורות בבריאות ביישוב שלהם הדורשות פתרון תואמת את הממצאים העיקריים של הסקר הטלפוני. רוב המרואיינים התייחסו לגישה מוגבלת לשירותי אמבולנס, לבתי מרקחת, לשירותי מומחים ולשירותי חירום בשל המרחק מביתם. חלק ניכר גם התייחסו לזמינות מוגבלת של שירותים (לדוגמה, המתנה ארוכה לתרופות ולשירותי מומחים). מרואיינים אחרים התייחסו לבעיות סניטציה, כגון לשירותים מוניציפליים בלתי-מספיקים של ביוב ושל איסוף אשפה, לבעיות הקשורות לבריאות הציבור כגון מחלות תורשתיות, ולצורך בחינוך ביחס למניעת תאונות בבית.

על בסיס הסקר של 1997, נראה כי קופות החולים מייחסות חשיבות גוברת והולכת לאוכלוסייה הערבית. אולם, ייתכן שקופות החולים עדיין העניקו עדיפות נמוכה יותר לאוכלוסייה הערבית מאשר לאוכלוסייה היהודית, ומכאן ההבדלים העקביים בשירותי הבריאות בין יהודים לערבים, על אף השיפור המתמיד בשירותי הבריאות בקרב האוכלוסייה הערבית. יש צורך בניטור מתמשך של סוג ההבדלים הללו ומידתם בכל הערכה של השוויון בבריאות ובשירותי בריאות.

חשוב לציין שאין מצפים שעקב חוק ביטוח בריאות ממלכתי ייעלמו כל הפערים הקשורים בבריאות בין ערבים ליהודים, כגון מצב הבריאות והגישה לשירותי בריאות, הנקבעים על-ידי מערך גורמים סוציו-אקונומיים, תרבותיים, התנהגותיים וסביבתיים; לא על כולם ניתן לפקח או להשפיע באמצעות החוק.

דברי תודה

מחקר זה נתמך במענק שניתן על-ידי המכון הלאומי לחקר מדיניות הבריאות ושירותי הבריאות ומומן בחלקו על-ידי ג'וינט-מכון ברוקדייל. החוקרים מבקשים להודות לנירה שמאי, המנהלת המדעית של המכון הלאומי, על תמיכתה ועל שהעניקה לנו הזדמנות להציג נתונים ראשוניים בסמינר של המכון הלאומי במרס 1998.

המחברים מודים לעאהד ערו על עזרתו הנדיבה בגיוס, באימון ובתיאום צוות השדה ב"משולש הקטן", ועל אירוח החוקר הראשי בביתו בגית במהלך עבודת השדה. אנו מודים גם לסלים עלי זידאני על עזרתו האדיבה בגיוס צוות עבודה השדה בצפון, על האירוח ועל ההשתתפות במפגשי ההכשרה לצוות השדה, ועל תמיכתו המתמשכת בחוקר הראשי ועל השימוש בביתו כבסיס המבצע. אנו גם מודים לסוהילה מוראד, מתאמת השדה וצוות השדה בצפון.

אנו מוקירים תודה לאביגייל דובני על תמיכתה המיומנת וללא סייג בתכנון ובניהול כל ההיבטים של עבודת השדה, מהתוויית אופי עבודה השדה ועד להכשרה, תמיכה ותיאומים עם צוות השדה. אנו גם מודים לחאלד אבו-עסבה, לתמרה ברנע, לאיילת ברג, לרויטל גרוס, לג'ק האדלי, לברוך רוזן - מנהל תחום מדיניות בריאות בג'וינט-מכון ברוקדייל, ולמנהל ג'וינט-מכון ברוקדייל - ג'ק חביב על הערותיהם, על תמיכתם ועל הנחייתם. אנו מודים גם למרים לוונברג על עזרתה במחשוב, ולעמיתים אחרים בג'וינט-מכון ברוקדייל אשר הציעו את עצתם ואת הנחייתם לאורך מהלך עבודתנו. תודה למרשה ויינשטיין שערכה את הדוח ולענבל יוניוב שסייעה בהדפסתו.

תודה לפייסל עזאייזה מאוניברסיטת חיפה על עזרתו בפיתוח השאלות החשובות במיוחד לאוכלוסייה הערבית, ולאלן רוס מבית הספר ע"ש ג'ונס הופקינס להיגיינה ולבריאות הציבור, המחלקה לביו-סטטיסטיקה, על הנחייתו בתכנון סקר פנים אל פנים במשקי בית ערביים ללא טלפון.

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			Model 1			Model 2	
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	-1.500	0.223	0.000	-0.932	0.394	0.000
Sick fund	KHC				-1.837	0.159	0.000
Income					0.236	1.266	0.000
Age					0.009	1.009	0.112
Education					0.028	1.029	0.690

Table 70: Logistic Regression Model Predicting Overall Satisfaction or Very High Overall Satisfaction with Sick Fund Services (n=1,196)*

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	0.026	1.026	0.922	-0.161	0.851	0.589	0.133	1.142	0.685
Gender	Female				0.165	1.180	0.437	0.117	1.125	0.587
Age					0.017	1.018	0.031	0.021	1.021	0.013
Education					-0.082	0.922	0.384	-0.123	0.884	0.194
Perceived health status					-0.383	0.682	0.001	-0.374	0.688	0.002
Sick fund	KHC							-0.614	0.541	0.013
Region	North							0.049	1.050	0.873
Size of town	Population 20,000 - 99,999							-0.041	0.960	0.88
Size of town	Population <20,000							-0.674	0.510	0.012

Table 69: Logistic Regression Model Predicting Very High Overall Satisfaction with Sick Fund Services (n=1,196)*

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	-0.420	0.657	0.020	-0.828	0.436	0.000	-0.645	0.525	0.004
Gender	Female				0.394	1.482	0.005	0.368	1.445	0.009
Age					0.008	1.008	0.093	0.010	1.010	0.042
Education					-0.249	0.780	0.000	-0.285	0.752	0.000
Perceived health status					-0.315	0.730	0.000	-0.307	0.735	0.001
Sick Fund	KHC							-0.400	0.670	0.007
Region	North							0.053	1.054	0.804
Size of town	Population 20,000 - 99,999							-0.145	0.865	0.392
Size of town	Population <20,000							-0.536	0.585	0.006

Table 68: Logistic Regression Model Predicting Never Having Had a Mammogram (n=224)

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	-1.756	0.173	0.001	-1.855	0.156	0.002	-1.824	0.161	0.004
Age					-0.024	0.977	0.188	-0.027	0.973	0.150
Perceived health status					-0.392	0.676	0.022	-0.410	0.664	0.020
Education					0.132	1.142	0.290	0.169	1.184	0.196
Sick fund	KHC							0.562	1.754	0.103
Region	North							-0.140	0.869	0.784
Size of town	Population <20,000							-0.485	0.616	0.278
Size of town	Population 20,000 - 99,999							-0.220	0.802	0.555

Table 67: Logistic Regression Model Predicting Never Having Had a Blood Pressure Test (n=1,055)

		Model 1			Model 2		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	1.141	3.129	0.000	1.258	3.518	0.000
Age					-0.016	0.984	0.037
Gender	Female				-0.542	0.582	0.005
Perceived health status					-0.114	0.892	0.361
Education					0.072	1.074	0.412
Sick fund	KHC				0.177	1.193	0.395
Region	North				-0.194	0.824	0.468
Size of town	Population <20,000				-0.225	0.798	0.373
Size of town	Population 20,000 - 99,999				-0.438	0.645	0.079

* It should be noted that the results of this analysis are dependent on the way the dependent variables categories are collapsed, i.e. a comparison of having had a blood pressure test during the past month versus having a test before that or not having one at all would not yield any difference between Arabs and Jews.

Table 66: Logistic Regression Model Predicting Forgone Care among KHC Members (n=687)

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	0.917	2.503	0.001	1.073	2.924	0.002	1.370	3.934	0.000
Gender	Female				0.739	2.095	0.017	0.877	2.403	0.007
Age					-0.031	0.970	0.008	-0.035	0.966	0.004
Education					0.097	1.102	0.440	0.071	1.073	0.588
Perceived health status					0.504	1.655	0.001	0.487	1.627	0.002
Region	North							-1.910	0.148	0.000
Size of town	Population 20,000 - 99,999							0.372	1.451	0.379
Size of town	Population <20,000							0.623	1.864	0.102
Distance to nearest hospital								0.046	1.047	0.007

Table 65: Logistic Regression Model Predicting Forgone Care (n=1,147)

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	0.733	2.081	0.001	0.760	2.138	0.005	0.885	2.422	0.004
Gender	Female				0.964	2.621	0.000	0.992	2.697	0.000
Age					-0.038	0.963	0.000	-0.040	0.960	0.000
Education					0.074	1.077	0.453	0.064	1.066	0.525
Perceived health status					0.351	1.421	0.006	0.330	1.391	0.010
Region	North							-1.386	0.250	0.000
Size of town	Population 20,000 - 99,999							0.551	1.736	0.055
Size of town	Population <20,000							0.891	2.438	0.004
Distance to nearest hospital								0.025	1.026	0.070

Table 64: Logistic Regression Model Predicting Report of Time Elapsed between Request for Referral and Visit to Specialist As Being Not So Reasonable or Not at All Reasonable among KHC Members (n=203)

		Model 1			Model 2			Model 3			Model 4		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	0.886	2.425	0.015	0.904	2.469	0.033	1.028	2.796	0.038	1.412	4.105	0.025
Gender	Female				-0.048	0.953	0.873	-0.114	0.893	0.726	-0.317	0.728	0.437
Age					-0.020	0.981	0.049	-0.021	0.979	0.049	-0.044	0.957	0.004
Perceived health status					0.300	1.350	0.069	0.330	1.391	0.068	0.322	1.380	0.172
Education					-0.035	0.966	0.782	-0.103	0.902	0.447	-0.046	0.955	0.790
Size of town	Population <20,000							0.609	1.839	0.222	0.684	1.981	0.294
Size of town	Population 20,000 - 99,999							1.239	3.451	0.003	1.661	5.262	0.002
Region	North							-0.740	0.477	0.090	-0.728	0.483	0.164
Distance to nearest hospital								0.037	1.038	0.126	0.050	1.051	0.098
Method of access to specialist	Direct							0.639	1.895	0.053	1.108	3.029	0.008
Time interval between request for referral and specialist visit											1.456	4.289	0.000

Table 63: Logistic Regression Model Predicting Report of Time Elapsed between Request for Referral and Visit to Specialist As Being Not So Reasonable or Not at All Reasonable (n=368)

		Model 1			Model 2			Model 3			Model 4		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	0.896	2.451	0.001	0.840	2.316	0.008	1.014	2.756	0.009	1.849	6.351	0.000
Gender	Female				0.186	1.205	0.428	0.126	1.135	0.606	-0.054	0.948	0.860
Age					-0.016	0.985	0.053	-0.019	0.982	0.027	-0.028	0.972	0.011
Perceived health status					0.257	1.293	0.055	0.232	1.261	0.101	0.255	1.290	0.165
Education					-0.035	0.965	0.716	-0.107	0.899	0.300	-0.087	0.917	0.495
Sick fund	KHC				0.593	1.809	0.014	0.699	2.012	0.006	0.395	1.485	0.211
Size of town	Population - - <20,000							-0.199	0.820	0.593	-0.397	0.673	0.408
Size of town	Population 20,000 - 99,999							0.707	2.028	0.021	0.739	2.094	0.050
Region	North							-0.488	0.614	0.163	-0.456	0.634	0.270
Distance to nearest hospital								0.043	1.044	0.016	0.051	1.052	0.018
Mode of access to specialist	Direct							0.567	1.762	0.034	1.035	2.814	0.002
Time interval between request for referral and specialist visit											1.454	4.282	0.000

Table 62: Logistic Regression Model Predicting Visiting a Specialist during the Past Three Months (n=975)

		Model 1			Model 2			Model 3			Model 4		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	-0.562	0.570	0.001	-0.317	0.728	0.091	-0.197	0.821	0.306	-0.374	0.688	0.083
Gender	Female				0.452	1.572	0.001	0.401	1.493	0.004	0.372	1.451	0.008
Age					0.002	1.002	0.677	0.002	1.002	0.645	0.004	1.004	0.495
Perceived health status					0.305	1.357	0.000	0.336	1.400	0.000	0.349	1.417	0.000
Education					0.114	1.121	0.055	0.083	1.086	0.174	0.077	1.080	0.214
Method of access to specialist	Direct							0.428	1.534	0.004	0.417	1.517	0.006
Region	North										0.303	1.355	0.136
Size of town	Population <20,000										0.191	1.211	0.312
Size of town	Population 20,000 - 99,999										0.143	1.154	0.405
Sick fund	KHC										-0.180	0.835	0.239

Table 61: Logistic Regression Model Predicting Travel Time to Primary Care Physician Being Not So Reasonable or Not At All Reasonable (n=1077)

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Sig	B	Exp B	Sig	B	Exp B	Sig
Nationality	Arab	1.448	4.253	0.000	1.270	3.560	0.000	1.624	5.072	0.000
Gender	Female				0.262	1.299	0.240	0.068	1.070	0.788
Age					-0.008	0.992	0.320	-0.009	0.991	0.302
Education					-0.163	0.849	0.097	-0.214	0.807	0.052
Perceived health status					0.394	1.483	0.001	0.275	1.316	0.048
Region	North				0.326	1.385	0.237	0.492	1.636	0.119
Size of town	Population <20,000				-0.062	0.940	0.823	0.053	1.055	0.868
Size of town	Population 20,000 - 99,999				-0.202	0.817	0.467	-0.379	0.685	0.242
Travel time to physician								1.178	3.247	0.000

Table 60: Logistic Regression Model Predicting Expenditures for Private Physician (n=1031)

		Model 1			Model 2		
Variable	Entered as:	B	Exp B	Significance	B	Exp B	Significance
Nationality	Arab	-0.431	0.650	0.153	-0.216	0.806	0.556
Gender	Female				0.288	1.334	0.215
Age					-0.002	0.998	0.813
Education					0.135	1.144	0.208
Perceived health status					0.092	1.096	0.521
Income					0.058	1.060	0.338
Number of people in household					0.081	1.084	0.145
Sick fund	KHC				-0.334	0.716	0.154

Table 59: Logistic Regression Model Predicting Health Expenditures being a Substantial Burden (n=1,014)*

		Model 1			Model 2		
Variable	Entered as:	B	Exp B	Significance	B	Exp B	Significance
Nationality	Arab	-0.799	0.450	0.000	-0.842	0.431	0.001
Gender	Female				0.137	1.147	0.394
Age					-0.001	0.999	0.821
Education					-0.172	0.842	0.018
Perceived health status					0.226	1.253	0.017
Income					0.065	1.067	0.123
Sick fund	KHC				0.181	1.198	0.283

*It should be noted that the results of this analysis are dependent on the way the dependent variables categories are collapsed, i.e. a comparison of expenditures being a substantial or moderate burden versus a minor burden or no burden at all would not yield any difference between Arabs and Jews.

Table 58: Logistic Regression Model Predicting Perceived Improvement in Sick Fund Service Level among KHC Members (n=604)

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Significance	B	Exp B	Significance	B	Exp B	Significance
Nationality	Arab	1.309	3.702	0.000	1.111	3.038	0.000	1.160	3.188	0.000
Age					0.003	1.003	0.594	0.003	1.003	0.618
Gender	Female				-0.007	0.993	0.970	-0.003	0.997	0.984
Education					-0.095	0.909	0.194	-0.103	0.903	0.163
Perceived health status					-0.224	0.799	0.027	-0.233	0.792	0.022
Region	North							0.075	1.078	0.747
Size of town	Population <20,000							-0.298	0.742	0.193
Size of town	Population 20,000 - 99,999							0.030	1.030	0.891

Table 57: Logistic Regression Model Predicting Perceived Improvement in Sick Fund Service Level (n=980)

		Model 1			Model 2			Model 3		
Variable	Entered as:	B	Exp B	Significance	B	Exp B	Significance	B	Exp B	Significance
Nationality	Arab	1.600	4.936	0.000	1.431	4.183	0.000	1.375	3.956	0.000
Age					0.001	1.000	0.807	-0.002	0.998	0.658
Gender	Female				-0.128	0.880	0.366	-0.072	0.931	0.616
Education					-1.285	0.883	0.039	-0.099	0.906	0.108
Perceived health status					-0.100	0.905	0.242	-1.136	0.873	0.115
Sick fund	KHC							0.648	1.911	0.000
Region	North							-0.096	0.909	0.640
Size of town	Population <20,000							0.058	1.060	0.756
Size of town	Population 20,000 - 99,999							0.152	1.164	0.388

Table 56: Logistic Regression Model Predicting Chronic Illness or Physical Disability of at Least Six Months' Duration (n=1,183)

		Model 1			Model 2		
Variable	Entered as:	B	Exp B	Significance	B	Exp B	Significance
Nationality	Arab	-0.556	0.573	0.033	-0.435	0.647	0.131
Age					0.040	1.041	0.000
Gender	Female				-0.189	0.828	0.304
Education					-0.099	0.905	0.208

Appendix II: Logistic Regression Models

Table 55: Logistic Regression Model Predicting Good and Very Good Perceived Health Status (n=1,169)

		Model 1			Model 2		
Variable	Entered as:	B	Exp B	Significance	B	Exp B	Significance
Nationality	Arab	0.843	2.323	0.001	0.782	2.186	0.002
Age					-0.063	0.939	0.000
Gender	Female				-0.694	0.500	0.000
Education					0.152	1.163	0.023

Table 54: continued

Topic	Group 1 vs. Group 2	Group 3 vs. Group 2	Group 2 vs. Group 4	Group 4 vs. Group 5
Lower rate of forgone care due to distance of service	Group 1	no difference	no difference	**Group 4**
Higher rate of satisfaction with family physician's professional skills	Group 2	Group 2	Group 4	Group 5
Higher rate of satisfaction with family physician's interpersonal manner	Group 2	Group 2	Group 4	Group 5
Higher rate of satisfaction with nurses' interpersonal manner	Group 2	Group 2	no difference	Group 5
Higher rate of satisfaction with specialists' professional skills	Group 2	**Group 2**	Group 2	Group 4
Higher rate of satisfaction with clerks	Group 2	**Group 2**	no difference	no difference
Higher rate of satisfaction with selection of medications	Group 2	**Group 3**	**split**	**Group 4**
Higher rate of satisfaction with referrals to specialists	split	no difference	**Group 2**	**Group 4**
Higher rate of satisfaction with laboratory services	Group 1	**Group 3**	**split**	**Group 4**
Higher rate of satisfaction with facility maintenance	Group 2	**Group 2**	no difference	Group 5
Higher rate of general satisfaction with sick fund services	Group 1	Group 3	**Group 4**	**Group 4**
Higher rate of transfer among sick funds	Group 2	Group 2	**Group 2**	Group 4
Greater prevalence of supplemental insurance	Group 1	Group 3	no difference	no difference
Greater prevalence of commercial insurance	Group 1	**Group 3**	no difference	no difference

sub-groups. Importantly, Arabs from unrecognized villages were most likely to have household expenditures for private physicians and to report forgoing care due to the distance of a service from their home.

Table 54: Comparison of Sub-groups on Selected Questions[29]

The appearance of a sub-group in a particular cell indicates a higher "score" (e.g., in the comparison of Groups 1 and 2 regarding health status, those in Group 2 had better health). When the sub-group name appears in bold, the difference is statistically significant (χ_2 p-value <0.05).

Topic	Group 1 vs. Group 2	Group 3 vs. Group 2	Group 2 vs. Group 4	Group 4 vs. Group 5
Better self-reported health status	Group 2	**Group 2**	**Group 2**	no difference
Greater perceived improvements in level of health services	**Group 2**	**Group 2**	Group 2	Group 4
Smaller financial burden	Group 2	**split**	**split**	**Group 5**
Lower prevalence of household expenses for private physicians	no difference	no difference	**Group 2**	**Group 4**
Higher prevalence of having a regular family physician	Group 2	**Group 2**	**Group 2**	no difference
Shorter travel time to family physician	no difference	Group 2	Group 4	**Group 4**
Travel time to family physician more reasonable	**Group 1**	**Group 3**	no difference	**Group 4**
Shorter office wait for family physician	**Group 2**	**Group 2**	**Group 2**	Group 4
Office hours of family physician more convenient	Group 2	**Group 2**	Group 2	**Group 5**
Office staff hours more convenient	Group 2	**Group 2**	no difference	Group 4
Laboratory hours more convenient	Group 2	Group 2	**Group 4**	**Group 4**
Specialists' office hours more convenient	Group 2	**Group 2**	**Group 2**	**Group 4**
Higher rate of visits to specialists	**Group 1**	Group 3	Group 2	Group 5
Shorter office wait for specialists	Group 2	Group 2	Group 2	Group 4
Shorter wait for appointment to specialist	**Group 1**	**Group 3**	**Split**	**Group 5**

[29] Group 1 =Jews in the telephone survey
Group 2 = Arabs in the telephone survey
Group 3 = Jews from small towns (fewer than50,000 residents) not located in the vicinity of a large city
Group 4 = All Arabs interviewed Face-to-Face, except those in unrecognized villages
Group 5 = The sub-set of Arabs without telephones interviewed Face-to-Face in unrecognized villages.

Appendix I: Comparisons of Sub-groups of Arabs and Jews

General

This section and the accompanying table summarize three additional components of the data analysis in which different sub-groups of Arabs and Jews were compared.

A comparison of the responses of Arabs in the telephone survey and those of Jews from small towns (fewer than 50,000 residents) that are not located near large cities (i.e. Haifa, Tel Aviv-Jaffa, Jerusalem).

The pattern of findings was similar to that of the main study comparing Arabs to all Jewish respondents in the telephone survey. These results indicate that differences between Arabs and Jews on multiple dimensions of health care remain even after controlling in this way for size of town and proximity to a large city. One notable exception was that similar percentages of Arabs (12%) and Jews (10%) reported that they had foregone some type of medical service from their sick fund during the past year because the service was not close enough to their homes.

A comparison of the responses of Arabs without telephones and those of Arabs with telephones from similar-sized towns and villages in the same two study regions.

This comparison showed that Arabs without telephones have more or less the same types of problem as do Arabs overall, although some of their problems are more acute. Arabs without telephones were more likely to prefer seeing specialists through their family physician, more likely to report lower health status, and more likely to have a higher prevalence of household expenditures for private physicians. Additionally, they were less likely to have a regular family physician in their sick fund, transfer to a different sick fund, and report improvement in or overall satisfaction with sick fund services. On other aspects of care they were no different from other Arabs (e.g., forgone care, supplemental and commercial insurance, travel time to family physician). These findings suggest that Arabs without telephones experience additional barriers to services not faced by Arabs with telephones.

A comparison of the responses of Arabs without telephones from unrecognized villages and those of Arabs without telephones from recognized towns and villages.

Arabs in unrecognized villages were found to be a particularly vulnerable and geographically remote sub-group, who had acute problems receiving health care due to a lack of local services. None reported having transferred among sick funds since the implementation of the law - an indication of a lack of sick fund competition. Compared to other Arabs, they were more likely to travel by bus to their family physician; report longer travel times (in many cases more than one hour); find travel times to be unreasonable and office hours of family physicians and specialists to be inconvenient. None reported walking to their physician's office. Residents of unrecognized villages were less likely to report improvement in sick fund services than were Arabs from other

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Next Steps

To this end, we plan to compare the responses of Arabs and Jews respondents to the JDC-Brookdale Institute's next national survey of the general population planned for late 1999 or 2000. Special focus will be placed on understanding the following:

- The degree to which identified gaps remain between Arabs and Jews (e.g., travel distances to the hospital, hospital-based specialty clinics, and community-based emergency care centers (CBECC); utilization of specialists/sub-specialists, CBECCs, mental health professionals and preventative services; the prevalence of commercial and supplemental health insurance; the tendency to forgo care due to distance; satisfaction with emergency care; waiting times for specialty care; and travel times for primary care).
- The degree to which identified improvements in the health care of the Arab population are sustained (e.g., access to sick fund family physicians, reduced reliance on private physicians for after-hours emergency care, self-reported health status).
- The degree to which Arabs and Jews know their rights under the National Health Insurance Law.
- How the new co-payments have affected access to care in the two sectors.

It also remains important to assess whether Arabs in unrecognized villages remain a particularly vulnerable sub-group with acute problems receiving health care due to a lack of local services, and whether greater equity in health and health care is attained.

A 1998 survey of Israeli women (Gross & Bramli-Greenberg, forthcoming) found significant differences between rich and poor women regarding the likelihood of reporting:

a) difficulties in getting needed care,

b) not receiving a needed health care service,

c) not seeing a specialist despite a perceived need to do so, and

d) not fulfilling a prescription because of the cost.

Note that these issues were not explored in the NHI survey which serves as the basis for the analysis presented in this paper. Because of the high correlation between income level and ethnicity, it is quite possible that gaps in these areas also exist between Arabs and Jews. This should be explored in future research.

Lastly, it is important to recognize that the National Health Insurance Law is not expected to eliminate all gaps between Arabs and Jews. In addition to health system factors that can be controlled or affected by the law, health and access to health services are determined by an array of socio-economic, cultural, behavioral and environmental factors.

The Arabs' relatively low utilization of mental health professionals (psychologists and psychiatrists) and greater utilization of family physicians for mental health problems may be related to differences in the availability of mental health professionals in the Arab and Jewish sectors, and to cultural differences between Arabs and Jews. In 1993, the CPHSAPI examined health services in the Arab sector and reported a need to reduce the relatively large gap in the availability of mental health services between the Arab and Jewish sectors and increase the number and training of Arabic-speaking mental health professionals (Ministry of Health, 1993).

Arabs without telephones were found to experience barriers to sick fund services (see Appendix I). For example, they had a higher prevalence of household expenditures for private physicians and were less likely to have a regular family physician in their sick fund or to transfer to a different sick fund. Arabs in unrecognized villages were found to be a particularly vulnerable and geographically remote sub-group, with acute problems receiving health care due to a lack of local services. Compared to other Arabs, they were more likely to travel by bus to their family physician; report longer travel times (in many cases more than one hour); report travel times to be unreasonable; and report family physician and specialist office hours to be inconvenient. None reported walking to their physician's office or having transferred among sick funds since implementation of the law; they were also less likely to report an improvement in sick fund services. Importantly, they were the most likely to have household expenditures for a private physician and to report having forgone care due to the distance of a service from their home.

Additional questions included in the face-to-face interview revealed a mixed picture of respondents' knowledge of their rights under the law (e.g., little knowledge of rights to emergency care and house calls by sick fund physicians). This topic warrants further investigation in various population groups. An open-ended question about respondents' perceptions of the major health-related problems in their village yielded responses consistent with the main findings of the telephone survey. More responses concerned either limited access to a variety of health services (e.g., ambulance, pharmacy, specialty, and emergency services) due to their distance from the respondents' homes (40%), or the timeliness of services (28%) (e.g., long waiting times for medications and specialty care). Other responses (32%) concerned public health and sanitation problems such as hereditary diseases, lack of municipal sewage services and garbage collection, and the need for education regarding rabies and home injuries.

The survey findings are consistent with the perceptions that the Arab population is of increasing priority to the sick funds and that the health care of the Arab population continues to improve. However, differences persist in the health care of Arabs and Jews, and the Arab population may still be of lower priority than the Jewish population. Ongoing assessments of future changes in the magnitude and direction of these differences will be important elements of any assessment of equity in health and health care in Israel, particularly in light of recent changes in copayment policies and practices of the sick funds.

Additionally, a number of related problems were found, which are likely due to the peripheral location of many Arab villages and Arabs' longer travel distances to various services, including hospitals and hospital-based outpatient specialty clinics, tertiary care centers, community-based emergency care centers and laboratories.

Importantly, Arabs were more likely to report forgoing health care due to the distance of a service, particularly specialty care, from their home. Within KHC, the pattern of findings was similar, though the difference between Arabs and Jews was even larger. Further, their distance from the nearest hospital and to community-based emergency care centers played a role for both Arabs and Jews who reported forgoing care. As noted, and regardless of whether they had forgone care, Arabs lived farther than Jews on average from hospitals and emergency centers. Because Arabs were twice as likely as Jews to have received specialty care in a hospital-based outpatient clinic, their greater distance from the nearest hospital represents at the least an inconvenience and at the most a potentially dangerous barrier to care that can contribute to under-utilization of care and delayed treatment.

Arabs were more likely than Jews to think that referral times to specialists (found to be shorter for Arabs than for Jews) and travel times to sick fund family physicians (found to be similar for Arabs and Jews) were not reasonable, and to be dissatisfied with the after hours emergency care they received. These findings are important, as one of the goals of the National Health Insurance Law is to provide timely and accessible health care services of reasonable quality to all segments of the population.

Differences between Arabs' and Jews' perceptions of what constituted reasonable travel times to sick fund physicians may be related to differences in rates of car ownership; the reduced availability of local public transportation in Arab towns and villages; poorer road conditions in Arab towns and villages; and the relative expense, time, distance and inconvenience Arabs associate with travel. Further, some Arabs need to travel outside their villages to see their family physician, a finding recently reported by Adler and Lottan (1997). That both Arabs and Jews reported being satisfied with numerous components of care underscores the significance of the Arabs' greater dissatisfaction with travel time to their family physician.

The Arabs' lower ratings of reasonableness of the time it takes to receive specialty care may be due to a more urgent need for care stemming possibly from under-utilization of services as a result of their distance from hospitals and other sources of care. It is also possible that their lower ratings of reasonableness are related to a subjective sense of the urgency of care, difficulties in the referral process, and the effort involved in reaching a specialist. Ratings of reasonableness were much lower among Arabs who had direct access to specialists than among Arabs who needed a referral from their family physician, and than among Jews who reported having direct access to specialists.

The high satisfaction levels found in this survey raise the question of whether or not they indicate high levels of service, particularly in the Arab sector. The 1996 panel of Arab reviewers commented that Arabs' satisfaction with services might be heavily influenced by their low expectations, their lack of consumerism, and the relatively low level of services in the Arab as compared to the Jewish sector. Under these conditions, any improvement in sick fund services might boost satisfaction to a greater degree among the Arab population than among the Jewish population. On the other hand, the finding that satisfaction levels among the Arabs were not uniform across all population sub-groups and components of care suggests that the higher levels of satisfaction in the 1997 survey do indeed reflect an improvement in the level of services.

Consistent with the findings of Arabs' improved access to various components of sick fund services are the findings indicating that the Arab population is less dependent on private physician services than it was in 1995. First, in 1997, few Arabs reported having a private physician, rather than a sick fund family physician as their regular primary care provider. Second, the percentage of Arab respondents who reported any expenditures for private physicians (excluding dentists) was significantly lower in 1997 than in 1995, and was no longer different from that reported by Jews. Third, unlike 1995, none of the Arab respondents in 1997 reported relying on a private physician for after-hours emergency care. This may be due in part to the growth in use of Hayat, a source of privately operated emergency services in some Arab towns and villages. Arabs also reported increased use of hospital emergency rooms, community-based emergency care centers (operated by the sick funds), and Magen David Adom for after-hours emergency care.

These changes reflect some increase in access to various types of after-hours emergency service for the Arab population, which in turn may improve the quality of emergency care for Arabs, given that private physicians in the Arab sector may have less access to equipment and specialists than do hospital and community-based emergency care facilities. However, Arabs reported less utilization of community-based emergency services than did Jews, most likely because of the reduced availability of such services to the Arab population. The Arabs' high rates of utilization of hospital emergency rooms for after-hours care suggest that improvements must still be made in this area, particularly given that Arabs were found to live at a greater distance, on average, from the nearest hospital than did Jews.

In addition to differences in utilization of community-based emergency services, differences between Arabs and Jews were found to persist in the following areas:

- utilization of specialists/sub-specialists and mental health professionals;
- the provision of preventative services (blood pressure testing);
- the prevalence of commercial health insurance; and
- the prevalence of having and knowing about supplemental insurance.

family physician in their sick fund improved; the prevalence of any household expenditures for private physicians and the use of private physicians for after-hours emergency care diminished; and self-reported health status improved. Notably, nearly all of the Arab respondents reported having a regular family physician affiliated with their sick fund, and most had had the same physician for the past three years. Having long-term access to a regular family physician affiliated with the sick fund is likely to enhance the continuity of care of the Arab population.

Furthermore, the language spoken by the family physician in the sick fund was not found to be a barrier to care for almost all Arab respondents. Improvements were also found with regard to the waiting times for primary and specialty care. Compared to 1995, Arabs reported shorter waiting times to see their family physician and shorter lag time between their request for referral and the visit to a specialist. Overall, Arabs waited less time than did Jews between the request for referral and the actual visit to the five most common types of specialist, analyzed together. There was also a significant increase in the percentage of Arabs reporting that the specialist's office hours were very convenient, or convenient, relative to 1995. Furthermore, Arabs were less likely than Jews to report that their expenditures for health constituted a substantial financial burden. Another indicator of improved access to sick fund services in the Arab sector is the higher rate of sick fund transfers since the inception of the law reported by Arabs, as compared to Jews. The finding that 71% of the Arab respondents, as opposed to 34% of the Jewish ones, reported an overall improvement in the level of sick fund services is consistent with the improvements in various aspects of care noted above. However, the gap between Arabs' and Jews' perception of improvement has widened since 1995.

A greater percentage of Arab respondents than Jewish respondents reported that their health status was very good or good in 1995. In 1997 this gap increased. This change may be related to improvements in access to health care for the Arab population, and to Arabs' greater sense of improvement in the level of services. A more in-depth understanding of changes in the level of services for Arabs and Jews will require information on the sick funds' allocation of resources to different population groups and sub-groups, as well as on changes in the quality of care.

Based on the large increase in the percentage of Arab respondents who perceived improvement in the level of sick fund services (from 30% in 1995 to 71% in 1997), one might expect a major increase in overall satisfaction with sick fund services; however, no such increase was found. Instead, small but statistically significant increases were found in Arabs' satisfaction levels with all but two components of care, relative to 1995. It is possible that improvements in the various components of care which we measured were not judged to be essential to the respondents' overall satisfaction and that addressing other problems summarized below might be more essential to Arabs' overall satisfaction with sick fund services.[28]

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28 Indeed, the bi-variate correlation coefficient between overall satisfaction and overall improvement was very low (0.13 for Arabs and 0.21 for Jews).

Forty percent (40%) of the responses (n=47) were categorized as being related to a lack of health services due to distance (Table 53). Most frequently mentioned was lack of service due to distance from the sick fund (n=14), from ambulance services (n=10), and from services in general (n=11). Others mentioned distance to emergency, pharmacy, and specialty services as well as distance from maternal and child health centers. Another 28% of the responses identified problems related to the timeliness of services. The most frequently mentioned problem was long waiting time for medication (n=14), followed by long waiting time for primary care (n=7) and specialty care (n=5). The remaining 32% of responses were related to public health and sanitation problems. Of these, hereditary disorders (n=14) and lack of municipal sewage services (n=9) were mentioned most frequently. Others mentioned the problem of road cleanliness and garbage collection, and the need for education regarding rabies and home accidents.

Summary of Findings and Discussion

The National Health Insurance Law has been viewed as an important step toward the advancement of health care services for the Israeli Arab population. First, by providing universal health insurance coverage, the law eliminated one dimension of inequality in health care between Arabs and Jews, i.e.– Arabs' lower prevalence of sick fund insurance prior to the law. Second, the law's capitation system, which finances each sick fund based on the number of its members and their age mix, but not income levels, was expected to make the Arab population more financially attractive to the sick funds. This, in turn, was expected to increase sick fund competition in the Arab sector and raise the level of health services.

Indeed, in the JDC-Brookdale Institute's 1995 survey of the general population eight months after implementation of the law (Farfel, Rosen, Berg and Gross, 1996), Arabs were significantly more likely than Jews to report perceiving an increase in the level of their sick fund services. The 1995 survey also provided evidence of a reduction of some differences in health care between Arabs and Jews, including in Arabs' lower prevalence of commercial insurance and higher prevalence of household expenditures for private physicians. Anecdotal evidence provided by Arab colleagues indicated that there had been an increase in the number of clinics of the various sick funds already established or being developed in some Arab towns and villages since implementation of the law. Yet, despite some improvements, known differences between Arabs and Jews were found to persist, including Arabs' lower utilization of specialists. Differences between Arabsand Jews not previously known were also identified, including Arabs' greater likelihood of not having a regular family physician and not having or knowing about supplemental insurance, and Arabs' lower reported reasonableness of travel time to their primary care provider.

The findings of the current survey show further improvements in the health and health care of the Arab population two and a half years after implementation of the law, and the elimination of some gaps between Arabs and Jews, alongside the persistence of others. For Arabs, access to a regular

An Open-Ended Question about Health-Related Problems in their Village

Arabs without telephones were asked an open-ended question about their perception of the major health-related problems in their village (e.g., health services provided by the sick funds and hospitals, illnesses, and public health problems).[27]

Table 53: Perceptions of Major Health-Related Problems among Arab Respondents in Face-to-Face Interviews

Problem	N	% Responses
Lack of service due to distance	**47**	**39.5**
Sick fund clinic	14	11.8
Ambulance services	10	8.8
Maternal and child health services	4	3.4
Emergency services	3	2.5
Pharmacy	3	2.5
Specialists	2	1.7
Other	11	9.6
Insufficient Level of Care or Long Wait	**33**	**27.7**
Medications	14	11.8
Primary physician	7	5.9
Specialists	5	4.2
Other	7	5.9
Public Health Issues	**19**	**16.0**
Hereditary disorders	14	11.8
Health education regarding home accidents	3	2.5
Health education regarding rabies	2	1.7
Local City Services	**18**	**15.1**
Sewage	9	7.6
Road cleanliness	5	4.2
Garbage collection	4	3.4
Other	**2**	**1.7**
Total	119	100

27 Respondents could cite up to 3 problems.

Table 52: Knowledge of Rights Among Arab Respondents in Face-to-Face Interviews (n=237) (%)

	Free of Charge/ Full Reimbursement	Payment on First Visit in Quarter	Partial Payment	Full Payment	Don't Know	Total
Visit to a primary physician	**97.9**	**0.2**	0.5	1.0	0.3	100.0
Physician house call outside of clinic hours	43.1	1.4	**5.0**	**28.5**	22.0	100.0
Visit to a specialist	**67.4**	**0.9**	1.7	6.3	23.7	100.0
Ambulance service in case of hospitalization	**17.5**	0.7	4.4	12.0	65.4	100.0
Emergency room visit with referral	**53.8**	0.0	1.1	0.5	44.6	100.0
Hospitalization (exclusive of elective surgery)	**83.2**	0.0	0.5	1.3	15.0	100.0
Dental care for adults (including fillings and extractions)	1.1	0.7	**1.5**	**80.5**	16.2	100.0

Answers in bold represent the correct responses.

Most respondents did not know their rights with regard to emergency care. Specifically, nearly half (45%) responded "don't know" when asked about their right to emergency room care with referral from a sick fund physician; nearly all the others (54%) responded correctly that the service was free of charge. Only 9% responded "full payment" when asked about their right to emergency room services without referral, and in the event that a person is not admitted to the hospital; 53% did not know. Eighty-three percent (83%) of the respondents stated correctly that admission to the hospital for most surgical procedures, excluding plastic surgery, was free of charge; 15% responded that they did not know. Most (81%) respondents correctly reported that dental care for adults required full payment; 16% did not know their right to such care.

A logistic regression revealed that women and older respondents were more likely not to know their rights than men and younger respondents. Also, those living close to emergency care centers were more likely to know their rights.

Commercial Insurance

A lower percentage of Arabs (7% of those with telephones, 6% of those without telephones) than Jews (19%) reported having any commercial insurance, including dental insurance; this difference was statistically significant (χ_2 p-value <0.01 – Table 51). This difference remained statistically significant after controlling for sick fund (KHC versus the other sick funds) and income. The difference between Arabs and Jews in 1995 was not statistically significant (11% versus 16%). Further, the change between 1995 and 1997 was not statistically significant for Jews or Arabs. According to the 1993 *Family Expenditure Survey* (Central Bureau of Statistics, 1994a), 5% of Arab families and 15% of Jewish families had expenditures for commercial insurance (including dental insurance) prior to the law; this difference was statistically significant.

Table 51: Prevalence of Commercial Insurance, by Population Group (%)

	Jews '95 (n=1258)	Jews '97 (n=958)	Arabs '95 (n=115)	Arabs '97 (n=233)	Arabs Face-to-Face (n=237)
Yes	16.2	18.6	11.3	6.9	5.9
No	83.8	81.4	88.7	93.1	94.1
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Knowledge of Rights under the National Health Insurance Law

Arabs without telephones were asked a series of questions concerning their knowledge of their right to some basic health care services (primary, secondary, hospital and emergency care) under the National Health Insurance Law.[26] Respondents were also asked if they knew whether these services were free of charge (or fully reimbursable), or required partial or full payment. Arabs without telephones had relatively good knowledge of their right to visit primary care providers and specialists and to be admitted to the hospital for surgery, and relatively little knowledge of their right to after-hours house calls, emergency care and ambulance services.

Nearly all (98%) respondents knew that access to a primary care provider (family physician, general practitioner or pediatrician) was free of charge under the law (52). However, when asked about after-hours house calls, 43% of the respondents gave incorrect responses or reported that they did not know what rights they had under the law (22%). A higher percentage of Arabs in unrecognized villages (35%) than other Arabs without telephones (21%) reported not knowing their rights. Most (69%) respondents provided correct responses regarding their right to specialty care (free of charge or partial payment in 1997); however, nearly one-quarter of the respondents reported that they did not know what their rights were concerning specialty care.

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26 The questions relating to knowledge of rights were not included in the telephone interview because of its length. The face-to-face interview, on the other hand, was carried out within a more comfortable environment and therefore included these questions, as well as one about health-related problems.

It should be noted that the difference in actual prevalence of supplemental insurance is not known, since a significantly higher percentage of Arab than Jewish members of all sick funds reported that they did not know whether they had supplemental insurance (19% and 5%, respectively; χ^2 p-value <0.01). This was also the case in 1995.

The Arabs' smaller likelihood of having supplemental insurance may be due in part to their being less informed about it. Forty-seven percent (47%) of Arabs with telephones, 69% of Arabs without telephones, and 31% of Jews reported that they had not received any information about supplemental insurance (Table 50). Only 18% of Arabs and 25% of Jews reported that the information they had received met their needs. The remainder either reported that the information they had received was partial, or that they did not know whether it was adequate. We did not ask about the language in which the information was provided; if the Arab population received information in Hebrew only, this may have influenced their likelihood of reading it. Further, the apparent difference in how supplemental insurance is marketed to Arabs and Jews may be related to a lack of supplemental services for the Arab population; difficulty reaching subgroups of the Arab population through the mail; the sick funds' potential perception that the Arab population is less likely to purchase supplemental insurance for financial or other reasons; or the sick funds' potential perception that the Arab population is less profitable than the Jewish population.

Table 50: Receipt of Information about Supplemental Insurance, by Population Group (%)

	Jews '95 (n=1216)	Jews '97 (n=943)	Arabs '95 (n=111)	Arabs '97 (n=229)	Arabs Face-to-Face (n=238)
Yes	31.7	24.9	18.0	17.5	8.4
Partial info	32.8	15.5	64.9	3.9	3.8
Received info but didn't meet needs	16.8	8.5	4.5	3.1	4.2
Received info	9.6	30.9	6.3	46.7	68.5
Can't remember, didn't explore	9.0	20.3	6.3	28.8	15.1
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

The 1997 findings also indicate that Arabs show only limited interest in purchasing supplemental insurance in the future. Eighty-eight percent (88%) of Arabs -- as opposed to 41% of Jews, who reported that they did not have supplemental insurance or did not know whether they had it -- reported that they did not know whether they would purchase such insurance within the next year. Less than 1% of Arabs and 11% of Jews reported intending to purchase supplemental insurance. Again, these findings may be due to differences in the degree to which Arabs and Jews were informed about supplemental insurance.

Supplemental and Commercial Insurance

Supplemental Insurance

Arab respondents were much less likely to report having supplemental insurance through their sick fund than were Jewish respondents (12% versus 43%; χ_2 p-value <0.01 – Table 48). Arab respondents were much more likely to report not knowing whether they had such insurance (19% versus 6%; χ_2 p-value <0.01). Both of these findings remained statistically significant after controlling for age, education, income, and sick fund (Table 71). The change in reported prevalence of supplemental insurance between 1995 and 1997 was statistically significant for Jews (an increase from 38% to 43%) but not for Arabs (a decrease from 16% to 12%).[25]

Table 48: Supplemental Insurance Ownership, by Population Group (%)

	Jews '95 (n=1255)	Jews '97 (n=961)	Arabs '95 (n=109)	Arabs '97 (n=233)	Arabs Face-to-Face (n=238)
Yes	38.1	42.8	15.6	12.0	7.1
No	52.7	51.6	67.9	69.5	82.4
Don't know	9.2	5.6	16.5	18.5	10.5
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Since the majority of Arab respondents are members of KHC, and since supplemental insurance coverage is smaller there than in other sick funds, Arabs and Jews were also compared within KHC. The difference in reported prevalence of supplemental insurance among Arab and Jewish members of KHC – which serves the majority of both populations – was statistically significant (7% of Arab members and 25% of Jewish members; χ_2 p-value <0.01 – Table 49). The difference between Arabs and Jews was somewhat smaller after controlling for income, but remained statistically significant.

Table 49: Supplemental Insurance Ownership among KHC Members, by Population Group (%)

	Jews '95 (n=702)	Jews '97 (n=543)	Arabs '95 (n=83)	Arabs '97 (n=174)	Arabs Face-to-Face (n=203)
Yes	15.7	25.4	9.6	6.9	4.4
No	73.4	69.1	73.5	73.6	85.7
Don't know	11.0	5.5	16.9	19.5	9.9
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

25 Among Arabs without telephones, 7% reported that they had supplemental insurance and 11% did not know whether they had it.

Table 46: Sick Fund Perceived to Offer Better Services(%)

	Jews '97 (110)	Arabs '97 (11)	Arabs Face-to-Face (n=34)
KHC	1.8	0.0	2.9
Maccabi	74.5	36.4	50.0
Leumit	10.0	9.1	35.3
Meuchedet	13.6	54.5	11.8
Total	100.0	100.0	100.0

$p<0.01$

Sick Fund Transfers

Arab respondents reported a higher rate of transfer among sick funds since the beginning of 1995 than Jews (12.5% among Arabs versus 6.7% among Jews (χ_2 p-value <0.05), and 10% among Arabs without telephones - Table 47). This difference appears to be due in large part to the higher rate of transfer among Arab respondents during the first eight months of 1995 (7.8% among Arabs versus 1.2% among Jews) – that is, at the first opportunity to transfer under the National Health Insurance Law.[24] Arabs may have transferred at a higher rate than Jews during 1995 because they were more likely than Jews to have been uninsured prior to the law's implementation and because previously uninsured Arabs may have transferred from the sick fund to which they were initially randomly assigned because their sick fund did not offer services close to their homes.

Table 47: Sick Fund Transfer, by Population Group (%)

	Jews '95 (n=1279)	Jews '97 (n=963)	Arabs '95 (n=115)	Arabs '97 (n=232)	Arabs Face-to-Face (n=237)
No previous insurance	1.5	0.0	1.7	0.0	0.0
Transfer	1.2	6.7	7.8	12.5	10.1
No transfer	97.3	93.3	90.4	87.5	89.9
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

It should be noted that the 1995 and 1997 survey data do not indicate the degree to which these findings reflect an increase in the availability of sick fund facilities in Arab towns following implementation of the law, an increase in the ability of the Arab population to use geographically distant services, or a high level of awareness among Arab respondents of the right to enroll in their sick fund of choice without being rejected.

24 Data provided by the National Insurance Institute indicate that the transfer rate among Arabs from KHC was higher in smaller towns than in larger ones.

Table 43: Satisfaction with Laboratory Services, by Population Group (%)

	Jews '95 (n=940)	Jews '97 (n=786)	Arabs'95 (n=76)	Arabs '97 (n=206)	Arabs Face-to-Face (n=219)
Very satisfied	26.4	24.8	6.6	20.4	32.0
Satisfied	53.6	59.7	72.4	46.6	41.1
Not so satisfied	13.0	9.5	10.5	30.6	10.5
Not satisfied	7.0	6.0	10.5	2.4	16.4
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Table 44: Satisfaction with Facility Maintenance, by Population Group (%)

	Jews '95 (n=1146)	Jews '97 (n=923)	Arabs '95 (n=96)	Arabs '97 (n=220)	Arabs Face-to-Face (n=236)
Very satisfied	39.4	42.3	32.3	65.5	66.9
Satisfied	54.0	53.7	66.7	30.5	28.4
Not so satisfied	4.0	2.7	1.0	3.6	3.0
Not satisfied	2.5	1.3	0.0	0.5	1.7
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Obtaining Better Service from Another Sick Fund

When asked whether they could obtain better service from another sick fund, 35% of the Jews and 11% of the Arabs reported that they did not know; 12% of the Jews and 5% of the Arabs reported that they believed that another sick fund would offer better service (Table 45)[23]. Of those who reported believing that a sick fund with better service exists, most Jews reported the better sick fund to be Maccabi (75%), while most Arabs reported believing the better sick fund to be Meuchedet (55% – Table 46). An additional 36% of Arabs reported believing that the better sick fund was Maccabi.

Table 45: Is It Possible to Obtain Better Services from Another Sick Fund? (%)

	Jews '97 (n=949)	Arabs '97 (n=229)	Arab Face-to-Face (n=237)
Yes	11.8	5.2	13.9
No	53.1	83.4	56.1
Don't know	35.1	11.4	30.0
Total	100.0	100.0	100.0

$p<0.01$

23 The question posed to the respondent was: "In your opinion, can you obtain better medical services in another sick fund?"

Table 39: Satisfaction with Specialist's Professional Skills, by Population Group (%)

	Jews '95 (n=971)	Jews '97 (n=780)	Arabs '95 (n=77)	Arabs '97 (n=212)	Arabs Face-to-Face (n=196)
Very satisfied	29.4	28.6	18.2	41.5	28.6
Satisfied	48.8	56.3	68.8	51.4	47.4
Not so satisfied	15.6	10.6	5.2	5.7	10.7
Not satisfied	6.3	4.5	7.8	1.4	13.3
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Table 40: Satisfaction with Interpersonal Skills of Clerical Staff, by Population Group (%)

	Jews '95 (n=1,083)	Jews '97 (n=855)	Arabs '95 (n=89)	Arabs '97 (n=219)	Arabs Face-to-Face (n=223)
Very satisfied	25.8	24.0	23.6	51.1	53.4
Satisfied	55.0	56.8	62.9	42.5	39.9
Not so satisfied	13.3	14.3	10.1	5.9	4.9
Not satisfied	5.9	4.9	3.4	0.5	1.8
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Table 41: Satisfaction with Selection of Medications, by Population Group (%)

	Jews '95 (n=982)	Jews '97 (n=770)	Arabs '95 (n=95)	Arabs '97 (n=171)	Arabs Face-to-Face (n=231)
Very satisfied	24.0	19.7	12.6	28.7	29.6
Satisfied	51.5	57.0	61.1	50.3	37.3
Not so satisfied	13.7	14.2	15.8	19.9	15.9
Not satisfied	10.7	9.1	10.5	1.2	17.2
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Table 42: Satisfaction with Ease of Obtaining Referrals, by Population Group (%)

	Jews '95 (n=1030)	Jews '97 (n=840)	Arabs '95 (n=90)	Arabs '97 (n=219)	Arabs Face-to-Face (n=231)
Very satisfied	30.5	29.5	22.2	26.5	38.1
Satisfied	48.4	49.4	64.4	54.3	31.6
Not so satisfied	10.9	12.3	4.4	17.4	10.4
Not satisfied	10.2	8.8	8.9	1.8	19.9
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Table 35: Satisfaction with Sick Fund in General, by Population Group (%)

	Jews '95 (n=1191)	Jews '97 (n=923)	Arabs '95 (n=96)	Arabs '97 (n=220)	Arabs Face-to-Face (n=236)
Very satisfied	26.1	29.3	18.0	21.4	34.2
Satisfied	57.3	61.9	72.0	69.5	50.6
Not so satisfied	13.3	7.1	5.0	8.6	14.3
Not satisfied	3.4	1.7	5.0	5.0	8.0
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Table 36: Satisfaction with Family Physician's Professional Skills, by Population Group (%)

	Jews '95 (n=1094)	Jews '97 (n=885)	Arabs '95 (n=77)	Arabs '97 (n=218)	Arabs Face-to-Face (n=234)
Very satisfied	33.7	33.6	26.0	41.7	42.7
Satisfied	47.8	53.4	66.2	48.2	43.6
Not so satisfied	13.0	9.6	5.2	8.7	9.4
Not satisfied	5.5	3.4	2.6	1.4	4.3
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

Table 37: Satisfaction with Family Physician's Interpersonal Skills, by Population Group (%)

	Jews '95 (n=1116)	Jews '97 (n=899)	Arabs '95 (n=81)	Arabs '97 (n=220)	Arabs Face-to-Face (n=236)
Very satisfied	47.6	48.9	39.5	53.6	55.5
Satisfied	42.3	42.6	54.3	40.9	39.8
Not so satisfied	6.3	5.7	3.7	5.0	3.0
Not satisfied	3.9	2.8	2.5	0.5	1.7
Total	100.0	100.0	100.0	100.0	100.0

$p=0.04$

Table 38: Satisfaction with Nursing Staff's Interpersonal Skills, by Population Group (%)

	Jews '95 (n=842)	Jews '97 (n=714)	Arabs '95 (n=89)	Arabs '97 (n=215)	Arabs Face-to-Face (n=229)
Very satisfied	37.2	33.3	22.5	52.6	57.2
Satisfied	49.5	56.0	66.3	41.9	36.2
Not so satisfied	8.6	8.0	9.0	5.1	5.2
Not satisfied	4.8	2.7	2.2	0.5	1.3
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

The 1996 panel of reviewers from the Arab sector commented on the strong preference of Arab women for receiving preventive services from women physicians. They noted that some Israeli Arab women traveled to towns in the West Bank (Tulkarm and Jenin) in order to be examined by a woman physician. Unfortunately, this survey did not ask women if they would request or consent to preventive testing, if it were performed by a woman physician.

Satisfaction with Sick Fund Services

Twenty-one percent (21%) of the Arab respondents said that they were very satisfied with their sick fund services, and 70% said that they were satisfied (35). The percentages of Jews who were very satisfied or satisfied with sick fund services were 29% and 62%, respectively. This represents a significant improvement in Jews' overall satisfaction with sick fund services since 1995. As for Arabs, the improvement was statistically significant but less dramatic. In 1997, there was a significant difference in the percentage of Arabs and Jews who were very satisfied (OR=0.66, p-value=0.02 – Table 69). This difference grew after controlling for age, gender, education and self-reported health status (OR=0.44, p-value<0.01), and diminished somewhat after controlling for sick fund, size of town, and region (OR=0.53, p-value<0.01).[22]

Regarding specific components of care (e.g., the professional level of physicians, interaction with staff, available medications, laboratory services, referrals, and maintenance of facilities), the majority (generally over 70%) of Arabs and Jews again reported being satisfied or very satisfied, as opposed to being not satisfied or not so satisfied (Table 36 through Table 44). In both groups, satisfaction was highest with facility maintenance and lowest with laboratory services, the selection of medications, and the ease of obtaining referrals. It should be noted that, in 1997, the satisfaction levels of Arab respondents with eight out of nine components of care were higher than those of Jewish respondents. The only component of care with which Arabs were less satisfied than Jews was laboratory services.

However, the high satisfaction levels of Arab respondents concerning the above service components are not reflected in higher levels of overall satisfaction. It is possible that the overall satisfaction levels are affected by factors not addressed by the current study. It should also be noted, however, that in 1997 there was a very strong correlation between satisfaction with laboratory services and overall satisfaction.

In 1997, Arabs were more likely to report being very satisfied with each component of care than they were in 1995. Among Jewish respondents, very high satisfaction levels increased in 1997 in only two areas.

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22 However, it should be noted that the difference between the Jewish and Arab respondents who reported being very satisfied or satisfied with sick fund services was not significant, and remained non-significant after controlling for the same variables (Table 70).

Mammogram

Under the National Health Insurance Law, a mammogram is recommended every two years for women over age 50. Arab women aged 50 years and older were significantly less likely (21%) to have ever had a mammogram, covered by their sick fund, than were Jewish women aged 50 years and older (61%) (χ_2 p-value <0.01 – Table 34). After controlling for age, self-reported health status, education level, sick fund, region and size of town, Arab women aged 50 years and older remained significantly less likely to have reported ever having had a mammogram (OR=0.16, p-value<0.01 –Table 68). Similar findings were obtained for women aged 50 to 65 years old in 1995, when 22% of Arab women and 60% of Jewish women reported having undergone a mammogram (χ_2 p-value <0.05).

Table 34: Ever Had a Mammogram, by Population Group (%)

	Jews '95 (n=687)	Jews '97 (n=524)	Arabs '95 (n=47)	Arabs '97 (n=130)	Arabs Face-to-Face (n=106)
Yes	51.5	61.3	33.3	20.8	3.7
No	48.5	38.7	66.7	79.2	96.3
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Reported incidence and mortality rates associated with breast cancer are approximately four times higher among Jewish Israeli women than among Arab Israeli women (Ministry of Health, 1994; Central Bureau of Statistics, 1992).[21] Given this, some might argue that the lower prevalence of ever having had a mammogram reported by Arab women is appropriate.

The purpose of testing – screening or diagnosis – was not asked, but may have contributed to the differences found between Arab and Jewish women. We would expect testing for diagnostic purposes to be more prevalent among Jewish women, given their higher incidence rates of breast cancer.

Cultural factors undoubtedly account in part for the lower rates of testing to detect breast cancer reported by Arab women. However, interpretation of our findings is limited by a lack of comparative information on the promotion of testing by providers in each sector, on Arab and Jewish women's knowledge about what constitutes an examination and its importance, and on the extent to which Arab and Jewish women request these preventive services.

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21 In 1989, the adjusted incidence rates of female breast cancer per 100,000 persons (standardized using the world population as the standard population) were 78.4 for Jewish Israeli women and 21.2 for Arab Israeli women. For the same year, breast cancer mortality rates per 100,000 persons in the population were 19 for Jewish women and six for Arab women.

Selected Aspects of Preventive Care

Health promotion and disease prevention are designated to be covered by the National Health Insurance Law, though they remain largely undefined in the mandated basic basket of sick fund services. The policies and actual practices of the sick funds, both overall and with regard to specific population groups, are unclear at this time and will warrant investigation in the future. This survey included questions about the receipt of only two types of preventive service. All respondents were asked when they had last received a blood pressure test by a physician or nurse, excluding tests done during a hospital stay, and women were asked if they had ever had a mammogram, provided by their sick fund.

Blood Pressure

Twenty-five percent (25%) of the Arab respondents, and 10% of the Jewish respondents, reported that they had never had a blood pressure test administered by a sick fund physician or nurse (χ_2 p-value <0.01 – Table 33).[20] The difference between Arabs and Jews remained statistically significant after controlling for age, gender, education level, self-reported health status, sick fund, size of town, and region (OR=3.5, p-value<0.01 – Table 67).

Table 33: Last Blood Pressure Test, by Population Group (%)

	Jews '95 (n=1135)	Jews '97 (n=857)	Arabs '95 (n=95)	Arabs '97 (n=226)	Arabs Face-to-Face (n=186)
Past month	28.6	26.4	13.7	31.9	30.1
1-6 months	23.3	24.3	15.8	17.3	32.3
6-12 months	14.0	13.2	16.8	7.1	15.1
1-2 years	9.4	12.7	8.4	11.5	7.0
2-5 years	7.6	9.6	9.5	5.8	8.6
Over 5 years	3.7	4.1	4.2	1.8	2.2
Never	13.4	9.8	31.6	24.8	4.8
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

These findings are similar to those from the 1995 survey, when 32% of the Arabs and 13% of the Jews reported that they had never had a blood pressure test (χ_2 p-value <0.01). The difference between Arabs and Jews in 1995 also remained statistically significant after controlling for age, gender, education level, sick fund, size of town, and region.

20 Only 5% of Arabs without telephones reported that they had never had such a test.

no Arabs reported using private physicians for after-hours emergency care, possibly due in part to the apparent growth in the availability and use of Hayat (Table 31).

Arabs' greater use of hospital emergency rooms for after-hours emergency care may be due in part to a lack of after-hours emergency care facilities in Arab villages and towns, as well as to more limited access to other sources of emergency care.[19] On the other hand, changes in the reported variety of after-hours emergency care between 1995 and 1997 may indicate an improvement in the quality of emergency care for Arabs, as the private physicians on whom they used to rely for emergency care probably had less access to equipment and specialists than do the emergency care facilities on which they now rely.

Even so, the Arabs' high rates of utilization of hospital emergency rooms for after-hours care suggests that significant improvements still need to be made in this area, particularly given that, on average, Arabs were found to live at a greater distance from the nearest hospital than were Jews.

Satisfaction with Emergency Care

Arabs who reported using emergency services were less likely than Jews to be satisfied with their emergency care (χ_2 p-value <0.01 – Table 32). Most Arabs who used emergency services reported that they were not satisfied (20%) or not so satisfied (37%) with their emergency care. Among Jews who reported using emergency services, "only" 14% were not satisfied and 12% were not so satisfied with their emergency care.

Table 32: Satisfaction with Emergency Care, by Population Group (%)

	Jews '97 (n=140)	Arabs '97 (n=35)	Arabs Face-to-Face (n=17)
Very satisfied	37.9	8.6	17.6
Satisfied	35.7	34.3	52.9
Not so satisfied	12.1	37.1	23.5
Not satisfied at all	14.3	20.0	5.9
Total	100.0	100.0	100.0

p<0.01

19 In 1993, the CPHSAPI reported a complete lack of a system of community-based emergency services for the majority of Arab villages and towns (Ministry of Health, 1993), and recommended training ambulance drivers and volunteers, providing night emergency services, and acquiring ambulances for 50 Arab villages and towns over a four-year period. A more recent survey found that only one Arab settlement had local Magen David Adom service, and that six others provided their own emergency services (Zidani, 1996).

Table 30: Utilization of Emergency Care, by Population Group (%)

	Jews '97 (n=963)	Arabs '97 (n=233)	Arabs Face-to-Face (n=237)
Yes	16.0	15.0	7.2
No	84.0	85.0	92.8
Total	100.0	100.0	100.0

$p<0.01$

Compared to 1995, an increased percentage of Arabs reported receiving care in hospital emergency rooms (from 41% of the Arabs who reported using emergency services in 1995, to 58% in 1997), in sick-fund owned emergency medical centers (from 3% in 1995 to 11% in 1997), and from Magen David Adom (from 0% in 1995 to 8% in 1997). Similarly, an increased percentage of Jews who used emergency services reported receiving care at a sick-fund owned emergency medical center (from 19% in 1995 to 28% in 1997).[18]

Table 31: Source of Emergency Care, by Population Group (%)

	Jews '95 (n=288)	Jews '97 (n=149)	Arabs '95 (n=29)	Arabs '97 (n=36)	Arabs Face- to-Face (n=16)
Hospital emergency room	42.7	41.6	41.4	58.3	25.0
Not-for-profit community-based urgent care clinic					
MARAM	19.4	28.2	3.4	11.1	0.0
MDA	16.0	7.4	0.0	8.3	18.8
TEREM	1.7	2.0	0.0	2.8	0.0
Physician services					
Hayat	0.0	0.0	0.0	13.9	0.0
Private physician (clinic or home)	11.1	10.1	44.8	0.0	18.8
House call by sick fund physician	0.0	5.4	0.0	5.6	37.5
SHARAL (for-profit night service)	0.0	4.7	0.0	0.0	0.0
Other	9.0	0.7	10.3	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

In 1995 Arabs and Jews differed greatly in their utilization of private physicians for after-hours emergency care (45% of the Arabs who reported using services, versus 11% of the Jews). In 1997,

18 It is interesting to note that Arabs without telephones who used emergency services reported less use of hospital emergency rooms (25%) and more treatment during a home visit by a sick fund physician (38%) than Arabs with telephones.

Table 28: Recently Sought Professional Help for Mental Distress, by Population Group (%)

	Jews '97 (n=222)	Arabs '97 (n=57)	Arabs Face-to-Face (n=59)
Yes	41.4	19.3	32.2
No	58.6	80.7	67.8
Total	100.0	100.0	100.0

p=0.01

Arabs and Jews who sought help for mental health problems differed greatly in where they turned for help. Arabs most often turned to a family physician (44%) or to a social worker (19%), whereas Jews most often turned to a psychiatrist (37%) psychologist (33%), or their family physician (29% – Table 29). This difference may be ascribed to the availability of professional services, and to cultural differences between Arabs and Jews in health seeking behavior, social support and other factors. Regarding the availability of services, it is important to note that in 1993 the CPHSAPI, which examined health services in the Arab sector, reported a need to reduce the relatively large gap between Arabs and Jews in the availability of mental health services and increase the number and training of Arabic-speaking mental health professionals (Ministry of Health, 1993).

Table 29: Type of Mental Health Professional Seen, by Population Group (%)

	Jews '97 (n=90)	Arabs '97 (n=11)	Arabs Face-to-Face (n=17)
Psychiatrist	36.8	14.8	39.6
Psychologist	33.0	14.8	8.7
Family physician	28.6	44.0	20.8
Social worker	9.7	18.5	30.9
Neurologist	8.1	7.4	0.0
Other	2.7	0.0	0.0

Emergency Services

Similar percentages of Arabs (15%) and Jews (16%) reported needing unspecified emergency treatment after clinic hours during the six months preceding the survey (this difference was not statistically significant –30). The most common source of emergency care used by Arabs and Jews was a hospital emergency room (58% of Arabs and 42% of Jews – Table 31). The next most common source of care for Arabs was Hayat, a private after-hours emergency service operating in some Arab villages (14%). A lower percentage of Arabs (11%) than Jews (28%) reported receiving care from a community-based emergency medical center (MARAM).

hand, Arabs were less likely than Jews to report forgoing primary care (e.g., family physician, nursing services): 14% of Arabs and 25% of Jews reported forfeiting primary care due to distance.

Further, distance to the nearest hospital and to the nearest community-based emergency care center (CBECC) played a role in both Arabs' and Jews' forgoing care.[17] For Arabs who reported forgoing care, the mean distances to the nearest hospital (13.6 km) and to the nearest CBECC (11.4 km) were greater than the mean distances for Arabs who did not forgo care: 10.1 km to the nearest hospital and 5.6 km to the nearest CBECC. For Jews who forfeited care, the mean distances were 7.2 km to the nearest hospital and 2.0 km to the nearest CBECC, compared to 4.5 km to the nearest hospital and 1.3 km to the nearest CBECC for Jews who did not forgo care. These data also show that Arabs, regardless of whether or not they forfeited care, were more distant on average than Jews from hospitals and community-based emergency care centers.

Since Arabs were twice as likely as Jews to report having received specialty care at a hospital-based outpatient department, their greater distance from the nearest hospital is at the least an inconvenience and at the most a potentially dangerous barrieto care, which may also contribute to under-utilization of care and delayed treatment.

Mental Health

One-quarter of both Arabs (26%) and Jews (24%) reported having at some time experienced mental distress (e.g., depression, high level of stress, deep sadness) with which they could not cope alone (this difference was not statistically significant – Table 27). Although the total number of Arabs who reported seeking help for mental distress was small (n=11), it is important to note that Arab respondents who acknowledged mental distress were significantly less likely to report having sought help (19%) than were Jewish respondents (41%) (χ_2 p-value <0.05 – Table 28). These findings are similar to those of the 1995 survey.

Table 27: Mental Distress by Population Group (%)

	Jews '95 (n=1218)	Jews '97 (n=946)	Arabs '95 (n=109)	Arabs '97 (n=229)	Arabs Face-to-Face (n=238)
Yes	24.3	23.6	28.4	25.8	24.8
No	75.7	76.4	71.6	74.2	75.2
Total	100.0	100.0	100.0	100.0	100.0

p=0.81

17 For each town, the air distance to all general acute care hospitals and to all community-based emergency care centers were computed based on a list of hospitals for 1996 obtained from the Ministry of Health, and a list of CBECCs obtained from Mark Taragin of the JDC-Brookdale Institute. For example, if an emergency room or CBECC was located in the same town as the respondent, the computed distance was zero.

Care Forgone Due to Distance

One of the goals of the National Health Insurance Law is to provide heath care service within a reasonable distance of peoples' homes. Nearly twice as many Arab respondents with and without telephones (14%) than Jewish respondents (8%) reported that they had forgone some type of medical care from their sick fund during the past year because the service was not sufficiently close to their homes (Table 25).

Table 25: Services Forgone Due to Distance, by Population Group (%)

	Jews '97 (n=966)	Arabs '97 (n=231)	Arabs Face-to-Face (n=31)
Yes	7.7	13.9	13.1
No	92.3	86.1	86.9
Total	100.0	100.0	100.0

$p<0.01$

This difference remained statistically significant after controlling for age, gender, education and self-reported health status (OR=2.1, 65). The difference between Arabs and Jews increased further when region, distance to the nearest hospital and size of town were taken into account (OR=2.4, p-value <0.01). Furthermore, forgone care was higher in small and medium-sized towns than in large towns with more than 100,000 residents. Within KHC, the pattern of findings was similar (66), although the difference between Arabs and Jews was even greater(OR=3.9, p-value <0.01). Among Arab respondents, living far from the nearest hospital provided a potentially significant impetus to forgo receiving care; also among Arabs, women and those not living in the north were more likely to forgo care.

Table 26: Types of Service Forgone Due to Distance, by Population Group (% respondents)*

	Jews '97 (n=71)	Arab'97 (n=28)	Arabs Face-to-Face (n=29)
Specialty care	54.9	96.4	34.5
Obtaining medication from pharmacy	2.8	0.0	48.2
Nursing services	12.7	7.1	17.2
Visiting the family physician	12.7	7.1	0.0
X-Ray examination	4.2	7.1	6.9
Other	18.3	7.1	6.9

* Exceeds 100% because each respondent could cite more than one service.

Respondents were also asked to specify the type of care they forfeited due to distance. Arab respondents were more likely to forgo specialty care (96% of them forfeited receiving specialty care compared to 55% of Jewish respondents who forfeited receiving care (Table 26)). On the other

not report having direct access to such care, or among Jews who reported having direct access to specialty care.

Specialist's Office Hours

Twenty-five percent (25%) of the Arab respondents reported that the specialist's office hours were very convenient, and 57% reported that they were convenient (Table 24). This represents a statistically significant improvement from 1995, when 15% of the Arabs reported that the specialist's office hours were very convenient and 56% reported that they were convenient. In 1997 satisfaction with this aspect of access to specialty care was statistically significantly higher for Arabs than for Jews, 12% of whom reported the specialist's office hours to be very convenient, and 59% of whom reported them to be convenient.

Table 24: Convenience of Specialist's Office Hours, by Population Group (%)

	Jews '95 (n=925)	Jews '97 (n=775)	Arabs '95 (n=68)	Arabs '97 (n=215)	Arabs Face-to-Face (n=191)
Not convenient	10.8	10.2	8.8	4.7	31.9
Not so convenient	18.2	18.7	20.6	13.0	13.6
Convenient	57.9	59.4	55.9	57.2	33.5
Very convenient	13.1	11.7	14.7	25.1	20.9
Total	100.0	100.0	100.0	100.0	100.0

$p<0.01$

To control for the different mixes of specialists visited by Arabs and Jews, the data were re-analyzed using only the five most commonly visited types of specialist noted above. Overall, Arabs remained significantly more likely than Jews to report that the specialist's office hours were very convenient or convenient ($^2=9.3$ p-value<0.01) even after controlling for type of specialist visited.[15]

Access to Specialists

Respondents were also asked to report how they access a specialist – directly or through their family practitioner. Slightly more than one quarter (26%) of the Arab respondents reported having direct access to the specialist, as opposed to 50% of the Jewish respondents (χ_2 p-value<0.01). Most (70%) Arab respondents reported having access to specialists through their family physician.[16] These differences remain when KHC data is analyzed separately from that of other sick funds, although to a lesser extent.

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15 Compared to Arabs with telephones, Arabs without telephones were less likely to report that the specialist's hours were very convenient (21%) or convenient (34%).

16 Among Arabs without telephones, 94% reported having access to specialists through their family physician, and only 4% reported having direct access to specialists.

their request for and receipt of specialty care was not reasonable or not so reasonable (p-value <0.01). However, it should be noted that in 1997 Arabs were much less likely to report that referral times were not reasonable (as opposed to not so reasonable); this represents a significant improvement over 1995 (^{2}=9.3 p-value < 0.01).

Table 23: Reasonableness of Specialty Care Referral Time, by Population Group (%)

	Jews '95 (n=522)	Jews '97 (n=379)	Arabs '95 (n=29)	Arabs '97 (n=66)	Arabs Face-to-Face (n=50)
Reasonable	67.8	64.4	48.3	40.9	44.0
Not so reasonable	10.7	15.3	20.7	54.5	16.0
Not reasonable	21.5	20.3	31.0	4.5	40.0
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Differences in Arabs' and Jews' perceptions of waiting time in 1997 remained significant after controlling for age, gender, education, self-reported health status, and sick fund membership (OR=2.3, p-value<0.01 –63). When size of town, region, distance to the nearest hospital, and mode of access to specialist (direct, not direct) was added to the analysis, Arabs were still significantly less likely to find the waiting time for receipt of specialty care reasonable (OR=2.8, p-value <0.01). After controlling for the reported time elapsed between the request for a referral and the visit to a specialist, the difference between Arabs and Jews increased (OR=6.4 p-value<0.01) due to the shorter waiting times reported by Arab respondents.

Due to differences in referral procedures and the organization of services in the four sick funds, members of KHC were analyzed separately (Table 64). As was the case with the entire sample, Arab members of KHC were more likely to report that the time they waited to see a specialist was not at all reasonable or not so reasonable (OR=1.4, p-value=0.025). However, the difference between Jewish and Arab members of KHC was not as great as the difference between Arab and Jewish members of all four sick funds.

The Arabs' lower satisfaction with the time it took them to receive specialty care may be due to their more urgent need for care, which may result from potential under-utilization of services, which in turn may be a consequence of their greater distance from hospitals and other sources of care (see section below on forgone care). It is also possible that their lower satisfaction results from a subjective sense of the urgency of care, as well as actual difficulties with the referral process. The low satisfaction of Arabs, relative to Jews, was particularly noteworthy among those who reported that the elapsed time between their request for a referral and their visit to a specialist was two to seven days. Perhaps the Arabs' lower ratings of reasonableness are associated with the extra effort it takes them to reach the specialist. It is important to note that ratings of reasonableness were much lower among Arabs who reported having direct access to specialty care than among Arabs who did

Table 21: Clinical Setting of Specialist Visit, by Population Group (%)

	Jews '97 (n=404)	Arabs '97 (n=68)	Arabs Face-to-Face (n=50)
Sick fund clinic	58.4	64.7	54.0
Consultant's private office	32.7	14.7	22.0
Hospital outpatient clinic	8.9	20.6	24.0
Total	100.0	100.0	100.0

p=0.00

Time Elapsed between Request for Referral and Visit to Specialist

A higher percentage of Arabs (74%) than Jews (66%) reported waiting no more than one week between the request for and receipt of specialty services (Table 22). This difference was statistically significant (p-value<0.05).

Table 22: Specialty Care Referral Time, by Population Group (%)

	Jews '95 (n=534)	Jews '97 (n=379)	Arabs '95 (n=28)	Arabs '97 (n=68)	Arabs Face-to-Face (n=49)
A week or less	55.1	65.7	71.4	73.5	44.9
8- 14 days	16.7	12.7	14.3	19.1	20.4
15 days or more	28.3	21.6	14.3	7.4	34.7
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

This finding represents a significant improvement for the Arabs compared to 1995, particularly in the reduction (from 14% in 1995 to 7% in 1997) in the percentage of Arabs reporting having to wait two weeks or more to see a specialist. Among Jews, as well, there was an improvement in the percentage reporting waiting two weeks or more to see a specialist, which decreased from 28% in 1995 to 22% in 1997.

To control for the different mixes of specialists visited by Arabs and Jews, the data were re-analyzed using only the five most commonly visited specialists noted above. Overall, Arabs waited less time than Jews to see these five types of specialist, analyzed together. Specifically, 77% of Arabs and 67% of Jews reported waiting no more than one week between their request for and receipt of these specialty services (p-value<0.01). Thus, even after controlling for type of specialist visited, the findings remained the same.

Reported Reasonableness of Time Elapsed between Referral and Specialist Visit

Despite the improvement in the reported time between referral and specialist visit, 59% of the Arabs believed that the waiting time between their request for and receipt of specialty care was not at all reasonable or not so reasonable, compared to 36% of the Jews (p-value <0.01 – Table 23). In 1995, slightly lower percentages of Arabs (52%) and Jews (32%) believed that the waiting time between

Types of Specialist Visited

Arab respondents reported a different mix of specialist visits than did Jewish respondents. The specialist most commonly visited by the Arabs was an orthopedist, while the specialist most commonly visited by the Jews was an ophthalmologist (Table 20). Eighty-four percent of the Arabs who visited a specialist reported having visited one of the following five types of specialist: orthopedist; gynecologist; ophthalmologist; ear, nose and throat (ENT) specialist; or dermatologist. Among the Jews, 77% visited these five types of specialist, while the remainder visited other specialists and sub-specialists. To control for the different mixes of specialists visited by Arabs and Jews, the data presented below on time elapsed between request for referral and visit to specialist were re-analyzed using only the five most commonly visited specialists.

Table 20: Type of Specialist Visited, by Population Group (%)

	Jews '97 (n=393)	Arabs '97 (n=68)	Arabs Face-to-Face (n=46)
Orthopedic surgeon	17.6	23.5	30.4
Ophthalmologist	19.6	14.7	21.7
Gynecologist	17.8	19.1	23.9
Dermatologist	12.5	11.8	8.7
ENT specialist	9.2	14.7	6.5
General surgeon	7.1	5.9	0.0
Cardiologist	2.5	4.4	2.2
Chest and vascular surgeon	2.8	0.0	0.0
Urologist	2.5	0.0	0.0
Neurologist	2.0	1.5	0.0
Endocrinologist & diabetes specialist	1.5	0.0	2.2
Gastroenterologist	1.3	2.9	0.0
Other	3.6	0.5	0.0
Total	100.0	100.0	100.0

$p<0.01$

Clinical Setting

Although Arab respondents were less likely to report visiting a sub-specialist than were Jews, they were twice as likely as Jews to report visiting a specialist at a hospital-based outpatient clinic (21% versus 9%), and more likely than to Jews visit a specialist at a sick fund clinic (65% versus 58% – 21). One-third of the Jewish respondents reported visiting a specialist at a private clinic, as opposed to 15% of the Arab respondents (p-value <0.01). These difference are due in part to the fact that Arabs are more likely to be members of KHC, which has a different organizational structure and different referral procedures than the other sick funds. Controlling for sick fund membership, Arabs are still more likely to visit a specialist at a hospital-based outpatient clinic.

Somewhat lower proportions (approximately two-thirds) of both Arabs and Jews found laboratory office hours (for both testing and receiving results) to be convenient or very convenient (Table 18). Twenty four percent of the Arabs reported the hours to be very convenient, and 45% reported them to be convenient, compared to 8% and 58%, respectively, in 1995. Eighteen percent of the Jews reported the hours to be very convenient and 47% reported them to be convenient, compared to 14% and 53%, respectively, in 1995.

Specialty Care

Arab respondents were less likely to have reported visiting a specialist in their sick fund during the past three months than were Jewish respondents (30% and 42%, respectively; OR=0.57, p-value<0.05 – Table 19).[13] These findings were similar to those of the 1995 survey.

Table 19: Visited Specialist during the Past Three Months, by Population Group (%)

	Jews '95 (n=1247)	Jews '97 (n=967)	Arabs '95 (n=103)	Arabs '97 (n=231)	Arabs Face-to-Face (n=237)
Yes	43.1	41.8	28.2	29.9	20.7
No	56.9	58.2	71.8	70.1	79.3
Total	100.0	100.0	100.0	100.0	100.0

p=0.00

Controlling for gender, age, self-reported health status, and education, the difference between Arabs and Jews was no longer statistically significant, although Arabs still tended to visit specialists less than Jews (OR=0.72, Table 62). After controlling for direct access to specialists (see below), the difference between Arabs and Jews was further reduced (OR=0.82). This is due to the fact that Jews were more likely to report direct access than Arabs and the fact that direct access to specialty care was associated with higher rates of visits to specialists among Jews than among Arabs. Controlling for sick fund and size of town did not change the findings (OR=0.69).

In 1995, the difference between Arabs and Jews remained statistically significant after controlling for education, income, self-reported health status, sick fund, and size of town. After controlling for age, Arabs still tended to visit specialists less, although the difference was no longer statistically significant.[14]

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13 An even lower percentage of Arabs without telephones reported that they visited a specialist in their sick fund (21%).

14 According to the 1993 *Use of Health Services Survey* (Central Bureau of Statistics, 1994b), Israeli Arabs had significantly lower rates of visits to specialists than did Jews, even after controlling for age, gender, size of town, insurance status, the presence of chronic conditions, and region (Farfel and Rosen, 1996).

Table 16: Convenience of Family Physician's Office Hours, by Population Group (%)

	Jews '95 (n=1075)	Jews '97 (n=875)	Arabs '95 (n=77)	Arabs '97 (n=220)	Arabs Face-to-Face (n=235)
Not convenient	7.6	6.9	6.5	4.1	14.9
Not so convenient	15.3	16.7	2.6	10.9	10.6
Convenient	58.2	59.9	58.4	52.7	36.6
Very convenient	18.9	16.5	32.5	32.3	37.9
Total	100.0	100.0	100.0	100.0	100.0

p=0.00

General Office Hours and Hours for Laboratory Services

Among the Arab respondents, 37% reported that the reception hours of their sick fund's (non-medical) office staff were very convenient, and 53% reported that they were convenient (Table 17). This represents an increase in the percentage of Arabs reporting these hours to be very convenient compared to 1995 (when 15% of them reported the hours to be very convenient, and 72% of them reported them to be convenient). Among the Jewish respondents, 18% reported that the reception hours of their sick fund's (non-medical) office staff were very convenient, and 66% reported that they were convenient. These findings were similar to those for Jews in 1995.

Table 17: Convenience of General Office Hours, by Population Group (%)

	Jews '95 (n=1050)	Jews '97 (n=796)	Arabs '95 (n=85)	Arabs '97 (n=221)	Arabs Face-to-Face (n=224)
Not convenient	6.2	6.0	3.5	2.7	4.9
Not so convenient	10.6	9.8	9.4	6.8	7.6
Convenient	66.0	66.3	71.8	53.4	46.9
Very convenient	17.2	17.8	15.3	37.1	40.6
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Table 18: Convenience of Laboratory Service Hours, by Population Group (%)

	Jews '95 (n=1006)	Jews '97 (n=797)	Arabs '95 (n=76)	Arabs '97 (n=211)	Arabs Face-to-Face (n=227)
Not convenient	18.2	16.4	22.4	6.2	17.6
Not so convenient	15.3	19.2	11.8	25.1	11.0
Convenient	53.0	46.8	57.9	45.0	40.1
Very convenient	13.5	17.6	7.9	23.7	31.3
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

substantially higher percentage of the variance in the reasonableness of travel time for Arabs (34%) than for Jews (11%). The biggest drop in reported reasonableness of travel time for Arabs occurred after five minutes of travel time. Also, Arabs who traveled by car to their family physician tended to be less satisfied with travel time than other Arabs, although the difference was not statistically significant.

Differences between Arabs' and Jews' perceptions of what constituted reasonable travel times may be related to differences in rates of car ownership; the reduced availability of local public transportation in Arab towns and villages; poorer road conditions in Arab towns and villages; and the relative expense, time, distance and inconvenience Arabs associate with travel. Further, some Arabs need to travel outside their villages to see their family physician, a finding reported by Adler and Lottan (1997). That both Arabs and Jews reported similar satisfaction with numerous other components of care underscores the importance of the Arabs' greater dissatisfaction with the reasonableness of travel time to their family physician compared to the Jews.

Waiting Time at the Clinic

A significantly higher percentage of Arabs (86%) than Jews (65%) reported that they waited no more than 15 minutes to see their family physician during their last visit (χ_2 p-value <0.05 – Table 15). Only 12% of both Arabs and Jews reported waiting more than 30 minutes. Compared to 1995, the increase in the percentage of respondents who reported waiting times of 15 minutes or less was greater for Arabs (from 66% in 1995 to 86% in 1997) than for Jews (from 59% in 1995 to 65% in 1997).

Table 15: Length of Waiting Time During Last Visit, by Population Group (%)

	Jews '95 (n=870)	Jews '97 (n=875)	Arabs '95 (n=59)	Arabs '97 (n=217)	Arabs Face-to-Face (n=221)
15 min or less	58.5	64.9	66.1	85.7	56.6
16-30 min.	25.4	23.1	20.3	1.8	16.3
30+ min.	16.1	12.0	13.6	12.4	27.1
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Convenience of Family Physician's Office Hours

Thirty-two percent (32%) of the Arab respondents reported that the office hours of their family physician were very convenient, and 53% reported that they were convenient (Table 16). Satisfaction with this aspect of access to care was higher among Arabs than among Jews (16% of whom reported office hours to be very convenient and 60% of whom reported them to be convenient). For both Arabs and Jews, the change relative to 1995 was not statistically significant.

Travel Time

On their most recent visit to their family physician, travel time was no more than 15 minutes for the majority (88%) of both Arab and Jewish respondents with a regular primary care physician (Table 13). Similar percentages of Arabs and Jews reported travel times of 16-30 minutes (10%), and over 30 minutes (2%).[11]

Table 13: Travel Time to Primary Physician, by Population Group (%)

	Jews '95 (n=902)	Jews '97 (n=891)	Arabs '95 (n=64)	Arabs '97 (n=222)	Arabs Face-to-Face (n=226)
15 min or less	84.1	88.2	85.9	87.8	81.0
16-30 min.	11.6	9.8	12.5	9.9	8.8
30+ min.	4.2	2.0	1.6	2.3	10.2
Total	100.0	100.0	100.0	100.0	100.0

p=0.00

Despite the similarity in travel times, Arabs were much more likely to report that their travel time was not so reasonable or not reasonable (21% and 3% of Arabs so reported, compared to 5% and 2% of the Jews; p-value <0.01 – Table 14).[12] These findings were similar to those of the 1995 survey, except that in 1997 Arabs were less likely to report that travel times were not reasonable (as opposed to not so reasonable); this represents a significant improvement since 1995 (p-value < 0.01).

Table 14: Reasonableness of Travel Time to Family Physician, by Population Group (%)

	Jews '95 (n=894)	Jews '97 (n=884)	Arabs '95 (n=64)	Arabs '97 (n=216)	Arabs Face-to-Face (n=228)
Reasonable	90.4	93.1	78.1	75.9	67.5
Not so reasonable	5.5	5.2	9.4	21.3	15.4
Not reasonable	4.1	1.7	12.5	2.8	17.1
Total	100.0	100.0	100.0	100.0	100.0

p=0.00

This difference between Arabs and Jews remained statistically significant (OR=3.6, p-value <0.001) after controlling for demographic variables (age, gender, education and perceived health status), size of town and region. After controlling for travel time in the model, the difference between Arabs and Jews increased further (OR=5.1, p-value <0.001). The relationship between travel time and reported reasonableness of travel time was much stronger for Arabs than Jews; travel time explained a

11 Arabs without telephone were more likely to report travel times of over 30 minutes (10%).

12 Arabs without telephones were even more disappointed with the travel time to their family physician: 17% reported that their travel times were not reasonable, and 15% reported that they were not so reasonable.

patient's health problems and past treatments. In fact, most Arabs (78%) and Jews (64%) reported that they have had the same family physician for three years or more.

Comfort Level with Language

The language spoken by the sick fund family physician was not an important barrier to care. Ninety-three percent (93%) of Arab respondents with and without telephones and 97% of Jewish respondents reported that they felt very comfortable with the language used by their family physician (Table 11). Most of the Arabs who reported not being comfortable with the language spoken by their physician reported that he spoke Hebrew; most of them reported feeling "not so comfortable" (as opposed to "not comfortable").

Table 11: Comfort with Language Used by Family Physician, by Population Group (%)

	Jews '97 (n=829)	Arabs '97 (n=226)	Arabs Face-to-Face (n=224)
Very comfortable	97.0	93.4	93.8
Not so comfortable	2.3	4.9	4.5
Not comfortable	0.7	1.8	1.8
Total	100.0	100.0	100.0

p=0.07

Mode of Travel

Significant differences were not found regarding how Arabs and Jews traveled to their most recent appointment with their regular family physician. Similar percentages (42%) of Arabs and Jews reported traveling in a private vehicle (Table 12). Arabs were slightly more likely to have walked (53%, versus 49% of the Jews) and less likely to have traveled by bus or taxi (4%, versus 9% of the Jews).

Table 12: Mode of Travel to Family Physician, by Population Group (%)

	Jews '95 (n=906)	Jews '97 (n=898)	Arabs '95 (n=64)	Arabs '97 (n=223)	Arabs Face-to-Face (n=226)
Walk	48.3	48.6	43.8	53.4	46.0
Car	40.6	42.2	48.4	42.6	49.6
Pub trns	11.0	9.2	7.8	4.0	4.4
Total	100.0	100.0	100.0	100.0	100.0

p=0.01

Table 9: Family Expenses for Private Physicians, by Population Group (%)

	Jews '95 (n=1,255)	Jews '97 (n=968)	Arabs '95 (n=111)	Arabs '97 (n=233)	Arabs Face-to-Face (n=235)
Yes	18.4	9.4	21.6	6.9	19.1
No	81.6	90.6	78.4	93.1	80.9
Total	100.0	100.0	100.0	100.0	100.0

p=0.00

Access to and Use of Health Services

Primary Care

Respondents were asked whether they had a sick fund family physician or a private physician (paid for each visit) who cared for them on a regular basis. Those who reported having a regular physician were asked a series of questions related to their access to this physician and the timing of such care.[9]

Having a Regular Provider

Virtually all (99%) of the Arab respondents, including those without telephones (94%), and most (88%) of the Jewish respondents reported having a regular family physician who was affiliated with their sick fund (Table 10). This reflects an increase from 1995, which was greater for Arabs than Jews. (In 1995, 63% of Arabs and 75% of Jews reported having a regular family physician.) It should be noted that the change in the gap for Arabs and Jews might be due in part to changes in how the question was phrased.[10]

Table 10: Regular Family Physician, by Population Group (%)

	Jews '95 (n=1,239)	Jews '97 (n=959)	Arabs '95 (n=102)	Arabs '97 (n=231)	Arabs Face-to-Face (n=236)
Yes	74.9	88.3	62.7	99.1	94.1
No	25.1	11.7	37.3	0.9	5.9
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Having a regular primary care physician can improve the continuity and coordination of care, and hence the quality of care (Starfield, 1992). For example, visiting the same primary care physician over time can result in better identification, understanding, and use of important information about a

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9 Most Arabs (63%) and Jews (58%) reported that they had seen their family physicians during the past three months. Thus, the information provided by most respondents is based on direct and fairly recent experience with the health care system. Further, our findings indicate little reliance on private physicians for primary care, particularly among the Arab respondents.

10 In 1995, respondents were asked whether they had a family physician who treated them regularly. In 1997, respondents were asked whether they had a family physician affiliated with their sick fund who treated them regularly.

substantial burden (13%), and a higher percentage (44%) reported that these expenditures constituted a moderate burden.[7] After controlling for gender, age, education, income, self-reported health status, and sick fund, Arabs remained significantly less likely to report that their expenditures for health constituted a substantial financial burden (OR= 0.43, p-value<0.01 – Table 59).

Table 8: Financial Burden of Health Expenditures, by Population Group (%)

	Jews '95 (n=1,183)	Jews '97 (n=909)	Arabs '95 (n=103)	Arabs '97 (n=230)	Arabs Face-to-Face (n=237)
Substantial burden	19.9	24.8	21.4	12.6	31.6
Moderate burden	32.2	34.8	35.9	43.5	27.8
Minor burden	20.8	18.5	6.8	26.5	14.8
No burden	27.1	22.0	35.9	17.4	25.7
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

Family Expenditures for Private Physicians

A slightly lower percentage of Arab respondents (7%) than Jewish respondents (9%) reported having household expenditures for a private physician (excluding a dentist) during the three-month period prior to the survey (Table 9).[8] This difference was not statistically significant, even after controlling for income level, household size, region and sick fund (see 60). The percentage of Arabs and Jews reporting expenditures for private physician care had dropped significantly since 1995. This reduction was greater for Arabs (from 22% in 1995 to 7% in 1997, χ_2 p-value <0.01) than for Jews (from 18% in 1995 to 9% in 1997, χ_2 p-value <0.01). A related finding is the reduced use of private physicians for after-hours emergency care reported by Arab respondents between 1995 and 1997 (see section on emergency care). Prior to the National Health Insurance Law, a statistically significantly higher percentage of Arab households (31%) than Jewish households (16%) were estimated to have expenditures for private physicians (Central Bureau of Statistics, 1994a).

7 The degree of burden reported by Arabs without telephones was similar to that reported by Jews (32% reported substantial burden and 28% reported moderate burden).

8 A higher percentage of Arabs without telephones (19%) than those with telephone reported having such expenditures.

fund's services since implementation of the law. However, it is important to note that this change may be due in part to a change in how the question was phrased and its context.[5]

As noted, an improvement in services for the Arab population was anticipated as an outcome of the introduction of universal health insurance and the capitation system of financing sick funds. The findings of both surveys indeed provide evidence of a sustained increase in the level of health services to the Arab population, based on sick fund members' perceptions. Further, the 1996 panel of reviewers of the 1995 survey provided anecdotal evidence of the establishment of new clinics, including those affiliated with the three smaller sick funds, in Arab towns and villages in the Galilee and the adjacent area, referred to as the "little triangle".[6] They also noted an improvement in the availability of specialty and pharmacy services in one sub-district (Hadera). The reviewers commented that they were aware of plans to establish additional sick fund clinics in the Arab sector. More recently, new clinics were observed in villages and towns by one of the authors during the field component of this study.

A more in-depth understanding of changes in the level of services will require information on changes in the sick funds' allocation of resources (personnel, equipment, facilities) to different population groups since implementation of the law, objective measures of the quality of care, as well as input from key informants, colleagues and reviewers.

Perceived Changes in Health Expenditures

In 1995, the National Health Insurance Law made health tax payment rates progressive, thereby increasing tax payments for high-income households and decreasing them for low-income households. However, the reduction in taxe rates for the poor has been partially offset by a gradual increase in wages since 1995. In addition, there may have been a minor increase in co-payment levels during the period prior to the survey.

Survey respondents were asked about the degree to which total family expenditures for health (including the health tax and payments to private physicians) constituted a financial burden. Among the Jews, 25% of the respondents reported that family expenditures for health were a substantial burden, and 35% reported that they were a moderate burden (Table 8). A smaller percentage of the Arab respondents reported that family expenditures for health constituted a

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5 In 1995, respondents were asked to report whether their sick fund's services had improved or deteriorated (on a three-point scale) since implementation of the law. This question was posed after the respondents were asked to rate the improvement or deterioration of nine components of sick fund service (e.g., professional level of physicians, interactions with staff, selection of medications, laboratory services, referrals, facility maintenance, etc.). In 1997, respondents were only asked to report whether their sick fund's services had improved or deteriorated (on a three-point scale) relative to the previous year.

6 It was noted that in one city, Umm el Fahm, the number of sick fund clinics had grown from one, prior to the law's implementation, to six, as of June 1996.

Perceived Changes in the Level of Sick Fund Services during the Past Year

Most (71%) Arab respondents, compared to only one-third (34%) of Jewish respondents, reported sensing an overall improvement in the level of sick fund services (Table 7). Furthermore, Jewish respondents were much more likely to report sensing a worsening of services (10%, versus 0.5% of the Arabs). The difference in perceived changes in the level of sick fund services was statistically significant (χ_2 p-value <0.01).[4] More than half of both the Arab and Jewish respondents reported having had some contact with their sick fund during the three months prior to the survey (63% of the Arabs and 58% of the Jews); it is likely that their perceptions were based at least in part on this contact.

Table 7: Change in the Level of Services, by Population Group (%)

	Jews '95 (n=1,065)	Jews '97 (n=775)	Arabs '95 (n=92)	Arabs '97 (n=209)	Arabs Face-to-Face (n=222)
Improvement	14.7	33.8	28.3	71.3	62.2
No change	80.3	56.0	71.7	28.2	35.6
Deterioration	5.0	10.2	0.0	0.5	2.3
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

The likelihood of perceived improvement remained statistically significantly higher for Arabs than for Jews (OR=4.0, p-value<0.01 – see Table 57) after controlling for demographic variables (age, gender, education, perceived health status), sick fund (KHC versus the smaller sick funds), size of town, and region in a logistic regression model. The only other significant variable in the model was being a member of KHC (OR=1.9, p-value <0.01). The likelihood of perceived improvement remained statistically significantly higher for Arabs than for Jews (OR=3.4, p-value <0.01) when the same model was applied only to respondents who reported that they had not transferred among sick funds since implementation of the National Health Insurance Law in 1995.

In a similar logistic regression model fitted to the data for KHC members only, Arabs were significantly more likely to report perceiving an improvement in the level of the sick fund's services than were Jews (OR=3.2, p-value <0.01 – see Table 58).

These findings reflect an increase in perceived improvement among both Arabs and Jews (regardless of sick fund affiliation) relative to 1995, and a widening of the gap between Arabs and Jews. In 1995, 31% of Arabs and 16% of Jews reported perceiving an improvement in their sick

4 Lower percentages of Arabs without telephones (62%) and Arabs in unrecognized villages (43%) reported sensing an improvement in the level of their sick find's services.

Findings

The presentation of survey findings begins with self-reported health status. Other findings have been divided into those concerning perceived changes in the level of sick fund services, the degree to which health expenditures are perceived to constitute a financial burden to the family, and the prevalence of any family expenditures for private physicians; and those concerning the functioning of the health care system two and a half years following implementation of the law, i.e. access to, utilization of, and satisfaction with primary, specialty and preventative sick fund services, transfer among sick funds, utilization of mental health and after-hours emergency services, satisfaction with emergency services, and the acquisition of supplemental and commercial insurance. Differences found to be statistically significant in bi-variate and logistic regression analyses are noted. The findings refer to the telephone survey unless otherwise indicated. Comparisons with the situation eight months after implementation of the law are based on the findings of the JDC Brookdale Institute's 1995 survey of the general population (Farfel et al., 1997).

Self-Reported Health Status

Arabs were more likely than Jews to describe their health status as being "very good" (62% of Arabs versus 33% of Jews – see Table 3). The remainder of the Arab respondents described their health status as being "good" (25%), "fair" (9%), "not good" (3%) or "poor" (1%). The remainder of the Jewish respondents described their health status as being "good" (42%), "fair" (21%), "not good" (3%) or "poor" (2%). After controlling for age, gender, and education, Arabs were statistically significantly more likely than Jews to report that their health status was "very good" or "good" (odds ratio, hereafter OR=2.2, p-value <0.05 – see Table 55). Further, between 1995 and 1997, the percentage of Arab respondents who reported that their health status was "very good" or "good" increased – from 71% to 87% – compared to a more moderate increase among Jews (of from 67% in 1995 to 74% in 1997). This may be due to improvements in access to health care in the Arab sector, and to Arabs' greater sense of improvement in the level of services, described below.

Table 3: Overall Health Status, by Population Group (%)

	Jews '95 (n=1,217)	Jews '97 (n=948)	Arabs '95 (n=109)	Arabs '97 (n=229)	Arabs Face-to-Face (n=238)
Very good	30.2	32.7	41.3	61.6	45.8
Good	37.0	41.6	29.4	25.3	28.2
Fair	24.6	20.7	22.0	8.7	16.0
Not good	5.8	3.3	3.7	3.5	7.6
Poor	2.5	1.8	3.7	0.9	2.5
Total	100.0	100.0	100.0	100.0	100.0

p<0.01

A lower percentage of Arabs (8%) than Jews (13%) reported suffering from a chronic illness, handicap, or disability of at least six months' duration (χ^2p-value <0.05 – see Table 4). After controlling for age, gender and education, the difference between Arabs and Jews was no longer statistically significant (Table 56).

Table 4: Chronic Illness or Physical Disability of at Least Six Months' Duration , by Population Group (%)

	Jews '97 (n=963)	Arabs '97 (n=232)	Arabs Face-to-Face (n=237)
Yes	13.1	8.2	8.4
No	86.9	91.8	91.6
Total	100.0	100.0	100.0

p=0.03

Among those who reported having such conditions, Arabs were somewhat more likely than Jews to describe themselves as being very limited in performing activities of daily living (38%, as opposed to 31% of the Jews – see Table 5).

Table 5: Degree of Limitation in Performing Daily Activities, by Population Group (%)

	Jews '97 (n=122)	Arabs '97 (n=16)	Arabs Face-to-Face (n=21)
Very limited	31.1	37.5	23.8
Limited	41.8	12.5	42.9
Not so limited	12.3	37.5	28.6
Not limited	14.8	12.5	4.8
Total	100.0	100.0	100.0

p=0.06

Further, among those with a chronic condition, Arabs were less likely than Jews (29% versus 43%) to report that they could walk 400 meters from their home without difficulty (Table 6).

Table 6: Ability to Walk 400 Meters, by Population Group (%)

	Jews '97 (n=108)	Arabs '97 (n=14)	Arabs Face-to-Face (n=19)
Yes, without difficulty	42.6	28.6	15.8
Yes, with difficulty	28.7	42.9	21.1
With mechanical aid	6.5	7.1	31.6
With human aid	11.1	0.0	21.1
Not at all	11.1	21.4	10.5
Total	100.0	100.0	100.0

p<0.01

Table 1: (continued)

	Arabs in Telephone Survey (n=233)	Arabs without Telephones (n=237)	Jews in Telephone Survey (n=972)
Marital Status*			
Married	76	87	74
Divorced	1	1	5
Widowed	3	5	7
Unmarried	20	7	14
Working*			
Yes	47	42	69
No	53	58	31
Reason for not Working*			
Retired	4	13	42
Housewife	82	52	21
Unemployed	8	14	13
Disabled	6	21	12
Student	-	-	5
Other	-	-	7

* Chi Square p-value<0.05 when comparing Jews and Arabs in telephone survey. Due to rounding, some totals do not equal 100%.

Table 2: Respondents' Sick Fund Affiliation, by Population Group (%)

Sick Fund	Arabs in Telephone Survey	Arabs without Telephones	Jews in Telephone Survey
KHC	75	86	57
Maccabi	9	1	26
Leumit	7	11	8
Meuhedet	9	2	9

Table 1: Demographic Characteristics of the Study Population (in %)*

	Arabs in Telephone Survey (n=233)	Arabs without Telephones (n=237)	Jews in Telephone Survey (n=972)
Religion (Non-Jews)			
Muslim	81	95	n/a
Christian	13	1	n/a
Druze	6	4	n/a
Gender*			
Men	40	52	45
Women	60	49	55
Age*			
22-44	68	71	51
45-64	26	20	36
65+	6	9	13
Monthly Income (in NIS)*			
$\leq$ 5,000	75	84	40
5,001-7,000	16	11	17
7,001-10,000	6	4	17
>10,001	3	1	26
Education*			
No education/elementary school	53	54	13
Secondary school, yeshiva	31	35	34
Post-secondary school/university	16	11	54
Household Size (Persons)*			
1-2	12	20	28
3-5	45	40	56
$\geq$ 6	43	40	16
Size of Town (Population)*			
100,000+	16	-	53
50,000 to 99,999	11	-	8
20,000 to 49,999	18	-	20
10,000 to 19,999	23	-	6
2,000 to 9,999	27	84	5
< 2,000	5	16	8
Region*			
North	78	100	23
Central	21	-	63
South	1	-	15

The following naming convention is used in this report:

Jews – Jews in the telephone survey.

Jews from small towns – Jews from small towns (fewer than 50,000 residents) not located near a large city (i.e. Haifa, Tel Aviv-Jaffa, Jerusalem).

Arabs – Arabs in the telephone survey.

Arabs from small towns – Arabs from small towns (fewer than 50,000 residents).

Arabs without telephones – Arabs interviewed face-to-face, excluding those living in unrecognized villages.

Arabs from unrecognized villages – Arabs (without telephones) interviewed face-to-face, who were living in unrecognized villages.

Arabs interviewed face-to-face – All Arabs interviewed face-to-face (that is, those living in recognized and unrecognized villages).

The Study Population

The study population consisted of Arab and Jewish respondents to the telephone survey of the general population, as well as a supplemental sample of Arabs without telephones. Table 1 presents comparative demographic data for these three groups. The Arab respondents with and without telephones were mostly Muslim, though smaller numbers of them were Christian or Druze. The Arab respondents were younger, had larger households and lower levels of income and education, and were more likely to be living in small rural communities in the north of Israel than were the Jewish respondents. Half of the Arab respondents to the telephone survey, as opposed to only 11% of the Jewish respondents, lived in villages and towns of between 2,000 and 19,999 residents. Five percent of the Arab and 8% of the Jewish respondents lived in settlements with fewer than 2,000 residents. Arab respondents were also less likely to be working outside the home, primarily due to the relatively large percentage of housewives in the Arab study population. Compared to Arabs with telephones, Arabs without telephones had lower levels of income and education, were more likely to be unemployed or disabled (Table 1), and had lower perceived health status (Table 3) .

With regard to sick fund affiliation, Arab respondents were more likely than Jewish respondents to be enrolled in KHC (75% of the Arabs versus 57% of the Jews[3]), and less likely to be enrolled in the Maccabi Sick Fund (9% of the Arabs versus 26% of the Jews). Similar percentages of both groups were registered with the smaller Leumit and Meuhedet Sick Funds (Table 2).

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3 KHC membership among Arabs without telephones was higher (86%) and membership in Maccabi Sick Fund lower (1%) than it was among Arabs with telephones.

Households were defined as groups of people living together on a permanent basis in the same dwelling. Households without telephones were defined as (1) households without a telephone line, and (2) households whose telephone line had been disconnected for financial (not technical) reasons, and had no plans to reinstate telephone service for at least one month. Thus a household could have a cellular phone and still be classified as a household without a telephone. One adult over the age of 22 was randomly selected from each household identified as being without a telephone; a face-to-face interview was then conducted with that individual in his home, using the Arabic version of the telephone questionnaire. The face-to-face interview included a section (not included in the telephone interview) on the respondent's knowledge of his rights under the law, and an open-ended question about the respondent's perception of health-related problems in his village. The overall response rate among households without telephones was 80%.

Data Analysis

For the purpose of data analysis, Arab and Jewish respondents were assigned weights to reflect their household sizes. Further, data from the face-to-face interviews were weighted to take into account the probability of selection of the village, and the incomplete census in one town.

Data analysis involved two stages. During the first stage, comparisons were made between the responses of Arabs and Jews to telephone survey questions about variables of interest. Overall differences were assessed using the Pearson chi square test. During the second stage, differences in Arabs' and Jews' responses regarding selected items were analyzed using logistic regression to control for demographic differences, sick fund, region and size of town.[2] Further, some of the comparisons among Arabs and Jew were made using members of Kupat Holim Clalit (Israel's largest sick fund; hereafter, KHC) only, due to the small number of Arab members of Israel's three smaller sick funds. In the Appendix, three additional comparisons are briefly discussed, as follows:

1. A comparison of the responses of Arabs with telephones living in towns with fewer than 50,000 residents and those of Jews from small towns (fewer than 50,000 residents) that are not located near large cities (i.e. Haifa, Tel Aviv-Jaffa, Jerusalem).
2. A comparison of the responses of Arabs without telephones and those of Arabs with telephones from similar-sized towns and villages in the same two study regions.
3. A comparison of the responses of Arabs without telephones living in unrecognized villages and those of Arabs without telephones living in recognized villages.

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2 Most differences between Arabs and Jews remained statistically significant after controlling for multiple demographic (e.g., age, size of town) and socio-economic (e.g., education, income) variables. In some analyses, small sample sizes precluded statistical control of all co-variates of interest, and limited our statistical power to detect differences between the two groups.

Funding from the Israel National Institute for Health Policy and Health Services Research enhanced the collection of data from the Arab population in several ways. First, selected questions were added to the 1997 survey to address issues of particular importance to the Arab population (e.g., language barriers, access to specialty and emergency care, and visits to private physicians). Second, the number of Arabs in the telephone survey was doubled. Third, face-to-face interviews were conducted using the same survey instrument in over 200 Arab households without telephones in villages and towns throughout the north and "little triangle". This allowed for the investigation and comparison of the perceptions and use of health care among various Arab sub-groups, including Arabs living in unrecognized villages.

Methodology

Telephone interviews were conducted between August and November 1997 with 1,202 randomly selected permanent residents of Israel over age 22 (972 Jews and 233 Arabs).[1] For Arabic-speaking respondents, the questionnaire was translated into Arabic and administered by Arabic-speaking interviewers. The total response rate was 85%, and was higher for Arabs (90%) than Jews (80%). The term "Arab" encompasses Muslim Arabs, Christian Arabs, Druze, and other Hebrew-speaking Christian respondents who were born in Israel.

Based on the Central Bureau of Statistics' 1992/93 Family Expenditure Survey, a higher percentage of Arab households (26%) lacked telephones than Jewish households (5%) (Central Bureau of Statistics, 1994a). To better understand the potential bias in the telephone survey, as well as this potentially vulnerable sub-population, the 1997 survey included an additional sample of 237 Arabs without telephones from 18 small towns and villages (fewer than 10,000 residents) in the north (sub-districts 21-25) and an adjacent region referred to as the "little triangle" (parts of sub-districts 32, 41, 42). The sample included four "unrecognized" villages – that is, villages which have no official municipal status – one of which was inaccessible due to poor road conditions (and consequently was not surveyed), and another of which had no households without telephones. Unfortunately, resources did not allow for a national sample of Arab households without telephones.

The small towns and villages in the selected regions were of interest because they represented approximately one-third of the Arab population, and had the highest percentage of uninsured Arabs prior to the law (Central Bureau of Statistics, 1994a). The 18 small towns and villages were randomly selected after stratifying by region (north, "little triangle"), religion (Muslim, Christian, Druze), and size of town (population under 2,000; population between 2,000 and 4,999; and population between 5,000 and 9,999). Households without telephones (as defined below) were identified through a complete door-to-door census in all but one small town, where a partial census was done.

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1 Arab respondents included residents of East Jerusalem.

Introduction

Arabs living in Israel constitute the country's largest and fastest growing minority group. In the area of health and health care, they remain a vulnerable population, which faces geographic, economic, social, and cultural barriers to care. They also stand to benefit from the National Health Insurance Law, which became effective on January 1, 1995 (State of Israel, 1994). Prior to implementation of the law, there were important differences in the health status and health care of Arabs and Jews, accompanied by incremental improvements in the health status and health care of the Arab population (Reiss, 1988, 1991; Shuval, 1990). In 1993, the Ministry of Health's "Committee for the Promotion of Health Services for the Arab Population of Israel" (CPHSAPI) viewed the enactment of a national health insurance law as a vital measure for promoting health services for the Arab population and reducing gaps in the health care of Arabs and Jews (Ministry of Health, 1993).

By mandating universal health insurance coverage, the law eliminated a key dimension of inequality in health care: Arabs' lower prevalence of sick fund insurance prior to the law, relative to Jews. In addition, the law's capitation system, which finances each sick fund based on the number and ages – but not income level – of its members, was expected to make the Arab population financially more attractive to the sick funds. This, in turn, was expected to increase sick fund competition in the Arab sector, expand freedom of choice, raise the level of health services and, potentially, advance the health care and health status of Arabs.

Indeed, eight months after implementation of the law, the JDC-Brookdale Institute's 1995 survey of the general population revealed that Arabs were significantly more likely than Jews to have reported an increase in the level of their sick fund's services (Farfel et al., 1997). The 1995 survey also showed a reduction in some differences in the health care of Arabs and Jews, including differences in household expenditures for private physicians. Anecdotal evidence provided by Arab reviewers of the 1995 survey findings indicated that the sick funds had already established, or were developing an increased number of clinics in some Arab towns and villages since implementation of the law. However, known differences between Arabs and Jews persisted, including Arabs' relatively low utilization of specialists. In addition, previously unknown differences were revealed, including the Arabs' lesser likelihood of having a regular family physician, having or knowing about supplemental insurance, and reporting that travel times to primary care providers were reasonable.

This report compares the responses of Arabs and Jews to the second national telephone survey of the general population following implementation of the National Health Insurance Law, carried out in 1997 by the JDC-Brookdale Institute. Conducted approximately two and a half years after the law's implementation, the survey's purpose was to investigate the public's perceptions of changes in the level of health services and health expenditures, as well as access to and utilization of primary and specialty care, receipt of selected preventive services and emergency care, satisfaction with care, and the acquisition of supplemental and commercial health insurance.

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household expenditures for a private physician, and to report forgoing care due to the distance of a service from their home.

Some questions were added to the face-to-face survey to assess respondents' knowledge of their rights under the National Health Insurance law. The responses revealed that knowledge of rights under the law varied among Arabs without telephones (e.g., relatively great knowledge of the right to visit primary care and specialist providers and relatively little knowledge of the right to emergency care, ambulance services or to physician house calls). This topic warrants further investigation. An open-ended question about respondents' perceptions of the major health-related problems in their village yielded responses consistent with the main findings of the telephone survey. Most responses were related either to limited access to ambulance, pharmacy, specialty, and emergency services due to their distance from the respondent's home, or to the timeliness of services (e.g., long waiting times for medications and specialty care). Other responses were related to sanitation problems such as lack of municipal sewage services and insufficient garbage collection, and public health problems such as hereditary illnesses, and the need for education regarding home injury prevention.

The 1997 survey findings are consistent with the perception that the Arab population is of increasing priority to the sick funds. However, differences persist in the health care of Arabs and Jews, and in 1997 the Arab population may still have been of lower priority to the sick funds than the Jewish population. Continued monitoring of the extent and type of these differences will be essential to any assessment of equity in health and health care. It is important to note that the National Health Insurance Law is not expected to eliminate all gaps in the health care of Arabs and Jews, or in health status or accessibility to health services. These are also influenced by socio-economic, cultural, behavioral and environmental factors, not all of which may be affected or regulated by the law.

may also grow out of a subjective sense that the need for care is urgent, difficulties reaching the specialist, or a cumbersome referral process. Arabs who reported having direct access to specialists found waiting times for specialty care to be less reasonable than did those who were referred to specialty care through their family physician, and lower than Jews who had direct access to specialty care.

Relative to Jews, Arabs were less likely to turn to a psychologist or psychiatrist with a mental health problem than to a family physician. This may be due to the relative availability of mental health professionals in the Jewish and Arab sectors, as well as to cultural differences between Arabs and Jews in health-seeking behaviors, social support and other factors. In 1993, the CPHSAPI reported a need to reduce the relatively large gap between the Arab and Jewish sectors in the availability of mental health services by increasing the number and intensifying the training of Arabic-speaking mental health professionals.

In analyzing the survey data, a question arose as to whether the study findings would change if the analysis were limited to Arab and Jewish residents of smaller towns located in the periphery. To answer this question, a comparison was made of the responses to the telephone survey by Arabs and Jews living in towns with fewer than 50,000 residents not near large cities (i.e. Haifa, Tel Aviv-Jaffa, Jerusalem). This analysis revealed findings similar to those of the main study and indicated that differences remain between Arabs and Jews regarding many dimensions of health care, even when controlling for town size and proximity to a large city. One notable exception was that in the more restricted sample there were similar percentages of Arabs (12%) and Jews (10%) who reported forgoing some type of medical care during the past year because their sick fund-sponsored service was not close enough to their home.

During the planning phase of the 1997 telephone survey, questions were raised about access to and utilization of health care services among Arabs without telephones. We subsequently received funding from the Israel Institute for Health Policy and Health Services Research to investigate this issue in 18 small Arab towns and villages (<10,000 residents) in the north and the "little triangle" using the 1997 questionnaire. Our findings indicate that Arabs without telephones face greater barriers to sick fund services. For example, Arabs without telephones had a higher prevalence of household expenditures for a private physician, were less likely to have a regular sick fund-affiliated family physician, less likely to transfer among sick funds, and less likely to report an improvement in sick fund services than were Arabs with telephones. Arabs in geographically remote unrecognized villages were found to be a particularly vulnerable sub-group, which faced acute problems receiving health care due to a lack of local services. They were more likely than other Arabs to have to travel by bus to their family physician; to report longer travel times to their family physician (often over one hour); and to find travel times unreasonable and the family physician's and specialist's office hours inconvenient. None reported walking to their physician's office or transferring among sick funds since implementation of the law, and they were less likely than other Arabs to report improvement in sick fund services. Moreover, they were most likely to have had

due to the lower availability of these services to the Arab population. The Arabs' high rates of utilization of hospital emergency rooms for after-hours care suggests that improvements must still be made in this area, particularly given that Arabs usually lived at a greater distance from the nearest hospital than did Jews.

Differences between Arabs and Jews also persisted regarding the utilization of specialists, sub-specialists and mental health professionals; the provision of preventative services (e.g., blood pressure testing); the prevalence of commercial health insurance; and knowledge about supplemental insurance. A number of related problems are likely a result of the peripheral location of many Arab villages, and these included the increased travel distances to services such as hospitals and hospital-based outpatient specialty clinics, tertiary care centers, and community-based emergency care centers.

A particular example of interest was the finding that Arabs were more likely than Jews to report forgoing health care, particularly specialty care, due to the service's distance from their home. Furthermore, the distance to the nearest hospital or community-based emergency care center is decisive in both Arabs' and Jews' decisions to forgo care; it is thus important to note that, on average, most Arabs live farther than do Jews from hospitals and emergency centers. Because Arabs were twice as likely as Jews to have received specialty care in a hospital-based outpatient clinic, their greater distance from the nearest hospital represents at least an inconvenience, and at most a threatening barrier to care; it may also explain the Arabs' potential under-utilization of care and delayed treatment.

Arabs were also more likely than Jews to report that referral times to specialists and travel times to sick fund-affiliated family physicians were unreasonable, and to be dissatisfied with emergency care. Given that one goal of the National Health Insurance Law is to provide all segments of the population with timely, convenient, and reasonable quality health care, these findings should be given due attention. It should be noted that travel times reported by Arabs and Jews were actually very similar. Differences in Arabs' and Jews' perceptions of what constitutes a reasonable travel time to their sick fund clinic may derive from differences in rates of car ownership; the limited availability of public transportation in Arab towns and villages; poorer road conditions in Arab towns and villages; and the relative expense, time, distance and inconvenience Arabs associate with travel. Moreover, some Arabs need to travel outside their villages to see their family physician, a finding recently reported by Adler and Lottan (1997). That Arabs reported being satisfied with numerous components of care underscores the importance of their greater level of dissatisfaction, compared to Jews, with travel times to their family physicians.

Arabs' assessment that it takes an unreasonable amount of time to receive specialty care, (despite the fact that they reported less lag time prior to receipt of specialist care than Jews), may be due to their more urgent need for care, which in turn may stem in part from their under-utilization of services due to their distance from hospitals, clinics and emergency centers, as noted above. This assessment

were less likely than Jews to report that their expenditures for health constituted a substantial financial burden.

The finding that 71% of the Arab respondents, compared to 34% of the Jewish respondents, reported an overall improvement in the level of sick fund services is consistent with the improvements noted above. Furthermore, the gap between Arabs' and Jews' perceptions of improvement has widened since 1995. A deeper understanding of changes in the level of services for Arabs and Jews will require information on the sick funds' allocation of resources to different population groups and sub-groups, and on changes in the quality of care.

A greater percentage of Arabs than Jews reported that their health status was very good or good, relative to 1995. This change may be the result of improved access to health care in the Arab population, and to Arabs' greater sense of improvement in the level of services.

Based on the large increase in perceived improvement in the level of sick fund services in the Arab population (from 30% in 1995 to 71% in 1997), one might expect a parallel increase in overall satisfaction with sick fund services. However, the improvement in overall satisfaction among Arab respondents between 1995 and 1997 was relatively small, and less than the improvement in overall satisfaction reported by Jews in 1997. Small but statistically significant increases in the satisfaction of Arabs were found in all but two components of care. It is possible that respondents did not judge improvements in those components of care that we measured to be essential to their overall satisfaction. Addressing other problems, summarized below, might be more crucial to the Arabs' overall satisfaction with sick fund services.

Consistent with the finding that access to certain sick fund services has improved for the Arabs is the finding that Arabs are less dependent on private physician services than they were in 1995. First, few Arabs reported having a private physician as their regular primary care provider. Second, the percentage of Arab respondents who reported having expenditures for private physicians (excluding dentists) was significantly lower in 1997 than in 1995, and no longer different from that reported by the Jews. Third, contrary to the situation in 1995, in 1997 none of the Arab respondents reported using a private physician not affiliated with an organized service for after-hours emergency care. This may be due in part to the growing use of Hayat, a privately-operated emergency service in some Arab towns and villages. Arabs also reported increased use of hospital emergency rooms, community-based emergency care centers (operated by the sick funds), and Magen David Adom for after-hours emergency care.

These changes reflect increased access to a greater variety of after-hours emergency services for the Arab population which, in turn, might represent improved quality of emergency care for Arabs. The private physicians on whom they once relied may have had less access to equipment and specialists than do hospital and community-based emergency care facilities. However, the Arabs' reported utilization of community-based emergency services was still less than that of the Jews, most likely

assessed the public's perceptions of changes in the level of health services and health expenditures, access to and utilization of primary and specialty care, receipt of selected preventive services and emergency care, satisfaction with care, and the acquisition of supplemental and commercial health insurance. Funding from the Israel National Institute for Health Policy and Health Services Research made possible the addition of questions on issues of particular importance to Israeli Arabs (e.g., access to specialty and emergency care, use of a private physician); the doubling of the number of Arabs in the telephone survey; and the conducting of face-to-face interviews (using a similar questionnaire) in 237 Arab households without telephones in villages and towns in the north and "little triangle". This enabled us to compare various Arab sub-groups, such as Arabs living in unrecognized villages. The summary below refers to the findings of the telephone survey, unless otherwise stated.

Relative to the Jewish respondents, Arab respondents with and without telephones were young, had large households, low levels of education and income, and were more likely to reside in small rural communities in the north of the country. Fewer Arab than Jewish respondents worked outside the home; this finding was primarily due to the relative prevalence of housewives in the Arab population. Multivariate analyses were carried out to control for demographic differences between Arabs and Jews and for sick fund, region and size of town for most survey topics (e.g., self-reported health status, improvement in the level of sick fund services, forgone care due to distance, receipt of selected types of preventive care, and the prevalence of commercial insurance). In most cases, differences between Arabs and Jews remained statistically significant in the multivariate analysis.

The findings of the 1997 follow-up telephone survey show that, since 1995, the health and health care of the Arab population have continued to improve; and some of the gaps in the care of Arabs and Jews have been reduced. For example, access to a sick-fund affiliated family physician had improved for the Arabs; regular household expenditures for private physicians had decreased, as had the use of private physicians for after-hours emergency care; and the Arabs reported improved health status. Notably, nearly all of the Arab respondents reported having a regular family physician affiliated with their sick fund; most had had the same physician for the past three years. Long-term access to a sick-fund affiliated regular family physician should enhance continuity of care for the Arab population.

The language spoken by sick fund-affiliated family physicians was not found to be a barrier to care for the majority of Arab respondents. The 7% of Arabs who reported not being comfortable with the language their physician spoke usually indicated that he spoke Hebrew. Waiting times for primary and specialty care were reduced in the Arab sector. Relative to their own responses in 1995 and those of Jews in 1997, Arabs reported waiting less time to see their family physician, and less time between requesting referral to a specialist and actually seeing that specialist; this was the case for the five most common types of specialist together. Also relative to 1995, an increased percentage of Arabs reported that the specialist's office hours were very convenient or convenient. Lastly, Arabs

Abstract

The Arabs living in Israel are a vulnerable population, which faces geographic, economic, social and cultural barriers to health care. They stand to benefit from the National Health Insurance Law, which became effective on January 1, 1995.

Prior to the law's implementation, there were significant differences in the health status and health care of Arabs and Jews, alongside incremental improvements in the health status and health care of the Arab population. According to the literature, prior to the law Arabs had poorer health status; lower sick fund enrollment; less access to health care practitioners and facilities; and lower rates of visits to physicians (family physicians, specialists, dentists) than did Jews. Arabs were also more likely than Jews to have incurred expenditures for private physician services – possibly a reflection of their reduced access to sick fund services. In 1993, the Ministry of Health's Committee for the Promotion of Health Services for the Arab Population of Israel (CPHSAPI) viewed the enactment of a national health insurance law as vital to the promotion of health services for the Arab population and to the reduction of gaps in the health care of Arabs and Jews.

The National Health Insurance Law mandated universal health insurance coverage, thereby eliminating one dimension of inequality in the health care of Arabs and Jews. Second, the law instituted a capitation system, whereby each sick fund is financed based on the number of its members and their ages, rather than on members' income levels, as was the case prior to the law. This was expected to make the Arab population more financially attractive to the sick funds and, in turn, to increase sick fund competition, raise the level of health services and, potentially, advance health care and health status in the Arab sector.

Indeed, based on the JDC-Brookdale Institute's 1995 survey of the general population, eight months after implementation of the law, Arabs were significantly more likely than Jews to report an increase in the level of their sick fund services. The 1995 survey also revealed a reduction in some differences between Arabs and Jews, including differences in the prevalence of commercial insurance and household expenditures for private physicians. Anecdotal evidence provided by Arab reviewers of the 1995 survey indicated that, following implementation of the law, the sick funds were establishing a growing number of clinics in some Arab towns and villages. However, known differences between Arabs and Jews, such as Arabs' lower utilization of specialists, were still found. Previously unidentified differences were also found, including Arabs' lesser likelihood of having a regular family physician, knowing about or owning a supplemental insurance policy, and reporting that travel times to primary care providers were reasonable.

This report compares the responses of 233 Arabs and 972 Jews to a follow-up national telephone survey of the general population conducted by the JDC-Brookdale Institute in 1997, approximately two and a half years after the law's implementation (the total response rate was 85%). The survey

Related JDC-Brookdale Publications

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Berg, A.; Gross, R.; Rosen, B.; Chinitz, D. 1997. ***Public Perception of the Health System Following Implementation of the National Health Insurance Law: Findings from a Survey of the General Population.*** RR-284-97.(Hebrew)

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Findings from a Survey of the General Population

Mark Farfel Dan Yuval

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Jerusalem November 1999

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