



JDC-BROOKDALE INSTITUTE OF GERONTOLOGY AND HUMAN DEVELOPMENT

1974 • 20 YEARS OF RESEARCH • 1994

Clinic Decentralization: An Israeli Model and Evaluation Strategy

Revital Gross¹ Asher Elhayany² Irit Zmora²

Reprint Series

¹ The JDC-Brookdale
Institute of Gerontology
and Human Development,
Jerusalem

² Kupat Holim Clalit,
Negev District

R-94-94





BR-R-94-94

Clinic decentralization :

Gross, Revital



002609542363

WHAT IS THE JDC-BROOKDALE INSTITUTE?

A national center for research on aging, human development, and social welfare in Israel, established in 1974.

An independent not-for-profit organization that operates under the auspices of the American Jewish Joint Distribution Committee (AJJDC) and the Government of Israel.

A team of professionals dedicated to applied research on high-priority social issues relevant to the national agenda.

A knowledge resource committed to promoting its findings and to assisting policymakers and service providers in the planning and implementation of effective social services.

The research involves an interdisciplinary approach with a focus on five main areas:

- ◆ Gerontology
 - ◆ Health Policy
 - ◆ Immigrant Absorption
 - ◆ Children and Youth with Special Needs
 - ◆ Disability
-

201-11-94

Clinic Decentralization: An Israeli Model and Evaluation Strategy

Revital Gross¹ Asher Elhayany² Irit Zmora²

Reprinted from *The Journal of Management in Medicine* 7(6):11-20



¹ The JDC-Brookdale Institute of Gerontology and Human Development

² Kupat Holim Clalit, Negev District

201-11-94
26095
C-1

JDC-Brookdale Institute of Gerontology
and Human Development
P.O.B. 13087
Jerusalem 91130, Israel

Tel: 02-557400
Fax: 02-635851

ISSN 0334-9128

Abstract

This article presents a model for clinic decentralization, implemented by Israel's largest health insurance fund, Kupat Holim Clalit (KHC). The main elements of the model are: allocation of a fixed budget; delegation of authority for budget utilization and service delivery; provision of incentives for fiscal responsibility; and the establishment of information systems in clinics. The article explores expected outcomes of decentralization on the basis of an extensive literature review, emphasizes the importance of evaluating such an organizational change, and outlines an evaluation strategy. A major concern of this strategy is to control for the effects of changes taking place at the same time as decentralization, and the effects of background variables such as demographic characteristics, health status, etc.. For those purpose, a quasi-experimental design was developed, based in the comparison of an experimental and a control clinic, both before and after decentralization.

Clinic Decentralization: An Israeli Model and Evaluation Strategy

Clinic
Decentralization

11

Revital Gross

JDC-Brookdale Institute, Jerusalem, Israel

Asher Elhayany and Irit Zmora

Kupat Holim Clalit, Negev District, Israel

Introduction

Organizational decentralization is perceived by health care providers throughout the world as one way to contain escalating costs while continuing to provide high-quality medical care. Various forms of decentralization have been implemented in Britain, Ireland, Sweden, Spain, Portugal, New Zealand and Russia[1,2,3,4]. The NHS fundholding initiative in Britain has been given special attention in the literature[5].

Decentralization is currently being introduced into Israel's largest health insurance fund, Kupat Holim Clalit (KHC). In 1990, KHC initiated a demonstration project for decentralizing primary care clinics in the Negev district of southern Israel. To date, ten urban clinics, serving more than 25 per cent of the district's population and representing one-quarter of its urban clinics, have been decentralized.

This article describes the decentralization model implemented by KHC, reviews the literature on the expected outcomes of decentralization, and presents an evaluation strategy. A brief comparison is also made between the KHC decentralization model and the NHS fundholding initiative.

A report on this decentralization model and evaluation strategy can be of value to other countries contemplating similar changes. It will add to the small number of studies of decentralization schemes and show how different organizational starting points and different cultural settings can affect the decentralization model adopted.

Overview of the Israeli Health Care System and the Organizational Structure of KHC

Israel's health care system is dominated by two main bodies: the Ministry of Health and KHC, which is owned and operated by Israel's powerful labour federation. The Ministry of Health has responsibility for the development of national health policy, operates Israel's public health services, owns and operates approximately half the country's acute-care hospital beds and finances long-term care services. It also plays a major role in regulating and subsidizing other agents in the health care system.

KHC is Israel's dominant provider and insurer of primary care services. It operates about 1,300 clinics and employs over 2,300 primary care physicians. KHC also owns eight acute-care hospitals, three psychiatric hospitals and three geriatric hospitals. Approximately 75 per cent of Israel's population are insured through KHC, another 20 per cent through three smaller health insurance funds, while 5 per cent of the population is uninsured[6].

At present, KHC has a centralized organizational structure: central management defines overall policy, allocates itemized budgets to its 14 districts and 14 hospitals, and supervises their activities. Each district has a district management responsible for the district's budget and for supervising its community clinics, specialty clinics, laboratories and diagnostic centres. District management is responsible for determining the drugs which physicians can prescribe, the hospitals and diagnostic centres to which they can refer patients, and clinic operating policy.

The community clinics are staffed by physicians, nurses, administrators, pharmacists and, in some cases, specialists. Some clinics also operate a laboratory. The clinic itself is managed by a team comprising a physician, a nurse and an administrator. The clinics provide services, but have little autonomy. They do not determine staff employment, operating hours or the scope of services offered by the clinic, nor do they have any fiscal responsibility.

Over the years, KHC's deficit has grown and its membership has declined[7]. KHC's decentralization programme is, in part, a response to mounting difficulties in containing costs, and increasing competition from other health insurance funds.

The main objectives of decentralizing KHC clinics in the Negev district are to:

- (1) improve services, with the aim of increasing client satisfaction and attracting more members;
- (2) make more efficient use of existing resources by introducing budgetary responsibility at the clinic and physician levels; and
- (3) upgrade the functioning of clinic staff by increasing individual motivation, responsibility and initiative, and by improving morale.

The KHC Decentralization Model

Although there is a single, standard definition of decentralization – the delegation of decision-making authority to lower ranks in an organizational hierarchy[8] – different countries report marked variation in significant features of decentralization schemes in primary care settings[1,2,3,4]. For example, a budget may be allocated to the district, the clinic or to the physician. It may be comprehensive or include only selected items, as in the NHS fundholding scheme in Britain. The decentralized unit may have the authority to contract with hospitals, as in the NHS scheme, or may be obliged to refer patients to providers with whom the organization has an agreement, as in some health maintenance organizations (HMOs). In some decentralization models, a bonus is given to physicians who manage to save money, while in others this is forbidden. Another difference between decentralization models lies in the scope of information available to the decentralized unit.

We will now turn to the main elements of KHC's decentralization programme in the Negev district, and explain in what ways the decentralized clinics differ from regular (i.e. not-decentralized) clinics in KHC.

Budget Allocation to Clinics

Each decentralized clinic receives a budget to cover salaries, administration and maintenance costs, and the cost of drugs, medical equipment, hospitalizations, diagnostic and consultation services, and laboratory tests. The size of the budget is determined using a formula based on average expenditures in the Negev district, the number of clients registered with the clinic, and their age distribution.

A regular clinic receives no budget and has no fiscal responsibility. However, expenses in some areas, for example, staff positions or the supply of drugs, may be limited by district management.

Transfer of Authority for Budget Utilization and Service Delivery from District to Clinic Management

A decentralized clinic can redirect funds among budget line items, expand the services offered to patients, and purchase services outside the KHC system. While some of these activities require the authorization of the district management, the clinic is assured prompt consideration of its requests. The clinic is not granted autonomy in hiring or firing permanent staff or in fixing wage levels.

A regular clinic wishing to expand activity in a given area, sell extra services to its members, or purchase services outside the KHC system, must receive authorization from the district management, which is not easily granted.

Incentives to Encourage Fiscal Responsibility

If a decentralized clinic does not use all of its budget, part of the money saved is given back to the clinic, to be used at its discretion.

A regular clinic has no budget from which to save money, and no incentive for lowering costs. This means that if it hospitalizes fewer patients than projected, the savings are credited to the district rather than the clinic.

Establishing Information Systems in the Clinics

These systems provide data on budget utilization, services provided, and the costs incurred by each physician. The reports are detailed by physician, area of expense and service supplier. Clinical information on the diagnosis and treatment of patients is not collected.

Figure 1 represents an example of a report produced through a clinic information system. It compares the expenses for consultation referrals made by physicians in the clinic. Such information can be used to monitor the physicians' expenses and to understand, perhaps even improve, individual practice patterns. Another function of such a report is to stimulate internal debate and contribute to decisions concerning the clinic's policy on medical treatment, for example, whether to use generic drugs instead of brand names.

A regular clinic does not receive information on expenses although, for some activities, information is gathered by the district management.

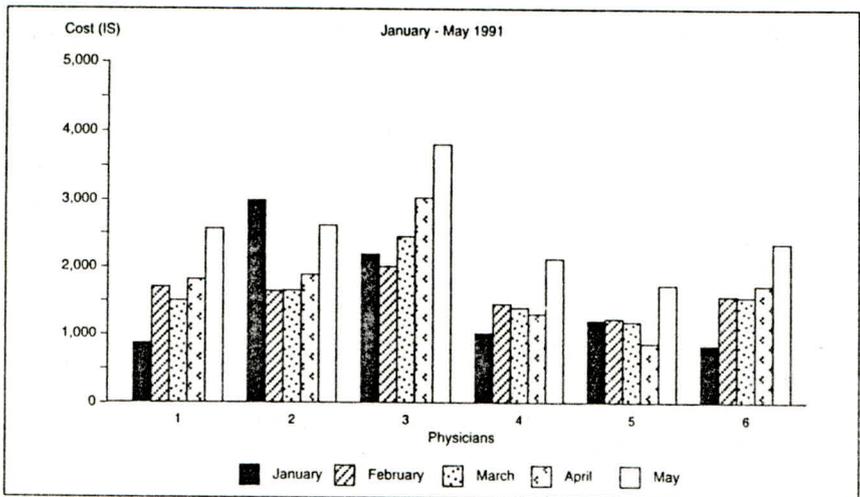


Figure 1.
Example of a Report on
Costs of Consultation
Referrals by Physicians

Comparison of KHC's Decentralization Programme and the NHS Fundholding Initiative

KHC's decentralization programme and the NHS fundholding initiative have a number of similarities. In both models, the primary care clinic/practice is given a budget and the authority to utilize it as efficiently as possible, in order to improve the care given to patients while reducing costs; an information system is installed in the clinic/practice and some of the budgetary savings are given back to it for future use.

However, important differences exist in a number of areas, including the way in which the budget is calculated, the types of data provided by the information system, the scope of authority, and restrictions on the use of savings.

A major difference is in the almost unlimited authority of the fundholding practice to contract with hospitals[5], compared with the restricted authority of the decentralized clinic, which must refer most patients to the local KHC hospital. Another major difference is that the KHC clinic receives a budget covering all medical and administrative expenses, while the fundholding practice budget covers selected expense items only[5].

In Britain, the fundholding practice operates in an environment in which hospitals are being converted into self-governing trusts, and district authorities act largely as independent decision makers[5]. The decentralized KHC clinic, in contrast, operates within a centrally managed organization, in which districts as well as hospitals are subject to central directives, budgetary cutbacks and other restrictions.

This brief comparison shows the importance of describing and comparing different models; an extensive comparison is beyond the scope of this article.

Expected Outcomes of Decentralization: A Review of the Literature

The underlying assumption of KHC's decentralization policy is that if clinics are given overall budgetary responsibility, adequate information, and the authority to

provide services in accordance with the needs of the population, then expenditure will be reduced, higher-quality services will be delivered, and staff motivation and satisfaction will be higher[9].

There is, however, little empirical data to support this assumption. In fact, it is possible that decentralization will have adverse effects. For example, the desire to reduce expenditure may lead to restrictions on the number of referrals, resulting in reduced patient access to specialists, and fewer laboratory tests and hospitalizations. This may adversely affect patient satisfaction and perhaps even compromise the quality of care.

Our analysis of the expected outcomes of implementing the KHC decentralization model is based on literature dealing with similar, but not identical, experiences of organizational change in primary care settings, especially those of HMOs and NHS fundholders[10]. The common element among these is the introduction of budgetary responsibility, and the provision of data for clinic management and physicians on costs incurred.

The Range and Quality of Services

As we have noted, the allocation of a budget, delegation of authority and provision of data to community clinics are expected to result in more efficient utilization of available resources and increased responsiveness to local needs. The assumption here is that, because they belong to small organizational units and are more familiar with the circumstances and needs of the local population, decision makers in decentralized units can respond to changing conditions more quickly and more effectively than central management[11,12,13].

However, enhanced authority also enables decision makers to delay or avoid action, in accordance with self-determined priorities, something which could lead to a deterioration in quality. The desire to economize could, for example, result in the neglect of needed repairs, or in failure to give treatment, especially when this is expensive.

The terms of the KHC decentralization programme do not allow the clinic to give fewer services than those included in KHC's basic "basket of services". However, exactly when a certain procedure is necessary and how soon it should be given, is not defined there. Thus, while a clinic cannot refuse to provide expensive medication or to refer patients for expensive diagnostic tests such as computerized axial tomography (CT) or magnetic resonance imaging (MRI), physicians can prescribe these less frequently.

At the same time, because the clinic is permitted to sell additional services not included in the "basket", the range of services should increase, leading to more comprehensive care. For example, the clinic can now offer preventive care services such as screening tests and health promotion courses. If it then decides that preventive care is a good "long-term investment", this approach can be extended, reducing the need for costly treatments. Research on HMOs shows that they provide more comprehensive care than fee-for-service delivery systems, especially in the area of preventive care[14,15].

Physicians' Practice Patterns and Levels of Expenditure

The decentralization programme incorporates strong incentives to cut costs: budgetary constraints, information on the costs of different procedures and

utilization levels among physicians, and rewards for saving money [16,17,18]. Yet there is evidence that physicians' practice patterns are not easily changed. Changes are more likely to be made if mechanisms not included in the KHC decentralization programme, such as education, participation in decision making, sanctions, audits and personal rewards, are used to reinforce incentives to reduce expenditure[18].

If physicians respond to these incentives and to clinic management policy and become more cost conscious, they may change their practice patterns so as to reduce diagnostic or treatment interventions. While such a change can both improve quality of care and optimize the allocation of resources[19,20], it can also restrict necessary care.

Comparative studies of HMOs and fee-for-service delivery systems (where physicians have no incentives to limit expenses) show that there is less unnecessary surgery and in-patient care in HMOs[15]. Other research has shown the quality of care in HMOs to be standard for process of care, morbidity and mortality rates, and number of working days lost[14]. On the other hand, while Luf[21] has confirmed that HMOs reduce admission rates to hospital, he found no evidence that the reduction was in unnecessary admissions only. Moreover, there is evidence that patients in lower socio-economic brackets do not receive all the care which they need[15,22].

Job Design and Staff Morale

Another expected outcome of clinic decentralization is the enrichment of job design through three programme elements: enhanced autonomy, increased responsibility and feedback on achieving goals. This is expected to produce desirable outcomes such as greater satisfaction, higher morale and increased motivation, which in turn produce better job performance[23,24].

KHC's decentralization programme, however, includes neither increased responsibility nor enhanced autonomy for regular staff members other than the clinic management. Thus the only programme element which can influence physicians' practice patterns and enrich job design is feedback on goal achievement, i.e. reports on expenditure and service utilization.

Decentralization may have a negative rather than positive effect on the performance of clinic management and staff, if it is perceived as creating additional stress or restricting professional autonomy. Uncertainty as to the effect of decentralization on employees is due to the fact that models describing the relationship between job design, employee satisfaction, motivation and performance are contingency models, i.e. models in which the response of employees is conditional on circumstances, personality and job expectations[23,25].

Physicians tend to value their professional autonomy[26], and may perceive new cost-containment procedures as restricting this autonomy. They and other staff members may resent decentralization, if it seems to be aimed solely at reducing expenditure. It has been shown that, although they are sensitive to the need to economize, physicians are reluctant to co-operate with cost-containment programmes[27]. Financial considerations may even be perceived as contradicting the medical ethos[28]. HMO physicians have reported that

“gatekeeping” compromises their role as patient advocate and may make it difficult for physicians to gain their patient’s trust[29]. Their motivation to cooperate with the clinic’s new aims may thus be low.

In order to achieve its budgetary goals, the decentralized clinic may increase staff supervision, thus creating antagonism and lowering morale. On the other hand, by providing feedback and involving staff in the decision-making process, staff motivation and job performance can be improved[25,30,31].

From this analysis, we can see that the outcome of decentralization is far from certain. This emphasizes the importance of monitoring and evaluating decentralization programmes. Effective monitoring requires an accurate description of the decentralization model adopted and identification of the process and outcome variables which are most likely to be affected. An evaluation will show whether or not a programme has achieved its objectives, and identify optimal ways in which to implement similar programmes.

The Evaluation Strategy

The broad aim of the evaluation is to determine the extent to which decentralization has achieved its objectives, and to advise KHC on how to make a smooth transition to decentralized management.

The evaluation strategy is based on the assumption that implementing the KHC decentralization model will lead to changes in work procedures and job designs in clinics (process variables), and that this will lead to certain desired outcomes: improvement in quality of care, enhanced patient satisfaction, lower costs and enhanced staff morale (outcome variables). In this conceptual model, there are thus six main areas to be evaluated, two pertaining to implementation, and four to outcomes.

Implementation

The process questions to be answered relate to two areas:

- (1) To what extent have the programme elements been implemented? In what ways have the clinic’s authority and responsibilities changed? What obstacles have there been to implementation, and how can these be overcome so that the programme can operate more effectively? What can facilitate implementation of the programme?
- (2) What changes in work procedures has the clinic made? Has the clinic management established internal controls over physicians? Are there new regulations concerning the prescription of drugs, tests etc.? Have changes in service provision been made in response to clients’ needs?

Outcomes

The outcome questions relate to four areas to be evaluated:

- (1) How has decentralization affected the level of expenditure?
- (2) How has decentralization affected clinic staff? Has there been an increase in staff satisfaction, motivation, morale, initiative and responsibility? Are staff more aware of costs? Are staff more sensitive to clients’ needs?

- (3) How has decentralization affected the number of clients registered with the clinic and their satisfaction with the services which it provides?
- (4) How has decentralization affected other indicators of quality of care in the clinic? Have improvements been made in structural criteria (physical conditions, equipment maintenance, and levels of training), process outcome criteria (availability, comprehensiveness, and appropriateness of services) and outcome criteria (health status)?

A major concern in conducting the evaluation is to control for the effects of changes taking place at the same time as decentralization, and for background variables such as demographic characteristics, health status, etc. For this purpose a quasi-experimental design was developed, based on the comparison of an experimental and a control clinic, both before and after decentralization. In addition, three other decentralized clinics are to be monitored in lesser depth, to gain insight into variations in the decentralization process. A number of research instruments were developed and administered for gathering baseline data: a questionnaire for in-depth interviews with key personnel at clinic and district management levels; a staff survey; a client survey; and instruments for analysing administrative data[9]. This method of evaluation, based on in-depth analysis of a small number of cases, is commonly used when studying a new phenomenon found only in a limited number of sites. Although it would be unwise to infer statistical generalizations from the findings, given the small number of observations and the non-random selection of clinics, some analytical generalization is possible, particularly if special circumstances in the observed clinics are taken into consideration[32,33].

Conclusion

The decentralization of KHC primary care clinics represents an attempt at organizational change unique in Israel. Traditionally, health care services have been organized in a centralized fashion both in KHC and in the governmental sector. Recently, similar decentralization schemes have been proposed for governmental hospitals, and for KHC districts and hospitals. The recommendations of the State Commission of Inquiry into the Functioning and Efficiency of the Israeli Health Care System[7], are no doubt partially responsible for these proposals. The commission identified centralization as one of the main obstacles to efficiency: "The Ministry of Health and KHC impose centralization on the hospitals and clinics under their jurisdiction. The management of these institutions, deprived of autonomy and true administrative and budgetary responsibility, have no incentive to develop initiatives leading to greater efficiency and economically sound operation"[7, pp. 52-3].

The documentation and evaluation of Israel's first experiment in clinic decentralization is thus of special importance. Other countries may also benefit from the findings for, while decentralization is a growing trend worldwide, systematic data on its effects remain scarce.

KHC's request for evaluation of the decentralized process is also unique in the area of organizational change in Israel, and perhaps even unique abroad. In Britain, for example, the government has made no request for a formal evaluation

of the way in which the NHS White Paper "Working for Patients" has been implemented[15].

If an organization is to initiate such evaluative efforts, it must have certain characteristics: commitment to acquiring knowledge; willingness to bear any costs; willingness to accept researchers as partners in service development; willingness to invest time; familiarity with research and its uses; and a policy-making structure into which research findings can be integrated[34].

KHC has shown true maturity in requesting that a public research institute should evaluate this major organizational change. This course of action should, in our opinion, be adopted by other public service organizations, because it makes a significant contribution to the process of rational decision making.

The full evaluation, as well as intermediary reports, will provide KHC with data which will be important for understanding the costs and benefits of clinic decentralization, and for formulating an effective process of change. Furthermore, the evaluation will make an important contribution to current knowledge about decentralization models for primary health care clinics, the effective implementation of changes in health care organizations, and the impact of decentralization on primary health care settings.

References

1. Godinho, J., "Tipping the Balance towards Primary Health Care: Managing Change at the Local Level", *International Journal of Health Planning and Management*, Vol. 5, 1990, p. 41.
2. Håkansson, S., Majnoni d'Itignano, B., Roberts, J. L. and Zollner, J., *The Leningrad Experiment in Health Care Management 1988 - Report of a Visit to the USSR, 21-28 May 1988*, World Health Organization - Regional Office for Europe, Copenhagen, Denmark, 1988.
3. Secretaries of State for Health, Wales, Northern Ireland, and Scotland, *Practice Budgets for General Medical Practitioners - Working Paper 3*, HMSO, London, 1989.
4. Malcolm, L. A., "Decentralization Trends in the Management of New Zealand's Health Services", *Health Policy*, Vol. 12, 1989, p. 285.
5. Glennerster, H., Matsaganis, M. and Owens, P., *A Foothold for Fundholding*, Research Report 12, King's Fund Institute, London, 1991.
6. Cohen, M. A. and Rosen, B., "New Directions in Israeli Health Care", paper prepared for the World Health Organization Conference, Leeds, England, 1990.
7. *Report of the State Commission of Inquiry into the Functioning of Efficiency of the Israeli Health Care System*, Government Printing Office, Jerusalem, 1990.
8. Simon, H. A., *Administrative Behavior*, Macmillan, New York, NY, 1959.
9. Gross, R., Cohen, M. R. and Nirel, N., "Decentralization in Primary Care Clinics: An Evaluation of a Demonstration Project", in Chytil, M. K., Duru, G., Van Eimeren, W. and Flagle, C.D. (Eds), *Proceedings of the Fifth International Conference on System Science in Health Care*, Omnipress, Prague, 1992.
10. Gross, R., Benbassat, J., Nirel, N. and Cohen, M. R., "Quality of Care in Decentralized Primary Care Clinics: A Conceptual Framework", *International Journal of Health Planning and Management*, Vol. 7, 1992, pp. 271-86.
11. Hodges, B. J. and Anthony, W. P., *Organization Theory*, Allyn and Bacon, Boston, MA, 1979.
12. Hall, J. H., *Organization: Structure and Process*, Prentice-Hall, Englewood Cliffs, NJ, 1972.
13. Koontz, H. and O'Connell, C., *Principles of Management: An Analysis of Managerial Functions*, McGraw-Hill, New York, NY, 1982.
14. Hornbrook, M. C., "Practice Mode and Payment Method, Effects on Use, Costs, Quality and Access", *Medical Care*, Vol. 23 No. 5, 1987, p. 484.

15. Weiner, J. P. and Ferriss, D. M., *GP Budget Holding in the UK: Lessons from America*, King's Fund Institute, London, 1990.
16. Tell, E. J., "Changing Physician Practices: A Key Piece in the Health Cost Management Puzzle", in Egdahl, R. H. and Chapman Walsh, D. (Eds), *Health Cost Management at the Community Level: Doctors, Hospitals, and Industry*, Ballinger, Cambridge, MA, 1982.
17. Myers, L. P. and Schroeder, S. A., "Physician Use of Services for the Hospitalized Patient: A Review with Implications for Cost Containment", *Milbank Memorial Fund Quarterly*, Vol. 59 No. 4, 1981, p. 481.
18. Eisenberg, J. M., "Physician Utilization: The State of Research about Physicians' Practice Patterns", *Medical Care*, Vol. 23 No. 5, 1985, p. 461.
19. Maynard, A., Marinker, M. and Gray, D. P., "The Doctor, the Patient, and Their Contract; III: Alternative Contracts: Are They Viable?", *British Medical Journal*, Vol. 292, 1986, p. 1438.
20. Schroeder, S. A., "Strategies for Reducing Medical Costs by Changing Physicians' Behaviour: Efficacy and Impact on Quality of Care", *International Journal of Technology Assessment in Health Care*, Vol. 3, 1987, p. 39.
21. Luft, H. S., "How Do Health Maintenance Organizations Achieve Their 'Savings'?", *New England Journal of Medicine*, Vol. 298 No. 24, 1978, p. 1336.
22. Ware, J. E. Jr, Rogers, W. H., Ross Davies, A., Goldberg, G. A., Brook, R. H., Keeler, E. B., Donald Sherbourne, C., Camp, P. and Newhouse, J. P., "Comparison of Health Outcomes at a Health Maintenance Organization with Those of Fee-for-Service Care", *Lancet*, Vol. 3, May 1986, p. 1017.
23. Nadler, D. A., Hackman, J. B. and Lawler, E. E., "Job Design", *Managing Organizational Behavior*, Little, Brown & Co., Boston, MA, 1979, p. 76.
24. Steers, R. M., "Work-related Attitudes and Behaviour", *Introduction to Organizational Behavior*, 2nd ed., Scott Foresman, Glenview, IL, 1984, p. 283.
25. Locke, A. L. and Schwiger, D. M., "Participation in Decision Making: One More Look", *Research in Organization Behavior*, Vol. 1, 1979, p. 265.
26. Schulz, R. and Harrison, S., "Physician Autonomy in the Federal Republic of Germany, Great Britain and the United States", *International Journal of Health Planning and Management*, Vol. 2, 1986, p. 335.
27. Pollit, C., Harrison, S., Hunter, D. and Marnoch, G., "The Reluctant Manager: Clinicians and Budgets in the NHS", *Financial Accountability and Management*, Vol. 4 No. 3, 1988, p. 213.
28. Scrivens, E., "The Management of Clinicians in the NHS", *Social Policy & Administration*, Vol. 22, No. 1, 1988.
29. Taylor, R., "Pity the Poor Gatekeeper: A Transatlantic Perspective on Cost Containment in Clinical Practice", *British Medical Journal*, Vol. 299, 1989, p. 1323.
30. Leana, C. R., "Predictors and Consequences of Delegation", *Academy of Management Journal*, Vol. 29 No. 4, 1986, p. 754.
31. Schultz, R. and Schulz, C., "Management Practices, Physician Autonomy, and Satisfaction", *Medical Care*, Vol. 26 No. 8, 1988, p. 750.
32. Patton, M. Q., *How to Use Qualitative Methods in Evaluation*, Sage, Beverly Hills, CA, and London, 1987.
33. Yin, R. K., *Case Study Research Design and Methods*, Sage, Beverly Hills, CA, London and New Delhi, 1984.
34. Habib, J., "Making the Link between Policy and Research in the Field of Aging: Some Lessons from Israel", *Approaches to Linking Policy and Research in Aging: Israel and Florida*, Conference Report, JDC-Brookdale Institute of Gerontology and Human Development, Jerusalem, 1988.

(All correspondence should be addressed to R. Gross, JDC-Brookdale Institute, POB 13087, Jerusalem, Israel.)

ג'וינט-מכון ברוקדייל לגרונטולוגיה והתפתחות אדם וחברה

תשל"ד • 20 שנות מחקר • תשנ"ד



ביזור מרפאות: מודל ישראלי ושיטת הערכה

רויטל גרוס⁽¹⁾ אשר אלחיאני⁽²⁾ עירית זמורה⁽²⁾

ס ד ר ת ת ד פ י ס י ם

(1) ג'וינט-מכון ברוקדייל
לגרונטולוגיה והתפתחות
אדם וחברה, ירושלים

(2) קופת-חולים כללית,
מחוז הנגב, באר שבע

ת-94-94





ג'וינט - מכון ברוקדייל מהו?

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

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

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

קבוצת חשיבה המחויבת לפרסום ממצאיה כדי לסייע לקובעי מדיניות ולספקי שירותים לתכנן וליישם תכניות רווחה.

המחקר מתבסס על גישה בין-תחומית ומתמקד בחמישה נושאים עיקריים:

- ♦ גרונטולוגיה
 - ♦ מדיניות בריאות
 - ♦ קליטת עלייה
 - ♦ ילדים ונוער עם צרכים מיוחדים
 - ♦ מוגבלות
-

ביזור מרפאות: מודל ישראלי ושיטת הערכה

עירית זמורה⁽²⁾

אשר אלחיאני⁽²⁾

רויטל גרוס⁽¹⁾



תדפיס מתוך: The Journal of Management in Medicine 7(6):11-20, 1993.

(1) ג'וינט-מכון ברוקדייל לגרונטולוגיה והתפתחות אדם וחברה, ירושלים

(2) קופת-חולים כללית, מחוז הנגב, באר שבע

גוינט-מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה
ת"ד 13087
ירושלים 91130

טלפון: 02-557400
פקס: 02-635851

ISSN 0334-9128

תקציר

המאמר מציג מודל לביאור מרפאות, המיושם על-ידי קופת-החולים הכללית. מרכיביו העיקריים של המודל הם: הקצאת תקציב למרפאה; האצלת סמכויות לניצול התקציב ולהספקת שירותים; מתן תמריצים לאחריות תקציבית; והקמת מערכת מידע מרפאתית.

המאמר בוחן את תוצאותיו הצפויות של הביאור בהסתמך של סקירת ספרות מקיפה. המאמר מדגיש את החשיבות שיש בביצוע הערכה של שינוי ארגוני כגון זה, ומתווה אסטרטגיה להערכה. נושא מרכזי באסטרטגיה זו הוא פיקוח על השפעותיהם של שינויים המתרחשים במקביל ליישומו של הביאור, ופיקוח על ההשפעות של משתני רקע כגון מאפיינים דמוגרפיים, מצב בריאותי וכו'. לשם כך, מערך המחקר מתבסס על השוואה בין מרפאת ניסוי למרפאת ביקורת, לפני יישום הביאור ולאחריו.