RESEARCH REPORT

INDEPENDENT PHYSICIANS IN KUPAT HOLIM CLALIT

THE HISTORICAL AND ORGANIZATIONAL CONTEXT

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Kupat Holim Clalit

Prepared with the financial support of the Kovens Health Systems Management Center, through the Israel Institute of Business Research, Faculty of Management, Tel-Aviv University

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Abstract

Kupat Holim Clalit (KHC) is Israel's largest health maintenance organization, with over three million members. Approximately 95% of the members receive their primary care in community clinics while approximately 5% receive their primary care in the private office of an "independent physician".

This paper analyzes how the independent physician (IP) program began and how it has grown within an organization with a strong historical and ideological commitment to clinic care. It is based, primarily, on in-depth interviews of senior managers in KHC headquarters and regional offices and of approximately twenty physicians, nurses, clinic secretaries and patients in the Jerusalem region. In addition, use was made of computerized KHC membership files and relevant KHC documents and publications.

The paper first describes the principal differences between the two methods. Next, it describes the organizational context leading to the initiation of the program, namely, the acute shortage of physicians within KHC and the increased competition from other sick funds. The paper then addresses the factors behind the program's consequent growth. It argues that the reasons for the growth are not identical to the reasons for its development at the outset. The IP program became an institutional vehicle for the satisfaction of various interests and needs quite apart from the issues which played a part in its creation. While consumer demand for a form of care similar to that available in the smaller sick funds remained a prime force behind the growth of the IP program, several other factors played a major role. Physicians were eager to participate because the program offered them large financial rewards and professional satisfaction. KHC management responded to these demands from consumers and physicians and developed the program in a manner which enhances management flexibility.

The growth of the IP program has been accompanied by various concerns over equity and quality. In addition, several new concerns have emerged: the program's cost and its effect on relations between provider and unions. There are some indications that cost has played a major role in slowing the growth of the IP program, and it is conceivable that other factors including institutional inertia, may have played a similar role, albeit to a lesser extent.

The paper concludes by describing recent developments in the organization of primary services in KHC and the possibility of developing intermediate models which adopt elements from both the clinic model and the IP program.

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ACKNOWLEDGMENTS

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Finally, we wish to thank Terry Benninga who so skillfully edited this paper.

INTRODUCTION

Kupat Holim Clalit (KHC) is Israel's largest sick fund. It serves as the principal insurer for approximately three-quarters of the country's population. It also owns and operates approximately one-third of the country's acute care bed capacity, over 1,300 primary care clinics, and a large number of laboratories, radiology centers and specialty clinics. Kupat Holim Clalit is owned and operated by the Histadrut—Israel's powerful labor federation.

The community clinic currently serves as the principal site for the provision of primary care in Kupat Holim Clalit. The clinic brings together—under one roof—professionals from a variety of disciplines and provides basic diagnostic and therapeutic equipment. The care of each patient is supposed to be coordinated by a physician who is a salaried employee of KHC. The underlying objective of the clinic is the provision of comprehensive, community-oriented care (Doron and Ron, 1987). KHC has a long tradition of commitment to community clinics as the preferred setting for providing primary care services.

In 1987 close to 164,000 KHC members (approximately 5% of the total membership) did not receive their primary care in clinic settings (Shavit, 1988). Instead, they received their care from independent physicians (IPs) at the IPs' private offices. The prevalence of this alternative model of primary care has grown steadily since 1971.

This paper analyzes how the independent physician program began and how it has grown within an organization with a strong historical and ideological commitment to clinic care. It reports the findings of the first phase of a larger research program on independent physicians in KHC. Subsequent papers in this series will report on empirical studies which compare clinic care and IP care with regard to patient satisfaction, health service utilization, and cost.

The analysis presented in this paper is based, primarily, on in-depth interviews of senior managers in KHC headquarters and regional offices and of approximately twenty physicians, nurses, clinic secretaries and patients in the Jerusalem region. In addition, use was made of computerized KHC membership files and relevant KHC documents and publications.

The paper is divided into six major sections. Section 1 describes the principal differences between the two modalities of primary care provision. Section 2 describes KHC's historical and ideological commitment to clinic care and the development of the IP program. In Section 3, we summarize the benefits provided by the IP model to patients, KHC management, clinic physicians and the independent physicians themselves. Section 4 summarizes the principal concerns raised by various informants regarding the IP model with regard to cost, quality and equity. Section 5 discusses recent developments and Section 6 presents the conclusions.

1 DIFFERENCES BETWEEN THE TWO METHODS OF PRIMARY CARE PROVISION

IP care and clinic care—the two practice modes—differ in three key respects:

1. **The Nature of the Physician-Sick Fund Contractual Relationship**
Clinic physicians are sick fund employees, whereas physicians working in the IP program are contractors whose contracts are reviewed annually.

2. **The Reimbursement Method**
The IP physician is reimbursed on a capitation basis; i.e., his compensation depends on the number of patients on his roster. In contrast, the primary component of the clinic physicians' compensation is "salary". Salary payments depend on the number of hours worked and not on the number of patients enrolled with the physician. Since KHC does not guarantee IPs a minimum number of patients and IPs are responsible for their practice expenses, IPs bear substantially greater risk than their counterparts in the clinics.

3. **Practice Setting**
Here there are four aspects to consider:

a. The place of work: Most IPs work out of offices which they own or rent, whereas clinic physicians work in premises owned by the sick fund. While this gives the IPs greater control than their clinic counterparts over working hours and other aspects of practice management, clinic physicians are more likely to have access to better and more varied equipment.
b. The number of sources of care: Every KHC member, whether he is cared for by an IP physician or a clinic physician, is affiliated with the clinic in his neighborhood. Even patients cared for by IPs must depend on the clinic for a variety of administrative and clinical needs (referrals, nursing care, laboratory services, etc.) Accordingly, these patients must interact with both their IPs and the clinics.
c. Organizational affiliation: IPs are not attached to particular clinics; they report directly to the regional management. Physicians in the clinic report to the clinic medical director.

d. Relationship with other health care professionals: While a small number of IPs work in group practices, most work alone[1]. In contrast, most clinic physicians work in a setting which employs other physicians, nurses, secretaries, etc.

Until recently, the two models differed in yet another way—the amount of choice patients had in selecting their physician. In the IP framework, the patient could choose any independent physician working in the region while in the clinic framework patients were restricted to the physicians working in the community clinic. In many instances, clinic patients were even assigned to a particular physician by the clinic secretary. Recently, freedom of choice within the clinics has been expanded, a point to which we will return in Section 6.

From a theoretical perspective, one might expect each of the two modes to have certain advantages in terms of service and patient care. The IP approach would appear to create a greater financial incentive for the physician to provide a high-quality service in order to attract patients. This could be translated into shorter waiting times and a longer duration of visit. The setting would also appeal to members who want greater privacy and later hours than the clinics currently offer. On the other hand, the clinic has advantages in terms of continuity and comprehensiveness (many services in the same location) and perhaps quality (peer review and a multi-disciplinary team). However, before examining in greater detail the relative advantages and disadvantages of the IP program it will be useful to review the growth of the IP program and provide some historical background. As we shall see below, the survival of the IP program in an organization committed to the clinic approach constitutes an intriguing puzzle which cannot be explained solely in terms of patients' preferences and needs.

[1] Recently, KHC adopted a new policy which stipulates that no new IP contracts will be issued to solo practitioners. However, it will be a while before group practice becomes the prevalent form among the IP physicians.

2 THE DEVELOPMENT OF THE IP PROGRAM

The following section addresses two major questions:

How did the independent physician program come into being within an organization with a strong historical and ideological commitment to clinic care?

How and why has the program grown?

As we shall see, the factors which led to the program's growth are not identical to those which led to its inception.

We will first describe KHC's commitment to the community clinic. We will then recount the milestones in the initiation of the IP program. Finally, we will describe the development of the IP program since 1971.

KHC's Historical And Ideological Commitment to Clinic Care

At least until the 1980s, KHC took tremendous pride in its nation-wide network of approximately 1,300 community clinics. KHC publications—with much justification—extolled the clinics as embodying the progressive ideas of continuity, availability, and team-work which were only just beginning to receive recognition in Europe and North America (Doron, 1987).

An acquaintance with Kupat Holim Clalit's history and political setting is critical to understanding the organization's commitment to community clinics. KHC was founded in 1912. In the ensuing 36 years before the creation of the State of Israel, it played a central role in Israel's nation-building process. Thereafter, it played an important role in Israel's development by making high quality primary care services available to poor as well as rich, in outlying rural areas as well as in large, urban centers. KHC also played a critical role in the absorption of large numbers of Jewish immigrants from Asian and North African countries who arrived in Israel in the early 1950s. Many of these immigrants arrived in Israel with a multiplicity of health problems and in need of education regarding personal hygiene.

KHC is closely tied to its parent organization, the Histadrut—Israel's powerful labor federation. Historically, ideology has played an important role in both the KHC and the Histadrut, with an emphasis on equality, pioneering values, workers' rights and the dignity of labor (Shuval, 1988).

KHC's commitment to the clinic model can best be understood within this historical and organizational context. Prior to the founding of KHC, medical care in Israel was provided primarily by solo practitioners. They operated either on a fee-for-service basis with patients paying for care on an out-of-pocket basis or on a charitable basis with the physicians' salaries covered by the local community or Jewish philanthropies from abroad. As part of Israel's experiment with socialism and the efforts to establish an equitable society, KHC rejected both of these approaches, preferring a pre-paid arrangement in which the rich subsidized the poor and the healthy subsidized the sick (Reis, 1978).

In those days the choice was viewed as being between "private medicine" and socially organized group practices. No one thought in terms of the mixed forms familiar today, such as Independent Practice Associations in which HMOs contract with independent physicians. Thus, the principles of pre-payment and equity led to the establishment of organized practice settings in which the sick fund could bear the financial risk and physicians worked as employees. Egalitarian values and the emphasis on the dignity of manual labor militated against conferring status and privileges on professional elites; the doctor was viewed as just one member of the care-giving team.

As a result of KHC's intimate relationship with the labor federation and the affiliated Labor Party, the position of the "clinic secretaries", i.e. the clinics' administrative directors who were usually local party and Histadrut operatives, was bolstered[2]. Part of their job was to ensure that physicians and other professionals did not provide care on preferential terms to those of superior financial means. On the national level, power was concentrated in a lay elite which was seen as playing a key role in ensuring that the organization did not sacrifice such important socialist and national goals as equity and the establishment of Jewish settlements in border areas in pursuit of narrow financial concerns (Halevi, 1980).

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[2] Personal communication—R. Dycian, KHC.

While ideological concerns regarding nation-building and equity were probably the main forces shaping KHC's organizational structure, professional norms also played an important role. The waves of immigrants from poor and less developed countries during the late 1940s and early 1950s, fostered the belief among the sick fund's leading physicians and nurses that they, the professionals, were in a much better position than the patients to know what the patients needed.

Even after the pace of immigration slowed, KHC was dominated by a clinical/ production mentality: health services existed to maintain health rather than to provide frills. Little attention was given to consumer needs and wants. Over the years, consumer wants gradually received more attention, but the loss of members in recent years to the smaller sick funds suggests that the organizational changes in KHC have not kept up with consumer demands.

In summary, one can identify three possible factors that account for the centrality of the community clinic.

a. **Egalitarianism**: The community clinic is KHC's vehicle for egalitarianism. It enables KHC to promote equality within a particular setting and across various locations.
b. **Administrative Hegemony**: The community clinic structure, characterized by a strong administration, enables KHC to control the various professional groups involved in service provision.
c. **Quality of Care**: The community clinic enables KHC to provide a high quality of basic care based on multi-disciplinary teams and within a single setting to a broad spectrum of clients.

Given KHC's commitment to community clinics, it is quite puzzling that KHC has established and developed the independent physician program within its midst. The IP program violates many of the ideological principles which led to the establishment of the clinic system. Capitation reimbursement and a contractor-contractee relationship accord the physician a different status from other health care workers. When the site of the practice is the physician's home or his private office, there is less opportunity for the organization and its representatives, such as the clinic secretaries, to supervise and

ensure that all patients are treated equally regardless of ability to pay[3]. In addition, as will be discussed in Section 4, professionals within the sick fund have serious concerns about the IP program's implications for cost, quality and equity. The puzzle looms even larger when one recognizes that KHC has traditionally been run as a fairly centralized organization with a strong emphasis on uniformity. In general, it has not tolerated a great deal of inter-regional variation. How, then, did this small program of quasi-private medicine get its start and how has it survived?

The Initiation of the IP Program

In this subsection we will review the major milestones in the development of the IP program. Though the IP program was officially started in 1971, its origins are in a 1956 proposal put forth by Moshe Soroka—then the treasurer of KHC. Soroka suggested that KHC allow its members to visit any private physician. Members would pay the physician and then KHC, in turn, would reimburse them according to a predetermined fee schedule. Hand-in-hand with the shift away from community clinics, Soroka proposed that KHC establish large specialty clinics. In practical terms, this proposal implied the abolishment of KHC's community-based primary care clinics.

The primary objective of the proposal was to overcome the anonymity of the over-congested community clinics and to increase the physician's personal responsibility for the care of his patients. It was met with considerable opposition, and in response, Soroka suggested that rather than reimburse the members, KHC compensate the physicians directly (Zertal, 1975). Soroka's modified proposal was accepted as a legitimate alternative to the clinic model; however, at the same time, the general assembly of KHC which met in 1957, reaffirmed the centrality of the community clinic (Zertal, 1975).

The new method was adopted on a very small scale in Jerusalem and elsewhere in the country and continued in operation until the official introduction of the IP program. We will refer to this early version of the IP program as the Private Physician (PP) program.

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[3] The ideological conflict between the IP program and the clinic method is illustrated by two important events in KHC history: the establishment of Kupat Holim Leumit in 1933 and the doctors' strike at the Beilinson hospital in 1946. Kupat Holim Leumit was established by the National Labor Federation, a fierce ideological rival of the labor movement. It is, therefore, not surprising that it was structured, to a large extent as an antithesis of KHC. In the founding statement of this institution, three elements were emphasized: profit sharing with physicians, the use of private clinics, and free choice for its members. The 1946 doctors' strike at Beilinson, KHC's major hospital, was about two issues: the practice of private medicine outside the hospital and the residence of the doctors within the hospital compound.

It should be pointed out that the PP program, at least in its early stages, was based on the services of private physicians (i.e., physicians not otherwise employed in KHC clinics or hospitals). The primary reason for this was KHC's affiliation with the General Labor Federation. KHC felt that it was ideologically inappropriate for its doctors to participate in such programs. In contrast, since the KHC Physicians Union (KHCPU) considered the PP program a threat to its members' professional security, it lobbied with the members of the Israel Medical Association (IMA) against joining the program. As a result of this pressure, KHC found it difficult to recruit physicians to the program (Kupat Holim Clalit, 1966b).

The debate around Soroka's proposal and other changes in the working methods at the community clinics continued throughout the 1960s. In a meeting of KHC's National Supervisory Board in October 1963, Soroka modified his 1956 proposal. He suggested that the Private Physician program be adopted alongside the conventional method (rather than replacing the community clinics altogether). Soroka pointed out that instead of waiting several hours in line, thousands of members prefer to pay 5-7 IL to visit a private physician. He argued that it was time for KHC to break away from the traditions that were contradictory to contemporary ways of life (KHC, 1963a). Several objections were raised with regard to Soroka's revised proposal. First and foremost was the claim that the program was ideologically objectionable and that it could foster inequality.

Critics claimed that the program catered to high-income members and not to the public at large (KHC, 1963a). As a result, it would create a two-tier system where members who lived in outlying areas would not have access to the quality of services provided to members living in the centrally-located regions (KHC, 1963a). It was also suggested on various occasions that the PP program would undermine the community clinic, the flagship of the Labor Federation and a bastion of equality (KHC, 1963b). Other criticism focused on the issue of medical quality. Here the argument put forth was that the physicians in the PP program, sole practioners, provide inherently inferior care compared to the clinic which is multidisciplinary in nature and enables supervision (KHC, 1963a; KHC,1963a). Finally, there were critics who argued that the PP program would not relieve the pressure at the clinic because of the inconvenience of having to return to the clinic to obtain pharmacy and laboratory services (KHC, 1963a).

In 1966, Kanev, then KHC's general manager, raised a further objection. He argued that the program was faulty primarily because it was based on a fee-for-service reimbursement system. He claimed that this could result in an increase in the number of visits and use of various services. Furthermore, he argued that there was no agreed-upon list of doctors whom the members could visit and that there was no mechanism for supervising these physicians. His major recommendation was that the private physicians should be reimbursed on a capitation basis (KHC, 1966a).

There were two important factors, however, that facilitated the implementation of the IP program: a growing shortage of doctors and increasing competition from other health funds. Starting in the mid 1960s, KHC faced growing difficulties in recruiting physicians despite the fact that even then, in relative terms, Israel had a rather high number of doctors per capita. The shortage of doctors in KHC was particularly acute in the community clinics, especially in outlying areas. Faced with the growing shortage of physicians, KHC undertook major efforts to recruit doctors. Among other things, KHC made efforts to increase the attractiveness of community medicine for Israeli medical school graduates, to recruit doctors from abroad, and to suggest that the government enact compulsory physician service in the outlying areas (KHC, 1965a; KHC,1968a).

Another strategy for overcoming the physician shortage was to tap into underutilized doctor services. Since KHC was facing difficulties in recruiting non-KHC doctors to its PP program, it was only natural that despite its ideological reservations, it would turn to its own doctors. In a meeting of the National Supervisory Board in 1965, Soroka suggested that the PP program be extended to KHC physicians as well. He argued that many KHC physicians practiced private medicine regardless of KHC's stated position and that the "legitimization" of such practice would enable KHC to mobilize physicians who otherwise would be unable to participate in the IP program. Soroka also pointed out that while KHC doctors refuse to work longer hours at the community clinics, many saw private patients at their homes (KHC, 1965a).

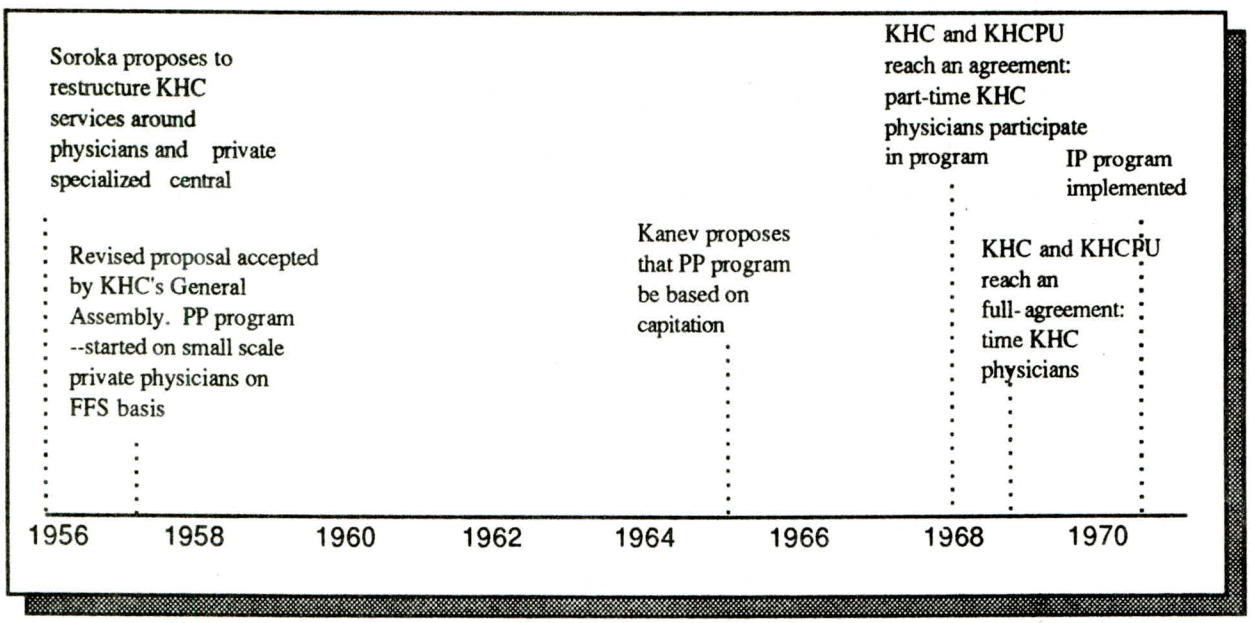
The second factor facilitating the implementation of the IP program was the growing competition from other sick funds, particularly Kupat Holim Maccabi. In October 1968, KHC's management held a meeting to discuss this issue. The results of a survey of disenrolled members were presented. The major reason for disenrolling, according to this survey, was the fact that other sick funds provided more personal care and

enabled their members to freely choose their physician. The fact that KHC charged higher premiums was only a secondary factor in disenrollment (KHC, 1968c). One of the proposals brought before KHC's management was to finalize, as soon as possible, the negotiations with KHC Physicians Union with regard to the PP program and to enable KHC members to choose their doctor.

Towards the end of 1968 KHC and KHCPU reached an agreement concerning the PP program. KHC doctors, it was decided, would also be included in the PP program. KHCPU also demanded that it be extended to full-time in addition to part-time doctors (KHC, 1968a). In a 1969 agreement, KHCPU's demand was accepted[4].

Figure 1

Milestones in the Initiation of the Independent Physician Program



To summarize, it should be noted that the ideologically-ladened debate surrounding the IP program (and its earlier form the PP program) lasted over 15 years. The adoption of the IP program—a program which was most characteristic of KHC's competitors and

[4]It should also be pointed out that the physicians, at least initially, were reluctant to seek an opportunity which could theoretically increase their professional autonomy, but put their incomes at risk. They opted for the safety of salaried positions. What might account for this apparent reversal in the positions of KHC and KHCPU from what one might expect? One explanation is that KHC faced grave difficulties in extending the working hours of its physicians (KHC, 1963a) and that it had little control over its salaried physicians (KHC, 1963a). The PP program was devised, among other reasons, to increase the bargaining power of KHC vis-a-vis the Physicians Union (KHC, 1963b).

portended the possible weakening of and maybe eventual liquidation of the clinic—was seen by many members of the National Supervisory Board as standing in direct contradiction to labor movement traditions and to the clinic as the "flagship" of KHC.

On a more concrete level, the inability to implement the program on a wider scale stemmed from the opposition of KHC's Physicians Union. The slow growth might have also been affected by another factor—institutional inertia. The community clinic is a central element in the institutional and service structure of KHC and thus there are many vested interests in its existence. The abolishment of the clinics would also mean a potential waste of the large financial outlays required to set them up.

There were few references made to the superior quality of community clinics. We believe that this argument emerged only later. No references were made to the possibility that the IP program might undermine the controllability of its physicians.

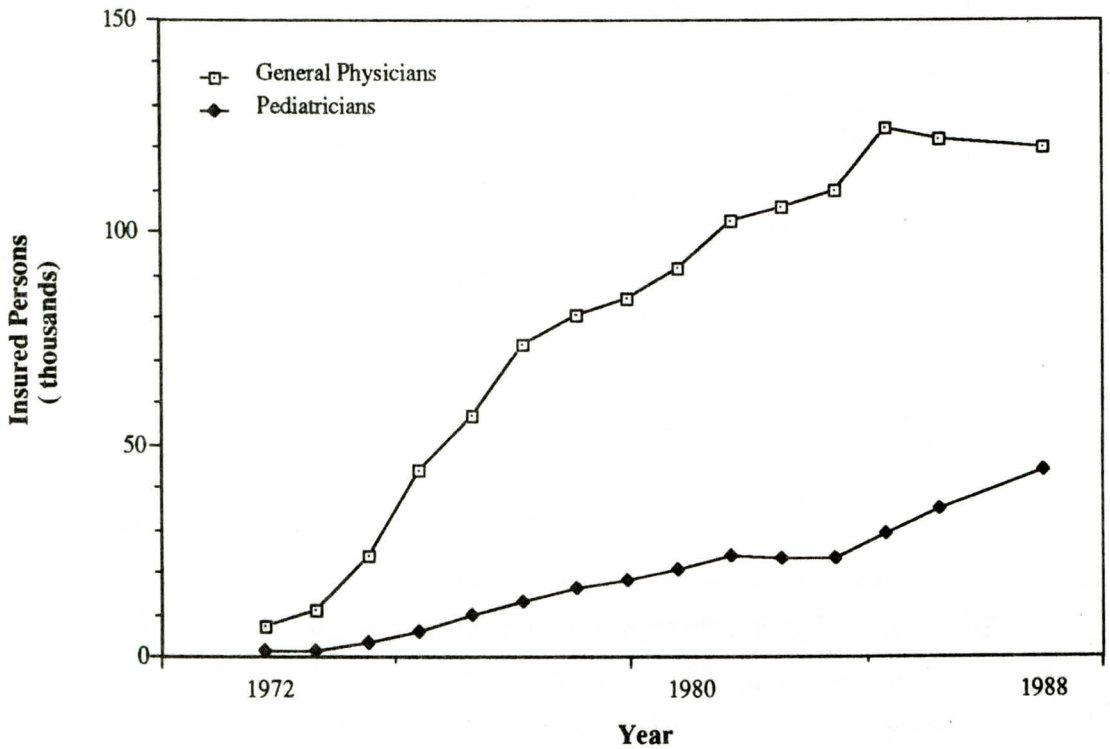
Several factors in the end led to the ultimate "go" decision. Probably the most important were the acute shortage of physicians and the growing dissatisfaction of KHC members, many of whom opted for other sick funds, coupled with the increased competition from the other sick funds.

The Growth of the IP Program

As described in the previous sub-section, the ultimate decision to initiate the IP program stemmed from several factors: the need to recruit additional physicians, overcome dissatisfaction among members, and combat competition. Soon after the IP program was officially implemented in May 1971, one of these factors quickly disappeared: the physician shortage. During the 1970s, large numbers of Soviet physicians arrived in Israel and KHC was able to attract them to its clinics. Nonetheless, the program continued to grow primarily in response to the competitive threat from the smaller sick funds. The benefits provided to various groups which are the major factors responsible for the program's growth, will be reviewed in Section 3.

Figure 2

KHC Members Enrolled with IPs, 1972-1988



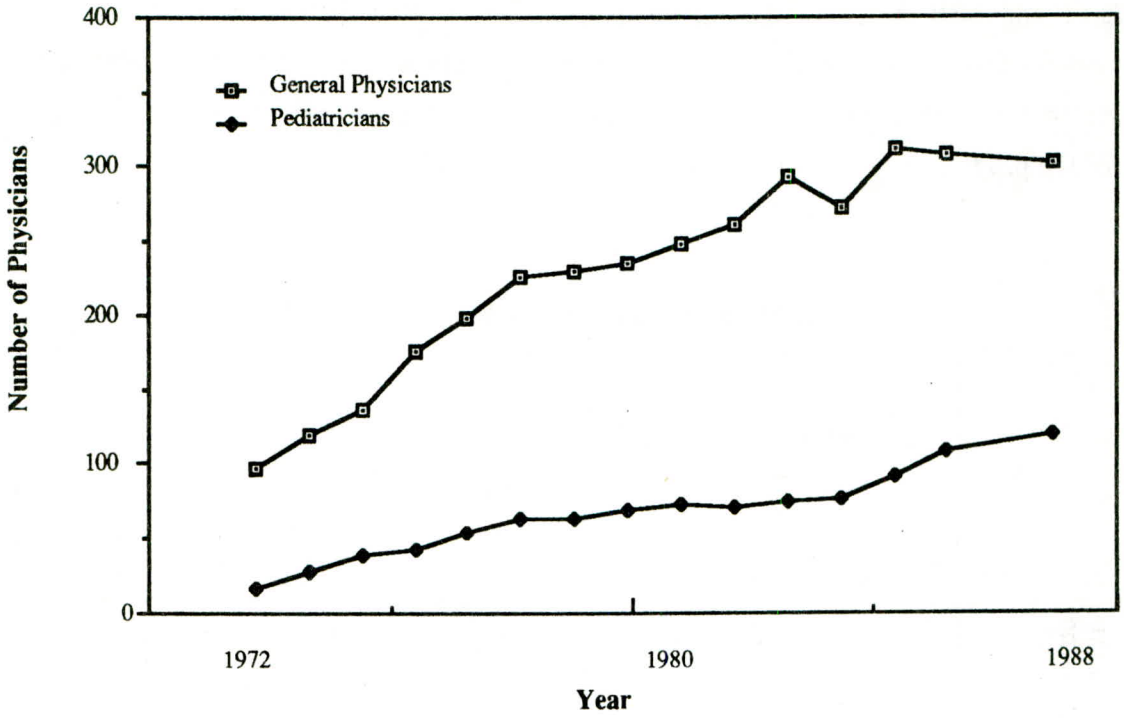
Figures 2 and 3 depict the development of the IP program between 1972 and 1988. Note that in 1985, the growth in the enrollment of adults with IPs was halted because of the financial crisis at KHC (the program was considered costly and something of a frill)[5]. In 1987, when it became clear that many younger and more educated persons were opting for the competition over KHC, top management once again became very interested in the future of the IP program.

[5] In that same year, the volume of visits to IP specialists was cut back dramatically.

In the same period, while the total membership in KHC grew from 2.2 million to 3.3 million, the IP program grew even more rapidly. Thus while the IP members accounted for less than one half a percent of the total membership in 1972, in 1988 they accounted for nearly five percent.

Figure 3

Number of IPs Working with KHC, 1972-1988



Source: Kupat Holim—Institutions and Services, 1988

Figure 4 presents data on the percentage of KHC members cared for by IPs by Kupat Holim administrative region. Note that the program is relatively large in centrally located regions—Petah Tikva, Hasharon, etc. It is precisely in those regions that KHC has faced the most intense competition from the smaller sick funds[6]. In outlying areas such as the Negev and the Upper Galilee, the IP program is virtually non-existent, despite the fact that from a cost perspective the IP option might be particularly suited to such sparsely populated areas.

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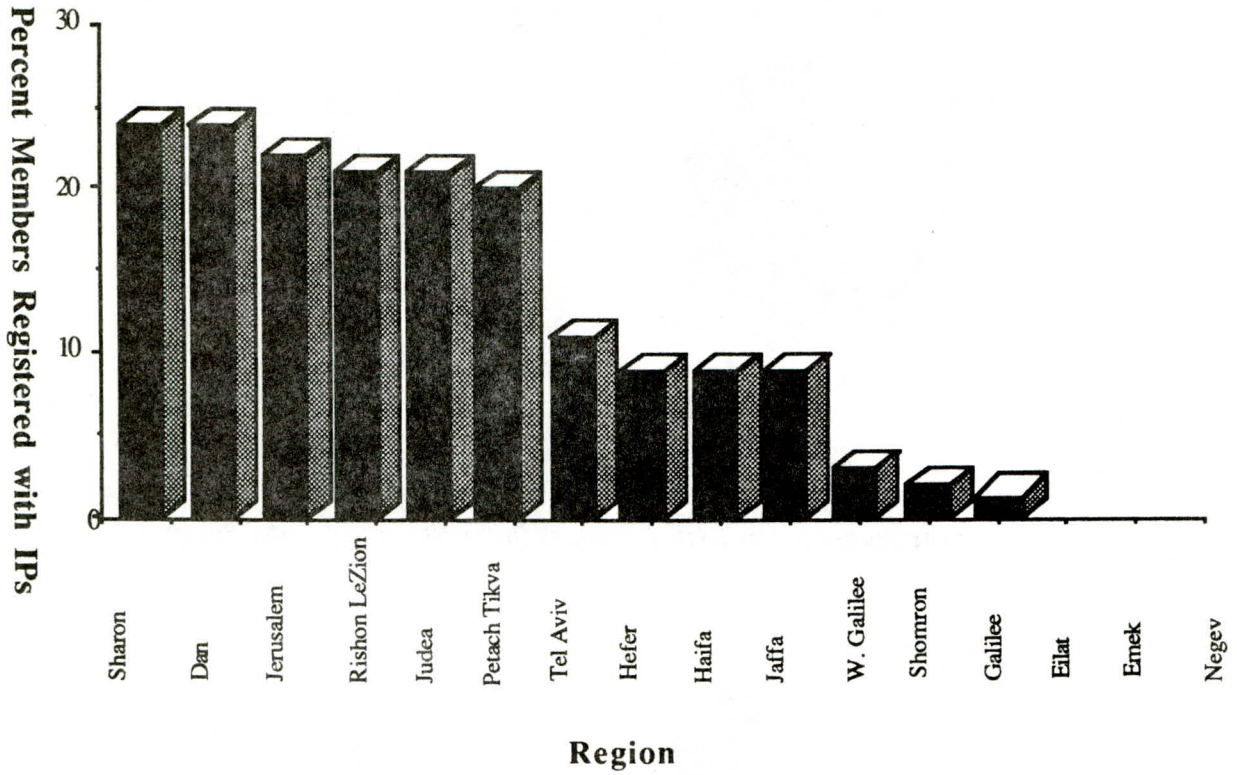
[6]If the major objective of the IP program had still been to attract physicians to under-served areas, the program would have been expanded in peripheral areas at least to the extent that it was introduced into centrally-located areas.

Figure 4

Percent Members Registered with IPs by Region



Figures 5 and 6 depict the distribution of members in the Rishon LeZion region. The region has approximately 190,000 members who receive care in 65 clinics. Four community clinics—Ramat Eliahu, Dror, Jerusalem and Goldrosen—account for 34% of total KHC membership in the Rishon LeZion region but for 67% of IP members. These four clinics are also located in moderate to upper income neighborhoods.

Figures 4, 5, and 6 suggest that enrollment in the IP program is not dependent solely on the preferences of the individual members. KHC policy also plays a major role. KHC has targeted the program in those areas where the most affluent (and therefore, lucrative) potential members reside and where it faces the stiffest competition from the smaller sick funds. It has also implemented the program in areas where KHC clinics have not been built. In contrast, there are regions, and areas within regions, in which the IP option does not exist.

Figure 5

Distribution of IP Patients in the Rishon LeZion Region

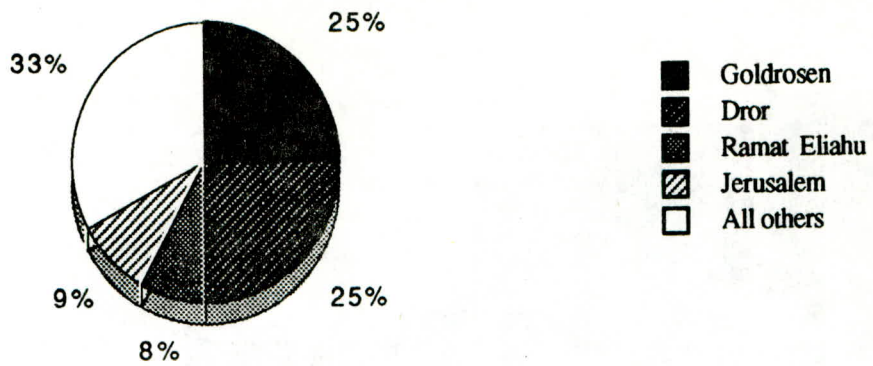
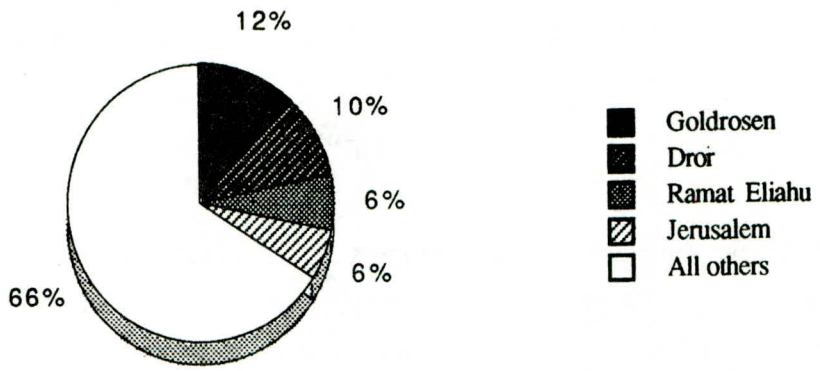


Figure 6

Distribution of all KHC Members in the Rishon LeZion Region



Source: KHC membership file

3 BENEFITS OF THE IP PROGRAM

The reasons for the development of the program since 1971 do not necessarily coincide with the reasons for implementing the program in the first place. The IP program has survived and flourished because it has provided important benefits to various interest groups affiliated with KHC. This section explores the benefits provided to members, to KHC as an organization, to the independent physicians, to KHC regional managers, and to the clinic physicians. The concerns about the IP program that were raised by the persons interviewed are presented in Section 4.

Benefits to Members

The independent physician model offers several features which appeal to potential members. To begin with, the existence of the IP program broadens the member's choice of physicians. The patient can chose any IP in the region and is not confined to the handful of physicians in his neighborhood clinic. In addition, the IP's office offers greater privacy and intimacy than the clinic, and waiting times are reported to be shorter.

In many cases the IP's office may be closer to the patient's home than the nearest clinic. Most clinics are open from 8 a.m. - 12 a.m. twice a week, 8 a.m. -2 p.m. twice a week, and 8 a.m. - 12 a.m. plus 4 p.m. - 7 p.m. twice a week. IPs tend to be open more often early in the morning and during the evening hours—a set-up which appeals to many working persons.

Some dimensions of quality are also perceived to be higher in the IP setting. Some of the patients interviewed felt that the average IP physician is more skilled than the average clinic physician, perhaps, in part, because a higher percentage of IPs work in hospitals or received advanced training in family medicine. In addition, other respondents noted that the average visit to IP physicians lasts longer than the average visit to a clinic physician, though this has not yet been demonstrated.[7] Longer visits

[7] It is important to distinguish among three related concepts: the amount of time a physician spends with a patient in the course of a year, the amount of time spent in each visit, and the number of visits per patient per year. Clearly,
TIME/PATIENT-YEAR = (TIME/VISIT) X (VISITS/PATIENT-YEAR)

provide greater opportunity for more thorough history-taking, physical examination, and patient education. This could, in turn, have an impact on both the patient's health and the likelihood that the patient will feel that an additional visit is needed in order to receive a comprehensive response to his problem. Several respondents expressed the belief that the IP was less likely than a clinic physician to hand a patient a prescription or a referral to a specialist simply to get the patient out of the office.

Benefits to KHC as an Organization

KHC's market share is currently about 75%, but in the past it was significantly higher. The smaller sick funds, which rely overwhelmingly on independent physicians rather than clinics[8], have proven to be increasingly attractive, particularly to the younger, healthier, and better-paid individuals who are the most lucrative members for a sick fund. In recent years, the top management of KHC has encouraged the growth of the IP program, primarily as a strategic response to the competitive threat posed by the nation's smaller sick funds (see Section 2). Thus, it is not surprising that in many respects, the IP in KHC works in a manner similar to that of physicians in Kupat Holim Meuhedet and Kupat Holim Maccabi.[9] (Rosen, 1988).

The distribution of IPs among regions can also be explained in terms of the competitive threat posed by the smaller sick funds. These sick funds have focused their marketing efforts in the centrally located areas. The KHC leadership responded by developing the IP program most intensively in those areas. In the outlying areas, where KHC continues to enjoy a virtual monopoly, the leadership has the luxury of being able to adhere more closely to its professional and ideological values by basing services exclusively on the clinic model (see Figure 3).

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where TIME/VISIT and VISITS/PATIENT-YEAR are probably not independent. It is generally believed that TIME/VISIT is greater in the case of IPs while VISITS/YEAR is greater in the case of clinic physicians. These hypotheses must be tested empirically. Such an empirical study would also yield information on how these two factors balance out and affect TIME/PATIENT-YEAR, the indicator of resource use. It will also be important to assess the relationship between each of the three variables upon the quality of care.

[8] Historically, these smaller sick funds emphasized the independent physician approach over the clinic approach both because they lacked the capital necessary to build clinics and because the physicians who were relatively more powerful in these sick funds preferred to maintain their independence.

[9] It should be noted that most primary care physicians in these two sick funds are paid on what is referred to in Israel as an "active capitation" basis (receiving the capitation fee only for those patients who visit at least once in the course of the three month period), whereas KHC uses the simple capitation method (Rosen and Ellencweig, 1987).

In certain regions of the country, the independent physician approach can also be a vehicle for reducing costs. When it contracts with IPs, Kupat Holim does not have to invest scarce capital in building a clinic. In addition, the sick fund need not employ nurses, pharmacists, clerks and maintenance workers who, as a group, account for approximately half of total personnel costs in the clinics. Finally, the sick fund retains much greater budgetary flexibility when contracting with independent physicians. As is the case with most salaried employees in Israel, clinic personnel are tenured whereas the contracts of independent physicians are reviewed annually and the sick fund is under no obligation to renew them. This can be particularly important for the sick fund during periods of tight budgets and retrenchment. For example, during the sick fund's financial crisis in 1985, the number of members allowed to receive specialty care from independent specialist physicians was reduced by over 50%.

Just as the IP program provides flexibility in periods of retrenchment, it provides flexibility in periods of prosperity. In times of relative prosperity, the IP program affords management an opportunity to provide additional compensation to a subset of the sick fund's physicians without having to increase the wages of the bulk of the medical staff and other professionals in the clinics whose wages are linked to the physicians.

One of the informants suggested yet another advantage for KHC leadership from the continued existence of even a small IP program. The existence of an alternative to the clinic model increases the bargaining power of management in negotiations with the representatives of the clinic physicians. If wage or other demands become too great, the management has the option to shift members from the clinics to the IP program. While it is difficult to lay-off clinic physicians due to the fact that they have tenure, a reduction in clinic volume would permit reduction of the clinic work-force through attrition.

Finally, several informants argued that the IP program enables KHC to increase physician income without major disruptions of labor relations (i.e., relations with nurses and clerks unions) and without violating national pay agreements which risks confrontation with the Treasury.

Benefits To Independent Physicians

The IP program provides substantial financial rewards for participating physicians. At the end of 1989, independent physicians received a monthly capitation fee of 12.1 NIS per registered adult (10.5 NIS + V.A.T.) and 13.8 NIS per registered child (12 NIS + V.A.T.). Thus, an IP with 400 adult patients grosses almost 5,000 NIS per month and an IP with 2,000 adult patients would gross (prior to practice expenses, value-added tax, income tax, etc.) almost 25,000 NIS per month. Clearly, the physician's take-home pay is far less, as taxes, supplies, rent, and other expenses must be deducted. It has been estimated that for large practices, the physician's take-home pay is approximately one-third of the gross; for small practices the net/gross ratio is likely to be somewhat lower as rent and several other expenditure categories constitute fixed costs. Still, working as an IP is far more lucrative for the physician than working in a clinic, where each month a typical physician with 2,000 adult patients costs the sick fund about 5,000 NIS, grosses about 3,500 NIS and (at average tax rate of 30%) nets approximately 2,500 NIS. Note that in 1989, the exchange rate was approximately $1 U.S. = 2 NIS; the median gross taxable income for wage-earners in Israel at that time was 1,800 NIS ($900) per month[10].

In addition to the financial rewards, an independent practice offers the physician several advantages over a clinic practice. Hours are far more flexible, making it possible for the physician to maintain a full-time hospital position, or receive patients from other sick funds and maintain a private practice. Medical and administrative supervision is far less pervasive than in the clinics. In general, the IP is his own boss and can organize his practice as he sees fit.

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[10] The historical reasons for the lucrative rates paid to IPs are unclear. There is some evidence that when it introduced the IP program, KHC adopted the capitation rate which prevailed among the smaller funds, despite differences in the systems: in the smaller funds the active capitation system is used, while in KHC the simple capitation system is used. In other words, in KHC the physician gets the quarterly capitation fee whether or not the patient visits him during the quarter, while in the smaller funds the payment is made only if the patient visits in the course of the quarter. This means that the effective pay per visit is higher in KHC; how much higher depends on the percentage of members who visit at least once each quarter.

It may be that to attract physicians to a new program, KHC had to offer a rate competitive with the smaller funds. Potential physician participants might not have been open to complicated explanations about the need to make adjustments for the difference between active and simple capitation; KHC's ability to staff the new program might have depended on its bid in terms of the readily comparable shekel rate. As the program was small at its inception, the overall cost impact of the level of the capitation was probably perceived within KHC as minimal.

Whatever the origin of the high rate, its persistence is probably partly due to the fact that many of the high-ranking medical managers in KHC work part-time as IPs. In addition, in Israel as well as other countries, once a benefit is given, it is very hard to take it away.

Note, however, that while many physicians are interested in working as IPs, others prefer the job and income security which a clinic practice offers. Having to shoulder all the administrative detail involved in dealing with the VAT authorities, the income tax authorities and landlords is something which many physicians are happy to avoid. Finally, the presence in the clinics of a readily available peer group is important to some physicians, for both professional and social reasons.

Benefits to the Regional Management

Many of the benefits discussed above with regard to top management apply to the management of KHC's 14 regions as well. In addition, the ability to decide who will be granted a license to work as an IP is an important source of power for regional managers. The central office lays down guidelines regarding who can work as an IP as well as standards which must be met regarding availability, training, etc. However, far more physicians are interested in working as IPs than the sick fund can accommodate. The choice of who shall get the lucrative licenses rests almost exclusively with the regional managers. While this power can potentially be abused, it also serves as an important managerial tool[11]. Reportedly, many regional managers use these licenses as "rewards" which can be used to induce physicians to work in hard-to-staff areas and clinics. The regional managers can say to individual physicians: If you work during the morning in the clinic in low-income area X, I will let you develop an IP practice of up to 400 patients during the afternoon in middle-income area Y.

Benefits to Clinic Physicians

As noted above, clinic physicians and other clinic personnel have much to fear from the IP program. Their concerns are offset somewhat by the fact that the program's existence reduces queues in the clinics. But the principal mechanism through which KHC management has secured the acceptance of the IP program by clinic physicians and their union has been by enabling them to participate in the benefits which the program has to offer. KHC management made it clear to these physicians that the sick fund was interested in the continued existence of the program and that if the clinic physicians did not wish to participate in the IP program as a supplement to their clinic

[11] It should be pointed out that because of KHC's centralized structure, there are not many managerial tools at the disposal of regional managers.

work, the sick fund would offer opportunities to hospital-based physicians to work as IPs. In light of this ultimatum, the clinic physicians recognized that it was in their interest to get in on what was clearly a financially rewarding program.

Benefits of the IP Program: A Synthesis

As can be seen, the reasons for the growth of the IP program since 1971 are not identical to the reasons for its development at the outset. The IP program became an institutional vehicle for the satisfaction of various interests and needs quite apart from the issues of over-crowding, anonymity, lack of physicians, and competition which played a part in its creation. While consumer demand for a form of care similar to that available in the smaller sick funds remained a prime force behind the growth of the IP program, several other factors played a major role. Physicians were eager to participate because the program offered them large financial rewards and professional satisfaction. KHC management responded to these demands from consumers and physicians and developed the program in a manner which enhances management flexibility and power.

4 CONCERNS AND PROBLEMS

In the course of discussions with KHC managers, physicians, and members, numerous criticisms of the IP program were voiced. These concerns—about equity, quality of care, cost, and labor relations—are presented in this section along with some data related directly to these concerns.

Equity

Perhaps the most important public policy issue raised by the existence of two different models of primary care provision is whether it leads to a two-class system of care. It is important to remember that enrollment in the IP program is not dependent solely on the preferences of the individual members; KHC policy also plays a major role. There are regions (such as the Negev and Eilat), and areas within regions, in which the IP option does not exist. Several informants interviewed suggested that this is due to deliberate policy decisions on the part of KHC management to limit the IP program to centrally-located, generally wealthier areas of the country (see Figure 3) where KHC faces stiff competition from the smaller sick funds. Other informants suggested that this is due to policy decision on the regional rather than national level. At the same time, there are other areas in which KHC clinics have not been built and KHC management in those areas refers all enrollees to independent physicians.

Within a region, the independent physician program is reported to be more available in those areas with wealthier populations, as reflected in Figure 4. There reportedly exists some filtering—even at the clinic level—where the clerk in the community clinic directs both the poorer patients to the clinic (in the belief that the revenues received by the sick fund for these patients would not cover the costs of the IP option, which is believed to be more expensive) as well as the more illness prone patients (in the belief that the continuity provided by the clinic is important for such patients).

Some summary data on the characteristics of IP patients and clinic patients in the Rishon LeZion region are presented in Table 1. The data should not be assumed to be

representative of all KHC regions. The average age in the clinics is slightly higher (31.3 v. 27.9) and a higher percentage of the patients are over 60 (12.4% v. 8.8%). However, the differences in age composition are not as great as many persons believe. The same can be said of the difference in the percentage of members in each group registered as having at least one chronic condition, a useful indicator of health status.

The socioeconomic differences among the two groups may be more significant. The rate of adult clinic patients on welfare is more than double the rate among IP patients. And, while approximately half of the clinic patients in the Rishon LeZion region live in the city of Rishon LeZion, almost three-quarters of the IP patients live there. This is a very gross, but nonetheless useful, measure of socioeconomic status as the city of Rishon LeZion is characterized, on average, by higher socioeconomic status than the rural settlements and the two other cities in the region (Ramle and Lod).

Table 1
Selected Sociodemographic Characteristics
By Patient Group (Rishon LeZion Region)

	Clinic Patients	**IP Patients**
Average Age	31.3	27.9
Percent on Welfare	3.3%	1.1%
Percent Living in Rishon	43.1%	72.6%
Percent With at Least One Chronic Condition	13.8%	11.2%
Percent Male	48.2%	48.5%
Percent 60+	12.4%	8.8%
N	6,924	6,964

Source : KHC membership file

In sum, the patient groups differ from one another with regard to a variety of characteristics. This should not lead automatically to the conclusion that there is an equity problem, with certain population subgroups getting a "better" type of care. As

discussed further in the sections that follow, it is quite possible that the clinic model is more appropriate for certain types of members and the IP model for others.[12]

Moreover, even if the clinic model is ultimately found to be "inferior" in some objective sense, one should be wary of concluding that a concentration of old and poor in the clinic setting is solely due to discriminatory behavior on the part of the sick fund. Differences between the two groups in age composition and socioeconomic composition are probably due to a combination of three factors:

a) self-selection on the part of patients,

b) screening out of certain types of patients by individual physicians, or

c) decisions by executives responsible for the IP program regarding the areas in which the program should be developed.

At this stage in our research program we do not know which of the three factors is the most influential.

Quality of Care and Quality of Service

It should be noted that while the two models of care are clearly different, it is by no means obvious that the IP model is superior. Several of our interviewees claimed that the clinic model offers several advantages in terms of quality of care. While the IP usually works as a solo practitioner, the typical clinic employs several physicians. This presents opportunities for consultation and peer review.[13] Moreover, the clinics employ approximately one nurse for every 1,600 patients under the age of 13, one nurse for

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[12] If all KHC members had had the opportunity to choose freely between the two practice settings then there would be less cause for concern. One could hypothesize that by and large members would select that model which is most appropriate for them. However, there is anecdotal evidence that patients lack the facts needed to make informed choices and that in some regions the IP option is either unavailable or restricted. Other informants deny that such restrictions exist, at least as a widespread phenomenon. Moreover, change may be underway in this regard, as KHC is giving a great deal of publicity to its efforts to expand patient choices. As part of our subsequent research we will seek to document the prevalence and nature of restrictions on freedom of choice of physician.

It should be noted, however, that freedom of choice alone will not necessarily ensure equity. Differences in the amount of resources allocated to each program remains an important issue. If, for example, the IP program was much more generously funded than the clinics, it could offer amenities not available in the clinics. Even if completely free to choose between the two options, persons with multiple chronic illnesses would probably tend to choose the clinic option because of the ready availability of nursing and pharmacy services. While the clinic option constitutes the "better" option for them, questions still remain regarding the fairness of a situation which in effect forces them to forgo amenities available to healthier persons.

[13] Several informants suggested that while theoretically the clinics provide a setting conducive to peer review, in practice there is little interaction of this sort among clinic physicians. They also question the contribution of the clinic nurse to the care process and suggest that, at present at least, the nurses' time is taken up primarily with the traditional, technical tasks.

every 2,000 adult patient in clinics where physicians and nurses have been organized in teams, and one nurse for every 3,500 adult patients elsewhere. In addition to their traditional roles of administering treatments such as redoing bandages and providing inoculations, KHC nurses are increasingly involved in follow-up, patient education, and health promotion. As only a very small percentage of IPs employ nurses in their practices, the patient will not receive such services unless he goes to the clinic nurse or the IP provides them himself.

Other interviewees suggested that the single most important advantage of the clinic in terms of quality as well as convenience is that it offers one-stop shopping. In one setting the patient can meet with the physician, receive care from the nurse, have prescriptions filled by the pharmacist, and meet with the clerk to deal with administrative issues. Access to pharmacy services can be particularly problematic for IP patients who see their physician during the evening hours and are given prescriptions, only to find that they must wait until the following day to have them filled[14]. However, the authors note that overall waiting time might still be less for IP members. The issues of waiting time and amenities will be discussed further in Section 5 where the benefits of the IP program are described.

Other quality concerns regarding the IP program have also been noted. Physical facilities, in terms of space, cleanliness and the availability of rest rooms, are widely believed to be superior in the clinics. With several physicians working in the same setting, cross-coverage during vacations and periods of reserve duty is more easily arranged than in the case of IPs. The IP makes certain commitments when he signs a contract regarding the physical setting of his practice and availability, but it is not known to what extent these commitments are honored in practice. Remember that the IP's contractual relationship is not with the nearby clinic, but with the regional director. The regional directors do not have the time or staff to carry out quality control activities with regard to all the IPs in their regions.

It should be noted, however, that the IP program may have advantages with regard to other aspects of quality. The IPs are reported to spend more time per visit with their patients. In addition, until appointment systems were recently introduced in the clinics, patients often had to wait in excess of an hour to see a clinic physician. In the IP

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[14] Recently, the problem has been alleviated somewhat in urban areas, where it was decided to keep one clinic pharmacy in each city open until 8 p.m.

setting waiting times are believed to be much shorter[15]. Unfortunately, no hard data exist with regard to these issues. They will be explored further in Section 5 below.

Cost

Many of those interviewed were critical of the IP program on cost grounds. Several cited a 1983 internal KHC study (Brody, 1985) which found that in terms of primary care costs, the independent physician model is approximately 30% more expensive than the clinic model.[16] Moreover, when KHC management thinks about whether to shift patients from the clinic setting to the IP setting, or vice versa, it is keenly aware of the fact that many of the costs in the clinics are fixed, so that shifting a small number of patients to IP setting means increased payments to the IPs without offsetting reductions in depreciation, financing, maintenance and clerical costs in the clinics. Some of the interviewees argued that money used to expand the IP program could be better utilized in improving the care within the clinics.

Although the interviewees focused heavily on primary care costs, these costs account for only one-quarter of total health expenditures.[17] The relationship between practice setting and costs for other major expenditure items cannot be deduced by theoretical considerations alone. On the one hand, IPs are reimbursed on a capitation basis and as a result have an incentive to maximize their practice sizes (Reinhardt, 1985). By frequently referring patients to specialists and hospitals instead of inviting them back for return visits, an IP can maintain a large practice without having to work many hours. At present, IPs are not at risk financially for the referrals that they generate and no attempt has been made to monitor and control their referrals through administrative means. On the other hand, IPs have an incentive to keep their patients satisfied and one way to do so is to try to minimize the amount of run-around—including both visits to the clinic and visits to the specialists. In addition, IP patients may use nursing and

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[15] The more relaxed pace of the IP setting may be due more to the higher rates of compensation which allow these physicians to schedule fewer patients per hour and less to structural issues such as the mode of reimbursement and the practice setting.

[16] The cost differential for primary care is naturally sensitive to changes in the payment rate for IPs and the salary levels of clinic physicians.

[17] In 1987, KHC spent approximately $370 per member on health services. Inpatient care is KHC's single largest cost component, accounting for roughly 45% of total outlays. The other major cost components are primary care clinics, specialty clinics (hospital outpatient clinics and community-based specialty care centers), and pharmaceuticals, accounting, respectively, for 25%, 15% and 10% of total KHC outlays.

pharmacy services less than their clinic counterparts because of the inconvenience involved in having to travel from the IP's office to the clinic. IPs reportedly have a more leisurely pace of work (i.e., the number of patients who visit the office per hour is lower than in the clinics). This leads to less of an interest in referring patients to specialists and nurses merely in order to ease the pressure and provides the primary care physician with more time to provide some of the services which might otherwise be provided by nurses and specialists.

Labor Relations

Clinic physicians, nurses and other clinic personnel have been affected by the growth of the IP program in several ways. On the one hand, IPs do take some of the burden off the clinics. At the same time, if the IP program grows substantially, it may be at the expense of jobs in the clinics. Many clinic personnel also resent the favorable terms under which IPs operate. The focus of their resentment is the high capitation rate used to calculate compensation for the IPs. This resentment is exacerbated by the fact that the clinic provides a variety of professional and administrative services to IP patients, without any special compensation for the clinic personnel. Clinic personnel also contend that IPs engage in skimming – selecting the healthiest and most lucrative patients while leaving the more difficult patients and those ethnic groups which tend to be high users of primary care services to the clinics.

Concerns about the IP Program: A Synthesis

Concerns over equity and quality, which were first raised during the initiation phase of the IP program, continue to be expressed over its future expansion. In addition, several new concerns have emerged: the program's cost and its effect on labor relations. There are some indications that cost has played a major role in slowing the growth of the IP program, and it is conceivable that other factors including institutional inertia, may have played a similar role, albeit to a lesser extent.

5 RECENT DEVELOPMENTS

In May, 1988 a new Director-General was appointed for Kupat Holim. He, in turn, made various changes in both structure and personnel. The new management team is perceived as being less tied to the traditional KHC ideology than its predecessor and as being representative of a new generation of professional managers. Responding to financial pressures, they have tried to introduce a more business-oriented approach. For example, there has been a growing interest in assessing the full cost implications of the two models, taking into account hospital pharmaceutical, and primary care costs.

One of the principal short-term objectives of the new leadership team has been to improve the primary care clinics, with special attention to the customer service dimension of care. The implementation of appointment systems, which historically were one of the hallmarks of the independent physician, and whose introduction into the clinics was begun under the previous administration, has been accelerated and such systems now exist in most of the urban clinics. The role of capitation payments in the reimbursement of clinic physicians has been strengthened, encouraging clinic physicians to compete with one another for patients, and total compensation of clinic physicians has been markedly increased. Perhaps, most significantly, the ability of members to select their primary care physician, and to switch from one physician to another, has been increased. It may be that these changes in the clinics will effect satisfaction levels, quality of care, and expenditure levels.

These changes are narrowing the differences between the clinic and IP models, but the two are still quite distinct. Traditional differences with regard to the physician-sick fund relationship and the practice setting remain. In the reimbursement area substantial differences remain: for IPs, capitation fees account for 100% of their income from KHC while for clinic physicians capitation fees are expected, on average, to account for at most 25% of income.

As the possibility of developing intermediate models increases, it becomes important to pinpoint about which dimensions of the IP and clinic models account for differences in performance. Consider, for example, the reported tendency of IPs to spend more time in each visit than clinic physicians. There could be several possible explanations for

this purported phenomenon. It could be that the IPs provide "better care" than the assembly-line medicine available in the clinic by providing fewer, longer visits but total time per patient-month is the same in the two settings. It could also be that the higher pay received by independent physicians allows them to take on fewer patients in relation to the number of hours worked per week and to dedicate more time per month to each patient. Similarly, it could be that the members who sign up with IPs tend to be younger and healthier, and therefore tend to visit the physician less frequently—leaving more time for each visit even though total visit time per patient-month is lower than in the clinic setting.

CONCLUSION

The principal objective of this paper has been to explain how the IP program has survived despite its being at variance with important elements of KHC's ideology and objectives. Accordingly, the discussion focused on the perceptions of various interest groups regarding the advantages and disadvantages of the IP program and did not examine, in depth, the validity of those perceptions. In planning for the future, however, it becomes more important to assess the true impact of the program on cost, quality, and equity. Recent developments within the sick fund suggest that interest in such assessments is increasing.

At this stage in KHC's evolution, it is important to ask not whether the clinic or the IP approach is "better" in some absolute sense, but what are the advantages of each and which is most appropriate for particular types of patients. As the IP model and the clinic model each has its strong points, it is not surprising that different people will have different preferences. For some persons evening hours are important, while others prefer the more traditional day-time hours of the clinics. For certain groups of patients (e.g., the elderly, persons without automobiles, etc.) the one-stop shopping available in the clinics may be the crucial factor in their choice between the two modes. For other types of patients, the short waiting times and privacy promised by the IP approach may be the determining factors in their choice.

Thus, in the coming years, KHC management is likely to carefully review the strengths and weaknesses of both the clinic program and the IP program. It is likely that it will maintain both programs, develop a series of intermediate forms, and work to correct the major drawbacks of each of the pure forms. Whether the overall shift will be in the direction of the clinic model or the IP model will depend on market developments, the influence of various interest groups within the sick fund, and the findings of empirical research regarding the impact of the two programs on cost, quality and equity. Findings from just such empirical studies will be reported in future publications in this series.

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דו"ח מחקר

מחקר דו"ח

רופאים עצמאיים בקופת חולים כללית

רקע היסטורי וארגוני

דן יובל וברוך רוזן
ג'וינט–מכון ברוקדייל

אורי גבאי ודני אופנהיים
קופת חולים כללית

המחקר מומן מקרן מרכז קובנס לניהול מערכות בריאות באמצעות המכון למחקר עסקים בישראל,
הפקולטה לניהול, אוניברסיטת תל–אביב

ג'וינט — מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה
גבעת־ג'וינט, ת.ד. 13087
ירושלים 91130

ג'וינט ישראל
גבעת ג'וינט, ת.ד. 3489
ירושלים 91034

דמ-19-91

מהו ג'וינט-מכון ברוקדייל?

מרכז ארצי לחקר הזקנה, מדיניות בריאות והתפתחות אדם וחברה בישראל.

מוסד עצמאי ללא כוונת רווח, הפועל בחסות ממשלת ישראל והג'וינט העולמי.

צוות מומחים המתמקד בזיהוי סוגיות מרכזיות ונוקט גישה רב-תחומית לפתרון בעיות במערכות שירותי רווחה ובריאות.

נקודת מפגש לחוקרים, מעצבי מדיניות ואנשי מקצוע, המסייעים לקשור את ממצאי המחקר לביצועם של שינויים בשטח.

מרכז לשיתוף פעולה בין ישראל לקהילה הבינלאומית.

תכנית לחקר מדיניות בריאות בישראל

בתגובה למשבר המעמיק בשירותי הבריאות ולבקשת ממשלת ישראל, פיתח ג'וינט-מכון ברוקדייל בשיתוף ג'וינט ישראל תכנית לחקר מדיניות בריאות בישראל. מטרת התכנית היא לתרום למאמצים לשיפור מימון שירותי הבריאות והספקתם דרך ניתוחן של סוגיות מדיניות נבחרות. לתכנית שלושה יעדים עיקריים:

- לסייע לממשלת ישראל בתהליך התכנון, הביצוע וההערכה של רפורמות מרכזיות לשיפור ניהול מערכות בריאות.
- לסייע לספקי שירותי בריאות ולמבטחים בישראל במאמציהם לשפר את יעילותם ואת מועילותם.
- לפתח פרוייקטים מחקריים אשר נועדו לתרום תרומה לטווח ארוך למערכת שירותי הבריאות בישראל.

רופאים עצמאיים בקופת חולים כללית

רקע היסטורי וארגוני

דן יובל וברוך רוזן
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המחקר מומן מקרן מרכז קובנס לניהול מערכות בריאות באמצעות המכון למחקר עסקים בישראל,
הפקולטה לניהול, אוניברסיטת תל-אביב, ובסיוע ג'וינט ישראל

אדר תשנ"א — מרץ 1991

ירושלים

תאריך	תאריך	תאריך

Yuval, D. ; Rosen, B. שם המחבר

INDEPENDENT PHYSICIANS IN שם הספר

KUPAT HOLIM CLALIT...

שם השואל	תאריך	חתימה
MAIJA AARIKKA		

רשימת פרסומים נבחרים

של התוכנית לחקר מדיניות הבריאות

ע – פרסום בעברית　　א – פרסום באנגלית

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תקציר

קופת חולים כללית היא הארגון הגדול בישראל לאספקת שירותי בריאות. מספר חבריה עולה על שלושה מיליון איש. כ–95% מחברי הקופה מקבלים טיפול ראשוני במרפאות קהילתיות, בעוד 5% מקבלים טיפול זה במשרדו הפרטי של "רופא עצמאי".

בעבודה זו אנו מנתחים כיצד נוצרה והתרחבה שיטת הרופא העצמאי, וזאת בארגון שהוא בעל מחויבות היסטוריות ואידיאולוגית חזקה למרפאה הקהילתית. העבודה מבוססת בעיקר על ריאיונות עומק עם מנהלים בכירים במרכז קופת חולים ובמחוזות, ועם רופאים, אחיות, מזכירי מרפאה וחולים במחוז ירושלים.

בתחילה מתוארים ההבדלים העיקריים בין שתי השיטות. לאחר מכן מתואר הרקע הארגוני שהביא לאימוץ השיטה, והוא המחסור החמור ברופאים בקופ"ח כללית, והתחרות הגוברת מצד הקופות האחרות. בהמשך נבדקים הגורמים שהביאו להתרחבותה של השיטה. נטען, כי הסיבות לגידול זה אינן זהות לסיבות שהביאו להפעלת התכנית מלכתחילה וכי שיטת הרופא העצמאי הפכה להיות מכשיר מוסדי לסיפוק אינטרסים וצרכים, שהם שונים במידת מה מן הסוגיות שבגללן הוחל בתכנית באופן מקורי. אמנם, דרישת קבוצות אחדות של צרכנים לאופן טיפול הדומה לזה שמספקות הקופות הקטנות נותרה בעינה כאחד הגורמים העיקריים להתרחבות השיטה, אך היו מספר גורמים נוספים שגם הם שיחקו תפקיד מרכזי. הרופאים עצמם קיבלו בחיוב את השיטה, משום שהיא הציעה להם תגמול כספי ניכר ושביעות רצון מקצועית. הנהלת קופ"ח כללית נענתה לדרישות אלה מצד הצרכנים והרופאים, ופיתחה את התכנית בצורה שהגבירה את הגמישות הניהולית.

בעקבות התרחבות שיטת הרופא העצמאי, התעוררו חששות לגבי נושאי השיוויון והאיכות. חששות נוספים התעוררו לגבי עלות השיטה והשפעתה על היחסים בין מגזרי עובדים שונים. קיימת עדות מסוימת לכך שנושא העלות היה אחד הגורמים העיקריים שבגללו הואט קצב הרחבת השיטה, ויתכן שגורמים נוספים, כולל אינרציה מוסדית, השפיעו באותו כיוון, אם כי במידה מועטה יותר.

בסיום המאמר מובא תיאור של ההתפתחויות האחרונות שחלו בארגון הרפואה הראשונית בקופ"ח כללית, ומועלית האפשרות של פיתוח דגמי–ביניים אשר ישלבו יחדיו מרכיבים משיטת המרפאה ומשיטת הרופא העצמאי.

תוכן העניינים

רשימת תרשימים ולוחות

דברי תודה

בעת הכנת עבודה זו ריאיינו אנשי מקצוע רבים שהיו בעלי ידע נרחב לגבי תכנית הרופא העצמאי: פרץ בלומברג, ראובן קריסטל, מיכאל דור, חיים דורון, פנינה אייל, ססיליה פיגלר, יואל פרוינד, סטפן גריק, יפה חרמוני, אלימלך לברון, עמנואל מרקו, לזר מרום, טד מילר, דוד רונן, רון שפיר, נלו שביט ומרים צנגן. ברצוננו להודות לכל אחד מהם עבור הערותיהם והזמן שהקדישו לנו. כמו כן ברצוננו להודות לאנשי הצוות ולחברים במרפאות הקהילתיות "דרום" ו"גילה", שם ערכנו תצפיות וריאיונות, ולרוני מזרחי ומיכאל רוזנבלוט, שברשותם התבצע הדבר.

אנו מודים לאלה שקרׂאו את הטיוטות הראשונות של מאמר זה: תמרה ברנע, דוד חיניץ, מרק כהן, פני פלדמן, נורברט גולדפילד, ג'ק חביב, ננסי קיין, אירה מוסקוביץ, מילט ויינשטיין ויעקב זילברג. תשומות נוספות התקבלו כאשר העבודה הוצגה בצורות שונות, כולל בסמינרים מטעם מחלקת הכספים, מחלקת התכנון והמידע, והמחלקה הרפואית בקופ"ח כללית, הנהלת קופ"ח כללית במחוז ראשון לציון, ובכנס WONCA שנערך בירושלים.

ברצוננו לציין במיוחד את תרומתה של שפרה שוורץ, אשר היפנתה את תשומת ליבנו לצורך להעמיק את הניתוח ההיסטורי והיפנתה אותנו לחומר ולמקורות חשובים.

לבסוף, ברצוננו להודות לטרי בנינגה אשר ערכה את העבודה בכישרון רב.