Myers-JDC-Brookdale Institute
Smokler Center for Health Policy Research
Jerusalem

Jewish Healthcare Foundation
Pittsburgh

HOW HEALTH PLANS IN ISRAEL MANAGE THE CARE PROVIDED BY THEIR PHYSICIANS

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This report is being prepared within the context of an intensive, multi-staged collaboration between the Myers-JDC-Brookdale Institute in Jerusalem and the Pittsburgh-based Jewish Healthcare Foundation. The goal is to enable policymakers in the US to draw lessons from Israeli health care, and vice versa.

In the first stage of the project, two overview documents that provide useful background to the current report were produced:

- ***Healthcare in the US and Israel: Comparative Overview***
- ***Healthcare in Israel for US Audiences***

The former may be purchased from the JHF or the MJB Institute and both can be downloaded from the JHF and MJB websites.

The current phase of the project includes four monographs:

- ***The Role of the Government in Israel in Containing Costs and Promoting Better Services and Outcomes of Care***
- ***Primary Care in Israel: Accomplishments and Challenges***
- ***How Health Plans in Israel Manage the Care Provided by their Physicians***
- ***The Medical Workforce and Government-Supported Medical Education in Israel***

This paper focuses on how Israeli health plans manage the care of their physicians, including both primary care physicians (PCPs) and specialists, and how the overall intent, structure and financing of the health plans contribute to these efforts. A parallel paper focuses in on primary care and at the same time covers a broader array of mechanisms through which the health plans, the government and the physician associations contribute to the development of sophisticated primary care delivery systems.

This paper begins with a brief background on the Israeli health care system and its health plans. Next, it describes the activities of the health plans in the areas of cost containment, quality improvement and equity promotion, with special attention to those involving managing, or working with, individual physicians. The paper concludes with an analysis of the factors that facilitate care management in Israeli health plans.

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FOREWORD

Israel's National Health Insurance Law of 1995 transformed its healthcare system. The law guaranteed all of the country's citizens access to a government-funded "basket" of services, delivered by four, competing, nonprofit health plans (HMOs). This fifth installment in a series of monographs commissioned by the Jewish Healthcare Foundation describes how Israel's health plans manage care under the new law. Each plan has a long and unique history of providing care (each has been around for at least 80 years), and this has produced different orientations – from the decidedly socialist origins of Clalit to the strong free market bent of Maccabi. However, all have demonstrated both willingness and ability to adjust to the new requirements of the 1995 law. Moreover, they all share the challenge of containing costs and providing care to a population that demands high levels of healthcare access and quality.

Israel's reforms produced a nationwide effort to measure and monitor quality, to emphasize primary care, to develop community-based alternatives to hospital care, to implement sophisticated ambulatory-care HIT systems for evidence-based decision making and utilization review. There is much to learn from the different approaches with which the health plans deliver both efficient and high quality care, at half the per capita cost of the US.

Karen Wolk Feinstein, PhD
President and CEO
Jewish Healthcare Foundation

1. Israel's Health Care System and its Health Plans

In Israel, insurance coverage is guaranteed by the 1995 National Health Insurance (NHI) Law. All residents are free to choose from among the country's four, competing, nonprofit health plans, which are required to provide their members with a package of stipulated benefits in a timely and accessible manner. In return, the government gives the health plans a capitation payment that reflects the number of members in each plan and their age mix. The overall NHI system is financed primarily by income-linked taxation, which, together with various services provided directly by government, covers about two-thirds of total national health expenditures. Households cover the remaining third through a mix of out-of-pocket payments and supplemental insurance packages.[1]

Israel has only 4 health plans, and they are all nonprofit organizations. Their 2009 sizes and market shares are displayed in Table 1. As can be seen from the table, Clalit Health Services is the largest plan, with almost four million members and approximately half of the market. Even the smallest plan, Leumit Health Services, is large by international standards, with almost 700,000 members.

Table 1: Health Plan Membership, 2009

Health Plan	Membership (thousands)	Market Share (percent)
Clalit	3,863	53
Maccabi	1,781	24
Meuhedet	978	13
Leumit	677	9
Total	7,300	100

The plans have several important features in common. They are all well-established, as each of them has been around since at least the 1930s. They all are nationwide in scope, and as noted above, all have more than half a million members. They also all have sophisticated information technology (IT) systems, with all primary care physicians working with electronic health records.[2]

At the same time, there are several important differences among the plans. To begin with, they vary in their historical origins and this has had significant implications for their ideological orientations and mode of operation. Clalit was founded by the Labor Party-affiliated General

[1] Payments by households cover co-payments for certain services included in the NHI benefits package (such as visits to specialists and pharmaceuticals), as well as services not included in that package (such as dental care and optometric care).

[2] In contrast, the US has hundreds of health plans, many of which are relatively new. There is a mix of for-profit and nonprofit plans. Many are regional or local in scope, rather than national. They also vary widely in terms of size, with many having fewer than half a million members. The availability of electronic health records (EHRs) among primary care physicians varies widely, and they are more prevalent in staff model plans than in independent physician association (IPA) plans.

Federation of Labor and, as such, historically had a decidedly Socialist orientation. Leumit was founded by the Nationalist Workers Association, which was affiliated with Israel's right wing parties; thus, while it did not share Clalit's Socialist origins, both approached healthcare as a service to be provided within the context of broader national goals. Maccabi and Meuhedet, in contrast, were founded by physicians with a liberal, free-market orientation.

Thus, whereas in Clalit and Leumit, the starting point was a health plan created to meet members' needs, which then hired physicians, in Maccabi and Meuhedet the starting point was physicians who created health plans to provide a framework in which they could secure the funds needed to earn a living and meet patient needs. However, one should be careful not to overstate this difference, as even the Maccabi and Meuhedet health plans, as organizations, have been around for a very long time. The physicians working for them today were recruited into large bureaucratic organizations that had long outgrown their origins as simple physician cooperatives. Moreover, as Clalit historically had a very dominant market share (i.e., in excess of 80% until the early 1980s), its approach to healthcare and the nature of its relations with its physicians had a significant impact on the market and the broader societal context.

Other significant differences among the plans include size, the mix of members in terms of age, income and geographic location, the extent of reliance on salaried physicians (as opposed to independents), the extent of reliance on group practices (as opposed to solo practitioners), and whether they own acute care hospitals. A full comparison is presented in the appendix.

2. How Israeli Health Plans Manage Care

In the sections that follow, we will review how Israeli health plans manage care with regard to three key organizational objectives: cost containment, quality improvement and equity promotion. In the chapter that follows, we then consider what characteristics of Israeli health plans and the environment in which they operate make it possible for them to engage so intensively, and apparently successfully, in the management of care. In doing so, we will refer to the health plans as a group, even while recognizing that there are differences among them with regard to the ways in which they manage care and how intensively they do so.

3. Cost Containment

Of the three areas we will consider, cost containment was the first to engage the attention of health plan managers. Many of their cost containment efforts involve influencing the practice patterns of individual physicians, the focus of this report. However, before reviewing those physician management efforts, it is important to note that the health plans also engage in other types of efforts to control costs, including:

- **Utilization review of hospital care:** All of the health plans[3] rely heavily on other organizations for their members' hospital care. In light of the high cost of hospital care, the plans manage these expenditures intensively, through a mix of prior authorization requirements[4] (for elective care) and non-payment for treatments deemed unnecessary.
- **The development of community-based alternatives to hospital care**: These alternatives include community-based specialists, emergency care centers, ambulatory surgery clinics, secondary care centers, diagnostic services, etc.).
- **Discounted bulk purchasing** from hospitals and pharmaceutical manufacturers
- **Creation of a network of primary care providers throughout the country:** This promotes access to timely care and helps avoid complications.

Health plan efforts to control costs through the management of the care provided by their own physicians include the following:

1. **Devolvement and clear assignment of accountability for staying within budgets**: The health plans are large national organizations and get a global budget from the government for the care they provide for all their members throughout the country. However, the national headquarters of the plans are too far away from the actual delivery of care and their thousands of frontline physicians to directly manage the use of budgetary resources through the care delivery process. Instead, the national health plan budgets are allocated (along with accountability for how they are used) to regional and local managers who are in a far better position to work with frontline providers on cost containment issues.[5]
2. **Implementing systems for monitoring utilization and expenditures at the individual physician level:** These data are typically available both to individual physicians and their supervisors/health plan liaisons. They typically involve trend data over time, along with

[3] This is true even for Clalit, which operates a large network of hospitals. Over half of the plan's hospitalization needs are met through services purchased from other hospitals. In the other plans, over 90% of hospital services are purchased from hospitals not affiliated with the plan.

[4] These prior authorization requirements are facilitated by a system and culture of rapid responses to requests.

[5] This situation contrasts sharply with the situation in US Medicare, where no global budgets are set for regions, states or counties and the individual physician interfaces with Medicare either directly or through a largely passive (and strictly financial and non-managerial) intermediary.

comparisons with data from the broader organizational unit.[6] In some of the plans, these data include some form of case mix adjustment.

3. **Enhancing physicians' interest in, and commitment to, controlling costs:** Generally speaking, Israeli health plans do not give their physicians strong financial incentives to control costs. Instead:
   - They avoid perverse financial incentives to *increase* costs, by relying heavily on alternatives to fee-for-service remuneration arrangements[7]
   - They provide small, symbolic rewards to clinics and groups that do a good job of controlling costs[8] (in some of the plans) by, for example, sponsoring weekends at a resort hotel for the relevant team and their families
   - They share with the physicians information on the plan's financial situation and how the plan (and ultimately their own practices) would be affected by deficits
   - In cases where a physician has a substantially above-average utilization profile, a one-on-one discussion will take place between physician and supervisor that will include both coaching on how to contain costs as well as managerial pressure to contain costs
   - Already when recruiting physicians, health plans give preference to candidates who impress them at the interview as being capable of fitting in with the plan's cost containment efforts.
4. **Providing physicians with the information and skills needed to contain costs:** This includes:
   - Presentations on such issues as appropriate use of generic vs. brand medications and low-cost vs. high-cost diagnostic tests
   - Dissemination of written clinical guidelines
   - Intensive use of the health IT systems to provide real-time care recommendations, as well as the opportunity for physicians to override system-generated recommendations if they are deemed clinically inappropriate
5. **Prior authorization requirements:** In the case of certain very high cost medications, treatments and diagnostic tests, frontline physicians require prior authorizations from health plan physician-managers. The IT systems are used to prevent unauthorized actions by frontline physicians, facilitate the request for authorizations and streamline the handling of these requests.

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[6] Some, but not all, of the plans also provide comparative data from peer physicians or clinics, without identifying them by name.

[7] Primary care physicians are paid primarily on the basis of salary and/or capitation. Community-based specialists are paid in part on a per visit or per session basis, with certain procedures that do incur fee-for-service payments.

[8] In some of the plans, regions with good overall performance (taking into account cost control, membership growth/retention, member satisfaction, and quality of care) will be rewarded with special, though small, budgetary increments in the following year's budget.

Note that pay for performance (P4P) arrangements are almost non-existent in Israel, whereas they are quite widespread in the US. It may be that, with healthcare accounting for a stable share of GDP in Israel, the need to pursue this approach is less felt than in the US, where health has gone from 14% of GDP in 2000 to 17% in 2009.

4. Quality Improvement[9]

The health plans have been engaged in efforts to improve quality for several decades, and these intensified when some of the plans began to work with quality indicators in the late 1990s. They intensified yet further with the initiation of the National Quality Monitoring Project (NQMP) in 2000, in which all four plans work together on a common framework for defining and measuring the various quality indicators. The NQMP also publicizes data on quality performance for the nation as a whole, without (at this stage) publicizing the performance of the individual health plans.

As we found with regard to cost containment, here too some of the health plans' interventions involve working with/through the individual physician, while others are more systemic in nature. As might be expected, though, the mix here is somewhat different, as in quality improvement efforts, frontline providers are even more central than they are in cost containment efforts.

Systemic efforts to improve quality that largely transcend the frontline practitioners include:

- **Improving access to care**, through such measures as:
  - Transporting patients in outlying areas to specialized clinics and diagnostic facilities
  - Eliminating co-payments for certain key services
  - Promoting cultural responsiveness through staff training, staffing assignments, adaptation of printed materials, etc.
- **Changing the broader cultural/social context** (beyond the clinic), through such measures as:
  - Working with cultural and religious leaders to encourage various types of health-seeking and health-promoting behaviors
  - Working with municipalities to create walking routes and other health promoting environments.

[9] The analysis presented here is based largely on a forthcoming Myers-JDC-Brookdale Institute report by Bruce Rosen and Rachel Nissanholtz, entitled ***From Quality Information to Quality Improvements***.

Efforts to improve quality that primarily involve working with or through frontline physicians parallel those outlined above with regard to cost containment and include:

1. **Devolvement and clear assignment of accountability for providing high quality care:** As in the case of cost containment, top managers in the health plans hold their regional managers accountable for quality, and they in turn hold the managers of sub-regional organizational units similarly accountable. This devolvement of accountability continues to cascade down through the various levels of the organization until it reaches a physician manager who has a direct working relationship with the frontline physicians.
2. **Systems for monitoring quality at the level of the individual physician:** All the plans have the capacity to monitor quality of all the PCPs working with them on over 50 quality of care measures.[10] The PCPs can easily access data on their own performance and that of the organization units of which they are a part, as well as data on trends over time.
3. **Increasing physicians' motivation to invest energy in improving quality:**
   a. The types of motivators used include physicians' innate desires to:
      i. Do right by the patients and fulfill the medical mission
      ii. Achieve peer recognition
      iii. Achieve supervisor/organization recognition
   b. The specific mechanisms used to activate those motivators include:
      i. Periodic discussions with a supervisor on quality performance relative to the physician's reference group and his own past performance
      ii. Establishment of quantified quality goals (in some plans)
      iii. Publicly recognizing outstanding regions or clinics
      iv. Provision of small, symbolic rewards to clinics or branches with high quality (in some plans)
      v. Developing joint health plan-physician action plans on how to improve quality and providing the funding necessary to operationalize these plans.
   c. When recruiting physicians, health plans give preference to candidates who are committed to quality improvement and capable of fitting it with the plan's QI efforts.
4. **Providing physicians with the infrastructure, information, skills and support staff needed to promote quality of care:**
   a. **The IT infrastructure** is used to provide basic information on the care processes and outcomes that have been deemed to be the ingredients of good quality care. The IT system provides:
      i. Ongoing feedback on performance over time and relative to peer group
      ii. Just-in-time clinical reminders
      iii. Lists of patients in need of particular tests or procedures
      iv. Smart screens with relevant clinical information
      v. Drug compatibility and dosage checks
      vi. And much more...

[10] The measurement of quality for community-based specialists is still in its infancy.

b. **People-to-people interactions** to disseminate more complex input on how to bring about changes in patient behavior or improved practice organization. These interactions include: coaching by an immediate supervisor or quality specialists, meetings of peers and conferences. Most of the ideas that the health plan managers have on how to bring about the desired changes come from hearing about successful initiatives launched in other locations of the same health plan.

c. **Staff support**: The plans provide the physicians with assistance from nurses, clerical staff and others, who can carry out tasks that would otherwise fall on the physicians. These tasks include patient outreach, patient counseling and reminding patients about appointments for various tests or consultations.

d. **Continuing medical education**. The collective bargaining agreement provides for a certain number of hours per week of CME, funded by the health plans. Some of the courses are organized by the health plans, while others are organized by the medical schools.

Note that Israeli quality improvement efforts make little or no use[11] of two key tools that figure prominently in the US – public reporting of performance and P4P. It may be that the cultural and organizational differences between the two systems have led them to evolve quite different strategies in pursuit of the common goal of improving quality.

5. Equity Promotion

Of the three areas examined in this paper, efforts to promote equity constitute the newest arena for concerted action by the health plans. This area of activity is still in its early stages and we will therefore deal with it more briefly than the other cost and quality areas. Note also that two of the health plans (Clalit and Maccabi) have focused more intensively on equity promotion than the other two plans.

In this area of activity, most of the health plan initiatives to date have been at organization levels that transcend the individual physician. These include:

- Adopting equity (i.e., the narrowing of disparities) as a key organizational objective
- Measuring and monitoring the extent of the disparities
- Analyzing the causes of the disparities
- Targeting resources on those regions and clinics where the needs are greatest

[11] The exceptions are that, in some plans, well-performing clinics or groups will be rewarded with free weekends at resort hotels. In addition, as indicated in footnote 8, in some plans, regions with good overall performance are rewarded with small budgetary increments.

- Ensuring that underserved areas have sufficient numbers of effective managers and professionals

At the same time, the health plans are involving individual physicians and small groups of physicians in efforts to reduce disparities by:

1. Placing some of the responsibility for narrowing disparities on mid-level managers and frontline professionals, and
2. Developing targeted and tailored intervention programs.

It remains to be seen how health plan/physician interactions in this new area of activity will evolve over time.

6. Factors Facilitating Intensive Care Management

This monograph has described intensive activities on the part of Israel's health plans to manage physician behavior. Before concluding that these approaches are adaptable to other countries, it is worth exploring what makes it possible for Israeli health plans to manage the activities of their physicians to such an extent.

Surely, a major factor is that in Israel both physicians and patients are accustomed to a managed-care approach and mindset. Managed care has been around since before most Israelis were born. Moreover, *all* of the health insurers that offer basic health insurance under the National Health Insurance program function as managed care organizations, so there really is no non-managed care alternative for the basic services. Physicians are similarly used to being managed and patients are used to constraints, not only on their choice of provider, but also on how their physicians will care for them. Clearly, key building blocks of the managed-care backlash in the US (e.g., the sense that a new organizational form would intrude on the doctor-patient relationship) are absent in Israel. Indeed, the NHI Law built on the existing system, which was already dominated by managed care organizations and sought to further strengthen that system.

Another key factor is the existence of sophisticated information systems. This makes it possible to give clinicians vital information they need to manage the care of their patients. At the same time, it gives the managers tools for monitoring the care provided by physicians and even for imposing real-time limits on treatment options.

The organizational structures of the health plans also play an important role.[12] They make it possible to devolve responsibility through the different layers of the organization down to a manager who, on the one hand is committed to the organization's goals and, on the other hand, has a personal relationship with the frontline physicians and can understand their needs and concerns.

Also important is the fact that the lion's share of PCPs work for only one plan. This not only gives the plan greater power to influence physicians' behavior, it also makes it easier for the physicians and plans to develop a sense of shared purpose. Further, it means that most PCPs need work with only one computer system and one set of practice guidelines and constraints

Moreover, even in the case of specialists, who tend to work for more than one plan, their work context is quite different from their American counterparts. In Israel, all the insurers with whom the specialist works are managed care organizations working within a common NHI framework and they need work with at most four health plans. As a result, the messages physicians receive from all the plans are similar, even while differing in the details.

There are also broader, social and societal factors at work. In Israel, both patients and physicians know that the health plans are nonprofit organizations and, while they do have financial concerns, they are not motivated by shareholder interests and profit maximization. Moreover, they understand that the nation as a whole, via the government, plays a central role in financing and regulating healthcare, contributing to a sense of trust in the health system and an understanding of the need for, and legitimacy of, some sorts of constraints.

All these factors contribute to an environment in which health plans *could* manage the care provided by their physicians. Still, the effective realization of this potential has required, and continues to require, sensitivity and wisdom. Despite the strong and deeply rooted tradition of physicians working for organizations in Israeli healthcare, even in Israel, physicians continue to see themselves as more than ordinary organizational employees. They see themselves as highly trained professionals with a commitment to the care of their patients, which transcends that of the organizations with which they work. Accordingly, efforts by health plans to influence their practices in ways that either degrade their sense of professionalism or impair the quality of the care provided to their patients, are resisted by Israeli physicians. This resistance can take several forms, including strikes, oral and written protests, sluggish implementation of health plan directives, reduced work hours, reduced motivation, switching to another plan, etc.

As a result, health plans have generally tried to be careful to manage care in a manner that is respectful of their physicians. This has entailed:

- Taking seriously their complains and suggestions about the monitoring system and how it is being used

[12] The organization of the health plans share certain features with one of Israel's preeminent institutions – the Israel Defense Forces. Both try to combine hierarchical organization with substantial frontline initiative and autonomy. It would be useful in the future to consider the extent of these parallels and their limitations. See also, *Start-up Nation: The Story of Israel's Economic Miracle* by Dan Senor and Saul Singer.

- Providing support staff to spread the burden of implementing the monitoring system
- Focusing the monitoring on a district or clinic as a whole rather than on the individual physician
- Allowing physicians to override the practice protocols, as long as they provide explanations for doing so.

Accordingly, it may be that this paper would have been more appropriately titled "How Health Plans in Israel Work with their Physicians to Manage Care" rather than "How Health Plans in Israel Manage the Care Provided by their Physicians."

It is interesting to note that many of the strategies used by the health plans to manage costs have parallels among their strategies to promote quality. It would be useful to assess the extent of these parallels and the exceptions to them, the reasons for the parallels, and whether they are appropriate. It would also be useful to examine whether similar strategies are employed to advance additional health plan objectives not covered in this paper, such as member satisfaction and retention.

Another issue for further consideration is the extent to which broad social changes in Israeli society and more specific changes in Israeli healthcare could make it more difficult for Israeli health plans to manage the care of their physicians in the future. In particular, an increase in the priority given by the society to personal and professional autonomy and the growth of private medicine could both have significant implications.

Finally, it will be useful to consider the extent to which US managed care organizations actually manage the care provided by their physicians, and whether some of the approaches that exist in Israel could be adapted to the US despite all the structural and cultural differences between the two systems.

APPENDIX: COMPARISONS AMONG THE HEALTH PLANS

	CLALIT	LEUMIT	MACCABI	MEUHEDET
Market share	53	9	24	13
% Elderly (65+)	13	8	7	6
% Young (0-14)	26	31	30	35
% New immigrants (since 1990)	9	16	20	16
Average monthly income	6,695	6,105	8,759	7,305
% Recipients of NII income support	62	11	18	9
% With supplemental insurance*	81 / 71	65 / 67	88 / 88	73 / 69
Main primary care MD status	Mostly salaried	Mixed	Mostly independent	Mostly independent
% Of acute beds owned by plan**	30	0	2	0
Original owner	Histadrut	Nationalist Histadrut	Independent	Independent
Strongest areas/groups	Arabs, elderly, low income	Judea & Samaria	Tel Aviv area; young***	Jerusalem; Haredim; young
Sophistication of info systems	Very	Catching up	Very	Moderately

* First figure based on survey data; second on administrative data.

** Other acute beds are owned by the government, religious institutions, independent non-profit organizations, and for-profit organizations

*** Maccabi also invests a lot of money and managerial effort in services for their elderly members; well beyond the percent of the elderly in the plan