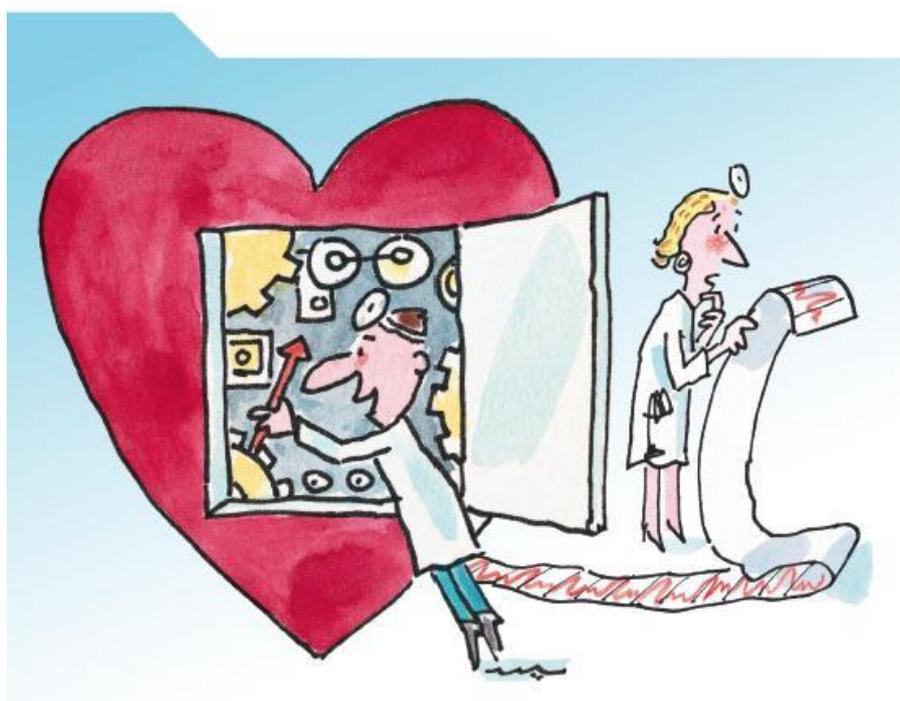




OECD REVIEWS OF HEALTH CARE QUALITY: ISRAEL

EXECUTIVE SUMMARY,
ASSESSMENT AND RECOMMENDATIONS

14 October 2012



Foreword

This report is the second of a new series of publications reviewing the quality of health care across selected OECD countries. As health costs continue to climb, policy makers increasingly face the challenge of ensuring that substantial spending on health is delivering value for money. At the same time, concerns about patients occasionally receiving poor quality health care has led to demands for greater transparency and accountability. Despite this, there is still considerable uncertainty over which policies work best in delivering health care that is safe, effective and provides a good patient experience, and which quality-improvement strategies can help deliver the best care at the least cost. *OECD Health Care Quality Reviews* seek to highlight and support the development of better policies to improve quality in health care, to help ensure that the substantial resources devoted to health are being used effectively in supporting people to live healthier lives.

Israel provides an interesting case study for this series. While many OECD countries are currently striving to improve primary care, Israel's efforts over the past decade have developed one of the most sophisticated programmes to monitor the quality of care in primary care across OECD countries. On the other hand, these practices do not extend to Israel's hospitals, which are characterised by high levels of occupancy and comparatively less information on the quality of care they deliver. A diverse immigrant population and deep inequalities further complicate the task of policy makers, who have been making efforts to improve health outcomes among the disadvantaged. After having sustained lower health care spending than most OECD countries for some time, Israel's health system is now coming under pressure as the population ages and chronic diseases rise, which are likely to continue to occur within the context of a tight fiscal environment. As with other OECD countries, Israel's Government will need to ensure that significant spending on health continues to deliver value for money. This report seeks to provide constructive advice to further these efforts, informed by the experience of OECD countries at large.

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Acronyms and abbreviations

ACEI	Angiotensin converting enzyme (ACE) inhibitors
ACSC	Ambulatory care sensitive condition
ARB	Angiotensin II receptor blockers
BMI	Body mass index
BP	Blood pressure
BRCA1	Breast cancer 1
BRCA2	Breast cancer 2
CABG	Coronary artery bypass graft
CHF	Congestive heart failure
CHE	Council for Higher Education
CHS	Clalit Health Services
CME	Continuous Medical Education
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
ED	Emergency department
EMR	Electronic medical record
ESRD	End stage renal disease
FOBT	Fecal occult blood test
FSU	Former Soviet Union
FTE	Full time equivalent
GDM	Gestational diabetes mellitus
GDP	Gross domestic product
GP	General practitioner

HbA1C	Glycated hemoglobin
Health Funds	Maccabi, Meuhedet, Clalit and Leumit
HEDIS	Healthcare Effectiveness Data and Information Set
ICD	International Classification of Diseases
ICDC	Israel Center for Disease Control
JCI	Joint Commission International
LDL	Low-density lipoprotein cholesterol
MHS	Maccabi Healthcare Services
MOH	Ministry of Health
MRSA	Methicillin-resistant staphylococcus aureus
NCQA	National Committee for Quality Assurance
NHI	National Health Insurance
NHIL	National Health Insurance Law
NIS	New Israeli shekel
PPA	Potentially preventable admissions
PCI	Percutaneous coronary intervention
PYLL	Potential years of life lost
QICH	Quality Indicators in Community Health Care
RN	Registered nurse
SES	Socio-economic status
Tipit Halav	Family Health Centres

Executive summary

This report reviews the quality of health care in Israel. It begins by providing an overview of the range of policies and practices and the role they play in supporting quality of care in Israel (Chapter 1). It then focuses on three key areas: strengthening community based primary care (Chapter 2), tackling inequalities in health and health care (Chapter 3), and improving care for people living with diabetes (Chapter 4). In examining these areas, the report seeks to highlight useful practices and provide recommendations to improve the quality of health care in Israel.

While most OECD countries have been grappling with rapidly rising health costs, Israel has contained growth in health care costs to less than half the average for OECD countries over the past decade. Health care spending in Israel absorbed 7.9% of GDP in 2009 – the eighth lowest among OECD countries. While low levels of health spending are likely to reflect successive years of tight control over spending and the lesser demands of a younger and healthier population, Israel has also made the most of tight budgetary circumstances to build a health care system with high-quality primary health care, though poor information and high occupancy rates makes it difficult to say the same for hospitals.

Israel provides a good example of how to undertake reforms to strengthen primary care. Over the past decade and a half, policy makers and health plans have sought to reorganise doctors working in the community into teams. This has provided them with a platform to do things that other OECD countries are struggling to do, like regular monitoring of a patient's health indicators, delivering follow-up support after a visit to the doctor, and tailoring preventative advice to the specific needs of communities. Israel's primary health care clinics are held accountable through extensive data collection on their activities. While Israel has benefited from a substantial migration of doctors, this has created a major challenge for the future as the cadre of older doctors heads towards retirement in coming years. Ensuring that future doctors and nurses choose to work in primary care ought to be a focus of policy, alongside continuing to expand the number of chronic diseases covered by performance data on health care clinics.

In contrast to primary care, too little is known about the quality of care delivered in hospitals. This lack of information is particularly concerning with Israel's hospitals operating at an occupancy rate of 96% in 2009, well above the average of 76% amongst OECD countries and significantly higher than the 85% level that is broadly considered to be safe occupancy in the United Kingdom, Australia and Ireland. Hospitals should have access to data on how they compare on quality measures – such as infection rates, patient safety and indicators of clinical quality – that can be used to inform improvements in care. While some major tertiary hospitals have sought to monitor their own performance, the development of a national data set that allows hospitals and plans to compare their performance relative to their peers remains in its infancy. The government's efforts on this front ought to be more ambitious and rolled out more quickly.

In addition to expanding data collected in hospitals, Israel has the potential to get more out of what it already collects. Efforts currently underway to begin reporting on the quality of care performance of each of the four health funds are worthwhile. The prospect of consumers being able to move with their feet should increase the likelihood that the management of health facilities and health funds consider quality of care as a dimension in which they compete.

A key area where health funds ought to focus their attention to improve the quality of care is the co-ordination of care between primary health care services and hospitals. While a patients' key health information, diagnostic test results and recent medications are often recorded, this information is not transferred to hospitals often enough. Health funds ought to use their financial influence across both hospitals and primary care to improve information exchange, and beyond this, encourage more communication between health professionals across facilities so that care can be better tailored to the patients' needs. This problem of care co-ordination looms large for those living with diabetes, who are often more susceptible to multiple health conditions. As they require care from multiple specialists, those living with diabetes are likely to be relying on informal co-operation amongst health professionals. However, the extent of their complications and previous treatments is not as well documented as it ought to be.

Finally, Israel's health system has to contend with a complex picture of health inequalities. In general, those who are not Jewish, live in the North or South, and those from other poor socio-economic groups are likely to suffer from poorer health outcomes. The government and health plans have undertaken commendable efforts in recent years to address these inequalities, by encouraging health information in multiple languages, incorporating remoteness into the formula for allocating resources across health funds, and through capital investments in peripheral regions. These

efforts ought to continue and be redoubled. As well as providing more support to community health workers, training to skill physicians and nurses in delivering culturally appropriate care would help build a more responsive medical workforce. The government should avoid increases in co-payments for essential health services that hit those on lower incomes hardest and can discourage worthwhile health seeking behavior. While health policy makers have been undertaking efforts to tackle inequalities across the health system, they need to be complemented by efforts to address wider socio-economic differences beyond health care.

Even with strong fundamentals such as a strong primary care system and a large number of doctors, Israel's health system faces major challenges ahead. Pressure on health system will only increase as chronic diseases rise, Israeli's relatively young population ages and the wave of older health care professionals who arrived from the former Soviet Union in the early 1990s head for retirement.

Addressing these challenges will require prudent reforms to strengthen the health system's capacity to support Israelis in living healthier lives in to the future. By pursuing a combination of policy reforms at a system-wide level and targeted reforms to address particular shortfalls, there is considerable scope to improve the quality of care in Israel's health system. This report contains the OECD's recommendations to help Israel do so.

Assessment and recommendations

Israel has established one of the most enviable health care systems among OECD countries in the 15 years since it legislated mandatory health insurance. While most OECD countries have been grappling with rapidly rising health costs, Israel has contained growth in health care costs to less than half the average for OECD countries over the past decade. Health care spending in Israel absorbed 7.9% of GDP in 2009 – the eighth lowest among OECD countries. While low levels of health spending are likely to reflect successive years of tight control over spending and the lesser demands of a younger and healthier population, Israel has also made the most of tight budgetary circumstances to build a health care system with high-quality primary health care.

Israel has a tax-funded national health insurance that provides universal coverage of health care. Israelis choose among four competing health insurance funds, which must offer insured people a basic package of health services. The two largest funds – Clalit and Maccabi – cover around 80% of the population. In addition to the basic package, around 75% of the population purchases complementary health insurance from one of the four health insurance funds and a third of the Israeli population buys commercial health insurance that covers services outside the basic package, such as dental care, ancillary services, and provides choice of private provider. A further two-thirds of the population also purchases commercial insurance for long-term care. The Ministry of Health has an overarching regulatory and policy making role, as well as owning about half of the country's hospitals, while local governments provide public health services and sanitation. The government provides health funds with a yearly per capita allocation adjusted for age, gender and location of the people insured by each fund. Funds seek to drive improvement in the system either by their direct control of the clinics they own (with Clalit having the most significant number of health facilities compared to the other three funds) or by contracting with independent health providers.

Health funds can boast impressive reforms over the past decade that have helped consolidate primary care services into teams and improved support for patients living with chronic disease. Health funds also play an active role in driving continuous improvement in the quality of care based on a broad range of data on whether good practices are being undertaken and what patient outcomes are. The sum of these efforts is that among OECD countries, Israel's health system is particularly good at identifying chronic diseases amongst patients early and supporting those living with a health condition to avoid an unnecessary hospital visit. Diabetes care is a revealing example of the good performance of Israeli health system. Efforts by the government to prevent and control diabetes have contributed to low number of admissions to hospitals for uncontrolled diabetes among OECD countries, while reductions in complications demonstrate ongoing efforts to improve quality of care provided to patients with diabetes.

However, while primary care services have been on a trajectory of improvement for some time, there exist substantial challenges for quality of care in Israel's health system:

- Ageing and the increasing specialisation of Israel's health workforce risks reducing the number doctors and nurses that are available to work in primary care in the future.
- Poor information on hospital quality makes it difficult to assess whether frequent reports of quality shortfalls are highlighting systematic problems.
- Though they finance both primary care and hospital services for a patient, most health funds do not do enough to ensure that these services are co-ordinated, and patients have little basis to make informed choices between funds and providers.
- While Israel has made commendable efforts to address substantial and complex inequalities, persisting socio-economic disparities and regional differences in health care capacity could undermine efforts already underway, and the recent trend of rising out-of-pocket expenses may disadvantage those without the capacity to pay.
- Governance of the health system is fuzzy, with the ministry involved in both setting policy and operating half the country's hospitals, making it difficult to locate responsibility for driving change.
- In the case of diabetes care, the fact that patient files in primary care are not linked to specialist and hospital services; that clinical guidelines do not extend to the management of certain co-

morbidities such as mental health; and that quality indicators do not include simple measures such as foot care, means that patients with complications might not get appropriate referral and control of their condition.

Addressing these challenges will require prudent reforms. After briefly profiling the strengths of primary health care in Israel, this first chapter will elaborate on these challenges and provide recommendations to help policy makers improve the quality of care in Israel.

Reform is all the more important at a time when signs are emerging that Israel's health system is coming under strain today. Protracted strikes and very high levels of bed occupancy ought not to be a norm. Pressure on health system will only increase as chronic diseases rise, Israeli's relatively young population ages and the wave of older health care professionals who arrived from the former Soviet Union in the early 1990s head for retirement. If the health system is not prepared to grapple with these challenges, or is not provided with the adequate resources to be able to do so, then the combination of good health outcomes and low health spending that Israel can boast of today is likely to be at risk in the future.

Delivering and sustaining high-quality primary health care

Israel delivers a high standard of primary care but there are areas of concern

As a consequence of conscious policy decisions made over two decades ago to prioritise the delivery of care in the community, Israel delivers a high standard of primary care to much of its population today. Patients generally turn to local primary health care clinics as their first point of call and they are gatekeepers to hospitals and specialist care. Out-of-hours care is available through 24-hour telephone hotlines staffed by nurses, evening care centres, urgent care centres and home visit services. The bulk of patients suffering from chronic conditions are likely to find doctors and nurses working to help monitor their health and manage their condition through proactive practices, such as regular measurement of blood glucose and blood pressure for those suffering with diabetes. These efforts are often supported by information technology platforms such as those that remind clinic staff which patients have not received a regular check-up.

Proactive primary care services are likely to have delivered dividends in health outcomes. In 2009, an estimated 3 601 years of life were lost in Israel by men under the age of 70, compared to an average of 4 689 amongst OECD countries. Similarly, an estimated 1 949 years of life were lost by women under the age of 70 compared to an average of 2 419 amongst OECD countries. This overall performance is reflected in lower

premature deaths from some chronic diseases, indicating that primary health care – where the bulk of chronic disease management takes place – is making a difference in helping people manage their health. For example, while 6.5% of the adult population lives with diabetes in Israel (equal to the OECD average), Israel had the second lowest number of admissions to hospitals among OECD countries for uncontrolled diabetes per 100 000 population in 2010.

Nonetheless, individual disease-based indicators also suggest that problem areas remain. With 68.4 visits to hospitals for asthma per 100 000 population, Israel is above the OECD average of 51.8 visits per 100 000 population. Similarly, male hospital admission rates for chronic obstructive pulmonary disease (COPD) in Israel are the fourth highest among OECD countries and a significant cause for concern.

Re-organising doctors into teams have been critical to helping Israel's primary health care services do things that other OECD countries are struggling to do

Over past years, health funds have proactively encouraged health professionals to work in teams. In Clalit, this was achieved by establishing clinics in which their salaried doctors were located. Other funds used a combination of financial incentives and dialogue to encourage independent doctors to work alongside other professionals, with the country's second largest health fund (Maccabi) having had more success than the two smaller health funds (Meuhedet and Leumit). Even in OECD countries regarded as having strong primary care, such as the United Kingdom, Australia and New Zealand, a large proportion of doctors continue to work as solo-practitioners. The average primary care clinic in Israel is staffed by the equivalent of 3.4 general practitioners, 2.6 nurses, 1.5 practice assistants and most have a practice manager.

Health care teams have made it possible for community health clinics to support patients suffering from chronic disease, such as by following up with patients after a visit, routine health screening and providing advice on improving lifestyles. In recent years, the United Kingdom, Australia, France and Switzerland have changed financing or provided additional payments to general practitioners to try and prioritise such services and had limited success in driving system-wide change.

Israel's approach has been different and had a more systematic impact. Health funds have focused on changing the structure of supply rather than seeking to influence physician behaviour through financial incentives. By promoting larger clinics, health funds have provided doctors with additional resources to support patients. Contrary to the concerns expressed in many

other OECD countries, Israel's experience demonstrates that the shift to larger clinics can create possibilities for worthwhile activities while preserving the importance of an ongoing patient-doctor relationship.

Primary health care in Israel has benefitted from a substantial migration but ensuring that future doctors and nurses choose to work in primary care and have the skills they need will be important

Primary care in Israel has benefited from the substantial migration of doctors. The population of doctors close to doubled over the late 1980s and early 1990s, with almost one in three of these new doctors choosing to practice in community-based facilities. This supply of family doctors is likely to dwindle as many of the older workers that migrated from the former Soviet Union retire. While Israel has made efforts to increase domestic medical graduates, younger doctors are choosing to specialise and work in a hospital. To ensure primary care facilities have the workforce they need, the government should encourage younger doctors to work in primary care, including through providing the opportunity to undertake their clinical training in primary care settings. Israel should complement these efforts with making sure that the skills of older medical workforce remain current. Currently, requirements on continuing professional development are weak compared to other OECD health systems. The government and the Israeli Medical Association should seek to progressively introduce mandatory forms of quality assurance such as participation in peer-review activities, assessment of professional performance and continuous medical education.

At the same time, the nursing workforce is also becoming older and increasingly specialised. Currently, around 55% of nurses in Israel have at least a first degree, of which nearly one in five also have a higher degree. Recent efforts to promote further academic training by nurses may affect the pipeline of nurses for primary care that are willing to undertake “practical” functions in community health care facilities. While the government's efforts to encourage the professionalisation of the nursing workforce is commendable, future policy should be sensitive to ensuring that there is a sufficient number of nurses with the necessary skills and a desire to work in primary care settings. In this context, re-introducing diploma qualified nurses should be considered as an option to help meet demand in primary care, particularly in high-need areas.

Clinics are held accountable through extensive data collection and management of their performance by health funds

A major strength of primary care in Israel is the extensive range of data that is collected by community health facilities on nearly the entire population. The basis for this has been electronic patient records that have

facilitated the collection of information on patients, and has led to the specification of a minimum data set called the Quality Indicators in Community Health Care (QICH) programme. The QICH includes basic patient demographics and thirty five measures across six key areas: asthma, cancer screening, immunisation for the elderly, children's health, cardiovascular health and diabetes. This data identify some risk factors for poor health (*e.g.* obesity), monitor the quality of care being delivered, track drug utilisation and measure selected treatment outcomes. Alongside the Quality and Outcomes Framework in the United Kingdom, the QICH is one of the most comprehensive programmes for monitoring the quality of primary care among OECD countries today.

The information collected as part of QICH provides the basis for health funds to review the performance of individual clinics. Most health care facilities receive feedback on their performance across key activities such as ensuring women of the appropriate age range receive breast cancer screening, through to ensuring that patients with diabetes registered with a particular practice have their blood glucose levels monitored regularly and that follow-up action is being undertaken where problems arise. For example, indicators collected in community care suggest that Israel delivers high-quality care for diabetic patients; more than 92% of diabetic patients had their blood glucose level measured in 2009, with comparable rates for blood pressure and cholesterol checks. While the two major health funds (Clalit and Maccabi) periodically set internal targets for clinics, these targets are rarely backed by significant financial incentives. It is likely these two funds can utilise their superior financial clout to drive health providers to improve performance more effectively than the smaller plans may be able to. Evidence of improvement across key indicators highlights that monitoring and feedback is a useful force in driving improvements in the quality of care.

Nonetheless, there is much that can be done to improve the QICH's ability to steer improvements in the quality of care. As a start, Israel should expand the number of domains covered to include major chronic conditions such as chronic obstructive pulmonary disease, heart failure and mental health. A more sophisticated direction for future development would be to develop patient-focused measures that draw on multiple indicators, such as reporting a wide range of other chronic conditions experienced by patients with diabetes. This will be increasingly important as the number of people with more than one chronic disease increases.

Improving quality of care in hospitals

Israel's hospitals ought to do more on quality of care, beginning with better monitoring

Unlike the situation in primary care, it is difficult to find public information on the quality of care that patients are receiving in hospitals. The extent to which data is collected varies dramatically by hospital. Where some major tertiary hospitals have comprehensive monitoring and improvement activities, these are more likely to be led by motivated individuals (both professionals and managers) rather than be part of a system-wide approach to raising performance. In the absence of data, there have been regular reports of crowded hospitals and instances of beds located in corridors. Israel also has the highest acute care bed occupancy rate among OECD countries, with hospitals running at 96% occupancy on average over 2009. This was significantly higher than the average of 76% among the 25 OECD countries which reported data, and higher than the 85% level that is broadly considered to be the limit of safe occupancy in the United Kingdom, Australia and Ireland. Concerns over shortfalls in the quality of care in hospitals have often been voiced by Israeli experts, particularly over hospital acquired infections – an example of one of the consequences when safety is not sufficiently prioritised.

The discipline of measuring performance and then using this to encourage improvement that has been successful in primary care should be brought to bear on the hospitals sector. The government has recently embarked on a project to improve quality indicators for hospitals; however it ought to be more ambitious and rolled out more quickly, given the expertise on quality measurement available in Israel. Hospitals should have access to data on how they compare and be held accountable for common quality measures – such as infection rates, patient safety and indicators of clinical quality – that can be used to direct improvements in care. Hospitals should also be encouraged to develop their own programmes to foster a culture of quality improvement amongst their staff. This should be implemented alongside the government's current path of rolling out the Joint Commission International-based accreditation model, as it provides scope to actively support hospitals in developing better processes for quality of care than the "inspectorate" model used today. If required to urge change, the government should mandate key priorities and a minimum data set for public reporting.

Making data more readily available and portable across care settings***Making the data collected today publicly available allows more scope for competition between funds and providers to occur on the basis of quality***

Israel may not yet have exploited the full potential of transparency to drive improvements in the quality of care. While Israel's health funds have developed a capacity to use indicators on quality of care to encourage performance improvement, this is largely a closed door process today. In private discussion with funds, a particular health facility can compare how it performed against other facilities within their fund. This may be useful for encouraging improvement within a fund, but limits comparisons to the larger group of facilities across the country. Given the significant differences in the size of health funds, facilities working with Clalit and Maccabi are likely to be able to compare themselves against a much larger group of peers than those working with Leumit and Meuhedet. The experience in other OECD countries such as the United Kingdom, Korea, the Netherlands and the United States suggests that being able to compare performance relative to their peers (and competitors) can motivate the management of health facilities to improve quality of care.

Until recently, patients in Israel have little basis on which to make informed choices should they wish to do so. Many within the Israeli health system have argued that publishing quality of care indicators would lead to consumers making skewed assessments of performance, as these indicators do not provide holistic measures of good quality health care. It has also been argued that the four health funds have highly diverse patient populations, which makes it difficult to meaningfully compare between health funds. Other sections of the clinical community and administrators of the health system argue that this information provides an insight into the efforts of providers. They also argue that health funds are big enough that inter-fund comparisons would be worthwhile indicators of performance across the system, even if it reflects differences in patients' health across the four funds. Evidence from the United Kingdom suggests that a small group of informed consumers can seek to make decisions about which facility they go to on the basis of quality of care information. Even if a large number of patients did not access this information, the prospect of consumers being able to move with their feet is likely to enhance the potential for the management of health facilities and health funds to consider quality as a dimension in which they compete.

Information exchange and co-ordination between primary care and hospitals is surprisingly weak and ought to improve

Given that Israel's health funds finance the full range of a patient's health care services, it is surprising that poor co-ordination of care between primary care and hospitals is too often the norm in Israel today. While patients within primary care have an electronic medical history with their key health information, results of diagnostic tests and their recent use of health services, these records do not extend to hospitals often enough. Poor information exchange between primary care and acute care is likely to mean that hospital doctors do not have medical histories for patients, and cannot benefit from the judgments and observations of their counterparts in the community. Similarly, primary care is not able to work as effectively as it could to ensure that the health professionals who have the most regular contact with patients are aware of their previous hospital treatments and their care requirements on discharge from hospital. This is particularly important for those living with diabetes, who are often more susceptible to multiple health conditions. As they require care from multiple specialists, those living with diabetes are likely to be relying on informal co-operation amongst health professionals, and find the extent of their complications and previous treatments not as well documented as it ought to be.

Improving information exchange between hospitals and primary care would help tailor care to a patient's needs. While efforts have been made in this direction (particularly, by Clalit, which benefits from its ownership of facilities) developing electronic medical histories that are portable across primary care and hospitals throughout the system ought to be a priority. Beyond this, health funds should seek to use their ability to contract with (or ownership of) hospitals to encourage co-ordination of care for patients, such as through obliging discharge information, planning and liaison with primary and social care.

Tackling health inequalities by acting on multiple fronts

The Israel population features a complex picture of health inequalities

Inequalities in health outcomes and access to health services have persisted in Israel for some time, but disentangling and addressing disparities in health is complex. The many dimensions of inequalities – socio-economic circumstances, ethnicity and geography – are often interconnected and mutually reinforcing. This makes it difficult to directly relate inequities to specific causes. At the same time, specific population groups also face health issues that are independent to other factors that cause inequality more generally. Israel's health policy makers ought to be commended for acknowledging these inequalities and making a range of efforts to address

them, although making serious inroads into addressing inequalities in Israel will require tackling the multiple axes of disadvantage within and beyond the health sector.

In general, Israelis who are not Jewish, live in the North or South, and those from other poor socio-economic groups are likely to suffer from poorer health outcomes. For example, the largest non-Jewish group in Israel, the Arab population:

- has a life expectancy that is four years lower than Jewish men and 3.2 years lower than Jewish women;
- is twice as likely to suffer from diabetes between the ages of 45 and 64 and experience diabetes at a younger age;
- is more likely to suffer from hypertension, a heart attack or a stroke.

While differences between Jews and Arabs are likely to account for a significant share of inequalities, disparities also exist within the Jewish population, with mortality for Jews born in Asia, Africa and Europe up to 70% higher than among Israeli-born Jews and with. Poorer health outcomes often reflect broader economic inequalities in Israel. For example, poorer (generally Arab) families are likely to be concentrated in more peripheral areas in the North and South, where access to services is more difficult than in major centres. There are also pockets of poverty concentrated among Ultra-Orthodox Jews, who often also have distinctive health behaviours.

Poorer Israelis are more likely to use health services. While this reflects a reality across almost all OECD countries – that the poor are more likely to be sick and more likely to need health services – meaningful gains have also been made in improving access amongst the poor. For example, poor patients are as likely to purchase drugs after cardiac surgery, and those among the poor who have diabetes are likely to have similar blood pressure and low-density lipoprotein (LDL) cholesterol control than their higher-income counterparts. However, infant mortality rates are high among Arabs and poor Israelis. Poorer Israelis are more likely to struggle with blood sugar control and cholesterol control following heart surgery. The prevalence of diabetes is almost five times higher among lower socio-economic groups. They are also likely to have lower uptake of mammography and flu vaccination, even when these are covered by health insurance.

This suggests that factors such as cultural norms and health literacy are likely to be affecting the quality of care for the poor, calling for action on multiple policy fronts. Critically, while health can play a significant role, making serious inroads into inequalities experienced by many of these people will require tackling the underlying dimensions of poverty – such as

low incomes, poor housing, shortfalls in basic infrastructure and a lack of transport – in order for health services to make a lasting difference.

With commendable efforts to date, further action should focus on making services more culturally appropriate, strengthening efforts on prevention and improving data on inequalities

Efforts have been undertaken to overcome the cultural factors and language barriers that often limit disadvantaged groups from getting the most out of health services today, but more could be done. The government's recent efforts to direct health funds and providers to deliver information and advice in multiple languages is a welcome start, but whether it is faithfully implemented remains to be seen. More substantial measures can also be pursued, such as up-skilling physicians and practice nurses in dealing with health inequalities in their practice and delivering culturally appropriate care, and encouraging the development of culturally sensitive clinical guidelines. Israel has already sought to establish community health workers, particularly those with interpretation skills, to help provide a “link” to worthwhile health care services for specific populations. Israel's local governments, many of which are already involved in preventative health care, provide an ideal platform to facilitate a further expansion of such services. In the longer term, increased efforts should be undertaken to strengthen the recruitment of medical health professionals from local communities and a diverse range of cultural backgrounds.

While there have been successes and consistent effort to date, preventing disease in Israel could be improved and better targeted to the most disadvantaged groups. In recent years, the government has undertaken efforts to reduce salt and sugar intake in industrial food products, improve the labelling of products with low nutritional value, develop public infrastructure that encourages physical activity and improve awareness of good lifestyle habits. This has been undertaken with the co-operation of local governments, health funds, schools and local communities, providing a worthwhile example of how a multi-pronged prevention strategy can be built to tackle chronic disease. However, a number of key risk factors for chronic disease and poor health exist amongst more disadvantaged groups in Israel. Smoking prevalence amongst Arab men is close to double rates for Jewish men and rates of obesity among Arab women are one and half times higher than among Jewish women. Smoking, diabetes and obesity are usually major risk factors associated with cardiovascular disease, one of the main causes of death in Israel. Efforts to roll out highly cost-effective services such as smoking cessation and obesity reduction programmes for low socio-economic groups across the system could help improve health.

Better information on the multiple dimensions of inequalities in Israel could also help improve the targeting of current and future programmes to those most at risk. Israel currently relies on a crude measure of disadvantage that identifies individuals as “low socio-economic status” on the basis of their entitlement to income support (such as unemployment benefits, pensions and family supplements). Moving beyond this categorisation and making quality indicators available by key dimensions of inequality such as geography, language and religion would help provide a richer picture of where disadvantage concentrates. This is likely to be a considerable task involving further recording or matching health information to other social data held by the government. In the short term, disaggregating quality information that is already being collected by region would help better map the geography of disadvantage than is possible today and help pinpoint which areas have room for improvement.

Health services ought to be located closer to those who need them most

Today, the north and south of the country are home to one third of the Israeli population, half of the Arab population and the majority of the country’s poorest and sickest persons. At the same time, the availability of primary, community and hospital care services is much poorer in the North and the South compared with other parts of the country. To a large extent, these reflect differences in the distribution of health services between major cities and other areas that exist across other OECD countries. Nonetheless, differences in the availability of health workers are large given the small size of Israel when compared to other OECD countries with significantly more dispersed populations. For example, Jerusalem and Tel Aviv benefit from 16.4 and 18.4 health care staff per 1000 workers compared to 11.2 and 10.0 health care staff per 1 000 workers in the North and the South respectively. As a consequence, health services in peripheral areas face high demand, complex cases and stretched resources.

While the Israeli Government has undertaken worthwhile steps to address this, there is potential to do more. The introduction from 2012 of a remoteness factor into the formula for allocating public health insurance funds to the four funds ought to reward health funds with populations living in more peripheral areas. The challenge will be to ensure that the health funds in question channel these resources towards their more needy populations. A forthcoming review of the capitation formula ought to consider the utility of introducing new variables that reflect determinants of health care need, such as morbidity, mortality and socio-economic differences across the country. The government can also extend efforts to steer where resources are directed. Some steps have been taken through initiatives to boost capacity outside of major centres, such as through a new

medical school in Galilee in the North, efforts to allocate more new hospital beds to peripheral areas, incentives for development of health promotion programs amongst disadvantaged populations and financial incentives to attract health personnel to peripheral areas. In this manner, future capital planning ought to be skewed towards locating services closer to those who need them most.

The rising burden of patients' out-of-pocket expenditure can make access more difficult for the poorest

An emerging area of concern for equity in access to health care is the trend towards rising out-of-pocket costs. Israel now has the eighth highest out-of-pocket expenditure as a share of household consumption among OECD countries, accounting for 4.1% of final household consumption in 2009. These rising costs hit those on lower incomes hardest and can discourage worthwhile health seeking behaviour, with long-term consequences for health care use and outcomes. In line with findings from global evidence, Israeli surveys indicate that some of the chronically ill and poor have forgone medication or treatment in some circumstances. Increasing co-payments are not an equitable or efficient means of raising funds as they disproportionately fall on the sickest and poorest in society and can lead to patients forgoing both unnecessary and necessary treatments. Recent initiatives to remove user fees at mother and infant care centres and extend preventative dental cover for young children are positive steps. Similarly, ceilings on insurance and medicines costs help provide some protection from out-of-pocket costs that Israeli patients are likely to face. Policy makers should limit further increases in co-payments and consider the equity implications of decisions taken in the annual update of the insurance basket. The government should also monitor the efficacy safety net mechanisms and if needed consider expanding those to a wider range of households with lower incomes and high health needs. This would reduce the risk that patients needing care are dissuaded from accessing it.

Ensuring governance is equipped to drive quality

The government has less capacity to drive change than would be desirable to steer improvement

There is a high level of awareness of quality issues amongst the Ministry of Health, major health funds and health providers, even though differences of opinion exist on how best to achieve this. Israel's legislative framework for quality of care designates the Ministry of Health's role in supervising health funds and facilities to uphold the delivery of quality services as a patient right.

The Health Ministry has an eclectic range of tools at its disposal. The ministry grants licences to most health care facilities, inspects them and investigates complaints. Through enforceable “directives”, the ministry can compel public and private hospitals to comply with certain procedures and it maintains regular dialogue with the four health funds on addressing gaps and improving quality. New regulations obliging reporting on quality indicators will add a new tool by which the ministry can use moral persuasion, and potentially, public opinion to help improve quality of care. However, between explicit sanctions and moral persuasion, it is debatable whether the ministry currently has the financial capacity and human resources to target shortfalls and elevate priorities.

A more fundamental challenge is the government’s dual responsibilities. There is a significant tension in the Ministry of Health between its role as the regulator of the health system and the owner and operator of half the country’s hospitals. The complexity of regular operational and management decisions relating to running public hospitals is often likely to dominate the time and resources of the ministry at the expense of developing and driving policy improvement for the system at large. There is also the potential that regulation for hospitals is too strongly influenced by the interests of its hospitals. While it would constitute a substantial reform and is likely to take a considerable amount of time, creating a Ministry of Health that can hold others in the system accountable for delivering high quality of care and that focuses on policy making could be a worthwhile reform.

Conclusions

Israel deserves credit for shaping a strong primary health care system. At a time when all OECD countries are grappling with more patients living with a chronic disease, Israel’s organisation of primary health care services is geared towards supporting people who will live longer with more frequent health concerns. Nonetheless, several challenges remain in maintaining and improving the quality of health care in Israel. To guard what is currently best about Israel’s health system, doctors and nurses will need to be encouraged to continue to choose a career in primary care. The quality of care in hospitals ought to be an area of focus, as should ensuring that different parts of the health system work to co-ordinate care for patients. Health policy makers deserve to be commended for making significant inequalities a priority, and ought to continue in the efforts to tackle inequalities, especially by resisting pressures to raise co-payments and strengthening targeted health promotion and prevention services for high-risk groups. Each of these challenges are significant in their own right. Taking steps to address them today will strengthen the health system’s capacity to support Israelis in living healthier lives in to the future.

Policy recommendations for improving quality of care in Israel's health system**1. Strengthen primary care by:**

- Expanding the number of areas covered in the Quality Indicators for Community Health programme to include major chronic conditions such as chronic obstructive pulmonary disease, heart failure and mental health.
- Over time, developing more patient-focused measures of quality of care that draw on multiple health indicators, such as the proportion of patients with diabetes who have had all their required annual health checks or the number of people living with multi-morbidities.
- Encouraging younger doctors to work in primary care by providing opportunities to undertake training in primary care settings.
- Re-introducing diploma qualified nurses to help meet demand in primary care and in high- need areas.
- Introducing mandatory professional development for doctors (*e.g.*, participation in peer-review, assessing performance and continuous medical education) as a condition of seeking professional re-certification.

2. Better assess the quality of care available in Israel's hospitals and drive improvement by:

- Establishing a quality monitoring programme in Israeli hospitals of the kind that exists in community care today and obliging public reporting of common quality measures for each hospital.
- Encouraging (or obliging) hospitals to develop their own quality improvement programmes.
- Continue the rollout of the new hospital accreditation model.

3. Improve the co-ordination of care for patients and exchange of information across settings by:

- Ensuring that electronic medical histories are portable across health care settings to support the transfer of information that can be used to help co-ordinate care.
- Using contracting between health funds and hospitals to promote co-ordination of care, such as through obliging discharge information, planning patient pathways and liaison with primary and social care facilities.
- Shifting towards public reporting of quality of care information across health funds to help inform the choices of informed consumers.

4. Further the current suite of worthwhile efforts to address the extent of inequalities by:

- Undertaking health-based interventions alongside broader efforts to tackle inequalities such as employment, housing, access to basic infrastructure.
- Systematically rolling out public health programmes that target health risk factors amongst disadvantaged groups, such as smoking amongst Arab men and obesity amongst Arab women.
- Ensuring that health funds and services are providing information and advice in multiple languages.
- Training physicians and nurses in dealing with health inequalities in their practice, developing culturally sensitive practice guidelines for providers and promoting community health workers. Over the long term, increasing efforts to recruit medical professionals from peripheral areas and diverse cultural backgrounds.
- In addition to remoteness, considering the introduction of variables that capture determinants of health care need, such as morbidity, mortality and socio-economic differences into the risk allocation formula.
- Limiting further increases in co-payments, and considering the equity implications of the annual update of the insurance basket. If necessary, expanding safety nets to a wider range of households with low incomes and high health needs.
- Making indicators available by key dimensions of inequality such as geography, language and religion to better map where disadvantage concentrates.

5. Improve the focus of the governance of the health system in driving quality by:

- Improving the government's capacity to target specific health priorities.
- Over time, better separating the government's role as both the owner and operator of half the country's hospitals and the regulator of hospital performance.
- Increasing efforts to share best practices between health funds, so that the smaller health funds have the ability to benefit from the quality monitoring and management expertise of larger funds.