

## *Chapter 1*

### **Quality of care in Israel's health system**

*This chapter provides an overview of policies and strategies to improve the quality of care in Israel's health system. It seeks to profile key quality of care policies and benchmark the extent to which Israel has deployed various policies that are commonly used across OECD countries to assure the delivery of high quality care. The chapter covers system wide policies such as legislative and administrative arrangements. It then profiles efforts to assure the quality of inputs into health care, such as education and training of the health workforce and accreditation of health facilities. The chapter then focuses on policies to monitor and drive improvements in the quality of care, which vary considerably in their maturity between hospitals and primary care. In general, Israel's approach to quality of care places considerable faith in collecting information and relying on dialogue between health care service providers and health funds to drive ongoing improvements in the services they provide.*

## 1.1. Introduction

The principal focus of this chapter is to describe and benchmark Israel's policies to assure the delivery of high-quality health care. In doing so, the chapter will seek to profile:

- the governance and legislative framework for quality of care in Israel;
- whether inputs into health care – people, technology and physical infrastructure – are appropriately equipped to deliver high quality of care;
- key policies to monitor the quality of services delivered; and
- whether policies support the health system in driving continuing improvements in the quality of care.

This chapter (and this report) will outline the institutional architecture of Israel's health system only in so far as it is useful to understanding how it drives the quality of care. A broad overview of the structure and financing of Israel's health system is contained in Box 1.1. For more detailed information on the Israeli health system and previous reforms, the European Observatory's *Health Systems in Transition* report on Israel (Rosen and Merkur, 2009) is a useful source of information.

## 1.2. Context

### ***Israel has high life expectancy and low levels of health care spending***

Most OECD countries have enjoyed large gains in life expectancy over past decades, driven by improvements in living conditions, public health interventions and progress in medical care. Israel's life expectancy at birth of 81.6 years in 2009 is two years more than the OECD average (79.5 years). This was the fourth highest among OECD countries, alongside Australia and behind only Japan, Switzerland, Italy and Spain (Figure 1.1).

Israel spends less on health than many other countries in the OECD. Total health spending accounted for 7.9% of GDP in Israel in 2009, which was below the average of 9.5% among OECD countries. Health spending at this level of GDP ranked Israel as the eighth lowest spending country in the OECD. This ranking is similar when measured on a per person basis – where Israel's spending of USD 2 164 per person in 2009 (adjusted for purchasing power parity) was lower than the OECD average of USD 3 223 per person in 2009 (Figure 1.2).

### Box 1.1. Overview of the Israeli health system

The framework for Israel's health system today was largely established in the 1995 National Insurance Law which ensures the provision of government-financed health insurance to all Israeli citizens and the right to enroll in any one of the competing health funds. Health funds are provided with a government subsidy for every enrolled patient, with most public funding sourced from payroll and general tax revenues.

Health funds play a central role in purchasing of health care services to the population, and in some cases, provide them. The largest health fund is Clalit, which covers 53% of the population and operates as a vertically integrated health care company. Clalit provides many of its services through community clinics and hospitals that it owns and operates and generally employs physicians and other health care workers on a salaried basis. The second largest health care fund is Maccabi, with a market share of 24% of the population. Maccabi primarily contracts with independent physicians and hospitals in financing the delivery of health care services. The two other funds, Meuhedet and Leumit, cover 13% and 10% of the population respectively and also largely contract with independent physicians and hospitals. The government is the major provider of hospitals in Israel, with the Ministry of Health owning and operating about half the nation's acute hospital beds. A further third of hospital beds are operated by Clalit and the rest are operated by a mix of profit and not-for-profit hospitals. Other than Clalit, health funds pay hospitals for the services they deliver through a combination of per diem charges and payments categorised by diagnostic related groups.

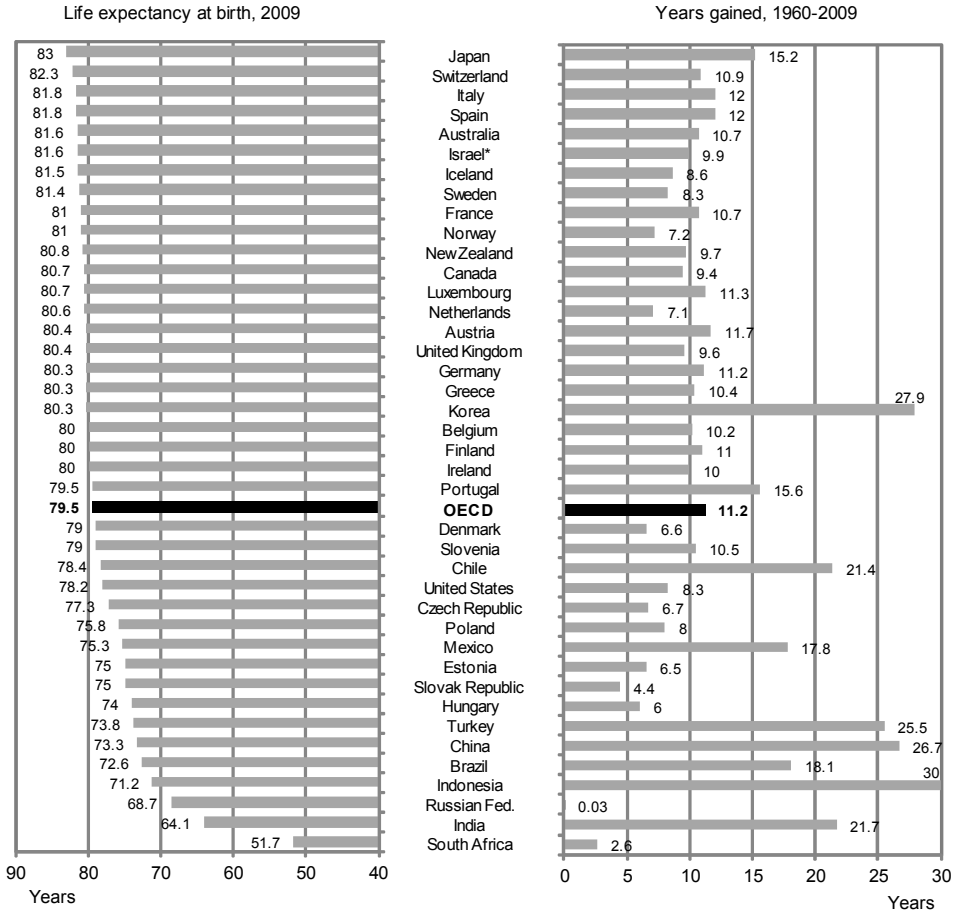
The government employs a number of budgetary controls on its health care system. At the highest level, the basic package of services is determined centrally by a professional committee which reviews and ranks new procedures and services and makes decisions based on overall budgetary constraints set by the Parliament. In addition, the government influences hospital budgets by setting caps on annual revenue to each hospital (though these caps can be flexible). The combination of these two controls provides the Israeli Government with significant influence over both the overall budget and some ability to influence the allocation of funds between hospitals and primary care. The balance of funding towards the cost of delivering the NHI's basic benefit package which is not provided by the government comes from privately financed sources: supplementary insurance and out-of-pocket payments.

Israeli citizens can and often do buy additional health insurance. The four health funds each offer supplementary voluntary health insurance to cover services not included in the NHI benefit package. Around 74% of the population currently holds this type of cover. In addition to this, a number of companies provide commercial voluntary health insurance products that cover around 35% of the population. It is estimated that some 32% of the population have supplementary health insurance from both health funds and by commercial insurers.

Relative to its population, Israel has slightly more doctors than most OECD countries. There were 3.4 practicing doctors per head of population in Israel in 2009, slightly above the average among OECD countries of 3.1 doctors per head of population. In contrast to doctors, the number of nurses relative to the population is significantly lower than most OECD countries. Israel's 4.5 practicing nurses per 1 000 population was nearly half the average among OECD countries of 8.4 practicing nurses per 1 000 population. Consequently, Israel's ratio of 1.3 nurses to physicians is the fifth lowest among OECD countries, ahead of only Chile, Greece, Italy and Mexico.

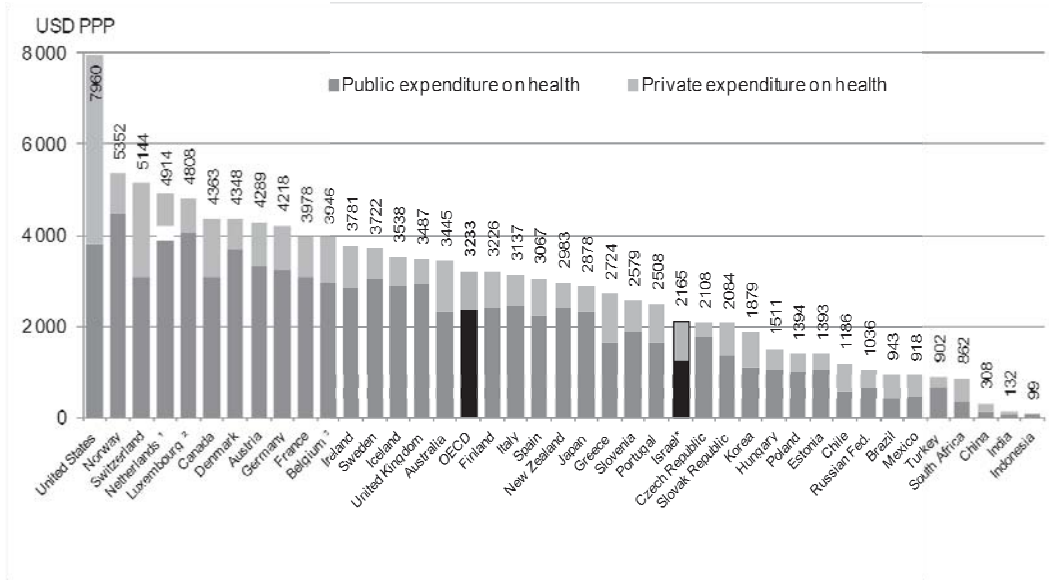
*Source:* Rosen, B. and S. Merkur (2009), "Israel: Health System Review", *Health Systems in Transition*, Vol. 11, No. 2, pp. 1-226, *OECD Health Data 2011* and Israeli Ministry of Health.

**Figure 1.1. Life expectancy at birth, 2009 (or nearest year available)**



\* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2011, DOI: 10.1787/health-data-en; World Bank and national sources for non-OECD countries.

**Figure 1.2. Total health expenditure per capita, 2009 (or nearest year available)**

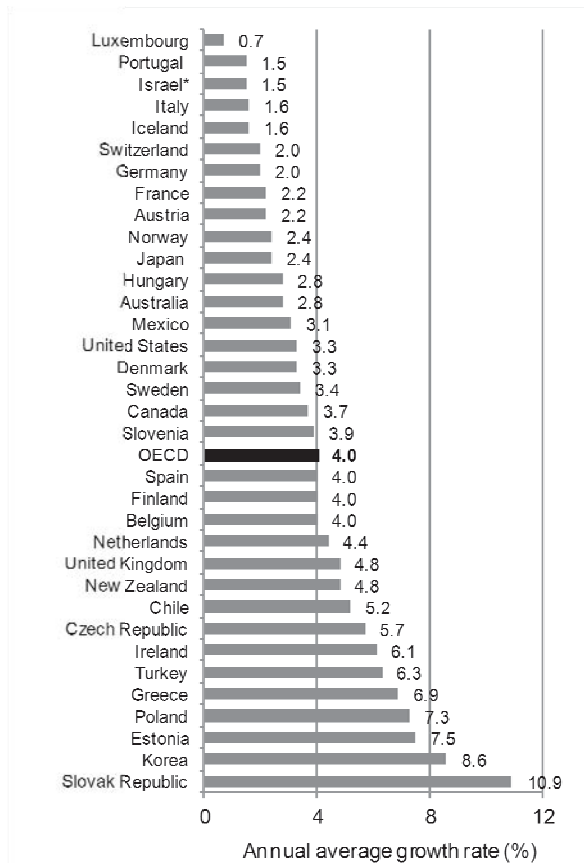
\* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Health expenditure is for the insured population rather than the resident population.
3. Total expenditure excluding investments.

Source: *OECD Health Data 2011*, DOI: 10.1787/health-data-en.

It is particularly remarkable that Israel has been able to maintain consistently lower growth in health spending over the past decade when compared to other OECD countries. While health expenditure per capita across the OECD has grown at an average of 4% a year between 2000 and 2009, Israel's spending on health per capita has grown at an average of only 1.5% a year (Figure 1.3). Over a decade when health systems have continually been under pressure to deliver more – driven by higher expectations, rising demands on services and advancements in medical technologies – Israel's health system has managed to contain growth in costs better than most. This is likely to reflect strong budgetary controls by the government, and to a lesser extent, the fewer demands of a relatively younger, migrant population.

**Figure 1.3. Annual average growth in health expenditure per capita in real terms, 2000-09 (or nearest year)**



\* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

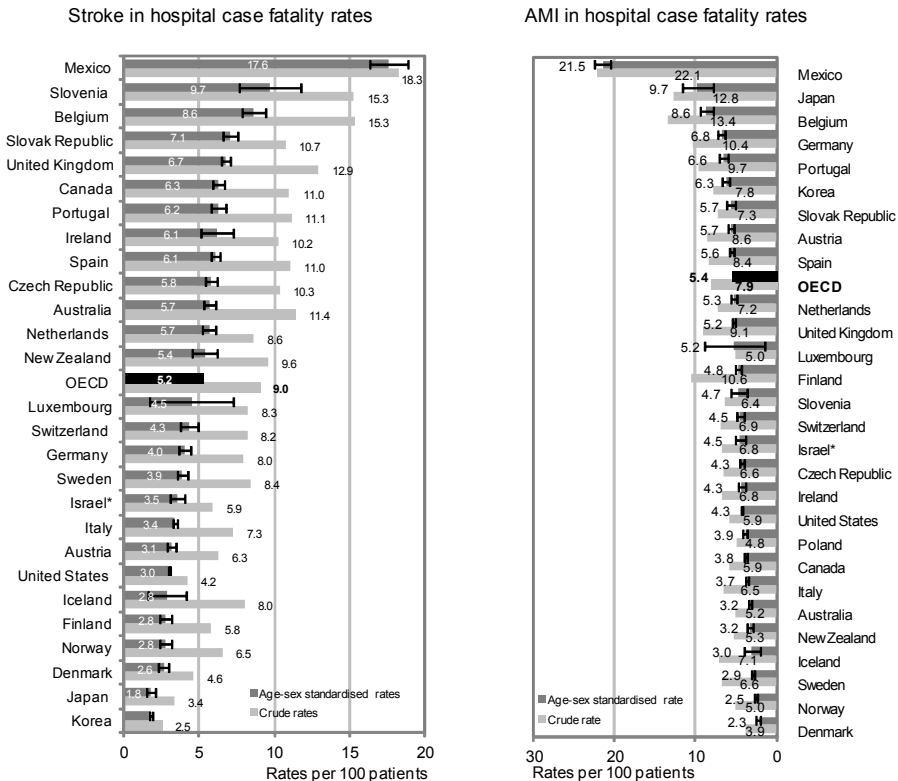
Source: OECD Health Data 2011, DOI: 10.1787/health-data-en.

***Quality indicators for acute and primary care for Israel are in line with OECD averages***

Israel's performance on quality of care indicators suggest that the health system is delivering outcomes that are in line with, and in some cases better than, the average across OECD countries. In the hospital setting, Israel's performance on two key measures is better than the average among OECD countries. In-hospital case fatality rates for acute myocardial infarction (AMI) are a useful measure of quality of care where most OECD countries have made significant progress in reducing mortality from

coronary artery disease over the past three decades. Much of this reduction is attributable to better health care. At 4.5 deaths per 100 patients (standardised for age and sex) in 2009, the in-hospital case fatality rate for AMI in Israel is lower than the OECD average of 5.4 deaths per 100 patients (Figure 1.4). Similarly, in-hospital case fatality rate after ischemic stroke is 3.5 deaths per 100 patients (standardised for age and sex), lower than the OECD average of 5.2 deaths per 100 patients (OECD, 2011). Along with most other OECD countries, Israel has made progress in gradually reducing case fatalities for AMI and stroke over the last decade. Yet with a number of countries – such as Italy, Iceland, Norway and Denmark – managing to achieve consistently better outcomes, it is likely that there is scope for improvements to be made.

**Figure 1.4. Stroke and AMI in hospital case fatality rates in Israel rank among the lowest in OECD countries**

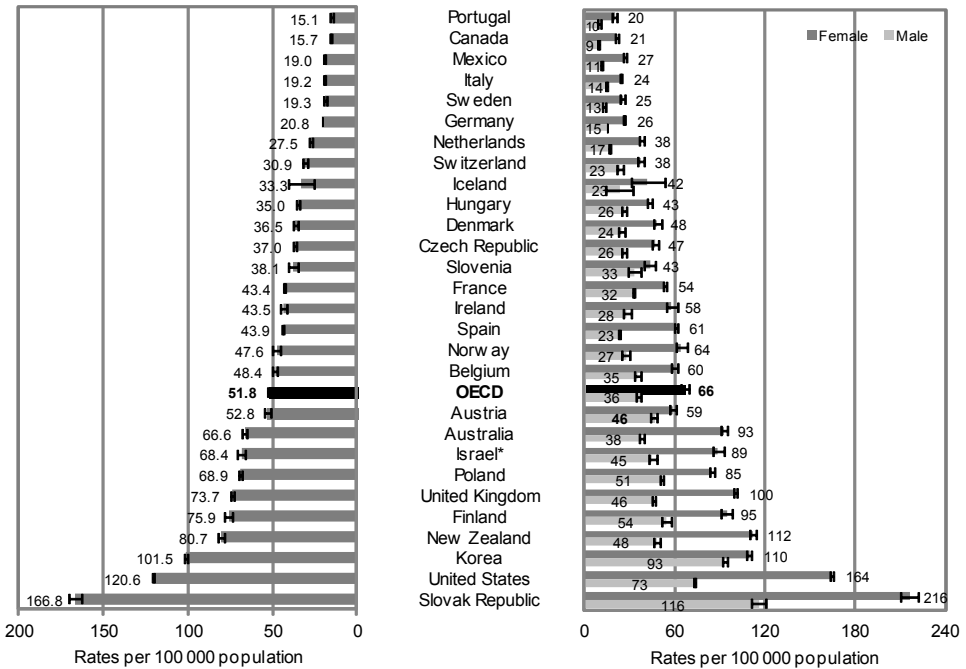


\* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2011, DOI: 10.1787/health-data-en.

Indicators of the quality of care in primary health care services suggest a mixed performance across chronic conditions. Good management of chronic conditions such as asthma, COPD (chronic obstructive pulmonary disease) and diabetes in primary care settings can often help reduce exacerbations that lead to hospitalisation. Therefore, hospital admission rates for these conditions serve as a proxy for the quality of a country’s primary care system. With 64.8 hospital admissions per 100 000 population in 2009, Israel’s admissions for asthma were higher than the OECD average of 51.8 and the seventh highest among OECD countries reporting data (Figure 1.5). Israel also had the seventh highest number of hospital admissions for COPD, with 234 admissions per 100 000 population, compared to an OECD average of 198 hospital admissions per 100 000 people (OECD, 2011).

**Figure 1.5. Asthma admission rates in Israel higher than the OECD average**



\* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2011, DOI: 10.1787/health-data-en.



### 1.3. Profiling policies on quality of health care and their impact

Quality issues have gained importance across OECD countries in recent years as governments and the public increasingly focus on what is being delivered in exchange for major public investments in health care. Policies to address quality of care can not only help improve patient outcomes, but can often do so at similar levels of investment. As with other OECD countries, Israel has been facing the challenge of improving quality within a tight budgetary environment for some time. This chapter seeks to profile the key policies and strategies that Israel has used to encourage improvements in the quality of health care. The description of policies in this chapter is structured according to a framework for categorising quality policies (detailed in Table 1.1 below).

**Table 1.1. A typology of health care policies that influence health care quality**

Policy	Examples
Health system design	Accountability of actors, allocation of responsibilities, legislation
Health system input (professionals, organisations, technologies)	Professional licensing, accreditation of health care organisations, quality assurance of drugs and medical devices
Health system monitoring and standardisation of practice	Measurement of quality of care, national standards and guidelines, national audit studies and reports on performance
Improvement (national programmes, hospital programmes and incentives)	National programmes on quality and safety, pay for performance in hospital care, examples of improvement programmes within institutions

#### *Health system design: legislation and institutions*

*Israel's legislative framework provides a solid platform for policies to improve the quality of care*

Israel's approach to supervision and regulation for quality of care has its legal basis three key pieces of legislation. At the highest level, the Ministry of Health has an authority to regulate health care service providers under the *1940 People's Health Edict* and the *National Health Insurance Law*. These laws provide the Ministry of Health with the ability to demand information from the four health funds and hospitals for the purposes of monitoring and control. In particular, the *National Health Insurance Law* specifies that the Ministry of Health has the ability to supervise the activities of the health

funds with reference to the “quality of services” provided by these health funds. In line with the practice amongst many OECD countries, these pieces of legislation provide a regulatory power over health funds and provider institutions that is broad and does not prescribe particular quality management practices.

It is through legislation on patients rights that the strongest basis for efforts to assure the quality of care can be found in the Israeli health system. Israel's *Patients' Rights Law* contains two key sections that provide the legislative basis for quality of care in Israel's health care system. Firstly, the law specifies that patients are entitled to get adequate medical treatment in terms of “professional level and quality, and in terms of an inter-personal relationship” (Section 1.3). Secondly, the law obliges health care providers, health funds and the Director General of the Ministry of Health to establish a “Control and Quality Committee(s)” in their respective organisations. The law specifies that their deliberations are not accessible to patients or the legal system, but that these committees have the ability to find that there is a case for taking lawful disciplinary measures against a health care practitioner. In addition to Control and Quality Committees, an Investigative Committee has been established to deal with patient complaints and exceptional events. Each medical facility is also expected to have an Ethics Committee that is responsible for dealing with patient grievances and informing members of staff on their rights under law. Studies undertaken of the implementation of the Patients' Rights Law suggest that the committee system has influenced providers to employ personnel with roles demanded under this law (Rosen and Merkur, 2009).

*Israel's Ministry of Health sets directions to assure quality of care, but its role is constrained on several fronts*

In addition to the supervisory role for health funds (as detailed above), the Ministry of Health has a range of other responsibilities that allow it to influence the quality of care. These extend to the licensing of health facilities, regulating the nursing workforce and emergency preparedness and response. Relatively recently, the ministry has established a Quality Assurance Division that is responsible for evaluating and promoting quality, leading national quality projects (such as surveys and studies) and monitoring clinical outcomes. The initial role of this division is to be a hub for the various other quality monitoring and assurance activities that the ministry has already been undertaking, and to undertake specific activities on monitoring quality of care along with other areas of the department or academic institutes (Table 1.2).

**Table 1.2. Key quality of care activities undertaken by the Ministry of Health's Quality Assurance Division**

Departments	Description of main topics	Description of their role
<b>Quality Assurance Division</b>	✓ Patient safety	This department accumulates all of the reports arriving from hospitals in accordance with public health regulations (death notices and adverse events). Data analysis from an organisational perspective enables identification of risk factors from a variety of sources in the health system, including human errors. The findings serve as a basis for the development of comprehensive, focused prevention plans in an effort to reduce the potential damage to the patient.
	✓ Quality survey	The department of Quality Survey is constantly monitoring processes in medical institutions. The department initiates periodic, planned quality surveys in selected areas. Each year several areas are surveyed at the national level, in hospitalisation and in the community, with the participation of the organisations relevant to the subject.
	✓ Investigation committees	The Public Inquiries and Complaints Department operates on two levels: 1. Individual handling of public inquiries and complaints falling under the responsibility of the Ministry of Health on matters concerning medicine, dentistry, requires under the Freedom of Information Law. 2. Managing a repository of inquiries and complaints received from the public at the Ministry of Health and all its branches, drawing system-wide and state-level conclusions from the findings.
<b>Medical Services Research</b>	Hospital quality indicators	Investigation of quality management of care where there is suspicion of medical malpractice. Since 2009, the Medical Services Research Department performs nationwide surveys of hospital quality indicators. The indicators are: post operative mortality, surgical site infection, re-hospitalisation, re-operation, mechanical complications.
<b>ICDC</b>	Israel Center for Disease Control	The center provides decision makers in the health system with up-to-date information in order to inform health policy and service planning. The center conducts health surveys, monitors infectious diseases, establishes registries for the various diseases, improves and maintains the records, writes publications on the population's health, conducts courses and trainings for students and doctors on public health, and provides information to various health professionals.
<b>Hebrew University Hadassah &amp; Israel National Institute for Health Policy Research</b>	Community care quality indicators	These organisations draw on data provided by the four health plans to develop and monitor primary and secondary health care indicators and performance measures.

Beyond the capacity for surveillance and sanctions, the ministry has indirect levers to drive changes in the health system to improve the quality of care. A tool for the ministry is to use enforceable “directives” on specific topics that all health care providers must comply with. Through the Medical Councils that the ministry supports, it is able to maintain a dialogue on specific areas of clinical care (*i.e.* the National Council on Diabetes, as detailed in Chapter 4) and bring together health funds and service providers across the system to foster co-ordinated approaches to improving quality. However, beyond explicit sanctions and moral persuasion, the ministry lacks an independent capacity to redirect resources within the system to target shortfalls (as discussed in Chapter 2).

The Ministry of Health has a dual role as the operator of nearly half the country's hospitals and as a principal regulator for the health system at large. This places the ministry in the difficult position of being engaged in both operational and management decisions relating to public hospitals and then assessing the direct consequences of these decisions. The complexity of operational and management decisions relating to running public hospitals is likely to demand significant time and resources in the ministry, along with its responsibilities for developing and driving policy improvements for the population at large. Indeed, the ministry is largely responsible for public health programmes to address nationwide issues, and in doing so also has to maintain relationships beyond simply health providers, with organisations such as schools, workplaces and local governments. There is likely to be a tension between the ministry's policy and regulatory responsibilities that could constrain its scope to focus on improving the quality of care.

### ***Inputs into health care***

*Israel's health workforce is well qualified but could do more to remain abreast of latest medical practices*

There is currently a considerable difference between the standards and practices demanded of nurses in Israel under the supervision of the Ministry of Health and that which is demanded of doctors by the Israeli Medical Association. Nurses can practice at one of three levels of qualification – registered nurses, practical nurses and midwives. To attain one of these levels of qualification, they must undertake professional training in an institution accredited by Israel's Chief Nursing Officer and pass a state licensing programme. Today, around four-fifths of Israel's nurses are registered, with half holding an academic degree in nursing. Nurses can also specialise through training in one of 13 advanced specialities, which following licensing examinations provides scope for extending the boundaries of professional autonomy within that specialised

area of practice. The accreditation of training institutions, conducting examinations and setting performance standards for nurses is undertaken by the Ministry of Health, which also conducts quality audits to verify standards of professional practice within the nursing profession.

In contrast to nursing, there are few means of continuing assessments of practice amongst doctors once they have gained their professional status. The Israeli Medical Association has the predominant influence in recognising doctors as medical specialists, once they have an approved medical degree and meet the requirements of their chosen specialty. These requirements entail an internship programme (generally of four to six years on average) and various examinations, both of which are set by the relevant specialist organisation. The Israeli Medical Association's Scientific Council must approve a person before the Ministry of Health issues a specialist certification.

Beyond these requirements to become a doctor, Israel currently has weak requirements on continuing professional education amongst the medical workforce when compared to other OECD countries. There is currently no professional re-certification process in Israel. A number of non-obligatory courses are provided by various organisations such as scientific associations and vendors of health and medical products, but these are not obligatory to maintain medical practice. To date, the government and the medical community have not established a procedure of re-certification for the significant number of doctors that have migrated to Israel over the past two decades. At the same time, Israel has a comparatively older medical workforce than in many OECD countries. To ensure that the skills of its doctors remain up to date, 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. This should be linked to the re-certification of medical professionals, as is increasingly becoming the norm across OECD countries.

*Recent changes in the approach to hospital accreditation are worthwhile*

Israel currently has two tier accreditation programme, through compulsory inspections linked to the licensing of medical facilities and a voluntary accreditation programme. The basis for assuring the quality of health care facilities in Israel is inspections by a team within the Ministry of Health, which is responsible for the licensing of all hospitals and health care facilities in Israel. These inspections are undertaken on a routine basis with a frequency of between three months to three years depending on whether the facility is a hospital, surgical clinic, dialysis facility or other type of facility

providing medical services. Each inspection is undertaken by a team appointed by the ministry that includes doctors, nurses and other professionals in charge of occupations such as physiotherapy, social work, occupational therapy, administration and finance. The Ministry of Health has undertaken more than 200 inspections over the last eight years.

The inspection process has recently shifted from reporting on provider's performance to providing a score for each facility. The ministry currently scores facilities across around 30 domains, with a maximum possible score of 100. Most facilities receive a score of between 80 and 90. Scoring was introduced recently to provide a uniform basis for benchmarking across the various inspections which could then be made available to the public through the Ministry of Health's website. Each facility is provided with a report following the inspection and required to address its comments, make necessary changes to their facilities and be able to account for these changes. Prior to the introduction of scoring, these reports did not contain scores. In cases where severe malpractices are identified, the Ministry of Health has the capacity to issue a warrant specifying a limited duration of time during which the provider must address deficiencies and make itself subject to a re-evaluation. In some cases, the Ministry of Health can also seek an immediate suspension of practice or a total closure of a facility (or ward) where it believes life endangering conditions are in place.

In recent years, efforts have been undertaken to progressively implement the Joint Commission International (JCI) model of accreditation. Currently, five government hospitals are in the final stages for JCI accreditation, which shall be extended to cover all 11 government hospitals by the end of 2012. Seven Clalit hospitals have already been accredited using this method and a further three are anticipated to be added in the near future. One Maccabi hospital has been accredited and a one other Maccabi hospital is seeking accreditation (Ministry of Health, 2012). Given the cost entailed with implementing JCI accreditation (which is currently conducted with the support of JCI), this new model of accreditation is currently a voluntary process. The gradual roll-out of JCI-based accreditation is a positive development for quality of health care in Israeli hospitals. The JCI model adopts less of an "inspectorate" style approach, than the process currently undertaken by the ministry, and places a focus on working with hospitals to help them improve quality. The Ministry of Health's intentions to continue to expand this model of accreditation is a worthwhile policy that holds the potential to support hospitals in adopting better processes for quality of care. Over the longer term, Israel should consider shifting the accreditation of all hospitals to its own best practice accreditation model, based on the JCI methodology, and adapted to meet the country's unique requirements (*e.g.* emergency preparedness).

## ***Health system monitoring and improvement***

### *The use of clinical practice guidelines varies considerably across Israel's health system*

The development and use of clinical practice guidelines is fragmented, likely reflecting differing views amongst health care purchasers and doctors on the role of clinical guidelines in Israel. The various professional organisations associated with the Israeli Medical Association are the principal developers of clinical guidelines in Israel. These guidelines are usually developed in compliance with evidence-based medicine principles. Some of these guidelines also refer to cost-benefit analysis, but these forms of assessments are more often undertaken under the auspices of the government's process for inclusion of medications and services in the annual health care budget. In a small number of cases, the Ministry of Health will develop and publish guidelines, particularly when the use of a certain technology included in the basket ought to occur within specific circumstances.

There are several mechanisms for the dissemination of clinical guidelines amongst the medical profession. The Israeli Medical Association informs its membership through booklets and through their website. Individual health funds distribute guidelines to physicians employed by (or contracting with) their funds and may even provide internal guidelines of their own. In recent years, the Ministry of Health has become more proactive in the dissolution of clinical guidelines, by compiling guidelines across the various national councils with which it consults. In limited cases, these guidelines are may include recommendations on appropriate clinical practice.

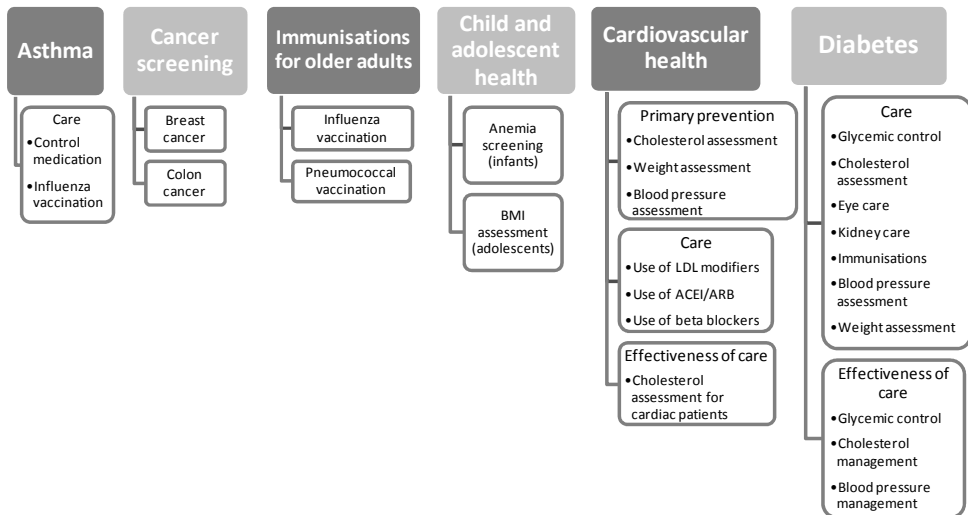
How clinical guidelines are used within Israel's health care system is likely to vary considerably across health funds, medical facilities and be subject to the awareness and initiative of individual doctors. While health funds and the ministry may seek to provide advice to encourage the adoption of certain guidelines, there are no systematic policies linking actual medical practice (or payment for medical practice) to the adoption of specific guidelines. Health care funds are more likely to collect data on process or outcome indicators of physician performance (as detailed in the following section) rather than seek to measure compliance with various recommendations detailed in clinical guidelines. To the extent that health funds and individual health care facilities monitor the appropriateness of pharmaceutical prescriptions, this is more likely to be driven by concerns over controlling costs than in appropriateness of medical practice. Indeed, the adopted approach of monitoring processes and outcomes is likely to reflect contested views within Israel's medical community over whether guidelines can be instructive for patients who have multiple health conditions and concerns that guidelines could become a means to constrain clinician autonomy.

*Community-based health care facilities have developed an advanced model for monitoring the quality of health care in Israel*

The community health care sector in Israel has one of the most sophisticated programmes for collecting data and monitoring the quality of care across OECD countries today. The focus of these activities is Israel's National Programme for Quality Indicators in Community Healthcare (QICH), which is a voluntary programme adopted by the Health Ministry and undertaken by the National Institute of Health Policy Research and Hebrew University, Hadassah (having originated at Ben-Gurion University). The QICH's key objective is to provide information to policy makers and the public on the quality of community health care provided across the four health funds in Israel, it covers the nearly the entire population of Israel.

The QICH draws on data collected by health funds (based on uniform indicator definitions) for their health facilities across six key topic areas: asthma, cancer screening, immunisation for the elderly, children's health, cardiovascular health and diabetes (see Figure 1.6).

**Figure 1.6. The National Programme for Quality Indicators in Community Healthcare is one of the most impressive examples of primary care data collection among OECD countries**



Source: Manor, O., A. Shmueli, A. Ben-Yehuda, O. Paltiel, R. Calderon and D.H. Jaffe (2011), "National Quality Indicators Programme", Report presented to the OECD, Jerusalem (unpublished).



In total, the programme captures more than 35 measures of quality of care across three key domains of primary prevention, disease management and effectiveness of care delivered in community-based medical facilities. Data across these categories is available for the entire population according to age, sex and a proxy for socio-economic status and is audited at three levels: by health funds, programme directorate and external auditors. Since 2006, five reports on the quality indicators collected have been published, and the data included in these reports form the basis to assess the quality of community health care provided by the four health funds, identify risk-factors among sub-populations and evaluate the quality of care over time (see Jaffe *et al.*, 2012).

The data collected as part of the QICH is an important resource for quality improvement activities undertaken by health funds. Through their participation in QICH, all four health funds are able to draw on this dataset to make comparisons between their performance and the *aggregate* national performance for a particular indicator. This feedback provides a useful means for funds to benchmark their own performance and identify potential shortfalls in performance. The data provided to individual funds is not adjusted for the patient (and risk) profile of each individual fund in order to protect each fund's patient information. However, with only four funds across Israel it is likely that health funds have a sufficient corporate understanding of the profile of their patients relative to other funds to make judgements on whether this ought to account for discrepancies in performance. The two larger health funds (Clalit and Maccabi) also collect a broader set of indicators beyond those specified under the QICH, including data on health outcomes of their patients.

A survey of health fund managers suggests that the information collected as part of the QICH brings a management focus on improving the quality of care. The study by the Myers-Brookdale Institute (Rosen and Nissanholtz-Gannot, 2010) found that managerial meetings for health fund managers included a review of performance in quality indicators and that this triggered conversations on efforts that could be made to improve performance within particular facilities. Similarly, health fund managers reported that the introduction of quality information encouraged those working to support quality across the health fund take efforts to disseminate information on successful efforts undertaken by individual practices or regions. This suggests that having data can form the basis for an informed discussion about quality alongside other operational considerations that are often the focus of health service managers. At the same time, it is important to note that the survey suggested that there were significant differences between health funds when it came to managers engaging in quality improvement efforts beyond the QICH indicators, whether managers were shown data on their peers, the staff at fund headquarters devoted to quality improvement and

the emphasis given to reducing disparities across population groups. This suggests that while each of the health funds are involved in collecting information for the QICH, the extent to which they are using this data to drive broader improvements in the quality of care is likely to vary considerably.

*The systemic collection of data on the quality of care in Israel's hospitals in its infancy*

Israel has the highest rate of hospital bed occupancy among OECD countries. In 2009, Israel's hospitals ran at 96% occupancy on average over the year (OECD, 2011). 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. Israeli experts have often voiced concerns over shortfalls in the quality of care in hospitals, particularly over hospital acquired infections (see Box 1.2) as one of the consequences when safety is not sufficiently prioritised. In the absence of data, there have been media reports of crowded hospitals and instances of beds located in corridors.

In contrast to the well-organised programme for primary care, the collection of data on quality of care in hospitals in Israel has largely relied on the initiative of individual hospitals and funds. The extent to which hospitals collect data on processes and outcomes within their facilities varies dramatically by facility. While some major tertiary hospitals were able to demonstrate comprehensive monitoring systems for quality of care, other hospitals report that they do not have systems in place and that quality monitoring was undertaken at the initiative of individual departments and clinicians. With operational control of its own hospitals, Israel's largest health fund has sought to introduce a quality monitoring programme in recent years (Box 1.3), though this covers a subset of activities for hospitals accounting for about one third of the country's hospital beds. In spite of the skills of Israel's hospital administrators and the incentive for funds to assess whether individuals are receiving high quality of care in hospitals, there is a lack of information to improve the quality of care across all hospitals.

While several other OECD countries – such as the United Kingdom, Germany, the Netherlands and Australia – have had programmes to monitor and compare quality of care in hospitals for some years now, the Ministry of Health in Israel has only recently sought to establish a Programme of Quality Indicators for Israel's hospital sector. A project to commence the collection of quality indicators across public and private hospitals commenced in 2009 and led to its first publication of data in 2011 (see Box 1.4). This project represents the first system-wide attempt to report on quality measures for hospitals across the Israeli health system.

### Box 1.2. Hospital-based infections

Media reports on shortfalls in the quality of care, particularly that of hospital-based infections, have been a regular occurrence in Israel, as in many other OECD countries. These reports are coincident with anecdotal evidence from hospital managers. Efforts to collect data in this area can suffer from the difficulty of having hospital staff report incidents and issues. Formally, all Israeli hospitals are expected to collect information on infections, including the isolation of patients, and report this to the Ministry of Health. This information is then provided to the public in yearly summary reports, without disclosing hospital identity.

A challenge for improving Israel's infection policies is a lack of standard policies and data to monitor whether hospitals are taking proactive efforts to prevent hospital acquired infections. In the absence of information available across the system on practices being undertaken at particular hospitals, one study on the compliance of hospital staff with guidelines for active surveillance of MRSA found that the compliance of medical and nursing staff with key actions was poor at one medical center. The study was conducted by reviewing the cases for patients admitted over the course of a particular year that had been affected with MRSA to see whether the appropriate screening processes were adhered to. This was supplemented by monitoring adherence to hand hygiene strategies. The study found that almost two-thirds of those who ought to have been screened for MRSA carriage were not, and more than two-thirds of those found to be carriers did not receive isolation treatment. However, despite these observations, rates of MRSA decreased continuously over the study period. Nonetheless, the study argues that deficiencies found ought to be addressed with a renewed focus on improving adherence to hand hygiene as well as other interventions to reduce hospital acquired infections.

While the results of this particular study may not be generalised to the hospital sector at large, such investigations of preventative actions and the extent of proactive monitoring by staff are often the mainstay of hospital quality programmes in many OECD countries. In some cases, the implementation of such programmes has been driven by governments and prominent purchasers through a National Patient Safety Programme.

*Source:* Ministry of Health (2012), "Response to the OECD Questionnaire on Quality of Care in Israel", Jerusalem (unpublished) and Zoabi, M., Y. Keness, N. Titler and N. Bisharat (2011), "Compliance of Hospital Staff with Guidelines for the Active Surveillance of Methicillin-Resistant Staphylococcus aureus (MRSA) and its Impact on Rates of Nosocomial MRSA Bacteremia", *Israel Medical Association Journal*, Vol. 13, December.

### **Box 1.3. Clalit's Hospital Quality Indicators Programme**

As the owner and operator of a number of hospitals, Clalit has sought to establish a quality indicators programme for its facilities. Clalit's programme covers its eight general hospitals, two psychiatric hospitals, three rehabilitation hospitals and one children's hospital. Following extensive preparation, Clalit has developed a set of 22 quality indicators that seek to cover administrative functions as well as clinical quality improvement. Examples of clinical quality indicators include:

- Performance of PCI in patients with ST-elevation acute myocardial infarction within 90 minutes from emergency department (ED) arrival;
- Length of hospital stay after colectomy in patients with colo-rectal cancer, recurrent visits to the ED within 24 hours from discharge;
- Recurrent hospitalisation within 30 days after discharge from a psychiatric department;
- Proper rehabilitation programme for patients after cerebrovascular accident or femur neck fracture in rehabilitation departments;
- Examples of administrative QIs are: percentage of ICD coding of discharge diagnoses in the emergency department and proper documentation of treatment programme in psychiatric wards.

For each quality indicator, Clalit's management seeks to set a target, informed by international benchmarks, trials and expert opinion. Hospitals are then scored on their performance relative to the target, which is then computed into a global score on a scale of 0-100. The relative weight of every quality indicator takes into account a number of factors such as the relevance, importance, patients' population size and the focus of stakeholders. The hospital and wards managers in the programme have access to software that enables them to see their performance and to compare their performance to the average organisational performance on a monthly basis. Having run this programme for five years, Clalit is now seeking to develop new quality indicators and enter new hospital departments into the programme.

*Source:* Clalit Health Services (2012), "Response to the OECD Questionnaire on Quality of Care in Israel", Jerusalem (unpublished).

### **Box 1.4. Israel's new Project for Quality Indicators in Hospitals**

Israel's Project for Quality Indicators in Hospitals commenced in 2009. This was initially proposed as a voluntary project, but secured the early support of the four health funds and most general hospitals. The project will initially focus on general surgery and orthopedics, with intentions to expand by adding an additional clinical specialty per year.

#### **Approach for collecting data**

The project will seek to screen all general surgery and orthopedic wards three times a year to analyse the care provided and patient outcomes following their operation. The screening team includes an infection control physician, epidemiology nurse and specially trained nurses. In every screened ward, a senior surgeon reviewed all post-operative complications for each patient and patients were followed for 30 days from surgery.

The specially trained nurses in each of these teams use medical records to collect data such as demographic information, case-mix, chronic diagnoses, pre-operative preparation, intra-operative data, post-operative complications, reoperation and rehospitalisation, etc. Data on deaths are verified through linking hospital-based information to the population-wide national registry.

Data is standardised by reviewing 20% of randomly selected records from each of the nurse data collectors and comparing their completed questionnaires with original medical records.

#### **Quality indicators collected**

The quality indicators collected as part of this project include:

- Surgical site infection (30 days)
- Mortality (30, 60, 180, and 365 days)
- Bacteremia (30 days)
- Re-operation (30 days)
- Re-hospitalisation (30 days)
- Post-operative bleeding (30 days)
- Pneumonia (30 days)
- Urinary tract infection (30 days)
- Mechanical complications (30 days)

This project design is identical for all hospitals in Israel. Each questionnaire has been approved by a Professional Steering Committee and every variable has a definition. While this is a highly labour intensive process, in the future it is intended that standardisation of electronic medical records across facilities could help facilitate better data collection.

#### **Feed-back to providers**

The outcomes of the Hospital Quality Project are presented on an anonymous basis to the Executive of the Ministry of Health and results are published on the ministry's website. Specific outcomes are presented on a yearly basis to individual hospitals and to their department managers.

*Source:* Ministry of Health (2012), "Response to the OECD Questionnaire on Quality of Care in Israel", Jerusalem (unpublished).

There are a number of policies to improve the collection on quality of care data in hospitals that could be undertaken in Israel. As a starting point, coding a patient's diagnosis more comprehensively, such as through present-on-admission or secondary diagnosis coding, could help hospitals assist their most complex (and most frequent) patients. More broadly, providing hospitals with data on how they compare and holding them accountable for common quality measures – such as infection rates, patient safety and indicators of clinical quality – can be used to direct improvements in care. The Ministry of Health's ownership of hospitals provides useful means through which to establish such programmes, as it could specify common themes and a common basis for reporting. If required to urge change, the government could mandate key priorities for action and legislate a minimum data set for public reporting.

With common and better information, the approach to driving improvement that has been successful in primary care may be brought to bear on the hospitals sector. Hospitals could also be encouraged to develop their own programmes to foster a culture of quality awareness and improvement amongst their staff. Through its work on a new initiative for hip fractures, the Ministry of Health has demonstrated that it has the capacity to develop policies that seek use evidence and financing levers to encourage improvements in the quality of care (Box 1.5).

**Box 1.5. An innovative use of financing to drive quality of care:  
Time-bound hospital payments for hip fractures in Israel**

The timeliness of operations to correct hip fractures can make a substantial difference in health outcomes, with studies suggesting that correcting a fracture to the upper part of the femur (a bone connected to the hip) within 48 hours considerably improves survival and reduces complications. Using National Trauma Registration data, the government has sought to introduce a time-bound payment for hospitals to increase the number of hip fracture operations, whereby the full DRG payment is only made to hospitals if the operation is performed within 48 hours.

This policy was applied to all hospitals and a study of its effects was carried out by the National Center for the Study of Trauma and Emergency Medicine. The change in the payment method resulted in a 24% increase in the number of operations performed within 48 hours, a decrease in median waiting times to two days from three days and decreased mortality during hospitalisation by 29%. Studies are currently being undertaken to assess the mortality rate up to two years following the operation prior to the government's new policy, compared to the period following the introduction of the policy.

*Source:* Ministry of Health (2012), "Response to the OECD Questionnaire on Quality of Care in Israel", Jerusalem (unpublished).

A further strength of the Israeli health system is that the majority of patients have an electronic medical record within their community care facilities. While the adoption of records varies considerably in hospitals, efforts to increase the transferability of records from community care to primary care would provide clinicians with vital information to help improve the quality of the care they provide. It would also deliver useful information to monitor health outcomes across both community and hospital settings.

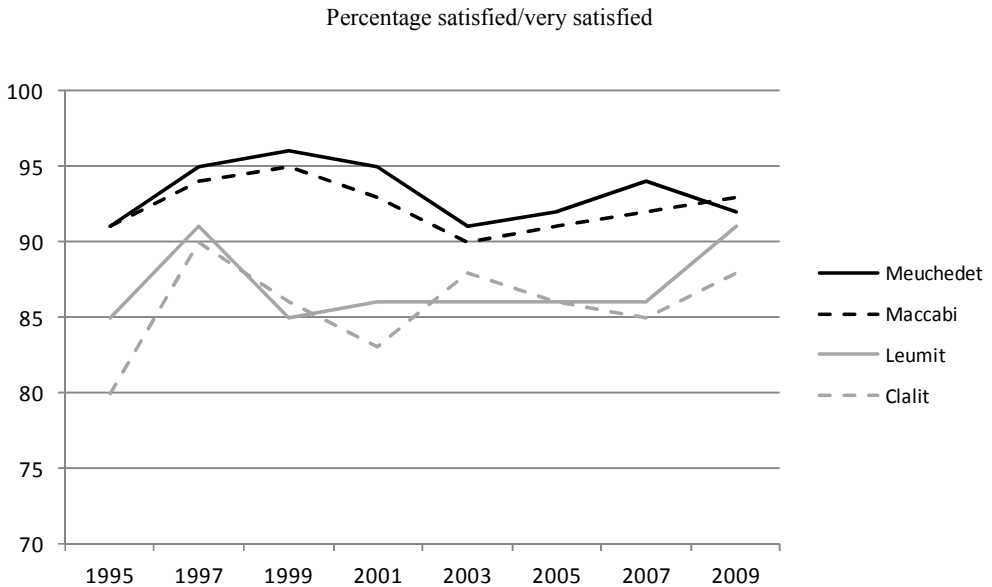
### *Israel has been improving systems to measure patient experiences*

The measurement of patient experiences varies considerably across Israel's four health funds, which have taken the lead in measuring patient experiences with individual health care services. For example, for community health care services, the largest of the four health funds (Clalit) conducts a series of patient experience surveys including a large scale telephone survey of all members, periodical surveys of patients following a visit to a GP, focus groups of patients and an in-house ombudsman to respond to queries, complaints and suggestions. These activities are generally combined with Clalit's other data collection and aggregated for distribution to clinical staff and their managers. Similarly, Maccabi regularly conducts evaluations of its range of services using telephone surveys and focus groups. Maccabi is also deploying evaluation methods using the internet (using patients and physician panels) and cellular telephones to evaluate the quality of services immediately after they are provided (Ministry of Health, 2012). As with other information on quality of care collected by or on behalf of the funds, data on patient experiences are not distributed beyond health funds. In addition, the Ministry of Health also operates an ombudsman for complaints related to health care facilities and health funds.

At a system-wide level, the government and the four health funds finance a national survey on the performance on of health care services from the perspective of patients. The Myers-JDC-Brookdale Institute has been undertaking this biennial survey for the last 20 years. The survey polls a representative sample of around 2 000 Israeli adults and focuses on issues such as satisfaction with health fund services, the availability of health care, waiting times, preventative health care services provided to patients, the burden of payments, the time devoted by doctors and efforts undertaken by funds and health facilities on care co-ordination, among other areas. With a series of core and variable questions, this survey attempts to monitor patient experiences in the Israeli health system over time, across the four sick funds and across population groups. The national survey is supported by a steering group of key bodies in the health sector and is based on a questionnaire that is administered in Hebrew, Arabic and Russian.

The results of this survey often receives considerable media exposure, with a summary and detailed report provided to key decision makers and made available to the public through a website. The most recent survey indicates that the four health funds enjoyed high levels of patient satisfaction with their services overall (Figure 1.7), with substantial variation across funds (Brammli-Greenberg *et al.*, 2011). While this survey represents a useful way of gauging overall levels of satisfaction across the system, it is a crude indicator of whether individual patients are satisfied from the care they received at specific occasions where they sought medical assistance. There is scope for the government to work with the four health funds to standardise the collection of patient experiences and publish more granular indicators of the experience of the users of health services in a particular year.

**Figure 1.7. Satisfaction with Sick Fund Services appear to be high in Israel**



Source: Gross, R. (2010), “Using Patient Experiences to Improve the Health Care System in Israel” (presentation), Smokler Center for Health Policy Research, Myers-JDC-Brookdale Institute and Bar-Ilan University.

***Is information and dialogue enough to drive continuing improvements in the quality of care?***

Unlike many other OECD countries that have sought to use the influence of government over health care providers to direct priorities and



programmes for quality of care, Israel's approach has been to appeal to a provider's innate interest in improving the quality of care. Many OECD countries have often sought to use their legislative power, managerial control or budgetary influence to establish national or regional programmes that seek to simultaneously drive improvements across the system. These programmes generally focus on areas such as what information is collected, patient safety efforts, the use of checklists, guidelines and pathways, and linking specific outcomes to financing.

While the Israeli Government has the capacity to implement such programmes, it has more often chosen an approach based on collating data and encouraging dialogue on the basis of this data. Implicit in this strategy for trying to improve quality is the view that other actors in the health system – notably, health funds and health care facilities – have a desire to continue to improve the quality of care once they are provided with the knowledge and freedom to do so.

This approach has delivered improvements in quality of care within Israel's primary care clinics. At the centre of quality improvement efforts in primary care is a management relationship between health funds and the clinicians that work for these health funds or contract with them. As detailed earlier, information collected as part of the QICH forms the basis for a dialogue between health plan executives, their regional managers and individual clinicians on improving quality. That this very dialogue is reported to occur across the system is to the credit of policy makers, health funds and health providers who have sought to make this a priority. Such processes often do not occur frequently enough in other insurance-financed health care systems in the OECD.

Furthermore, it is of note that unlike other countries (such as Australia, the United Kingdom, France, Germany and New Zealand) that have sought to use pay-for-performance arrangements to seek to improve quality, Israel's health funds rarely employ significant financial incentives. The premise of the Israeli approach to quality improvement is to use information and the influence of management to drive improvements in performance. By providing information to managers and clinic staff, managers have the ability to motivate them to improve performance by appealing to their innate desire to deliver high-quality care. This is combined with the ability to make organisational decisions such as promoting certain managers and recognising high performing individuals or clinics (Rosen and Nissanholtz-Gannot, 2010). This is demonstrated in the case study of quality improvement efforts by Maccabi (Box 1.6).

### **Box 1.6. Driving quality improvement as a purchaser: A case study of Maccabi's efforts in primary care**

Maccabi Healthcare Services is the second largest health care fund in Israel, providing ambulatory-based services to 1.9 million members in Israel. Services are provided throughout the country through relationships with 4 000 self-employed physicians and 1 000 nurses. The organisation is divided into five regions and 160 branches (the smallest administrative unit).

Maccabi's strategy to improve the quality of care consisted of:

- Senior leadership on the importance of quality of care;
- The development of “quality teams” in its central headquarters and local branches that trained staff throughout the organisation on awareness of quality of care issues;
- Introducing a performance management system with 25 indicators for good processes and patient outcomes in primary care, based on the National Programme for Quality Indicators.

In addition to these activities, Maccabi developed targets by region for performance on different quality of care indicators. Setting higher targets for units considered to be weaker was part of an active strategy to encourage management to invest more resources in areas where there was greatest scope for improvement. While the achievement of targets was not supported by significant financial incentives, outstanding units received recognition throughout the organisation. Similarly, all managers received information on the performance of different branches and regions and primary care doctors received performance data on their patients relative to their peers.

Maccabi argues that between 2004 and 2009, performance in key indicators of quality of care improved, with the following being observed:

- Breast and colorectal cancer screening increased by 44% and 146%, respectively;
- Poor HbA1C control decreased by 29% and control of LDL cholesterol increased by 96.2% and 90.3% among diabetic and cardiovascular disease patients, respectively;
- Influenza vaccination increased from 53% in 2003 to 62.9% in 2009, despite a decrease in 2006;
- Variance between regions and branches declined in the majority of clinical areas;
- Disparities between the general and targeted populations (the Arab sector, the poor) were reduced in some areas.

In addition to observed improvements in performance indicators, Maccabi managers believe that they have helped locate quality of care as more important concern within their organisation and actions. While such a programme has been operating in primary care, the quality of secondary care is not yet measured in a similar way on a regular basis.

*Source:* Maccabi Health Services (2012), “Response to the OECD Questionnaire on Quality of Care in Israel”, Jerusalem (unpublished).

However, the dialogue between health funds and providers on quality improvement largely occurs behind closed doors due to restraints on the use of quality of care data between funds, and Israel may not be making the most of the information it collects. Currently, the ability of individual health facilities to benchmark themselves is limited to those within their fund (*i.e.* Clalit clinics can compare themselves to other Clalit clinics but not to Maccabi clinics). This may be useful for seeking improvements within clinics that a fund contracts with, but limits the ability of clinics to benchmark themselves to facilities across Israel. Only being able to compare where a clinic sits amongst a few peers may be less useful than having a sense of how it performs nationally, particularly when the geographic concentration of fund membership may result in clinics associated with Maccabi, Meuhedet and Leumit largely being able to compare themselves with other clinics in Tel Aviv, Jerusalem and Judea and Samaria respectively.

Experience from countries such as the United Kingdom, Korea, the United States and the Netherlands suggests that giving providers information on their performance on quality of care relative to others can often motivate the poorest performers to undertake improvements efforts. While primary health care clinics in Israel are likely to benefit from consistent dialogue with health funds on improving the quality of care, the discussion may often be about raising standards to the best they contract with in the fund and not necessarily the best in the country.

At a higher level, restraints on information are likely to mean that the four health funds are limited in benchmarking the performance of their clinics overall. Funds are currently able to compare the performance of their clinics with that of the market overall, but they cannot compare themselves to other funds. This reduces the incentive between the four funds to be the best performer. Behind this sits a larger question that Israeli policy makers, like many others in OECD countries, are grappling with – whether relying on the virtue of funds and providers are enough to drive quality improvement or whether consumer choice of provider based on quality indicators ought to be encouraged to propel providers' competition on quality.

A lack of public information on quality of care by different providers is likely to mean that consumers make decisions on which fund they choose (or which facility they choose) on the basis of perceived quality and other factors. Experience from other OECD countries such as Switzerland, the Netherlands and Germany suggest that the *quality of customer service* patients receive from their funds and financial cost are major factors driving patient decisions to switch between funds. Today, Israel has comparatively lower rates of switching between funds and high levels of patient continuity with a fund.

Israel's health funds and some providers have argued that the publication of a sample of specific measures on clinical performance is

difficult to interpret without clinical expertise and could provide a skewed picture of performance. There are also concerns about the extent to which data on processes and outcomes ought to be standardised to reflect the diversity of patients across the four health funds. However, other sections of the clinical community and administrators of health system argue that this information is useful – it provides insight into how much effort particular providers are making, and can be aggregated to compare differences across health funds.

A recent court ruling will oblige the publication of information on community care across Israel's four health funds from March 2012. This will mandate that all information is published for the public, including a comparison between health funds. This is a step in the direction of allowing consumers to make informed choices between health funds. In the longer term, Israel may wish to consider reporting quality of care outcomes at the level of the provider. Research on competition in hospital services in the United Kingdom has suggested that the prospect of a small number of highly informed patients acting on the basis of quality information can conduce management to improve quality of care for fear of even losing small volumes. Currently, Israel leaves little scope for patients to make informed decisions on the basis of quality of care outcomes, whether it is for choosing their fund or choosing a hospital. This could limit the potential for using market pressure and choice to encourage quality improvements in the Israeli health system.

#### **1.4. Conclusions**

There is a considerable disconnect between world-leading quality of care policies in Israel's community care sector and weaker than expected quality of care policies in place in hospitals. While there are variations across the country, the community care sector at large has developed a highly sophisticated model for monitoring and improving the quality of care. This is not mirrored in the hospital sector, where further efforts to specify the measurement of quality of care could in the future form the basis of the kind of quality improvement efforts that have served primary care well to date. Israel also has been developing systems to measure patient experiences. To date, Israel has used dialogue with providers informed by quality indicators as a main tool for stimulating quality improvements. This seems to be working well at community care level, yet performance in the hospital care sector is difficult to assess. An open question for the future is whether quality indicators ought to be used to encourage informed patient choices and thereby enforce more competitive pressures onto providers and funds.

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