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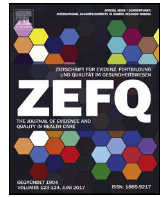

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On the verge of shared decision making in Israel: Overview and future directions

Auf dem Sprung zur Implementierung von partizipativer Entscheidungsfindung in Israel: aktueller Stand und künftige Entwicklungen

Orit Karnieli-Miller [1,*], Talya Miron-Shatz [2], Gil Siegal [3], Yaara Zisman-Ilani [4]

[1] *Department of Medical Education, Sackler Faculty of Medicine, Tel-Aviv University, Israel*
[2] *Center for Medical Decision Making, Ono Academic College, Kiryat Ono, Israel*
[3] *Center for Health Law, Bioethics and Health Policy, Ono Academic College, Kiryat Ono, Israel*
[4] *The Dartmouth Institute for Health Policy & Clinical Practice, Geisel Medical School, Dartmouth College, NH, USA*

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A B S T R A C T

Israel has a universal-national healthcare system and a progressive health policy legislation which, together, provide its residents with high-level healthcare services and either free or highly subsidized coverage without any pre-existing conditions. However, it is surprising that shared decision making (SDM) practices and policy are not an integral part of Israel's healthcare system. The purpose of this overview is to describe the gap between the organizational-infrastructure compatibility of Israel's universal healthcare policy and the efforts needed to advance SDM as part of routine healthcare practice. Review of recent research and education initiatives will be described as well as recommendations for policy and clinical practice.

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Z U S A M M E N F A S S U N G

Israel verfügt über ein allgemeines staatliches Gesundheitsversorgungssystem und eine fortschrittliche gesundheitspolitische Gesetzgebung, die zusammen genommen der Bevölkerung des Landes eine medizinische Versorgung auf hohem Niveau mit entweder kostenlosen oder stark subventionierten Gesundheitsleistungen ohne jegliche Vorbedingungen ermöglicht. Erstaunlich ist dabei jedoch die Tatsache, dass Maßnahmen und Strategien der partizipativen Entscheidungsfindung (PEF) kein integraler Bestandteil des israelischen Gesundheitssystems sind. Ziel dieser Übersicht ist es, die Kluft zu beschreiben, die in Israel zwischen den organisatorisch-infrastrukturellen Voraussetzungen einer allgemeinen Gesundheitsversorgung und den Anstrengungen besteht, die unternommen werden müssen, um partizipative Entscheidungsfindung zu einem Bestandteil der medizinischen Routineversorgung werden zu lassen. Wir geben einen Überblick über aktuelle Forschungs- und Bildungsinitiativen sowie Empfehlungen für Politik und klinische Praxis.

Introduction

Shared Decision Making (SDM)[1] has been advocated in different Western countries around the world as the pinnacle of Patient Centered Care (PCC), which should become routine practice in healthcare delivery [1,2]. This paper addresses the gap between the organizational-infrastructure compatibility with SDM in Israel's universal healthcare system, on the one hand, and the lack of implementation and supporting policy, on the other. Even though the country appears well attuned to SDM, it is not put into practice on a broad scale, and clear training and policy to encourage its implementation is needed. The paper begins by describing the suitability of the Israeli public health system for SDM and PCC. The following section discusses the educational, research, and practice initiatives taken in Israel since the last review [3]. Prospectively, we conclude

* Corresponding author: Orit Karnieli-Miller, Department of Medical Education, Sackler Faculty of Medicine, Tel-Aviv University, Israel.
E-mail: oritkm@gmail.com (O. Karnieli-Miller).

[1] Acronym used: SDM - Shared Decision Making; PCC – Patient Centered Care; NP-HMO – Non-Profit Health Maintenance Organizationl; OECD - The Organization for Economic Cooperation and Development.

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that Israel is on the verge of presenting a potential breakthrough for advancing SDM and PCC in its healthcare policy. Our discussion section elaborates on the opportunities that arise and the necessary steps for making SDM a routine practice in healthcare delivery and health policy in Israel.

The compatibility of SDM with the Israeli healthcare system

Israel has a national health insurance system that provides high-level universal coverage for all its citizens and permanent residents [4]. Health services and benefits packages are provided through four *Non-Profit Health Maintenance Organizations* (NP-HMOs). These organizations receive public funding for managing and providing these services. Residents choose their NP-HMOs without exclusions or individual risk assessment (no-screening and no pre-conditions policy). The NP-HMOs are financed by employee health tax (currently at 4.8%), although unemployed residents are also eligible for coverage. Only small co-payments are required for pharmaceuticals, physician visits, and certain diagnostic exams. Over and above the Israeli national health insurance benefits package, which is broader than in other OECD countries [5], two forms of *Private Voluntary Health Insurance* are also available in Israel: (1) supplementary insurance, offered by the NP-HMOs to all of their own beneficiaries, and (2) commercial insurance, offered by commercial insurance companies to individuals or groups. Overall, Israel's private insurance market is one of the largest compared with other OECD countries; in 2014 over 80% of Israel's adult population had a supplementary private insurance provided by the NP-HMOs, and over 50% had a supplementary NP-HMOs provided by commercial companies [6].

Israel's universal, modern, and inclusive healthcare system offers an infrastructure that is compatible with providing choice and potentially empowering patients. For example, patients in Israel have a great deal of freedom in choosing their community-based physicians—both primary and specialist—from among physicians affiliated with the NP-HMOs. In most cases, specialists are accessed directly and do not require a primary care referral. For most specialties, and in most areas of the country, each NP-HMO is affiliated with numerous physicians, providing a genuine choice of care provider. Similarly, using the private insurance services, even more freedom of choice is available to supplement the options already available in the universal public healthcare system [5]. However, in practice, according to a recent report [5], each year only approximately 1.0–1.5% of the population switches NP-HMOs and, interestingly, switching behavior is relatively more common among lower-income individuals.

The basic right of freedom to choose providers is rooted in the progressive *Patient's Rights Law*, enacted back in 1996 (the second law in the world to be passed on this subject). This advanced legislation stipulates that each patient has rights that are very relevant to enhancing SDM: the right to a second opinion and to be informed about their medical condition, treatment options and risks, and the right of access to personal medical information [3]. It also includes rights for equal access to treatment and care as well a formal and clear ban regarding discrimination [5,7]. For example, The *Ministry of Health* has established centers for assistance including online translation services and cultural competency training for health professionals [https://www.health.gov.il/hozer/mk07_2011.pdf]. In addition, the Israel Ministry of Health, along with the NP-HMOs, has invested in Information Technologies to make personal and evidence based health information accessible to the public [5]. This is aligned with an important SDM principle—provision of evidence-based and personal-subjective knowledge [8].

Another factor that impacts the ability to enhance SDM is the public's willingness and preferences to be involved in their care. Two recent exploratory national surveys have been conducted to assess attitudes toward health care among the general population. One focused on the Israeli public's attitudes to the Patient's Rights Law 20 years after it was enacted (N=500), and its results indicate that more than half of the sample wanted to be familiar with all or nearly all the details about their medical condition. This was particularly true when discussing a decision to undergo surgery, when most respondents (96%) wanted some form of SDM.[2] Another recent survey was conducted by the *National Institute for Health Policy Research* and focused on public attitudes to PCC (N=600).[3] Results show that most respondents wish to receive detailed information and explanation regarding any medical treatment, and prefer to play an active role in their care. These surveys shed light on the readiness of the Israeli public for greater engagement and information provision. That said, it is important to assess what people mean when they claim that their decisions are based on information. For example, recent studies show that pregnant Israeli women decided whether or not to undergo amniocentesis, often without taking into account or even seeking all available information prior to making the decision [9,10]. All this leads to the need to explore further the meaning of receiving information, and being involved in decision making for the Israeli public, in order to enhance its implementation.

Updates related to SDM education, practice, and research initiatives in Israel

The previous review in 2011 showed that the SDM model is neither a formal and common health policy nor a clinical practice in Israel [3] and that various forms of paternalistic communication and decision sharing exist [11,12]. No updated data exists on observations of actual practices, and neither is there a new formal policy to advance SDM. However, since the 2011 review, a few sporadic initiatives related to education, practice, and research have begun, and are presented here.

On the medical education front, only one of the five Israeli medical schools has made genuine efforts in the past five years to integrate SDM into the curriculum [13,14]. Currently, SDM is taught at Tel-Aviv University as part of a theoretical mandatory course focused on humanism in medicine. This theoretical course includes discussions about SDM with a focus on the implications and interpretations of the Patient's Rights Law, on SDM as an ethical imperative, as well as on theories of communication in healthcare. The second mandatory course includes learning and practicing communication skills (with simulated patients), including learning how to build partnership with patients', how to assess patients' preferences, provide neutral and clear information about the diagnosis and treatment options, and allow deliberation and discussion toward decision making.

No formal continuing education initiatives related to SDM have been formed, and we are unaware of any hospital or NP-HMO's initiatives on this subject. But some specific organizations have offered short training sessions on SDM. For example, D-Cure—'advancing diabetes care to cure,' included three half-day training sessions for diabetic educators, the delivery of a keynote speech at their national meeting, and a lecture on the topic at an educational course [15]. Another example is the *Israel Cancer Association*, which invited a training module for breast cancer nurses to involve them in SDM practices, and several training

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