First online: 23 September 2016

The Implications of the National Health Insurance Law and the Law Regulating the Practice of Healthcare Professions for Physical Therapy Services in Israel

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***Abstract*-Aim: To provide a summary of a comprehensive study evaluating the implications of the National Health Insurance Law (NHIL) and the Law Regulating the Practice of Healthcare Professions for physical therapy (PT) services in Israel.**

Methods: A qualitative study was conducted in 2012, based on interviews with all the national managers of PT services in Israel (13 managers) and on information available on Internet websites pertaining to these institutions. The interviews dealt with the general effects of the NHIL and the Law Regulating the Practice of Healthcare Professions for physical therapy, equity and accessibility of services, regulations, and supervision. Additional responses of senior medical directors from the HMOs were added as an appendix.

Results: All of the managers noted the important contribution of the laws mentioned herein to regulating services and establishing standards for the quality of treatment and the professional training of physical therapists. However, they are aware of areas in which there is a gap between the law and the actual service provided. These gaps manifest mostly in the lack of equity between the services provided by each of the HMOs, between the services provided in the center of the country and those provided in the outlying areas and between the services provided by the HMOs and by other organizations. Providers differed in quality of service and treatment quota policies. The Ministry of Health audits its own state-funded PT services, but not those provided through other ministries.

Conclusions: Physical therapy services are available throughout Israel as part of basic state-funded healthcare services. The gaps between the actual PT services and the services dictated by the laws are similar to services provided by other health-care professions in Israel. Several suggestions have been offered to improve the auditing system, including: 1. Establishment of a mechanism to evaluate PT services objectively; 2. Creating a framework of cooperation among the HMOs to solve lack of equity rooted in geographical distance; 3. The HMOs should be obligated to provide services to patients affiliated with the ministries of education and welfare; 4. Establishment of a training program to prepare physical therapists to work with people with developmental and intellectual deficiencies; 5. A committee should be established to review the issue of quota of treatments; 6. Mandatory continuous professional development should be established as a condition for renewal of licenses to practice PT. This would also contribute to the standardization of professional levels.

Keywords- National Health Insurance Law; Physical Therapy; Equality; Supervision and Auditing

I. INTRODUCTION

The National Health Insurance Law (NHIL) [1, 2] held the promise of providing equitable health services for all citizens of Israel. The law indeed helped bring the health system closer to this goal; nevertheless, inequity remains a characteristic of the healthcare system in Israel [3, 4]. The inclusion of physical therapy (PT), as well as other allied-health professions, in basic services proves that the legislature considered it important to ensure the rehabilitation and improvement of the quality of life for people with functional limitations. The role of PT and its relevance in the trajectory of care across the human lifespan has been described by the World Confederation for Physical Therapy (WCPT) [5].

According to the law, "Healthcare services are to be provided as recommended by the examining physician, at a reasonable quality, within a reasonable timeframe, and at a reasonable distance from the client's place of residence". In addition, "The Ministry of Health (MOH) is obliged to supervise the HMOs, according to the standards determined by the Minister; the methods employed for this purpose will be determined in the bylaws". Service providers are responsible for conducting their own internal professional audits [6].

One of the limitations of the NHIL is its lack of clarity regarding the manner in which the law is to be implemented [3]. As it pertains to PT services, the law does not specify who is entitled to provide services, the scope of the service provided, or which treatments are defined as unique to this profession. In addition, the law includes an administrative model for determining the number of treatments per patient, which was based on the practices of the largest HMO at the time. However, the law failed to take into account either the opinion of a professional or the special needs of patient subgroups. It should be

DOI: 10.5963/PHF0501001

noted that the law provides only general statements and that most of the instructions formulated by the ministries are based on bylaws and various regulations.

In 2008 the Law Regulating the Practice of Healthcare Professions [7] was established, which, to a great extent, complements the NHIL. This law defined, for the first time, the type of title required for practicing the health profession. The law also mentions the requirements of reliability and adhering to professional ethics, as well as exercising professional and personal discipline.

Physical Therapy services, which are offered as part of the state-funded public health services, are provided by HMOs, several government ministries and private providers. The scope of responsibilities is different for each organization. For more details, see Table 1.

TABLE 1 PHYSICAL THERAPY PROVIDERS IN ISRAEL

Organization	Population
Health Maintenance Organizations (HMOs)	General population Children of ages 0 to 3 with developmental disabilities
Ministry of Health (MOH)	State-funded hospitals Geriatric centers
Ministry of Education (MOE)	Framework of special education for children between the ages of 3 and 21
Ministry of Welfare & Social Services (MOWSS)	Individuals with developmental and cognitive deficiencies
Israel Defense Force (IDF)*	Those serving in the army
Ministry of Defense*	Those enlisted or serving in defense-related positions
Private clinics*	Mainly for ambulatory patients→

*Not included in the study

A comprehensive study examining the implications of the two laws mentioned was performed in 2012 [8-10]. This issue is interesting particularly in light of the Law Regulating the Practice of Healthcare Professions of 2008, which partially addressed some of the less clear aspects of the NHIL. The present article aims to provide a summary of that study, examining various aspects of the implications of the two laws on PT services in Israel. Additional responses of senior medical directors from the HMOs were added as an appendix.

II. METHODS

A qualitative study was conducted in 2012-2013, based on personal interviews with all national managers of PT services in Israel and on information available on Internet websites pertaining to these institutions. The interviews dealt with the general effects of the two laws, equity and accessibility of services, regulations, and supervision. The interviewees were asked to additionally consider bylaws and regulations during the interview. The interviews were recorded and then transcribed. The transcriptions were sent to the interviewees for confirmation before analyzing the data. Data was analyzed by the principle investigator and by a research assistant separately, using a thematic analysis procedure [11]. Next, the categories defined were reviewed. Finally, interviews pertaining to a single category were combined, and the names of the participants and of the HMOs were concealed.

Each public organization providing PT services is headed by a nationwide manager who is responsible for the services and the professionals affiliated with said organization. One of the roles of the manager is to ensure the implementation of the directives of the law as they pertain to PT services. Consequently, the assumption underlying the current study was that these managers have the necessary knowledge and are authorized to report on the degree to which the law has been implemented in the realm of PT services in the particular organization under their management.

The study was authorized by the ethics committee of Ariel University. Participants were asked to sign an informed consent form prior the interviews.

III. RESULTS

The majority of the managers, 13/14, confirmed their participation. Their positions and affiliation have been described previously [8]. The testimonies provided by the managers regarding the implementation of the NHIL (13/13) revealed the following issues [8-10]. The main results are shown in Table 2.

TABLE 2 EQUITY OF PT SERVICES ISSUES, IMMERGED BY THEMATIC ANALYSIS

Categories	Physical therapy service organization			
	HMO's	MOH	MOE	MOWSS
Implementation of The National Health Care Low				
Equity of Access to Services:				
• Geographic accessibility	Fewer services of any kind in the outlying parts of the country			
• Access to unique PT treatments (e.g.:	Insufficient accessibility to unique services. Worse in outlying areas.		Provide treatment only for patients	Provide treatment mainly for patients with chronic

DOI: 10.5963/PHF0501001

urogynecology, lymphatic edema, balance disorders)			with chronic conditions	conditions
• Patient subgroups' access to treatment	There are subgroups of patients who have a very difficult time gaining access to conventional PT (e.g.: patients with chronic conditions who reside in the community)			PT provides only a partial response
• Neglected aspects of treatment (e.g.: health promotion, ergonomic)	There are areas of treatment that have been neglected over the years, despite the fact that they are considered an important –part of the profession.			
Equity in Terms of Availability of Treatment	There is a constant problem of long waiting periods and for patients with chronic conditions in particularly		The problem is even worse for children with developmental disabilities	Physical therapists in HMOs' clinics are not trained to treat patients with cognitive disabilities
Equity in Terms of Number of Treatments Per Patient	Contrary to the dictates of the law, this decision should be professional rather than administrative. The policy varies from one HMO to the next.		Dictated by by-laws. Sufficient only for the treatment of chronic conditions	
Mechanisms for Controlling the Quality Service	Each HMO provides internal supervision complementary to the MOH supervision.	Oversees PT services provided by HMOs, but not services provided by other government ministries.	In neither of these ministries is the national physical therapist authorized to manage or enforce regulations; furthermore, no positions are allocated for regional support of this role	
Implementation of the Law Regulating the Practice of Healthcare Professions				
Authorization to practice PT	The law has had an important effect in unifying the basic professional level of practitioners in all areas of PT, and currently only those certified in accordance with the law are able to practice			
Basic and post-graduate education	Post-graduate professional development is not mandatory in any of the HMOs. Undergraduate curriculum is not satisfactory in the areas of the treatment of patients with cognitive and developmental disabilities.			
Employment framework	The ratio of employed versus independent physical therapists differs among the HMOs. In the smaller HMOs, particularly in outlying areas of the country, the relative number of independent physical therapists is much greater than it is in the larger HMOs.			

A. Equity of Access to Services (4/13)

Geographic accessibility: All of the HMOs make an effort to provide services in all parts of the country through their organizations. Nevertheless, all of the HMOs, and especially the smaller ones, run fewer clinics in the outlying parts of the country. This generally reflects the ratio between the numbers of affiliated patients in the central vs. the outlying areas.

Access to unique PT treatments: In all of the HMOs, there is a problem of accessibility to unique services such as uro-genycology, lymphatic edema, and balance disorders. This is mainly due to a lack of personnel with the appropriate specialization. The problem intensifies in the clinics in the outlying areas, particularly those pertaining to the smaller HMOs.

Patient subgroups' access to treatment: In all of the HMOs, there are subgroups of patients who have a very difficult time gaining access to conventional PT treatments. One example is that of patients with chronic conditions who reside in the community and are unable to receive treatment in regular ambulatory clinics. According to the managers, the arrangements for home visits are sufficient only for patients in acute conditions. Another subgroup of patients is that of children with developmental disabilities. Interdisciplinary child development centers are available throughout the country. However, not all those in need can be treated – particularly in the outlying areas. One of the managers of an HMO noted that "…parents are forced to travel with their children [to receive treatment in distant locations]." Travel for this purpose constitutes both a financial and a physical burden, and the service is not as accessible as needed. Subgroups of patients with a physical or cognitive deficiency whose treatment is under the auspices of the Ministry of Education (MOE) and the Ministry of Welfare and Social Services (MOWSS) fare even worse. Patients in this population receive PT to prevent worsening of their condition through the frameworks to which they belong. However, for this population, the issue of access to treatment becomes especially problematic in acute conditions, such as injury or when rehabilitation is needed.

Neglected aspects of treatment: According to the managers, there are areas of treatment that have been neglected over the years, despite the fact that they are considered a core part of the profession. Examples include areas such as health promotion (both in healthy populations and in populations with physical disabilities), ergonomic consultation in the workplace, and the recommendation of specific physical activities for the treatment and prevention of non-communicable diseases, such as

DOI: 10.5963/PHF0501001

diabetes and hypertension. These areas have not been addressed sufficiently in terms of either clinical practices or allocation of resources, nor have they received adequate emphasis in the curricula for training of physical therapists.

B. Equity in Terms of Availability of Treatment (5/13)

All of the managers of PT services in the HMOs indicated there is a constant problem of long waiting times, particularly for patients with chronic conditions. According to one of the managers, "the long waiting time for treatment is one of the main complaints that patients have about the PT services". One of the reasons for treatment delay is an inadequacy or complete absence of positions allocated to professionals in the field. Solutions have been suggested, including to add personnel, to open additional clinics, and to develop group treatments that will enable a greater number of patients to be treated simultaneously.

The problem of availability becomes even worse when the needs of children with developmental disabilities are discussed. In Israel, provision of PT in the special education system is determined using an "allocation key" defined in 1994; consequently, only patients with chronic problems are able to receive treatment. "The key to allocating positions for medical services, allied-health services, and social services was determined by an inter-ministerial committee comprising the ministries of education, health, and welfare, and it has not been altered since 1994" [12]. Physical therapy received through the framework and auspices of the MOWSS provides only a partial response, and according to the advisor, "there is a problem of availability of professional services. When the need arises for a special type of treatment, a "battle" ensues with the HMOs in an effort to obtain the proper treatment". At the same time, "… the MOWSS has recognized the therapeutic needs of those under its auspices and has expanded the range of health services available through its framework".

C. Equity in Terms of Number of Treatments Per Patient (8/13)

Another major issue that is subject to debate is determining the number of treatments that patients are entitled to in a single year. Contrary to the dictates of the law, most of the managers of the HMOs believe that this decision should be professional rather than administrative. They claim that it represents an important aspect of the professional autonomy of the physical therapist. According to the managers, the shift from a predetermined quota to a determination of the number of treatments based on expert opinion is in varying stages of implementation in different HMOs. While the policy regarding the number of treatments per patient varies from one HMO to the next, they all have a supervisory mechanism for receiving approval to increase the number of treatments for any patient in need.

D. Mechanisms for Controlling the Quality of Service (10/13)

According to the NHIL, the Ministry of Health (MOH) is obligated to supervise the health services [1]. The mechanisms for this include the ombudsman's auditing the implementation of said law, the department of HMO supervision, and ongoing supervision from the MOH. The Department of PT in the MOH oversees PT services in hospitals (general, rehabilitation, and geriatric hospitals), in community clinics, in child development centers, and in geriatric institutions. The Department is responsible also for determining and implementing policies, setting standards and regulations, implementing control and supervision, and organizing professional development [13].

All of the managers in the HMOs acknowledge the importance of control and supervision by the MOH, and they even noted that both professionally and objectively, "supervision is important for maintaining our dialogue with the MOH… There is a reciprocal learning that is part of this process". One manager remarked that "the audits [conducted by the MOH] have had a positive effect in terms of obtaining equipment, setting regulations, and the public's perception of PT services".

However, the managers at the HMOs described several limitations to the review process. One of the major limitations stems from the fact that the audits evaluate only administrative aspects and they are implemented in only a small sample of PT clinics. Moreover, the lapse between the time when inspections are conducted and the receipt of the inspection reports. In addition, the audit reports do not obligate the HMOs to make changes accordingly; rather, these are only considered recommendations. In most organizations, there is an internal audit process, as required by law. According to the managers, there are differences between the various HMOs' internal review mechanisms, the budgets that they allocate for this purpose, and the depth and detail of the review.

However, the major limitation of the review process is that the MOH does not supervise PT services provided within the framework of other government ministries. In those frameworks, there is only an internal partial review process. In the MOE, the role of the national physical therapist is to provide guidance, and in the MOWSS, the definition of the national physical therapist's role is that of an advisor. In neither of these ministries is the national physical therapist authorized to manage or enforce regulations. Furthermore, no positions are allocated for regional support of that role [9]. In addition, there is no auditing mechanism to oversee the PT services provided by private clinics. One of the managers added that "one of the greatest weaknesses is the reliance on independent providers. Reliance on salaried professionals makes it possible to oversee their work, to obtain their loyalty to the organization, and to dictate certain demands… It is difficult to maintain such control over outsourcing providers". Finally, the MOH, which is both a regulator and a health services provider, audits its own services.

DOI: 10.5963/PHF0501001

1) Implementation of the Law Regulating the Practice of Healthcare Professions (10/13)

Basic and post-graduate education: According to the managers, the Law Regulating the Practice of Healthcare Professions [7] has had an important effect on unifying the basic professional level of practitioners in all areas of PT, and currently only those certified in accordance with the law are able to practice. Nevertheless, all of the managers were of the opinion that post-graduate courses should be a mandatory tool for the professional development of service providers. Currently, post-graduate professional development is not mandatory in any of the HMOs. According to one of the managers, "professional development is a requirement that is not necessarily enforced. It depends on the manager's assertiveness and the degree to which there will be a sufficient number of service providers if some are away for professional development". The HMOs vary in terms of the degree to which they encourage workers to develop and in terms of the budget allocated for this purpose. The majority of the managers agreed that professional development must be regulated and also be part of a mandatory requirement for the renewal of the practitioner's professional license. Also, it must be made clear that it is the employer's responsibility to ensure and oversee employees' professional development.

Employment framework (5): There is agreement among the managers that employing salaried professionals from within the organization is preferable to outsourcing to independent providers, in terms of the professional level of service. In their opinion, independent physical therapists generally do not tend to identify with the organization and are subject to little or no professional supervision. In addition, their post-graduate professional development depends on their personal motivation, which is guided for the most part by financial considerations. The ratio of employed versus independent physical therapists differs among the HMOs. In the smaller HMOs, and particularly those in the outlying areas of the country, the relative number of independent physical therapists is much greater than it is in the larger HMOs. Employing independent service providers was intended as a means to improve service availability; however, as noted, it creates a professional problem.

IV. DISCUSSION

Physical therapy services are available throughout Israel as part of the basic state-funded healthcare services. All of the managers noted the important contribution of the laws mentioned herein for regulating the service and establishing standards for the quality of treatment and the professional training of physical therapists. However, they are aware of areas in which there is a gap between the law and the actual service provided. The discussion of the implementation of each law is presented separately.

A. The Implementation of the NHIL

Equity of access to services: Most of the managers are of the opinion that despite the dictate of the law, the availability of services is insufficient throughout the country, and that accessibility is deficient mostly in the outlying areas. This applies not only to access to unique treatments or to subgroups with special needs, but also to the regular facilities. One assumption, raised by the managers, is that lack of number of positions in PT clinics may explain inequity of access to services. Indeed, while in the departments of rehabilitation and geriatrics and in child development centers, the number of positions allocated for PT professionals is clearly defined [12], this is not the case in general hospitals or in ambulatory clinics in the community [13]. Another explanation suggests that these findings do not relate to shortage of PT man-power but coincide with the state of affairs found in other healthcare services in Israel [14, 15]. Since the funding for all the HMOs comes from a single governmental source, and since the laws apply across the HMOs, the question is why the government does not insist on cooperation between the HMOs. This question was addressed to three HMO medical directors (Appendix). The directors noted that all HMOs have had to deal with an insufficient budget for the last 10 years; therefore, it is very difficult to improve facilities even when it is justified and needed. According to them, the budget inadequacies only encourage competition between the HMOs, and therefore cooperation between them is not a viable option.

The issue of access for patients with developmental disabilities to PT deserves more attention. For children under age three, accessibility to PT, which is provided by the HMOs, is insufficient throughout the country. Physical therapy provided through the ministries of education and welfare are available to all those in need in an equitable manner; however, the availability of these services is not on par with the services available to the general population at all HMOs. It is especially noticeable in regards to those who reside in the community. In effect, the system is not equipped professionally to provide treatment to patients in this subgroup, and the care they receive is deficient. In addition, as in all of the PT services, accessibility to treatments that require specialization is especially absent in outlying areas. In these locations, the physical therapists have poorer access to professional development than do their peers in the center of the country. Heads of PT services in the ministries of education and welfare claim that it is not clear whether the HMOs bear the responsibility for caring for special-needs sub-populations under their auspices. This claim echoes the conclusions of the Public Committee for Assessing the Special Education System in Israel [12] and contradicts the dictates of the NHIL. The committee that oversees the system for special education in Israel described the situation as follows: "When the therapy services that the child requires are not offered through the MOE, the service is frequently provided through the HMOs, which in turn claim that they are not obliged by the NHIL to provide these services". In effect, the HMOs provide only a partial solution, which varies according to patient's age group and the framework of healthcare with which they are affiliated.

DOI: 10.5963/PHF0501001

Another interesting issue is the neglect of several aspects of PT. One of the goals of the profession, according to the World Confederation of PT (WCPT) [5, 16], is to provide preventive services to the general population, with an emphasis on preventing skeletal/muscular deficiencies. To date, the majority of PT services target patients in need, and the resources allocated for preventive services are smaller. Health-promoting PT services are provided occasionally through additional healthcare frameworks that offer services beyond those included in the state-funded basic healthcare program. This state of affairs also pertains to PT services available through the MOH. Preventive services are also at the bottommost rung of priorities in the curricula for undergraduate degrees in PT in Israel. This could be explained by the fact that PT services, both preventive and therapeutic, are provided through the same framework in the HMOs. Thus, the conflict between caring for patients in need or providing preventive care for the healthy population becomes manifest also in the case of PT services [15, 17]. Israeli [17] states that there is a problem of duality, given that the MOH is currently responsible both for treating patients and for offering preventive treatment to the healthy population. In cases such as this, there is always a preference for treating patients in need. However, Israeli's recommendation is to let the MOH be responsible for public health in the context of preventive medicine only in areas such as inoculations against infectious diseases, but not as pertains to PT services, which for the most part are provided by the HMOs, and only in part by the MOH itself.

Equity in terms of number of treatments: All of the managers agreed that the number of treatments should be determined according to professional discretion and according to the condition of the patient, rather than as an administrative regulation determined by law. This attitude is congruent with previous publications about the number of PT sessions available to patients with low back pain from the Netherlands [18] and about utilization of outpatient PT for American Medicare beneficiaries with musculoskeletal conditions [19]. Whether professional decisions are more appropriate and exhibit less variation in relation to need than administrative decisions remains an empirically unanswered question. Based on directors' opinions and on previous literature [18, 19], it is suggested that implementing such a change would be clinically beneficial and additionally would empower the physical therapists professionally.

Mechanism for controlling the quality of service: Managers of all frameworks felt that the control and auditing system of the MOH is necessary and expressed the need to increase the frequency and the level of both internal and external audits [10]. However, they agree that there is a gap between the dictates of the law and the actual implementation and practice. Although stipulated by law, there is no external auditing mechanism to supervise PT services provided in the framework of other governmental ministries, and the supervision of private service providers is partial at best. It should be noted that currently, the issue has not been addressed through any legal statute and no authority has been assigned to act on this matter. In addition, the MOH oversees services provided under its own auspices. The conflict of interest that exists in general between the roles of the MOH as policy maker and as supervisor and auditor of government-managed hospitals [17] is patent also in the context of PT services. In addition, the Department of PT in the MOH has developed measures, regulations, and auditing tools that can be used in the various frameworks to determine the level of services [20]. However, the reliability and validity of these quality measures must be examined, and additional means must be created for the department to be able to enforce all of the recommendations in the auditor's report. Internal auditing in the large HMOs is both extensive and profound, much more so than in the smaller HMOs, probably due to the stronger financial capabilities and greater resources available to the former.

B. The Implementation of the Law for Regulating Healthcare Professions

All managers agree that the Law for Regulating Healthcare Professions has led to standardization of the basic professional level of physical therapists, and currently only certified physical therapists can be employed. However, the level of professional services offered cannot be guaranteed if practitioners acquire only the basic level of professional training. The level of services provided is determined, to a great extent, through practitioners' participation in post-graduate professional development courses afforded within the framework of their job. To date, the different organizations vary in their professional demands. One example is the training of physical therapists to work with people with developmental and cognitive deficiencies. In most of the departments teaching PT in Israel, the curricula rarely address this issue. This situation is exacerbated by the fact that even after studies are completed, there are almost no advanced professional courses that focus on these topics. Indeed, the Assessment Committee of the MOE found that there is a paucity of allied-health professionals trained to work in the educational system, and that this deficiency is particularly acute in regard to the treatment of patients with intellectual disabilities [12].

Study limitations: Data is based on interviews with national service directors; however, directors in the field, physicians, or the patients themselves may see the subject differently. In addition, for ethical considerations, it was impossible to present the opinions of PT leaders in the HMOs separately from those of the non-HMO affiliated PT leaders without exposing the identity of the parties involved. Other limitations include the lack of standards for staffing levels in community clinics and the absence of statistical data regarding the actual number of physical therapists in different regions in Israel. Details about MOH supervision frequencies at the various service areas could not be provided, as they are not available to the public. Finally, there is no representative body of the private sector, and therefore no representative of this sector could be interviewed.

V. CONCLUSIONS AND RECOMMENDATIONS

The gaps between the actual PT services and the services dictated by the laws manifest mostly in the lack of equity between

DOI: 10.5963/PHF0501001

the services provided by each of the HMOs, between the services provided in the center of the country and those provided in the outlying areas and between the services provided by the HMOs and by other organizations. This was the case in all of the criteria examined in the study. However, there is evidence that this also has implications for services provided by other health-care professions in Israel. Several suggestions are offered in order to improve the auditing system. 1. A mechanism should be established to evaluate all of the PT services in the country in an objective manner. Such a mechanism should address the degree to which patients' needs for access are being met and the quality of the services offered. It is also important to create uniform standards for internal auditing of the HMOs and to coordinate these between the HMOs and the MOH. 2. The lack of equity rooted in geographical distance can be amended by creating a framework of cooperation among the HMOs. As noted, referring patients to external providers comes with certain limitations; instead, efforts should be made to centralize the services provided by all of the HMOs, and additional clinics should be established in the outlying areas. It is also suggested to consider developing centers of excellence for specialized services both in peripheral areas and in the center of the country. 3. The HMOs should be obligated to provide services throughout the patient's lifespan and to provide PT also to patients affiliated with the ministries of education and welfare. A training program preparing physical therapists to work with people with developmental and intellectual deficiencies should be established. 4. A committee should be established to review the issue of quota of treatments in an effort to amend the existing inequity between the HMOs. This can be attained by establishing similar auditing mechanisms in an effort to increase the per-patient treatment quota and to ensure that this aspect of treatment is not arbitrarily determined. It is reasonable to assume that the quota of treatment may differ between various patients. 5. Mandatory continuous professional development should be established as a condition for renewal of the license to practice PT. This would also contribute to the standardization of professional levels.

Possible implications for other countries - This study may raise awareness of PT managers in other countries of the need to study the services under their responsibility. Given that PT services in other complex health systems might face similar difficulties and dilemmas, managers may get some ideas for relevant issues to discuss. Awareness of services' strength and weaknesses may lead managers who wish to improve service to look for solutions. Furthermore, the NHIL and the Law Regulating the Practice of Healthcare Professions Services may set an example to other countries who wish to improve their health care services.

Finally, this study provides an insight into the world of PT services in Israel as affected by the law. During the last four years, there have been no significant changes in PT services or in legislation related to them. Therefore, it is assumed that the data presented here is also relevant today. Future studies should focus on planning programs to address the above-mentioned recommendations and to review the implementation of said programs.

Notes:

- Senior medical directors from each HMO were requested to respond to the recommendations of this article. Three of four directors responded. Their opinions were quite similar, and are presented in the appendix.
- This study was supported by The Israel National Institute for Health Policy Research.

ACKNOWLEDGMENT

The author thanks the Israeli PT directors for sharing their ideas with her.

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APPENDIX: HMO MEDICAL DIRECTORS' RESPONSE

All HMOs have had to deal with an insufficient budget for the last 10 years; therefore, it is very difficult to improve facilities even when it is justified and needed. Due to the inadequate budget, there is an ongoing competition between the HMOs, and therefore cooperation between them is not a viable option. The truth is that the government in effect wants to increase the competition.

Disadvantages of contracting self-employed clinicians are well known to all HMOs, and they try to minimize their employment. However, the cost of employing them is lower than that of hiring organizational employees and therefore unavoidable, especially in the peripheral areas. Providing outsourced medical services decreases — to some extent — the problem of long waiting periods until patients can receive treatment.

Medical care for people with developmental disabilities is determined today based on the considerations and preferences of government offices, rather than by the patients' best interest. This problem should be solved by the government and not by the HMOs. Nevertheless, HMOs that do provide services to this population incur the costs of training their staff, and therefore deserve an increased budget, something that they cannot expect to receive in the near future. In principle, medical and allied health services for this population should be removed from the educational system and assigned to the HMOs, as is customary in the USA.

The present state of affairs regarding the quota imposed on the number of physical therapy (PT) treatments allotted per patient should be changed, and auditing mechanisms for PT should be established based on the needs of subgroups of patients. Unfortunately, at present, not enough budget is allocated to allied health professions. Regardless, this issue can be solved only by the regulator and by imposing a control mechanism on the HMOs.

There is no doubt that the idea to establish a mandatory and ongoing professional development program is excellent and has the potential both to empower the physical therapists and to save money. The questions are, who will finance the project — the regulator or the HMOs, and how will this be applied to self-employed therapists?

It is important to establish an objective mechanism for evaluating all of the PT services in the country. Such a mechanism may be beneficial to citizens and urge the HMOs to improve their service in this field. The establishment of this mechanism should be initiated and prioritized by the managerial system of the PT services.

DOI: 10.5963/PHF0501001