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Israeli Arab Independent Health Clinics: Personal Incentive Systems and Motivational Rewards

Mohamed Z. SHEABAR [1], Stefan COJOCARU [2]

Abstract

The Israeli healthcare system is a universal system, based on the National Health Insurance Law 1995 (NHIL), which mandates all residents in the country to join one of four official health insurance organizations, known as *'Kupat Holim'* (HMOs). This resulted in an increase in the accessibility of health services and their distribution throughout the country. Lack of physicians, especially in the peripheries, and the competition to recruit clients forced HMOs to change and expand the concept of operating medical services. One way was to establish independent health clinics (IHCs). The current study focuses on a social and cultural phenomenon that was changed and expanded following the NHIL. The research literature lacks studies addressing IHCs in the context of the impact of the NHIL on Arab society.

The research design is mixed methods with a qualitative stage followed by a quantitative stage. Specifically compiled research interviews and questionnaires were built to collect information. The main findings of the studies indicated that most physicians and managers recognized the NHIL and its contribution to the population. Addressing social and environmental rewards and deciding on moral rewards at an early stage anchored in the contract from the beginning was significant and strengthened the future of contracts between HMOs and self-employed physicians. Findings and conclusions of the study indicated a need to continue operating IHCs on condition they kept initial promises and provided feedback to physicians from time to time while improving terms of engagement, visits, and problem solving when needed in a timely manner.

Keywords: The State Health Insurance Law (NHIL), Arab society, Health Maintenance organizations (HMOs), independent health clinics (IHCs), Reward system, The Ministry of Health (MoH).

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Introduction

The topic of this research is the diverse cultural and social aspects of implementing the Israeli National Health Law, i.e., exploration of the phenomenon of "Independent Health Clinics" in three Arab societies in Israel (Arab-Muslim, Christian, and Druze). The conceptual framework included the following research disciplines: sociology of health services, culture and multiculturalism, public health services institutions (in this study, "Independent Health Clinics") and rewards). Over the years, the phenomenon of IHCs has increased and spread, especially in Arab society. It was worthwhile and important to examine whether and how the existing motivational rewards system serves to promote and retain physicians in an HMO.

Literature review

The research literature lacks studies addressing IHCs in the context of the impact of the NHIL on Arab society. Several social theories were selected for this research in the context of IHCs. Hofstede's (2011) model describes six independent dimensions of national cultures**.** Another theory is Giddens (1984) theory of social responsibility, macro and micro level retaliation and how to bridge them. Social capital and human capital theory (Dakhli & Clercq, 2004), finally, the theory of organizational change that represents a specific collective organizational identity (Alison *et al*, 2021**).**

Sociological and Cultural Aspects

The NHIL was enacted and implemented in Israel in 1995 (Ministry of Health Israel, 1996) stating and based on principles of justice, equality and solidarity (Horev & Keidar, 2010). To analyze the sociological and cultural aspects of this law's implementation in Israeli Arab health clinics, four theoretical models were used: (1) Dimensions of national cultures (Hofstede, 2011); (2) Social responsibility; (e.g., Giddens 1979, 1984); (3) Social capital and human capital (e.g., Dakhli & Clercq, 2004); and (4) Organizational change. (e.g., Alison *et al*., 2021).

Hofstede's (2011) model described six independent dimensions of national cultures: power distance, uncertainty avoidance, individualism and collectivism, masculinity/ femininity, long/short-term orientation, and indulgence/restraint. These are in accordance with organizational sociology; they may identify and describe variances in organizational practices. This model defines culture as a set of ideas, expectations and norms shared by the members of a culture (Smith *et al*., 2002).

Hofstede researched 160,000 IBM employees in 60 different countries. He claimed that the environment influenced people and that their personalities could be quantified, so it was possible to define conventional behavior, with exceptions within "standard deviations" but in general claimed that cultures could be categorized by four dimensions. A further two dimensions were added later:

1. *Power distance* – based on Hofstede, the distance of power leads to a social hierarchy, with high power and low power distance. High power distance is behavior according to a hierarchy and authorization, compared to low power distance, which believes that power must be divided equally and people are equal. Israel is a very egalitarian state in this sense of power. In India, there are cluster castes. Many cultures do not call managers by their first names but use titles. Small distances help creative thinking but are liable to harm discipline. For example, in Asian countries where there are greater distances, workers are more disciplined, but less creative.

2. *Uncertainty avoidance* - (avoiding uncertainty) do not take risks, toe the line. Japan for example, is very conservative, they are good in controlling accuracy and quality, but they take a stand of preventing risks. On the other hand, Sweden and other Nordic countries are open and less conservative. Denmark is a leader in product design with people who think creatively and do not avoid uncertainty.

3. *Individualism and collectivism* - (individuality and collective) in individualism, everything designed, values, duties, and personal ethics are at individual level interests. Israel, as a society is rather conservative and quite stable as far as the health system is concerned. IHC are opened as part of the policy of making healthcare services accessible and maintaining the system's stability. In Australia or the U.S.A., for example, people are classified as individualist. In the context of organizational behavior, it should be understood that in some places, it does not help management to give bonuses to teams to motivate individual employees, but rather encourage competitiveness such as "employee of the month". The system is based on individual rewards to encourage growth. In South America, the concept of tribe is strong, so individual competition is better replaced by a "Best team" competition. This is not about good or evil; it is a cultural matter within a society. To sum up individualism in this context is a doctrine motivating individuals to be creative and independent. Collectivism, on the other hand, speaks to the interests of groups that individuals manage and in which they must perform. Working towards societal goals, what is good for society, promotes and produces for society, where it thrives on success and continuity. It produces a common mindset for social adaptation and adjustment between diverse cultures. Collective behavior develops on the basis of individuals' behavior. In Israel, rewards are collective in the health domain, and individual in the Hi-Tech world.

4. *Masculinity/femininity* - (male/female) – This addresses women's status in society. Places where women are more integrated in society (such as Scandinavia) are considered feminine countries. Japan, however, is a highly masculine

country in the sense that there are few women managers, very few engineers and relatively few female workers because Japan is a very conservative and traditional country. %ages are usually used to reflect masculinity/femininity. In countries leading femininity, this reaches 40% whereas in other countries women are only symbolically represented. Is Iran a feminine or masculine country? We may consider it to be masculine because of its religious practices, but there are many women in professions that, in classical terms, are considered masculine. Where does Israel sit in this context? On the one hand, it has a very masculine image, but on the other hand, women are fully integrated into society, for example senior military officers, physicians and women managers in health and education.

In recent years, Hofstede added a fifth and six dimensions.

5. *Long/short-term orientation* - In "long-term" cultures (for example, China and other Asian countries) emphasis is placed on the future - people are willing to save and sacrifice in the present for a better future. In "short-term cultures (for example, Russia, West Africa), emphasis is on past and present and fulfilling social obligations now. In Israel, the approach has been predominantly short-term. Recently, investments are based on considerations regarding the future, and in the health system, this is mostly expressed in opening IHC for the benefit of the future of the system.

6. *Indulgence/restraint*- In 2010, a sixth dimension was added: Self-fulfillment represents societies that enable relative free satisfaction of basic and natural human desires related to life enjoyment. The quality of restraint represents societies that control the satisfaction of needs and regulate it through strict social norms. Israel is essentially a conservative society. Social norms may prevent individuals to behave differently. In the field of health, there are ethical rules to ensure respect for people.

Hofstede's theory has set up a critical assessment of management and practice theory around the world. Society is complex, and it is often impossible to understand or explain its dynamics, disarray, humanity in a global society. Hofstede's paradigm provides an understanding of different models of organizational management. Cross-cultural management is significant, understanding the diverse cultures in a single organization helps create and maintain that organization.

Social Responsibility

This theory addresses how people can be made to take responsibility for their actions and whether all people have similar responsibilities. Encouraging people to take responsibility involves a wide variety of techniques, including psychological techniques, personal up close techniques and those requiring individuals' participation. Voluntary rather than coerced obedience is where people are free shape themselves, choose what is good for their future according to their potential. This is customary in countries that shape liberal policies for their citizens. Freedom is chosen as the instrument of political power instead of enforced discipline. States act by providing security, and its representatives are elected to act

responsibly. States give citizens different techniques to manage guaranteed raised levels of economic productivity healthcare and greater personal responsibility. However, all people are not alike. Individuals are agents and responsible for acting morally and legally. Responsibility is something that can be trained and produced, it is not removed. All people must be included in social pursuit and risk reduction when states privatize or regulate, they must address tasks of realizing policy goals, employing collective methods, self-management and regulated social adjustment (Peeters, 2017).

Giddens stated there were no rights without responsibility and no authority without democracy (Cammack, 2018). From its beginnings, social studies have been divided into two levels, one examining society at a macro level, entire external structures around individuals, and the other addresses the micro level, everything that individuals do daily thus producing the social behavior and outcomes. Macro level analysis refers to everything related to the characteristics and relationships of a society or company, while micro analysis refers to individuals themselves, analyzing the nature of their relationships in everyday social situations. There is also an intermediate level referring to a similar group in a community or organization. Analysis at this level shows interactions produced between the micro and macro levels and how closely they interrelate (Giddens 1979, 1984).

Society according to constructivist theory is revealed according to how individuals perform in a space and time defined. Elements of time and place are important in all social actions individuals perform. The macro approach maintains that society is a superstructure and the micro approach maintains that society is individuals' personal experiences interpreted by details. In constructivist theory, Giddens attempted to bridge the gap between these two theories, individuals and structures complement and do not contradict each other, one supports the other, when individuals work to produce change. Structure rewrite their paths and affect every action they perform. It is a constant two-way process, society is constantly shaped by individuals who are themselves affected by society. What is important is the effect of reciprocity between individuals and society (Giddens 1979; 1984). Giddens argued that such changeable structural properties of political or social systems are both the medium and outcome of practices they recursively organize (Luo, 2006). According to Giddens, society must be sensitive to all institutional changes that modernity constantly introduces Changes including political and geopolitical tactics, to recognize that commitment to moral purposes and "good intentions" can in themselves be dangerous in a world where there are risks of far-reaching consequences. Creating models of a 'good society', not limited to nation states, and nor to one institutional dimension of modernity, must recognize that emancipation politics or self-realization policies must be linked (Kovačević, 2017). According to Giddens, social relations link distant communities in the same way as local events are shaped by events that take place only within that locality (Moghaddam, 2017).

Social Capital and Human Capital

The theory of social and human capital pertains to individuals' knowledge and abilities allowing for changes in actions and economic growth. To bring about growth in society, several factors are needed: financial, human and social capital and their components. Social capital consists of feelings of social solidarity, social and public information and investments in functioning physical and social infrastructures, economic and legal systems, internal and external security. Funding social capital relies primarily on the payment of taxes. Payment makes individuals members of a community whose members have agreed to a synergistic relationship. Human capital consists of everything that is considered personal, work, technological information, sense of wellbeing for both salaried employees and self-employed people, about the effects of learning and education on advancement in life, earnings and employment and even occupation and unemployment of both women and men and between different groups and races (Becker, 2009).

Studies have indicated that it is necessary to invest in social and human capital to achieve economic growth and increased personal wellbeing for all community members, i.e., social capital (Adrai, 2018). Social capital can affect people's health, it can affect risks they may consider in relation to their health. In fact social networks and friends create support and trusting relationships, which are resources that can help achieve health goals, for example cancer patients receiving information to support and help them to discover sources of health and economic support (Lin, 2017). An absence of social capital can damage health and lead to psychosomatic diseases and symptoms, such as muscular skeletal pains and even depression (Aslund *et al*., 2010).

Organizational Change

Another theory is that of organizational change representing a specific collective organizational identity. Jerry Allison (2021) defined organizational change as organizations changing their organizational culture or organizational structure (strategies, technologies, operating methods). An organization examines how much changes have affected it. The change can be perceived as temporary or occur at different periods. Kurt Lewin's (1951) change management model comprises three change stages. This model is an early change model, changing the equilibrium by possibly increasing or decreasing the forces striving for change or combining both forces for reactive and proactive change using employees' knowledge sharing with help of stimulating change leadership style (Hussain *et al*., 2018).

Methodology

This study employed a mixed methods research paradigm where qualitative and quantitative methods complement one another, helping to obtain a rich and relevant picture that enables data collection and examination of characteristics from the world of the NHIL, the IHC phenomenon and the different incentive systems particularly in independent medicine. This link could help in physicians and managers' attitudes towards continuing and expanding the idea of IHCs in the Arab society in Israel and perhaps all societies.

Collecting data from managers and physicians from the various health HMOs helps understand the law's impact on the Arab population. Tools used for this study were interviews and survey questionnaires. The main goal was to build a theoretical conceptual framework for engagement between self-employed physicians and the HMOs.

Population and Sampling

The research is based on a sample of the population. In qualitative research the study population refers to all people belonging to a predefined group according to preliminary criteria. The sample includes the interviewees and questionnaire respondents who expressed their consent to participate in research. Participants in the qualitative part of the study were managers, and physicians from two HMOs. Participants in the quantitative part were managers and physicians from all HMOs.

A non-probabilistic convenience-availability sampling was performed at the first study, i.e., some of the participants were selected based on the researcher's acquaintance with them based on present and past working relationships and stratified, by religion and specific HMOs.

Table 1. Qualitative research population

Gender	Religion/ Culture	Age Range	Seniority Years	Current Clinic Years	Ownership Status
Male	Arab: 2 Muslims 2 Christians 2 Druze	46 – 69	19 - 43	2 - 26	Owner
Managers					
5 Male 2 Female	Arab: 2 Muslims 2 Christians 2 Druze 1 Jew	39 - 60	3 - 25	Irrelevant	No Ownership

A non-probabilistic convenience-availability sampling was performed at Quantitative study with snowball sampling was a way of as not enough interviewees were found, to provide equal representation between HMOs at all levels and equal belonging to the group under study.

In the quantitative research stage, questionnaires were sent to physicians and managers, from Haifa and northern districts. Respondents, physicians and/or managers were asked to complete the questionnaires as 79 participants (89.7% percent) completed 93 questionnaires: 14 participants answered as both physicians and managers. The medical questionnaire was completed by 49 physicians (52.7 %) and the questionnaire in the field of administration was completed 44 managers (47.3 %).

Results

Most managers and physicians replied at the qualitative study that they were familiar with the law (Managers: Yes – 71%, generally yes – 28%; Physicians: Yes – 83%, generally yes – 16%). Most knew that the law respects the right of all citizens to receive treatment.

Example of interviewees' statements, at the familiarity with NHIL "It is built on the principle of social solidarity, regardless of whether a citizen works or does not work". (Christian Manager)". At NHIL and IHC, Their working hours are flexible" (Christian Physician)."An HMO can offer rewards without limitations on the art of the Ministry of Health" (Christian Manager).

At the quantitative study most physicians (67.3%) and managers (84.1%) are acquainted with the law and its principles generally or well. At the quantitative study regarding the contribution of the NHIL 1995 to society and to the Arab population; on average, they all agreed that it has contributed to a high extent. This tendency was found in all the statements in this section. However, the law has generated change especially in the following areas: "*Patients can choose a physician based on their preference"," All residents now have medical insurance in one of the HMOs which provides them with equal entitlement to treatment in accordance with the "health basket", "There are more clinics in the Arab sector and their distribution has grown". However, the law has generated the lowest change in two areas –" the clinics are less crowded than in the past", and "Physicians have more time to devote to each patient.*"

Another categories and samples of interviewees' statements were declared from the work relations with the organization. These statements explain the type of opinions and the relations, For example Advantages and disadvantages of HMOs' association with self-employed physicians. Advantage: "*A salaried physician is an employee within the organization with a contract and with clear social conditions*";

Disadvantage: *"Regarding the with the contract with the self-employed physician, then you receive the money and you must guarantee the clinic, guarantee your personal security if you want to move up... and be independent in maintaining the clinic, equipment and this whole system" (Muslim* Physician). Self-employed vs. salaried employee: *"When you are in an IHC, you must use the full power of your knowledge to solve the patient's problem"; "When you are in a central clinic and you are an employee, then the service is divided between you and the nurse, and the clerk, and the service person"*)Muslim Physician).

To preserve these clinics and continuing the existing arrangement of IHC, "*There is a need for a change, not in the arrangement, but with the way of engaging the physician*" (Christian physician).

It was found that methods to motivate establishment and preservation of Independent Clinics are In addition to the existing financial rewards, social and moral rewards should be added and embedded in the primary contract. Financial rewards are important for the preservation of physicians in the independent health clinic. Combining three types of rewards (social, moral, and Financial) into one motivational reward system for self-employed physicians – may lead to formulating a standard contract. Both physicians and managers agreed to a certain extent that 1. Uniform financial reward for self-employed physicians and that 2. Differential financial rewards for self-employed physicians based on their functioning – are suitable for increasing the physician's motivation and satisfaction with working in an IHC.

Why physicians transfer between HMOs, they both agreed that. A gap between the organization / HMO's promises to the managing physician at the beginning of the engagement, and their implementation are a reason that causes self-employed physicians turnover between HMOs. From the findings it may be concluded that the three incentives should be included in the contract in the first combining three types of rewards (social, moral, and Financial) into one motivational reward system for self-employed physicians – may lead to formulating a standard contract. Most Physicians (83.3%) agreed that the preferential approach toward IHCs should be continued, as compared to 68.2% of the managers. In accordance, most managers (31.8%), twice as many as physicians (16.7%) agreed that this preferential approach should be stopped.

Table 2. Preferential approach toward independent clinics

	Physician	Manager	Total	χ2	df	Sig.	Cramer's V	Sig.
Yes	83.3	68.2	76.1	2.917	1	.088	.177	.089
No	16.7	31.8	23.9					
Total	48	44	92					

Discussion

National Health Insurance Law

Initial findings indicated that most physicians (67.3%) and managers (84.1%) were acquainted with the law and its principles in general or well. The study sought to test the knowledge and attitudes of managers and physicians regarding the impact of the NHIL on Arab society, in the context of opening IHCs and changes in the consumption and accessibility of medical services. The result obtained showed excellent knowledge among managers about the NHIL itself compared to the physicians. An explanation for this finding is probably related to and depends on the degree of managers' exposure to Health Administration studies, healthcare client service and the actual performance of the work directly vis-à-vis clients on a daily basis. The findings support the literature, emphasizing the competition between HMOs, meaning, the need to accept anyone who applies, according to a uniform 'Health Service Basket' under government supervision (NHIL Section III).

Components of models to motivate physicians

The contractual reward methods are suitable for increasing physicians' motivation and satisfaction with working in an IHC. Ought to be a standard financial reward for self-employed physicians and that financial reward must be based on self-employed physicians' performance. On the one hand, this study encouraged continuing provision of financial incentives based on physicians' status and how influential they are in society, and whether they are considered dominant figures who can recruit patients and build up strong clinics. On the other hand, the research found that social and moral incentives need to be considered from the outset and added to initial contracts. Combining three types of rewards (social, moral, and financial) into one motivational reward system for self-employed physicians – may lead to formulating a standard contract. These rewards are suitable for increasing physician's motivation and satisfaction with working in an IHC, and therefore, their retention. It appears they know that this will benefit both physicians and future IHC stability.

The research findings reaffirm the theory of social capital and human capital (Becker, 2009). Presented in the literature (e.g., Adrai, 2018). Other researchers have focused on material incentives (Chaix *et al*, 2000), moral incentives (Ostbye *et al*, 2005) and social incentive content (Brassey *et al*, 2001).

The study suggested adopting models to reward self-employed physicians, in ways that will affect their motivation and satisfaction in their work in the community. These rewards are proposed as a built-in part of the standard contract they sign. There is no innovation in the different types of rewards. The innovation is that they are offered for self-employed physicians as one package combining

different basic rewards, some of which have been found to be given from the beginning and recognized basic motivational rewards that will be given according to performance. Physicians see financial rewards as a crucial factor when signing the contract and a motivating factor to preserve at the same HMO. The physical conditions, technology and training are seen as equally crucial factors but not as important as financial rewards.

IHCs in Arab society in Israel

The research findings showed that most Physicians (83.3%) and managers (68.2%) agreed that the preferential approach toward IHCs should be continued, as compared to 68.2% of the managers. In accordance, managers (31.8%), twice as many as physicians (16.7%) thought that this approach should not be continued predominantly because of their advantages, "Self-employed physicians have greater flexibility in managing their own practice and the clinic", "Self-employed physicians have the option of giving hours beyond those required by the HMO", "Self-employed physicians have a higher commitment to their clients, which contributes to their quality of service and availability to clients". However, three factors were considered advantageous only to a certain extent: "Self-employed physicians do not have less financial and employment security", "Self-employed physicians do not get less in-service training than staff physicians", "Self-employed physicians do not carry the full weight of responsibility on their own". No studies supporting these findings were found in the literature. The conclusion emerging from this findings is that the IHC system is recommended and ought to continue both for the benefit of HMOs, Physicians and managers. A small majority of physicians (53.1%) compared to a minority of managers (31.8%), opposed the idea of being salary employed physicians, and answered preferring to remain self-employed. Those who agreed to be salaried employees put forward a condition that they work with more than one HMO as employees. Most managers, however, would agree if offered to turn an IHC into an HMO clinic. The physicians agreed (significantly more than managers) that small IHC do not provide optimal service to the population and that physician-patient boundaries are blurred. Additionally, they all agreed only to a certain extent that "In IHC the managing physician does not have financial stability" as a reason to terminate the IHC model. The literature supports the research findings with regard to the need to maintain physicians' economic security and stability. Physicians work in a number of HMOs or workplaces is an example. According to the literature, self-employed physicians manage personal businesses and are responsible for their income and outcomes. They can be both self-employed physicians and salaried employees at hospitals and/or HMOs. They can work with more than one HMO. Contracts are personal (Bin Nun *et al*., 2020).

Conclusion

Research findings revealed that according to the perception of the physicians and managers, NHIL has influenced and contributed a lot and significantly to the Arab society, reduced health, and social disparities, benefited the weak populations a lot and enabled a medical response for all citizens. Moreover, the influence and contribution of the law is evident in the areas of medical service deployment, availability, and proximity to home in the periphery. The law influenced the employment of physicians and their economic prosperity, allowing income and competition in the admission of physicians and their continued specialization in the various medical professions.

Research findings revealed that the field of financial rewards is perceived by managers and physicians as most important factor that influences their retention in IHCs on condition that HMOs fulfills all the promises from the start. Additional motivating reward types include IHCs environmental and social conditions and providing moral support to physicians and appreciating their work

These integrated incentives should be included in the engagement contract, and thus increase physicians' satisfaction and motivation to provide better treatment and recruit more clients and making sure they feel a sense of belonging to the IHC. The findings suggested that the IHC model is good and should continue to be applied by all HMOs. IHCs alleviate healthcare problems of small and remote settlements by being available and accessible to these places' inhabitants. Being more 'intimate' by nature, IHCs offer proximity to home, flexible admission hours and in general a more friendly atmosphere. IHCs in small places can thrive more if HMOs cooperate and pool resources, thus saving resources and improving accessibility and treatment.

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