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Sociological-Cultural Aspects of National Health Insurance Law Implementation in Israeli Arab "Independent Health Clinics", via Personal Incentive Systems and Motivational Rewards

Long Abstract

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Acknowledgements

The PhD thesis is dedicated with love and gratitude in memory of my father Zidane Nemer Sheabar may he rest in peace, and my mother Badea Sheabar may she live a long life, in the knowledge that they planted in me acceptance of others and not to hate others in consideration of which I act in my personal life and in my professional life.

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List of Abbreviations

HMO	Health Maintenance Organization
IHC	Independent Health Clinic
NHIL	National Health Insurance Law
MoH	Ministry of Health

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. An additional result was HMOs' competition for clients. 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). This means that physicians can open their own clinic, manage it as an independent business and recruit and treat clients under contract with HMOs.

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. 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**).**

The research design is mixed methods with a qualitative stage followed by a quantitative stage. In the qualitative research, general subjective information was collected from interviewees and objective data from questionnaires. Specifically compiled research interviews and questionnaires were built to collect information. They underwent expert validation and were found to be suitable and reliable. The main findings of the qualitative and quantitative 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.

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.

The incentive rewards system relating to the Israeli NHIL at the IHCs is based on a varying rate, per capita or person, based on the total number of insured persons (passive capitation). It was worthwhile and important to examine whether and how the existing motivational rewards system serves to promote and retain physicians in an HMO. Moreover, it was also important to investigate options to integrate more incentives to strengthen services provided under a uniform structured process, based on standard contracts. This research presents different methods known and used incentives, including models of communication with HMOs.

Theoretical Rationale for This Study

Physicians' behavior and functioning within different medical organizations are influenced by various incentive systems: (1) Moral incentives which relate to professional ethics and individual professional considerations, and are rooted in physicians' sense of social mission; (2) social incentives related to external considerations and physicians' work environment; (3) material incentives – material rewards have an impact on various measures of medical personnel's actions, including professional behavior and commitment (Vardi et al, 2008). The study proposed a theoretical engagement model between HMOs and physicians that may be implemented in full or in part, a targeted model based on a uniform inclusive incentive system

Gap in Knowledge

Based on the literature review, no previous research has investigated the cultural and social aspects associated with implementation of the NHIL on Israeli Arab-Muslim, Christian, and Druze societies especially addressing the phenomenon of IHCs. Incentives in the self-employed physicians' model, especially moral and social aspects of reward systems have not yet been studied. However, options for contracts with physicians are diverse, but it

has been proposed that Ministry of Health regulations need a uniform method and structured process to incentivize physicians in independent health clinics. In addition, most studies have been conducted in general clinics, but not in IHCs, and not holistically, addressing moral, social and material rewards together.

Contribution to Knowledge (Local and Universal)

This study offers a possibility to change or influence the existing health system in Israel, starting with Arab society, which currently is primarily financially based, and less focused on moral or social rewards. This may be unique research on IHCs. Its results may open ways of establishing dialogue between physicians and management teams, in all HMOs, leading to less competition, strengthening cooperation and formulating similar equivalent contracts. Suggested changes in the system of motivational incentives will be based on a new theoretical model based on this study's findings.

Research Boundaries

The research started at the first Corona outbreak and was conducted in two interventional stages. Data was collected through pioneer interviews and questionnaires and by reviewing some documentation (Basic internal general contracts). The two-stage studies were carried out, only in the North District and only in Arab societies. The study examined IHCs in general, it did not examine and compare clinics that existed before the NHIL compared to new ones. Nor did it compare Village IHCs vs city ones.

Thesis Structure

The thesis consist of five chapters, chapter one a literature review and theoretical background, chapter two discusses the research methodology, chapter three presents the findings obtained from the studies, chapter four constitutes a – discussion of findings and chapter five presents the summary and conclusion of the research, its contribution to theory, practice (organizational level - administration / clinic level - physicians), methodological contributions (new tools for examining an unexplored topic). Finally, proposing a conceptual framework model.

Key Words: The State Health Insurance Law, Arab society, Health Maintenance organizations (HMOs), independent health clinics (IHCs), – Reward system, The Ministry of Health (MoH)

CHAPTER I:
LITERATURE REVIEW AND THEORETICAL BACKGROUND

The chapter presents the literature review and theoretical background: the combination of three interrelated theories found to be relevant and appropriate to this research. The discussion in the theoretical framework or models anchoring the research helps to analyze the sociological and cultural aspects of the NHIL implementation,Systemic aspects regarding the implementation of this NHIL (1995) in Israeli Arabs "IHCs and personal aspects of incentive systems and motivational rewards,(See Figure 01). These theories help to describe the IHC phenomenon and the research findings.

Interrelated components' aspects: (1) Sociological-cultural aspects, based on several sociological theories regarding the NHIL (1995). (2) Systemic aspects regarding the implementation of this law in Israeli Arabs IHCs. (3) Personal aspects of incentive systems and motivational rewards.

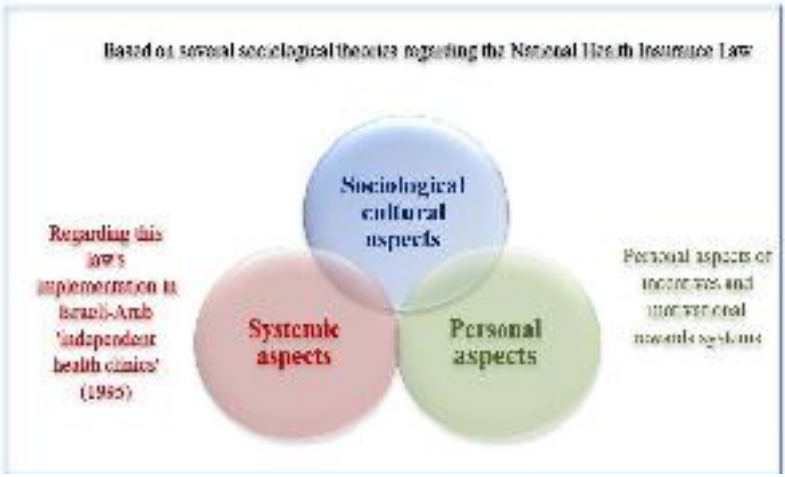

Figure 1: Theoretical rationale for this study – combination of three interrelated theories Sociological and Cultural Aspects

In order to Analyze the sociological and cultural aspects of the NHIL implementation in the Israeli Arab IHCs, four theoretical models were used: (1) Dimensions of national cultures (Hofstede, 2011); (2) Social

responsibility (Giddens,1979, 1984); (3) Social capital and human capital (Dakhli & Clercq, 2004); and (4) Organizational change (Alison, Cook, et al., 2021).

I.1.1 Dimensions of National Cultures (Hofstede, 2011)

Hofstede's (2011) model describes six independent dimensions of national Cultures:

1. Power Distance–The distance of power leads to a social hierarchy. High-power distance is behavior according to a hierarchy and authentication, compared to a low power distance, which believes that power must be divided equally and people are equal.
2. Uncertainty Avoidance - (avoiding uncertainty) do not take risks, toe the line.
3. Individualism and collectivism - In individualism, everything designed, values, duties, personal ethics are at an individual level interests. Collectivism, on the other hand, speaks to the interests of groups that individuals manage and in which they must perform.
4. Masculinity/Femininity - (male/female) – This is about the status of women in society. Places where women are more integrated in society are considered 'feminine'.
5. Long/Short Term Orientation - In "Long term" cultures, emphasis is placed on the future - people are willing to save and sacrifice in the present for a better future. In “short-term" cultures, emphasis is on past and present and fulfilling social obligations now.
6. Indulgence/Restraint - The self-fulfillment feature represents a society that enables relative free satisfaction of basic and natural human desires related to the enjoyment of life. The quality of restraint represents a society that controls the satisfaction of needs and regulates it through strict social norms.

I.1.2 Social Responsibility

This theory addresses how people can be made to take responsibility for their actions and whether all people have similar responsibilities.

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 one another and do not contradict each other, when individuals work to produce change. Structure rewrite their paths and affects 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). According to Giddens, society must be sensitive to all institutional changes that modernity constantly introduces.

I.1.3 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. Unlike the economic view of human action that sees individuals as a resource to be developed that can shape environmental factors, social capital takes a sociological view of human action and perceives individuals as actors who are shaped by social factors. Human capital can be developed through formal training and education aimed at updating and renewing people's capabilities to do well in society (Dakhli & Clercq, 2004).

I.1.4 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 structure (strategies, technologies, operating methods). The change can be perceived as temporary or occur at different periods. Kurt Lewin's (1951) change management model comprises three change stages as follows:

Unfreezing Stage

In this stage, organizational members admit that change is necessary. People will support change when they are convinced against the status quo (Cummings & Worley, 2014). It is important to note that when their attitudes become more fluid, change will succeed Employee involvement will be effective if the organization empowers them in terms of authority and responsibility (Mathieu, Gilson, & Rubby, 2006).

Change Stage Movement

At this stage, new processes occur, a transitional stage is conducted, and people in an organizations begin to respond to the change. It is desirable to

convince employees that the change is beneficial to them and should be adopted. Employees, then, will adapt their behavior towards the change and/or pressure for change on the part of higher levels (Hussain et al., 2018).

Refreezing Stage

The system is safer, emphasizing to employees that new concepts are developed during change and they have nothing to fear so it is important for them to integrate new processes. The implementation of change to meet the desired need will not occur quickly but rather simultaneously (Beckhard & Harris, 1977) .

I.2 Systemic Aspects

I.2.1 The Israeli Context and Arab Societies

Most of the population in Israel belongs to Jewish (about 76%) or Arab (about 24%) societies. There are 1.8 million Arab citizen. Arab societies consist of Muslims (86%), Christians (7%) and Druze (7.6 %) (Central Bureau of Statistics, 2019). The existence of these three socially and culturally different Arab societies in Israel is reflected in of implementation of the NHIL (1995).

I.2.2 Implementation of the National Health Insurance Law (1995)

The law itself granted the right to health services, insurance obligations for all residents/insured, and receipt of services according to an equal basket of services from sources listed in the law. Patients are free to choose an HMO of their choice, tax payments are taken through national insurance, which reimburse HMOs according to uniform capitation of persons insured in each HMO standardized by age (Bin Nun et al., 2020).

I.2.3 Health Medical Organizations

The health system in Israel operates under supervision of the Ministry of Health. Four HMOs provide community services and some provide hospitalization services ('*Clalit*' and '*Maccabi*') (ibid, 2020).

I.3 Personal Aspects

I.3.1 Incentive Systems and Motivational Rewards

There are several methods for remunerating community physicians. To redesign and improve the functioning and conduct, especially physicians, to achieve outputs and benefits in a range of health areas, overall patient quality

and employee economic efficiency, incentives require reorganization. The need for care values leading to better patient outcomes and employee loyalty demands rethinking links to incentives, both financial or non-financial(Doran et al., 2017).

1.4 Summary

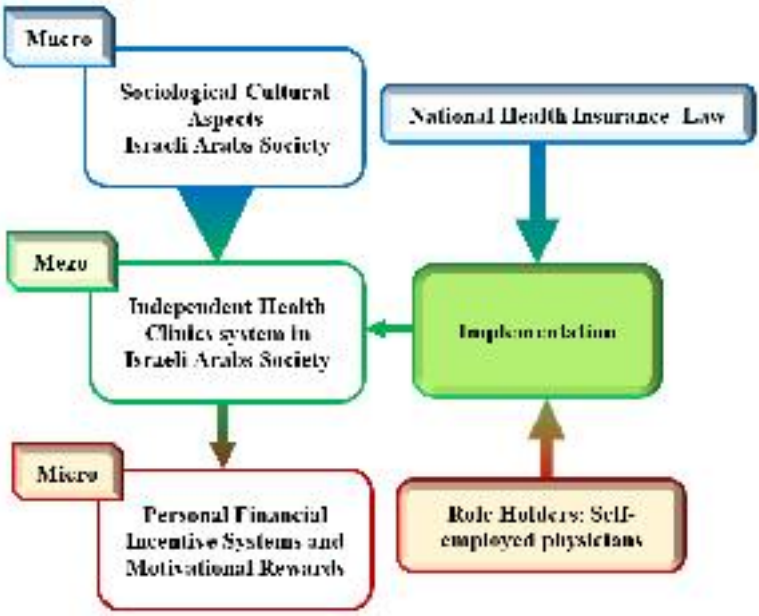

Figure 2: Conceptual Framework: Sociological-Cultural Aspects of NHIL implementation in Israeli Arabs IHCs, through a personal incentive systems and motivational rewards

CHAPTER II: METHODOLOGY

Research Aims

The main research aims were:

(1) To investigate cultural and social aspects associated with the implementation of the NHIL in Israeli Arab-Muslim, Christian, and Druze societies, with reference to the phenomenon of IHCs.

(2) To develop a new conceptual framework about new methods of motivating physicians in addition to material rewards in use today, in the context of IHCs in Israeli Arab societies (Muslim, Christian, and Druze).

(3) To examine physicians' and managers' attitudes towards continuing and expanding the model of IHCs in Arab society in Israel.

Research Questions

(1) How does the implementation of the NHIL affect the foundation of IHCs in Arab societies in Israel (cultural and social aspects) according to physicians and managers?

(2) What are the main components of methods to motivate physicians, in addition to existing material rewards, according to physicians and managers?

(3) Should the idea and model of IHCs in Arab society in Israel continue and be expanded, according to physicians and managers?

Research Hypotheses

(1) Both physicians and managers will agree that the NHI Law has changed how IHCs operate in Arab society.

(2) All three methods of reward are important to establish and preserve IHCs in Arab society:

(2.1) Social and moral incentives are important when physicians signs a contract.

(2.2) Financial rewards are important to retain physicians in IHCs.

(2.3) Combining three types of rewards (social, moral, and financial) into one motivational reward system for self-employed physicians will lead to formulating a standard contract, regarding terms of their employment.

(3) Both physicians and managers will agree that the idea of an independent clinic model operating in Arab society should be continued and expanded.

II.1 Methodology Design and Structure

This chapter includes the research design (qualitative, quantitative, and mixed methods), population and sampling (interviews and questionnaire respondents), research tools (interview guides and questionnaire – construction and validation), research procedure and data analyses (qualitative systematic content analysis of interviews and statistical analyses of questionnaire data). Finally, ethical considerations are presented.

II.2 The Chosen Research Paradigm – Justification

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.

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. It is proposed as a model to be adopted in the future. This model was proposed and built after calculating convergent validity by triangulating NHIL 1995 with qualitative and quantitative findings. 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.

II.2.3 Qualitative Research Design

The study helped to identify and understand the phenomenon and most of its manifestations, through interviews with physicians and managers from Arab society, from different religions and levels, in both urban and rural society. In addition, relevant documents were reviewed to expose the nature of physicians' engagement with HMOs, and types of incentives offered to retain this engagement.

II.2.4 Quantitative Research Design

In the current research, based on the literature review, the documents, and themes produced from the interviews, a quantitative survey questionnaire was constructed and validated. The choice of a survey questionnaire as a

research tool is based on the consideration that this topic has not yet been researched and this research is preliminary in its field.

II.1.5 The Research Design

Figure 3 below depicts the research design

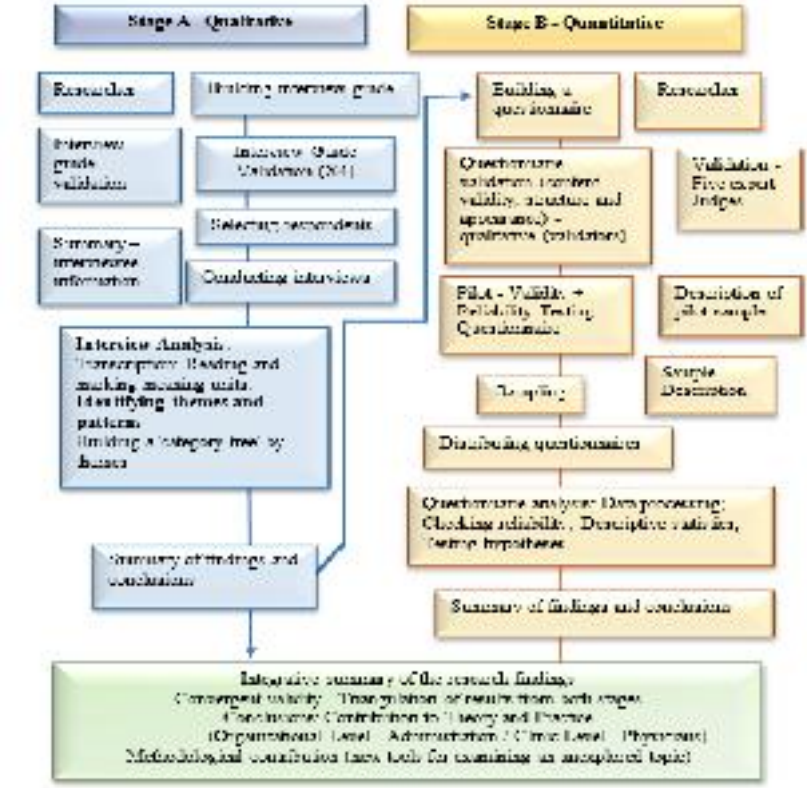

Figure 3: The research design

II.2 Research Context and Field

The research focused on the study of IHCs as a social and cultural phenomenon in rural and urban Arab society. The current research field included IHCs belonging to physicians, a clinic of one physician or a group of physicians managing it, and/or several clinics together, belonging to an entrepreneur who is not a physician, or to a non-profit association operating

clinics under the name of a physician. The researcher was interested proposing a theoretical framework, collaboration between all HMOs to strengthen service providers' and in particular, status that of physicians.

II.3 Population and Sampling

II.3.1 Background

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.

II.3.2 Qualitative Research Sampling Method

(a) Sampling in qualitative research: Convenience Sampling - a non-probabilistic method

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

(b) Stage 1 Qualitative: Interviewees' Population and Sampling Interviewees were physicians and managers from two HMOs at various levels. Some medical staff interviewees were both physicians and managers; however, they were interviewed as physicians only. Interviewees were physicians and managers at various levels from two HMOs. Some medical staff interviewees were both physicians and managers; however, they were interviewed as physicians only. Managers, all Arabs, some of whom were employees and others - self-employed, were interviewed as managers only except one who chose to be interviewed as a physician. Physicians can work at the HMO as employees or as freelancers compared to a clinic manager who usually works in only one place at a certain HMO. There were only two managers that work as HMO employees in an IHC.

Table 1: Qualitative research population

Physicians					
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	None

II.3.3 Method of Sampling in Quantitative Research

(a) Sampling in Quantitative research

Researchers choose Probabilistic or Non-Probabilistic sampling (Barreiro & Albandoz, 2001; Birenboim, 1993) according to emerging problems (Westfall, 2009). Convenience non-probabilistic sampling was chosen. Snowball sampling was used when not enough interviewees were found, to reach equal HMOs' representation and belonging to the group under study at all levels.

(b)Stage 2: Quantitative study population and sample

Questionnaires were sent to physicians and managers from Haifa and northern districts. 79 participants completed 93 questionnaires: 14 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 %).

II.4 Tools

II.4.1 Qualitative - Interview Guides (Physician and Manager)

Guided interviews were used, relying on a pre-written guide addressing issues that are relevant to the research aims and questions.

(a) Construction and Validation of the Interview Guides

An initial tool was constructed including a guide for physicians and another for managers. The guides relied on personal and practical knowledge in the field of operating IHCs and the NHIL of 1995. Interviews included background questions, some common to physicians and managers (age, religion, seniority, location and type of IHC in which they were employed). Some questions were adapted according to participants' roles.

(b) Interview Guide Validation

A theoretical initial stage was performed with four senior judges, experienced in the IHC field with knowledge and involvement in the field. The judges went through, corrected or revised the questions and proposed re-formulating. The interview guide was validated by a statistics expert. Validation of its content, construct, and face validity .The stages of the validation were as follows.

Each expert-validator was asked:

1. Are the questions in the interview guide relevant to the research topic? (Suitable, compatible).
2. Do the questions encompass and exhaust the research topic? (Inclusiveness)
3. Are there any other relevant questions worth adding to the interview guide? If so, please suggest suitable wording.
4. Are there any irrelevant questions that can be removed? Why?
5. Is the wording clear to the interviewees? (Face validity).

Validation of the Final Interview Guides

An additional validation process was conducted by the researcher and a fellow researcher (research methods and assessment expert) followed by two judges, a physician, and a manager, with knowledge of and involvement in the operation and engagement of IHCs. A physician and a young manager were interviewed. The interview guides have been revised and refined after this process.

Summary

The interview guides were validated in two stages, in the initial stage after they were constructed and in the second stage when conducting a practical interview with a physician and a manager. Validation was performed through several medically, administratively, and statistically appropriate factors

II.4.2 Quantitative Research Tools

(a) Introduction – Questionnaires

A questionnaire is a tool to gather data (Dornyei, 2007). It contains questions, statements, or both, which research participants are required to answer, often anonymously. A questionnaire is used in research regarding phenomena for gathering data about participants.

(b) Construction of the questionnaire based on interview results

Questionnaire for physicians for manager were used, validity and reliability were examined by judges and a pilot study conducted. The questionnaire was found to be appropriate, corresponding to the research topic, research questions, and research hypotheses.

(b1) Content analysis – revealing themes and categories

Interviews were recorded and transcribed unto a computer by a neutral expert. After reading the answer to each question, content analysis was performed and answers were placed in a table. It was noted that answers may later be an item in the questionnaire. Units of meaning typical were identified and marked. Marking the themes or typical answers was important later when a comparison between physicians and managers was needed. Themes were coded and divided into categories.

(b2) Formulation of statements based on the produced themes and categories

Statements were based on physicians and managers' answers in the interviews. Care was taken to formulate common statements for physicians and managers. Similar responses were merged into one statement expressing an opinion for or against, positive or negative. Certain questions were divided into sub-questions and worded "sub-statements" which the respondents were asked to rate on the questionnaires. It was determined that relevant questions would appear in the questionnaires if they were found to be reliable, and valid.

(b3) Validation of the questionnaires after selection of items (July-August 2020)

For the construction of the survey questionnaire, statements were formulated based on wording in the interview guide; Statements extracted from

interviews, from identified themes were part of the questionnaire. This questionnaire was validated in terms of content, structure and face validity by five expert judges. A validation form was constructed that included the following questions:

1. Which of the questions and statements are unnecessary?
2. Are the statements clearly worded? If not, please suggest an alternative wording / correction / change?
3. Are there any additional questions or statements that should be included in the questionnaire.

(c(The Final Questionnaires (Physicians and managers)

The questionnaire was constructed after completing all the interviews, which adhered to the validated and reliable interview guides constructed specifically for the qualitative stage of this research. To summarize the process all the interviews were transcribed, units of meaning were marked, themes and patterns were identified, categories built, and stemming from these, statements and questions were formulated. Finally, the resulting questionnaires were validated by five judges (validity of content, structure, and visibility).

(c1) Structure of the Questionnaire

The questionnaire was divided into parts addressing familiarity with the NHIL, relationship with the HMO, work as self-employed compared to a salaried employee reward methods and what is acceptable to participants, reasons for turnover between HMOs? Finally, the questionnaire contained background information.

(c2) Pilot - Reliability and Validity

Questionnaires were constructed and validated in a pilot study with a sample of managers and physicians and managers from different fields, all interviewees agreed that the questionnaire included all relevant questions that were clearly worded (content and structure validity).

I I.5 Data Analyses

II.5.1 Analysis of the Interviews

The qualitative findings were derived from the analysis and summary of interviews with the physicians and managers. All answers were analyzed in parallel to producing themes that came up and salient statements representing

these themes and categories. For each theme, a list of statements that may represent it was recorded in the quantitative questionnaire. In cases where there was a difference in wording for the physicians and the managers - two statements were formulated

II.5.2 Analysis of the Questionnaires

The physicians and managers' responses were coded into Excel. The statistical analyses were conducted with SPSS 21. Descriptive statistics included frequencies and percentages for the discrete variables (such as: yes/no questions and rank-order scales) and means and standard deviations for continuous variables.

Correlations between discrete variables (nominal or ordinal) were calculated through a $\chi 2$ test, and estimation of the strength of association between these variables was calculated with the Cramer's V test, which ranges between 0-no correlation and 1-strong correlation. Comparisons between the means of two groups (physicians and managers) was conducted with t-tests.

II.5.3 Triangulation of Qualitative and Quantitative Results

An integrative summary of the research findings, both from the qualitative and quantitative phases, was conducted by establishing convergent validity. As this research utilized mixed methods, the data collected as well as the conclusions the data – was triangulated to enhance the reliability, credibility, and trustworthiness of the final conclusions and methodological contributions (new tools for examining an unexplored topic).

II.6 Ethical Considerations

The two-stages of the study are backed by the Faculty of Philosophy and Sociology's ethics committee, signed by the Dean of the faculty.

The researcher undertook to maintain the confidentiality of the participants and to maintain the confidentiality of their workplace.

Due to the corona pandemic, the state of morbidity and lack of economic stability limited the researcher's involvement in both research phases, and he had to address pressures and difficulties in recruiting participants. Nonetheless, the researcher managed to secure participants, who signed an informed consent form. Special difficulties concerned recruiting participants, especially those from district high levels working for competing HMOs.

All participants signed informed consent forms after hearing explanations about the research and its aims. Participants were not at risk of harm in any way. They were promised that they would need to answer questions that made them feel uncomfortable and could withdraw from the research if they wished to do so. They were promised that their answers would be confidential and would be used only for research purposes, their identities would not be disclosed. Participants were treated with respect throughout the process.

The next chapter depicts the research findings.

CHAPTER III: FINDINGS

The findings of both stages of the study are presented in the following chapter: Section III.1 Stage 1 Qualitative – Interviews, and Section III.2 Stage 2 Quantitative – Questionnaire.

III.1 Stage 1: Qualitative – Interviews

Presentation of the qualitative findings is congruent with the research questions, and themes and categories arising from the interview.

III.1.1 National Health Insurance Law

Most managers and physicians replied 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. The following table presents categories and samples of interviewees' statements.

Theme: National Health Insurance Law (1995)	
Familiarity with NHIL	"*It is built on the principle of social solidarity, regardless of whether a citizen works or does not work*". (Christian Manager).
Lack of familiarity with NHIL	"*People who actually do not work and do not pay health insurance tax do not have to pay for medical expenses but they only pay part of the health tax*" (Druze Manager).
NHIL main points	"*The health service basket changes from year to year and are anchored in legislation*." (Christian Manager).
NHIL and IHC	"*Their working hours are flexible*" (Christian Physician). "An *HMO can offer rewards without limitations on the part of the Ministry of Health*" (Christian Manager).

III.1.2 Work Relations with the Organization (Question B2)

The interviewees were asked about their relationship with the HMO, the advantages and disadvantages of the method, work as a self-employed person compared to salaried employee, and whether it is worthwhile or not worthwhile to continue the IHC method. They were also asked whether it is advisable for them to turn their clinic from independent to a clinic that

belongs to the HMO, whether there are management differences in the two methods, whether it is worth pooling resources between the HMOs to unify the service under one roof, and whether such an action will change the quality of care. Categories and sample quotes are presented in the following table.

Work Relations with the (HMO) Organization	
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)
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 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)
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).
Differences in management of independent and Primary clinics	"*IHC are often managed by a physician who is considered a strength by the HMO, because a physician in an IHC is the one who brings the customers and unfortunately HMO management sometimes tends to cut corners and skip things that do not go through HMO centers on a daily basis*" (Christian Manager)
Pooling resources between HMOs	"We have to provide the same service to all clients." "I am not sure how we can adhere to HMO instructions in an organized manner" (Christian Physician).
Transition to employee contract and change to an HMO clinic	"*For now I don't agree, I'm comfortable and I get all the rights I deserve*" (Druze Physician).
HMO intervention in physicians' considerations	"*Administrators to approve the physician's considerations is a problem. The level of intervention should be at a very professional level*" (Druze Physician).

III.1.3 Work Relations with the Organization (Question B2)

The interviewees were asked about other aspects of IHC relationship with the HMOs: HMOs' responsiveness to IHC's needs, satisfaction with communication between HMO and IHCs, reasons for physicians turnover from one HMO to another. The following table presents categories and samples of interviewees' statements.

Relationship with the (HMO) Organization (B2)	
HMOs responsiveness to the needs of IHC	"*In the beginning there is this eagerness and in the end … Every request becomes a task. And there is accompaniment- enough, not enough... Are the requests we make fulfilled? Not fully*." (Christian Physician)
Satisfaction with the HMO and IHC Communication	"*Our clinic's service is very successful. The clients have what is called HMO's feedback questionnaires of customer satisfaction. We are in a highly excellent place. The highly skilled professional physicians prefer to work independently to utilize their power*" (Christian Manager)
Change in terms of engagement between IHC and HMOs	"*I see no reason to change except for changing the amount, as it has hardly risen" "The agreement is such that I cannot do it, but others can, so I say, there is room for changing the agreement*" (Druze Manager).
Reasons for physicians' turnover between HMOs	"*Changes in salary and conditions in the agreement, you find a physician who suddenly decides that he wants addition X and the HMO can't approve it, so he gets up and leaves. HMO failure to keep promises of various kinds, tempting offers from other competing HMOs*" (Christian Manager)
Clinic growth and clients' state of health	"*There is a connection because the bigger the clinic the better service and a wider service, and this will help and really contribute to the health of the patients…*" (Muslim Physician)
Impact of management on manager outcomes and relations with physicians: Workload and service.	" *… Creates a load, yes. … It sometimes creates unpleasant incidents, it also leads in some places to conflicts between staff and self-employed physicians. There are conflicts around this matter, the work is not really …yes it takes time*" (Muslim Manager)

III.1.4 Reward Model (Question B3)

The interviewees were asked about important issue regarding the basic contract model and whether to improve the reward model for Self-employed physicians?

The following table presents categories and samples of interviewees' statements.

Reward Model (Question B3)	
Alternative to change and improve the reward model for self-employed physicians	"*Apart from the financial part? … First of all they should work in a slightly different way… They don't work in the same method with all physicians. It should be something uniform for everyone and …visits they do not make, who comes to the clinic and receives service to offset it from the self-employed physician and alternatively reward him for cases he treats clients that are not his. In terms of other rewards, I don't think there are any…*"(Muslim Manager).
Reward model - best approach reg appreciation and rewarding physicians for their achievements	"*…It should be integrated, integrated and more... the client care part should be a little more significant*" (Muslim Manager). "*I wish there were uniformity in terms of wages*" (Muslim Manager).
Rewards contribute to motivation and willingness to continue as self-employed physicians	"*Financial reward – number 1; Physical work environment – number 2; Assistance in financing personnel – number 3 and technological work environment – number 4. The answer is quite clear and I agree with them. I would say the same*" (Muslim physician).
Reward as a letter of appreciation	"*A very important matter, the physician will feel that he is valued not only financially, but also morally*". (Druze manager).
Influence of work conditions on satisfaction with professional achievements	"*Even the non-self-employed are affected when there are bad environmental conditions. So many times more when you are self-employed and you are alone in the clinic, so multiply it several times. It has a very bad influence*." (Muslim physician). "*If you are not rewarded and do not have the technological means because the clinic is not properly equipped, this may affect your concentration on your work…*" (Druze physician).

III.1.5 Work Relationship with Clients (Question C)

The interviewees were asked about clients' satisfaction with medical treatment, availability and accessibility of physicians', belonging to an IHC and limited opening hours compared to an HMO clinic. The table below presents categories and samples of interviewees' statements regarding work relations with clients

Work Relations with Clients (Question C)	
Feedback from self-employed physicians' clients	"*Our main growth of clients in the clinic gives me the feedback that we are in the right direction, very good feedbac*k" (Druze Physician). "*Most praise. Some clients come, from my experience, they came and either praised or complained about the physicians… also give some kind of small gift to the physician which symbolizes satisfaction*" (Druze Manager).
Clients' satisfaction with medical treatment	"*Clients are happy, otherwise they would not remain…*")Druze Physician). "*HMO questionnaires about clients' satisfaction. We are in a very good place*." (Christian Manager).
Availability and Accessibility	"*Satisfaction with medical treatment…availability is quite high*" (Druze Physician).
Belonging to an independent health clinic	"*Belonging is quite strong") Druze Manager).* *"I think they have a sense of belonging because they are satisfied, and I believe they are satisfied…Yes*") Druze Physician).
Compromised to limited opening hours compared to an HMO clinic	"*…You need to define the hours you know your patients want you the most*" (Muslim Physician)

III.1.6 Acquaintance with and Closeness to Clients (Question D)

The interviewees were asked about the relationship with clients and family closeness with clients, whether this contributed to choosing a manager, and influenced medical decisions. The following table presents physician's closeness to clients and whether it affected IHC's performance. The following table presents categories and samples of interviewees' statements.

Acquaintance with and Family Closeness to Clients (Question D)	
Self-employed Physicians' relationships with clients	"*Strong and good relationship" (Druze Physician) "Relationships are…making personal contact, if whether in participating in all kinds of social events, it strengthens relationship with people. … In many cases, the clients are also their relatives. There is … acquaintance between them outside the framework of physician-patient relationship*" (Muslim Manager).
Family closeness with clients	"I come from the smallest family in the village, 50 *people, and we have 1700 clients in the clinic. I don't have many family relations in the clinic*" (Druze Physician). "*It can be first degree or tenth degree. Sometimes it goes by family groups*" (Muslim Manager).
Acquaintance or family closeness as contributing to choice of an IHC	"*… family closeness between physicians and patients, … family relationship contributes to the customers' decision to choose the IHC to a large extent*." (Christian Manager)
Acquaintance or family closeness likely to influence medical decisions	"*Yes, It can have an effect, let's say, also in terms of what to do and how, and if let's say his cousin comes and he really insists that he wants to go to the emergency room, then the doctor is not so much in my opinion.. In my opinion …more flexible and more compromising… sending a family relative to hospital instead of the primary HMO*" (Muslim Manager.)

The following section presents the Quantitative research findings.

III.2 Stage 2 Quantitative – Questionnaire

III.2.1 Question 1 - NHIL (Part (A) National Health Insurance Law)

(a) Familiarity with the NHIL

Research Question 1: How does the implementation of the National Health Insurance Law affect the foundation of independent health care clinics in Arab societies in Israel (cultural and social aspects) according to physicians and managers?
Hypothesis 1: Both physicians and managers will agree that the NHIL has changed how independent clinics operate in Arab society.

(a1) Are you familiar with the National Health Insurance Law?

The participants were asked: A1. Are you familiar with the NHIL? $\chi 2$ and Cramer's V tests were conducted to examine relationships between discrete background variables. a) Due to more than 25% of cells with less than 5 participants, $\chi 2$ cannot be calculated

Most physicians (67.3%) and managers (84.1%) are acquainted with the law and its principles generally or well.

(a2). Knowledge about what the National Health Insurance Law of 1995 includes

The participants were asked: A2. To the best of your knowledge, what does the NHIL of 1995 include? Participants were presented with a list of statements, five right and four wrong. They were requested to check if a statement is **correct** (included in NHIL) or **incorrect** (not included in NHIL). Most physicians and managers correctly answered that "3. Every citizen must be insured in an HMO", "5. Every citizen will be given equal medical care (regardless of socioeconomic status)", "1. Every Israeli citizen is entitled to medical treatment based on the health basket", "7. The patient is entitled to choose the attending physician".

Less than a quarter (21.5%) answered that the statement "2. Health tax payment grants insured individuals medical service free of charge" as not correct.

The participants answered between five to nine correct answers. No significant difference ($t = -.88$, $p = .379$) was found between physicians (mean = 6.80, SD = 1.04) and managers (mean = 6.98; SD = 0.93) in the number of correct answers[1].

(b) Contribution of the NHIL of 1995 to society and to the Arab population

[1] The Overall knowledge of NHIL (number of correct answers)
No significant difference was found between physicians and managers

(b1) A3.1 To what degree do you think the law has contributed to the society in which you work

The physicians were asked: A3.1 To what degree do you think the law has contributed to the society in which you work? (i.e., Arab society, the population served by the clinic), and the managers were asked: A3.1 To what degree do you think the law has contributed to the society in which you work? (i.e., Arab society, the population served by the clinics)?

Means, standard deviations and between groups t-test was done, No significant difference was found between physicians (mean = 4.09; SD = 0.64) and managers (mean = 4.04; SD = 0.64) 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.

(b2) A3.2 To what degree do you think the law has generated change in the following areas? (Means, standard deviations and between groups t-test)

No significant difference was found between physicians (mean = 3.68; SD = 0.57) and managers (mean = 3.61; SD = 0.59) regarding the change the law has generated; on average, they all agreed to a moderated-high extent that it has generated changes in these areas. This tendency was found in all the statements in this section. However, the law has generated change especially in the following areas: "9. Patients can choose a physician based on their preference", "8. 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", "1. There are more clinics in the Arab sector and their distribution has grown". However, the law has generated the lowest change in two areas – 5." the clinics are less crowded than in the past", and "6. Physicians have more time to devote to each patient."

(c) Summary of findings regarding question 1 and hypothesis 1

In response to research question 1, regarding implementation of the NHIL and its effect on the foundation of IHCs in the Arab sector in Israel, it was found according to both physicians and managers, the law created some change; mainly, patients can choose their physician according to their preference, and all Israeli citizens, including the Arab sector, have medical

insurance (in one of four existing HMOs), and they are equally entitled to medical treatment (the "health basket"). Moreover, following the NHIL, additional clinics were established in the Arab sector and their distribution has grown. However, following the NHIL, clinics are not less crowded, and the physicians do not have much more time to devote to their patients[2].

Most physicians and managers are acquainted with the law and its principles. They answered correctly that every citizen must be insured in an HMO, will be given equal medical care, is entitled to medical treatment based on the 'health basket' and to choose the attending physician. Most of them did not know that the statement "Health tax payment grants insured individuals medical service free of charge" – is not correct. They all agree to a high extent that the NHIL has contributed to the Arab population but has generated moderated-high change.

Overall, the first hypothesis was confirmed; most physicians and managers agreed that the NHIL has inserted changes and affected the way the IHC model operates in the Israeli Arab society.

III.2.2 QUESTION 2 - Methods to Motivate Establishment and Preservation of Independent Clinics

Research Question 2: What are the main components of methods to motivate physicians, in addition to existing material rewards, according to physicians and managers?
Hypothesis 2: All three methods of rewards are important to establish and preserve independent clinics in Arab society:
(2.1) Social and moral incentives are important when physicians signs a contract.
(2.2) Financial rewards are important to retain physicians in independent clinics.
(2.3) Combining three types of rewards (social, moral, and financial) into one motivational reward model for self-employed physicians will lead to formulating a standard contract, regarding terms of their employment.

[2] Meaning - physicians and managers alike agree on the areas where the law has brought about change - a large amount (three areas) and only a moderate amount (two areas) meaning the clinics are busier and the time a physician devotes to a patient is low event it is an independent clinic

Hypothesis 2 was confirmed.

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

(a) B11. Reward methods for IHC physicians

The participants were asked: B1.1 To what degree do you think each of the contractual reward models is suitable for increasing physician's motivation and satisfaction with working in an IHC (Methods anchored in the personal standard contract).

Both physicians and managers agreed that the contractual reward methods are suitable for increasing physicians' motivation and satisfaction with working in an IHC (presented by descending means among physicians, the differences are not significant). 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.

(b) B10. Reasons for transfer of self-employed physicians between HMOs

The participants were asked: B10. In your experience, to what degree is each of the following reasons a cause for self-employed physicians to transfer between HMOs?

1. Higher salary and financial offers are a reason that causes self-employed physicians to transfer between HMOs; physicians agree significantly less ($t_{(91)} = -2.15$, $p =. 034$) than managers with this reason (physicians mean = 3.94, SD = 1.07, managers mean = 4.39, SD = 0.92). Additionally, both physicians and managers agree that 2. A gap between the organization / HMO promises to the managing physician at the beginning of the engagement, and their implementation are a reason that causes self-employed physicians to transfer between HMOs (physicians mean = 3.80, SD = 1.00, managers mean = 4.11, SD = 0.95).

However, 3. Next-generation decisions (physician's children) have only a certain influence affecting the self-employed physician's decision to transfer between HMOs.

(c) Q8. Reasons for leaving an HMO

The physicians were asked: 8. if you left a clinic/HMO, what was the main reason for doing that? And the managers were asked: 8. in your opinion, what are the main reasons for leaving a self-employed physicians' clinic/HMO?

The main reason for leaving an HMO, according to 75% of the managers, is 1. Financial (better salary / higher income), as compared to 14.3% of the physicians ($\chi 2_{(1)} = 37.43$, $p \leq .000$).43.2% of the managers referred to 3. Responding to the temptations offered, as compared to 8.2% of the physicians as a reason for leaving an HMO ($\chi 2_{(1)} = 16.16$, $p \leq .000$). The third reason, according to both physicians (18.4%) and managers (22.7%) is 2. Respect involved in being a "self-employed physician".

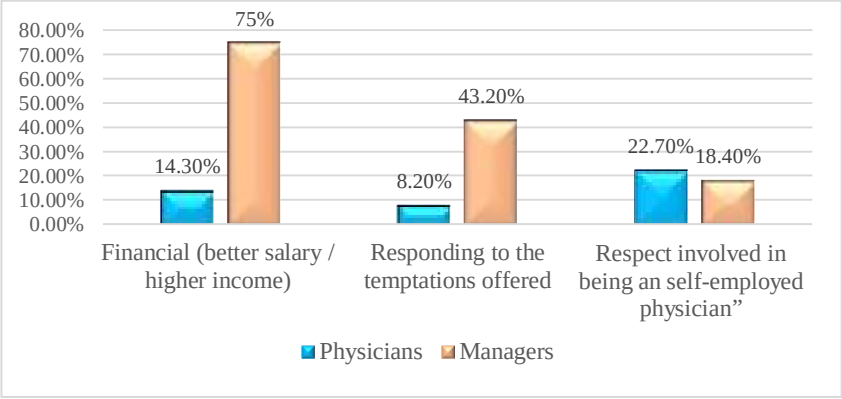

Figure 4: Main reasons for Physicians to leave an HMO

(d) Summary of findings regarding question 2 and hypothesis 2 -

Research question 2 is: What are the main components of methods of motivating physicians, in addition to the existing material reward s according to physicians and managers?

In response to research question 2, regarding the main components of methods of motivating physicians, in addition to the existing material rewards it was found that both physicians and managers, agreed that the

contractual **(**while the physician signs a contract) reward models are suitable for increasing a physician's motivation and satisfaction with working in an IHC; mainly, improving the physical conditions in the IHC, real-time troubleshooting assistance, technological support, providing support (organizational and financial) in continuing education and internships, periodic evaluation and feedback for improving the professional work of the self-employed physician, publicizing the IHC's achievements in the HMO and the community, giving a letter of appreciation and publishing it in the HMO and the community, assistance in the allocation of administrative and professional personnel.

Moreover, regarding preservation of physicians in the IHC, according to both physicians and managers, a periodic evaluation and feedback to increase financial reward is needed, in order to prevent transferring.

Both physicians and managers agreed to a certain extent that 1. Uniform financial reward for self-employed physicians and that 2. Differential financial reward s for self-employed physicians based on their functioning – are suitable for increasing the physician's motivation and satisfaction with working in an IHC. It was also found that a higher salary and financial offers might cause self-employed physicians to transfer between HMOs, especially according to the managers. Additionally, both physicians and managers agreed that a gap between the organization / HMO promises to the managing physician at the beginning of engagement, and their implementation are a reason that causes self-employed physicians to transfer between HMOs. However, next-generation decisions (physician's children) have only a certain influence affecting the self-employed physician's decision to transfer between HMOs.

Overall, the second hypothesis was confirmed; all three reward methods were mentioned as important to establish and preserve IHC in Arab society. Although managers and physicians did not agree equally about the reasons why physicians transfer between HMOs, they both agreed that 2. 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.

This finding is congruent with hypothesis 2.1, and with the findings that both physicians and managers agreed that in addition to the existing financial rewards – social and moral rewards should be added and embedded in the primary contract. However, the financial incentive should be given its

uniqueness, an incentive according to the physician's expertise. These findings are also in accordance with hypothesis 2.2, claiming that financial rewards are important for the retention of physicians in the independent clinic.

Although the researcher did not ask directly about the suggestion of combining three types of rewards (social, moral and financial) into one motivational reward system for self-employed physicians that will lead to formulating a standard contract, regarding terms of their occupation, both physicians and managers agreed to a certain extent that uniform financial reward for self-employed physicians and that differential financial reward for self-employed physicians based on their functioning – are suitable for increasing the physician's motivation and satisfaction with working in an IHC. Social and moral incentives can be primarily equal and standard. From the findings it may be concluded that the three incentives types(social, moral and financial) should be included in the contract from the beginning as one motivational reward system for self-employed physicians – may lead to formulating a standard contract (according to hypothesis 2.3).

III.2.3 Question 3 - Perceptions of the Independent Clinics that are established following the National Health Insurance Law - Work Relations with the Organization

Research Question 3: Should the idea and the model of IHCs in Arab society in Israel continue and be expanded according to physicians and managers?
Hypothesis 3: Both physicians and managers will agree that IHC model operating in Arab society should be continued and expanded.

(a) B1. Self-employed physician as compared to being an HMO salaried employee

The respondents were asked: B1.2 In your opinion, should the preferential approach toward independent clinics be continued?

Table 2: Should the preferential approach toward independent clinics be continued? (Percent's, χ2 and Cramer's V tests)

	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					

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.

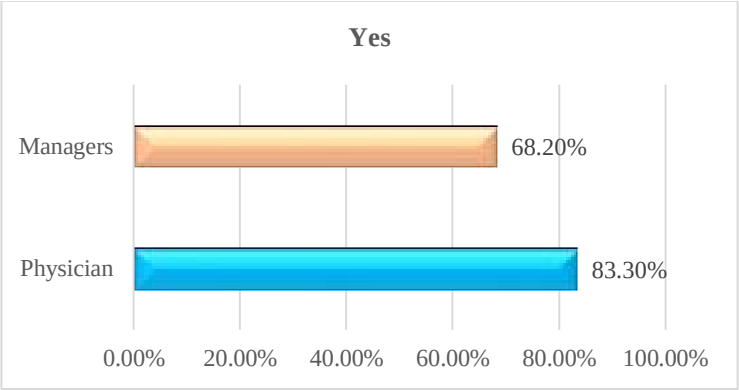

Figure 5: should the idea and the model of IHC in Arab society in Israel be continue and be expanded?

The physicians were asked: B1. To what degree do the following factors constitute an advantage or disadvantage of the HMO's engagement with a self-employed physician (as opposed to an HMO-staff physician)? And the managers were asked: B1. To what degree do the following factors constitute an advantage or disadvantage of the HMOs' engagement with self-employed physicians (as opposed to HMO-staff physicians)?

No significant difference was found between physicians (mean = 3.59; SD = 0.40) and managers (mean = 3.42; SD = 0.40 regarding the advantage or

disadvantage of the HMO's engagement with a self-employed physician (as opposed to being an HMO-staff employee physician).

On average, they all agree that the primary advantages (sorted by descending order of means according to the physicians) are: "3. Self-employed physicians have greater flexibility in managing their own and that of the clinic", "2. Self-employed physicians have the option of giving hours beyond those required by the HMO", "1. Self-employed physicians have a higher commitment to their patients, which contributes to their quality of service and availability to patients".

However, three factors serve as advantages only to a certain extent (sorted by descending order of means according to the physicians): "5. Self-employed physicians ***do not*** have less financial and employment security", "6. Self-employed physicians ***do not*** get less in-service training than staff physicians", "4. Self-employed physicians ***do not*** carry the full weight of responsibility on their own".

(b) B2. Preference of IHC approach

The respondents were asked: To what extent do you agree with the following statements, regarding preference of IHCs, under the following conditions? (Means, standard deviations and between group's t-test done) was done.

Most physicians agreed significantly (p =. 028) more than managers that the preferred method of operating IHC should be continued.

A similar tendency was found regarding the "conditions for preference of IHC" and reasons to "operating IHC should be continued" (they all agree with the statements to a high extent). Both the managers and the physicians think that the IHCs should be (1) supervised, (2) the working methods should be the same as the working methods in the regular clinics in all reference to procedures, quality indices and guidelines of the MoH.

Regarding the questions about reasons why "Operating IHCs should be continued" physicians and managers tend to agree "6. IHCs provide patients with personal treatment and personal care" the "5. IHCs offer patients flexibility and access to the medical care to which they are entitled" and that "4. Running IHC benefits physicians and patients alike".

However, significant differences were found between physicians and managers agreement with two of the statements regarding reasons that the operating method of IHC should be canceled. The physicians agreed

(significantly more than managers) that "7. Small IHCs do not provide optimal service to the population, (p =. 002) and that "8. In IHC, boundaries are blurred between physician and patient" (p =. 006).

Additionally, they all tend to agree only to a certain extent that "9. In IHCs the managing physician does not have financial stability" as a reason to cancel the IHC.

(c) B3. Transfer to being an employed physician / IHC

The physicians were asked: B3. If your HMO offered, you an employee contract and turned your clinic into an HMO clinic - would you agree or oppose the offer? And the managers were asked: B3. If your HMO were to offer to turn an independent clinic into an HMO clinic - would you accept or oppose the offer?

$\chi 2$ and Cramer's V tests were conducted to examine relationships between discrete background variables.

The difference in the answers of physicians and managers was found significant (p =. 003). Most physicians (53.1%) compared to 31.8% of the managers, opposed the idea of being an employed physician, and answered that "I would prefer to remain a self-employed physician".

However, the rest agreed (20.4%) or agreed to become employees-staff on the condition that they could work with other HMOs (26.5%) while 54.5% of the managers agreed or 13.6% "Accept, on condition that we will provide service to all HMOs".

In conclusion, most physicians do not agree to be employees and if they do, they agree only on the condition that they work with more than one HMO as employees. Most of them oppose giving up being self-employed physicians. Most managers will agree if they are offered to turn an independent clinic into an HMO clinic.

(d) B4. Differences in management and control in IHC compared to HMO clinics.

The respondents were asked: To what degree do you agree with these differences in management and control of IHC as compared to HMO clinics? (Means, standard deviations and between groups t-test) was conducted

On average, the physicians significantly (p =. 018) agreed to a certain extent, but more than managers (who less agreed) that the differences in

management and control in IHC, as compared to HMO clinics, are for the benefit of the organization. A similar tendency was found in three statements: 1.The organization has good control over an independent clinic, because it evaluates and measures its performance, 3. the organization has less control because an independent clinic is run as a business owned by the managing physician, 4. representing the deployment of HMOs has less control over the staff employed in an independent clinic. In contrast, managers significantly (p =. 002) agreed to a certain-high extent, but more than physicians (who agree to a certain extent) that 2.The working method in an HMO clinic is more organized and subject to procedures than managing an independent clinic.

(e) B5. Benefits of pooling the resource of several clinics

The respondents were asked: To what degree do you agree with the following statements, regarding pooling of resources of several HMOs? (Means, standard deviations and between groups t-test) was conducted

On average, both physicians and managers agreed to a certain high extent about the benefits of pooling the resources of several clinics. The differences in the average and each statement are not significant. They tend to agree[3], that 1. The work of one physician in a locality contributes to organizational savings, especially in small localities. 2. Pooling of the resources of several HMOs contributes to patients' better accessibility to additional medical services, and that 3. It contributes to the functioning of the IHC

(f) B6. HMO's attentiveness to the needs of the clinic

The physicians were asked: To what degree is the HMO attentive to the needs of your clinic (e.g., service, equipment, competition with other clinics, addressing your needs as a physician, etc.)? And the managers were asked: B6. To what degree is the HMO attentive to the needs of the IHC (e.g., service, equipment, competition with other clinics, addressing your needs as a physician, etc.)? (Means, standard deviations and between groups t-test) were calculated.

On average, both physicians and managers agreed that the HMOs are attentive to the needs of the clinic (e.g., service, equipment, competition with other clinics, addressing your needs as a physician, etc.) to a certain extent, indicating that the agreement with these statements is diverse, and ranges

[3] (Certain to high extent – means between (3-4)

between1-5. Most of them tend to agree[4] that the organization 1. Maintains ongoing contact with IHCs and their managing physicians, 2. Responds to requests from IHC (e.g., staff, equipment, patient services) and 3. Assists on its own initiative in the maintenance of the independent clinic (e.g., equipment, clothing, implementation of work procedures).

(g) B7. Satisfaction with the contractual arrangement of the clinics with the HMOs

The physicians were asked: B7. How satisfied are you with the contractual arrangement of your clinic with the HMO? And the managers were asked: B7. How satisfied are you as a manager with the contractual arrangement of your independent clinic with the HMO? **(**Means, standard deviations and between groups t-test were calculated).

On average, the physicians were satisfied to a certain-high extent with the contractual arrangement of IHCs with the HMO, significantly (p =. 006) more than the managers (who are satisfied only to a certain extent).

(h) B8. Allow the HMO to intervene in physician's considerations

The respondents were asked: Do you think it is right to allow the HMO to intervene in physician's considerations (such as referring a patient to a hospital, determining treatment plans and medication)? **(**Percent's, $\chi 2$ and Cramer's V TESTS were calculated).

Both (p =. 282) physicians (56.3%) and managers (55.8%) thought that intervention of the HMOs in physician's considerations should be allowed in some e cases. About a third (35.4%) of the physicians and a quarter (25.6%) of the managers think that the intervention of the HMOs in physician's considerations should not be allowed at all. The rest, the smallest percentage of both groups, think it should be allowed.

(i) B9. Involvement of HMO administration in the professional considerations of the Physician in an independent clinic

The respondents were asked: B9. To what degree do you agree with the following statements, regarding the involvement of HMO administration in the professional considerations of the physician in an IHC**?** (Means, standard deviations and between groups t-test) was conducted.

(Certain to high extent – means between 3-4-5)

Both (p =. 929) physicians and managers agreed to a certain extent that 1. Physicians' ability to treat and provide professional medical service may be impaired if the organization interferes with their work. However, they tended to agree to a certain-high extent **that it is important that** 2. The organization has some involvement in the managerial aspect of IHC, to benefit the professional functioning of the self-employed physician, and 3. The organization has control over the professional work of the self-employed physician, to offer other alternatives if necessary.

(j) Summary of findings regarding question 3 and hypothesis 3

In response to research question 3, regarding the idea and the model of IHCs in Arab society in Israel should it continue and be expanded according to physicians and managers? It was found that according to most physicians (83.3%), the preferential approach toward IHC 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.

III.3 Summary of Findings

Most physicians were salaried employees; their work in the IHC was extra income for economic security. Most of them worked in primary and integrated clinics; few worked as self-employed in an IHC defined as specialized. The NHIL: Research participants in both stages demonstrated a great deal of knowledge about the law. The preferred terms of employment involve a combination of: a uniform reward model (adjusted to physicians' expertise), based on financial, social and moral principles. All these will contribute to physicians' motivation and clinic success. Hypothesis three in all its parts was confirmed

CHAPTER IV: DISCUSSION

Theoretical Rationale of the Study

Combining three interrelated components based on several sociological theories regarding the NHIL, systemic and social aspects regarding its implementation among Israeli Arabs, with IHC and personal aspects of incentive models and motivational reward. This chapter presents a discussion on the research findings and their explanations with reference to the research questions and links to the theories and literature review that help explain the findings.

IV.1 Discussion of Research Question 1: "How does the implementation of the National Health Insurance Law affect the foundation of independent health care clinics in Arab societies in Israel (cultural and social aspects) according to physicians and managers?"

The research had three aims: The first was to investigate social and cultural aspects related to the impact of the NHIL on Arab society with regard to the phenomenon of IHC. 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. This finding supports findings in the literature by emphasizing the importance being updated at all times with regard to the NHIL and managing clinics. The NHIL emphasizes that a person who is not a physician can manage provided that a medical director is appointed to co-manage (Noiman, the Marker, August 29, 2016). 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).

The conclusion is that managers dealing with all the bureaucracy and granting approvals for the various actions on a daily basis in addition to their rich healthcare management knowledge is probably related to and affects their level of knowledge about the NHIL and its principles.

The conclusions arising from this discussion is that both managers and physicians have appropriate knowledge of NHIL and its principles. Managers' level of knowledge of NHIL and its principles supports the conduct of teams with clients in the various fields.

Addressing NHIL's (1995) contribution to society and the Arab population, on average, all participants agreed that it had made a great contribution. It has generated change especially in the following areas: "Clients 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 service basket" (NHIL, Section 7), "There are more clinics in the Arab sector and their distribution has grown". The findings support the principles of NHIL Section 13, there was an increased distribution in the layout of IHCs and their accessibility to the general population including Arab society, the growth in the number of IHCs was part of an overall expansion, allowing the clients' personal choice of clinics and physicians.

Related to the theory of Giddens, Social Responsibility, the research findings point out that there is a macro structure and a microstructure, there are mutual relationships between the organization and IHCs and self-employed physicians, when everyone at all levels takes personal responsibility in building responsibility and promoting the common interests that give success to the organization and the individual himself. Physicians and managers recognized the NHIL’s contribution to the principle of social solidarity and how it had influenced medical services through IHCs in Arab society and in general. The literature reviewed in the research supports the change brought about by the law to Arab society, but no literature was found on the direct effect of NHIL on HICs, which are considered clinics like the primary HMO ones in terms of service provision but as a private business with regard to physicians and entrepreneurs, or an association. This study has presented for the first time such a reference from the points of view of physicians and managers. It has presented a direct link between the NHIL and emergence of the IHC service model that has gained momentum and expanded. This has led to interrelationships and working relationships adapted to the Law that are unlike what was before.

IV.2 Discussion of Research Question 2: "What are the main components of models to motivate physicians, in addition to existing material rewards, according to physicians and managers?

The second research aim was to develop a conceptual framework regarding ways of motivating physicians in addition to the existing financial system, in the context of IHCs in Arab society. The findings indicated that both physicians and managers agreed that the contractual reward methods are suitable for increasing physicians' motivation and satisfaction with working in an IHC. There ought to be a standard financial reward for self-employed physicians and that financial reward must be based on self-employed physicians' performance.

According to the findings, it should be noted that financial incentives alone are insufficient. 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. Physicians' conduct and functioning within different medical organizations are influenced by various incentive systems (1) Moral incentives; (2) Social incentives; (3) Material incentives. 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. Rewards in all areas are important for physician retention, performance and results. 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.

The conclusion emerging from this discussion is that it is important that similar processes to those existing in the HMO clinics be adopted for self-employed physicians as well, thus establishing the mutual relationship through the various incentives. The connection between all reward types is important and necessary.

Financial offers are a reason for turnover between HMOs; physicians agree significantly less than managers with this reason. Additionally, Both physicians and managers agreed that a gap between the organization / HMO's promises to managing physicians at the beginning of the engagement, and their implementation causes self-employed physicians' turnover between HMOs. Turnover may occur as a result of other HMOs' means of persuasion for physicians to join them promising good financial rewards, being assigned clients in advance to anchor their status and clients and securing specializations in medicine on their part.

These findings are congruent with the scarce literature stating that individuals are responsible for acting morally and legally. There is a need to address tasks of realizing policy goals, employing collective methods, self-management and regulated social adjustment (Peeters, 2017). Giddens stated there are no rights without responsibility and no authority without democracy (Cammack, 2018).

The research findings are unique in that they emphasize adoption of a future method for building mutual relationships. These recommendations cannot be adopted without acknowledging the need for a change in ways of engagement. (Allison, 2021) depicted in the theoretical and literature review chapter, supports these findings and emerging recommendations.

The conclusion is that it is important for HMOs to take responsibility for physicians. Promises must be kept from set-out and throughout the entire contract period, maintaining mutual relations, work meetings and visits can preserve the IHCs and prevent physicians' turnover. Physicians, on their part, must adhere to their contract. Both physician and HMO must be encouraged

to act responsibly. Uniform financial rewards and differential financial rewards for self-employed physicians based on their performance are suitable for increasing physician's motivation and satisfaction with working in an IHC. Social and moral incentives can be primarily equal and standard. All three incentives should be included in the contract and combining them into one motivational reward system can lead to formulating an equal standard contract, regarding terms of their employment.

IV.3 Discussion of Research Question 3: "Should the idea and model of IHCs in Arab society in Israel continue and be expanded, according to physicians and managers?"

The third, comprehensive research question examined current modus operandi of IHCs and the viability of their continuation. In the study itself, several social theories relating to the research topic were proposed. Numerous examples from the literature were given for these theories. It was found that combining these aforementioned social theories could explain the IHC phenomenon and its continuation in Arab society.

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. Nevertheless, statistical data in 2018 showed there were approximately 38,523 physicians in the country, of which 5,025 practiced family medicine in the community. A high percentage of services in the community are provided by self-employed physicians. Only 2,100 are specialists in family medicine, most of whom are women. Annual visit rates to family physicians,

according to the Central Bureau of Statistics are 8.4 visits per year (Bin Nun et al., 2020).

With regard to Arab society, it was found that local physicians from large families can recruit patients and promote their personal businesses, in addition to being salaried physicians and even specialists, which can further advance their financial situation and ability to thrive and succeed. Central bureau of Statistics findings (2015) showed overall satisfaction with patients' proximity to IHCs, satisfaction with family physicians' availability hours, but lower satisfaction levels with regard to waiting times for physician appointments and waiting times at clinics.

In an article published by Mohana (Globes, 14.01.2022), he maintained that government leverage is required in the Israeli Health system, so as to promote the deployment of medical services and IHCs. Without the support of civil society, medical professionals and patients, it is impossible to promote taking responsibility as Mohana suggested. Medical systems have proven this and therefore it is recommended to adopt Mohana's recommendation to take responsibility for the future, but this is no less important in the present

The conclusion emerging from this discussion is that the IHC system is recommended and ought to continue both for the benefit of HMOs, Physicians and managers.

The question of the future of IHCs pertains to the cost of adhering to this system. 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.

Physicians and managers tend to agree IHCs provide patients with personal treatment and personal care, offer patients flexibility and access to the medical care to which they are entitled and that managing an IHC benefits physicians and patients alike. 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). The conclusion is that it is important to allow physicians to choose their way of engagement. It is important for HMOs to sign an agreement on cooperation between HMOs with regard to pooling resources in small and peripheral areas, so as to share the burden, and for all teams to be committed to this cooperation for the benefit of saving resources and achieving better healthcare service.

Findings presented in the literature reaffirm the findings with regard to providing health care treatments based on the need to close existing gaps. This came up in the research as an issue of pooling resources between HMOs, in particular with regard to IHCs. According to the literature, competitions between HMOs has rendered pooling resources difficult, especially in small settlements, and thus, instead of saving and becoming more efficient, efforts are duplicated.

Already a decade ago, Ariele et al. (2012) noted that HMOs must consider costs and accessibility gaps and shortages in small communities and peripheries, and save expenditures at the same time. Enhancing access to health care and the ongoing medical service in the community for target populations is the responsibility of HMO clinics, as well as medical framework and pharmacies associated with their contract (Horeve et al., 2012).

Most physicians agreed significantly, more than managers that the preferred method of operating IHCs should be continued. Both the managers and the physicians think that IHCs should be (1) supervised - the law does not regulate IHCs work nor physicians' employment (Bin Nun et al, 2020); (2) There is a need to build trust between parties - the working methods should be the same as the working methods in the regular clinics in all reference to procedures, quality indices and guidelines of the MoH.

The findings clearly point to IHCs and the idea of cooperation in terms of pooling resources in small places, but no less importantly, supervision of a method improves services to citizens. Supervision of IHCs and work

conditions in them must resemble those of regular HMO clinics. This refers to the theory of organizational change (Alison et al, 2021) that can bring about positive results.

In conclusion, it appears necessary to adhere to the IHC model, but it is necessary to make changes in terms of self-employed physicians' engagement with HMOs. This change in regulation will lead to the promotion of a healthy society while reducing health disparities.

The following chapter presents the conclusions arising from the research.

CHAPTER V:
CONCLUSIONS AND RECOMMENDATIONS

V.1 Factual Conclusions Arising from Research Question 1: How does the implementation of the National Health Insurance Law affect the foundation of independent health care clinics in Arab societies in Israel (cultural and social aspects) according to physicians and managers?"

Research findings emerging from the first question 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.

V.2 Factual Conclusions Arising from Research Question 2: What are the main components of models to motivate physicians, in addition to existing material rewards, according to physicians and managers?

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.

V.3 Factual Conclusions Arising from Research Question 3: Should the idea and model of IHCs in Arab society in Israel continue and be expanded, according to physicians and managers?

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.

V.4 Research Limitations

This research was rather limited in its scope and population. Thus research limitations are presented in this sub-chapter.

The two-stage research was conducted in the North District among IHC physicians and managers from all the HMOs in the Arab population. The North District was chosen both for reasons of convenience and because the majority of Arab Christian, Muslim and Druze population live in the north. It seemed important to include members of all religions in order to get as accurate a picture as possible from all. As the research progressed, it appeared there are no differences between the diverse religions, and thus they were not compared. Since the main point of the research was to examine IHCs in Arab society, no other groups in the population were addressed.

The study examined IHCs **in general** regardless of the HMOs to which they are affiliated. It did not examine and compare IHCs that existed before the NHIL and those established after NHIL enactment. Nor did it examine city IHCs compared to village ones. The research examined IHC physicians and managers of various levels. However, no comparison was made between medical management teams' in HMOs and IHCs, nor between the HMOs.

The research was conducted during the Corona period, the field of research involved health officials who were busy with the pandemic and at the same time dealt with non-pandemic 'routine' issues. The closures and the whole situation made it difficult to receive immediate and flexible responses from potential participants who categorically refused to be interviewed face-to-face and/or fill out questionnaires in person. This limitation was partially

addressed by conducting most interviews over the phone after the interview guide had been sent to them in advance via e-mail or fax. Owing to sensitivity of the research topic and fearing potential participants' reluctance to cooperate, questionnaires were delivered in person after obtaining informed consent on the phone. This was particularly difficult among participants from competing HMOs to that of the researcher, who considered information to be confidential and 'harm competition.

Since the research field was limited, the researcher had to select the participants in a non-probabilistic sample convenience sample and compromise on participants' selection. Some physicians answered two questionnaires, once as managers and again as physicians.

In the current study, documental analysis was used as a foundation for the literature review only. The study examined the attitudes of physicians and managers regarding the effects of the NHIL and regarding the phenomenon of IHCs but did not examine the attitudes of clients to these issues.

V.5 Contribution to Knowledge

This unique and pioneer study about IHCs was conducted in specific geographical district at the North of Israel among physicians and managers from diverse Arab religions. This study of physicians and managers' views about how the IHC phenomenon developed and gained momentum in the Arab society since the NHIL enactment. IHC physicians and managers knowledge of the NHIL is of great significance. Knowledge of the law means recognizing rights of health care services to which citizens are entitled and what NHIL allows.

This research bring this topic into public discourse on the level of patients' rights.

This research contributes knowledge to young physicians and managers, pertaining to learning and awareness of the effects of the NHIL while constantly monitoring the additions and changes that the law has brought about especially with regard to accessibility to medical services, thus reducing existing disparities With regard to healthcare services.

V.5.1 Contribution to Theoretical Knowledge

This study is unique and the first of its kind in that it examined physicians' and managers' perceptions of independent HMOs. It was also unique in that it examined the physicians' and managers' opinions from different

management levels and clinics whether to continue the method of operating IHCs or whether to expand it. This research reveals that the system needs to be preserved and even expanded in remote locations. This will result in Physicians' occupational security and better health services.

The research findings with regard to HMOs holistic engagement with self-employed physicians from the outset throughout the engagement period is innovative. The knowledge gained theoretically refines which factors to take into account and strengthen at the beginning and throughout the engagement. Postponing crises and/or preventing them to the extent possible can constitute a positive outcome. The study contributed important knowledge by clarifying the issue of but parties' mutual respect and compliance to contract articles to the letter. When the promises are not fulfilled, Arab physicians regard it as disrespectful and insulting.

V.5.2 Contribution to Practical Knowledge

The research has a conceptual and practical contribution including recommendations for HMOs to promote action anchored in a standard structured contract including financial, moral, social and motivational incentives for IHC physicians and managers from the start. This is important in encouraging physicians to invest in quality treatment leading to HIC growth and success and guarantee their retention. The proposed reward model to promote engagement and strengthen IHC model is based on providing classic financial incentives according to the physician's expertise and influence while combining and providing motivational rewards which are determined in advance in the personal contract between the parties. All this may lead to a healthy society, closing gaps and improved health services, mainly in the Arab periphery.

The model is elaborated and presents the elements that led to the law and continue to be involved today. (Grey). Presents the main points of the law and the research findings and support for the first hypothesis (Light blue). The budget model is classic (Grey). Brown presents the second hypothesis that connects all incentive components anchored from the start emphasizes its last part as a pioneering model. Retaining IHCs with self-employed physicians makes health services more accessible, thus promoting a healthy society.

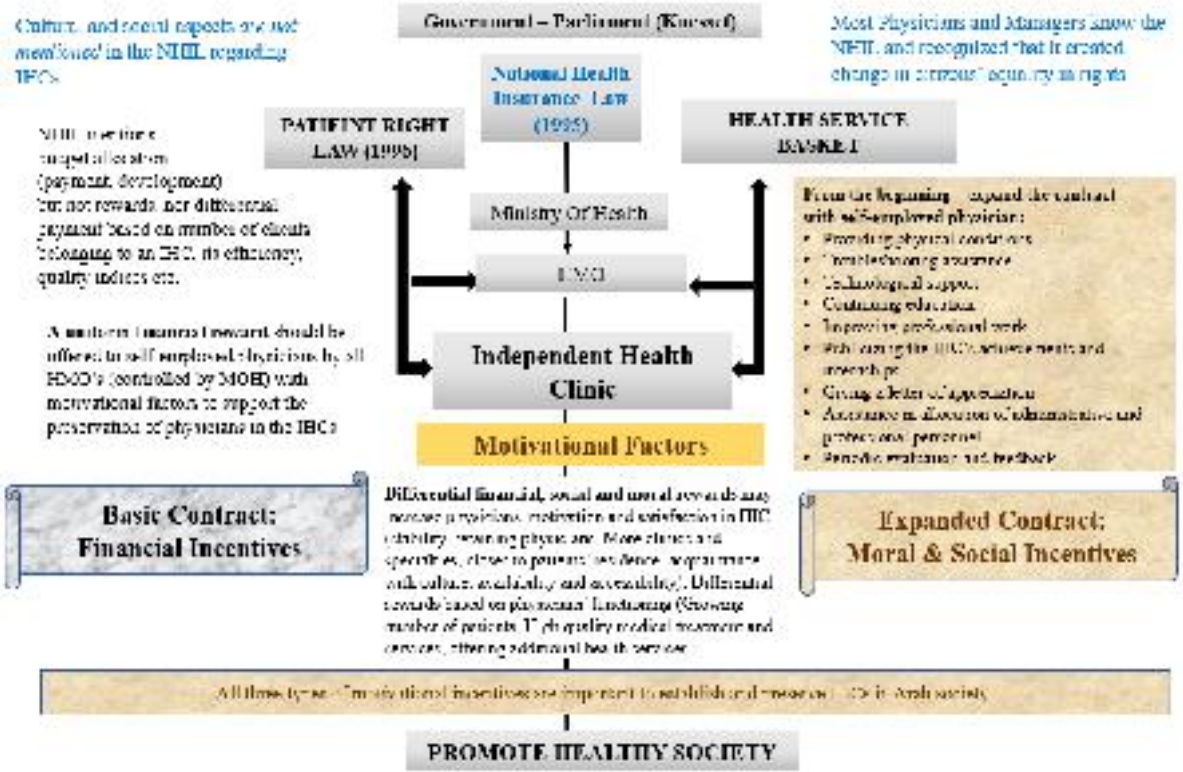

Figure 6: The research model

V.5.3 Recommendations

With regard to self-employed physicians and their terms of employment, it is recommended is to promote action anchored in a structured standard contract according to fixed financial rewards with additional moral social and motivational incentives from setout. The financial contracts ought to be adapted to physicians' role and expertise and the degree of a physician's influence in society. The additional incentives will benefit physicians and the IHCs, leading to their while leading deliberate and controlled actions. It is recommended that IHC managers and physicians be given the choice whether to work as self-employed or salaried employees. As for continuing the IHC model, it is recommended that IHCs continue to operate so that all citizens, including those in small and remote settlements can have access to quality healthcare services like those living in cities or other large population centers.

Regarding the MoH, it is recommended that the Ministry regulate HMOs and IHCs' operation and supervise them.

V.6 Recommendations for Future Research

1. It is recommended to carry the research nationwide comparing all HMOs. This recommendation refers to promoting quantitative research among IHC physicians, managers and clients with regard to the question whether the IHC model should continue, whether pooling resources is desirable and which reward systems ought to be strengthened. Such expanded research may provide information about all HMOs and their affiliated IHCs.
2. It is recommended to conduct comparative research of perceptions and attitudes of IHCs from the perspectives of Jewish and Non-Jewish physicians and managers from the diverse HMOs.
3. It is recommended to conduct research exploring IHC clients' perceptions and attitudes to the IHC issue and examine for differences between Jewish clients and non-Jewish ones.
4. A follow-up study should be carried out that will examine whether the different reward models – whether they increase satisfaction and motivation among the physicians and managers, whether they prevent turnover from one HMO to another and whether the reward system will promote IHC stability in the future

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