מאיירס - ג'וינט - מכון ברוקדייל
MYERS - JDC - BROOKDALE INSTITUTE
مايرس - جوينت - معهد بروكديل

SMOKLER CENTER FOR HEALTH POLICY RESEARCH

Immigrant Physicians: Healthcare Perceptions and Experiences of American Physicians Following Aliyah to Israel

Eliana Meirowitz Nelson
in collaboration with Bruce Rosen

FOUNDED IN 1974 - ייסד

RESEARCH REPORT

RR-633-13

Immigrant Physicians:
Healthcare Perceptions and Experiences of American Physicians Following Aliyah to Israel

Eliana Meirowitz Nelson
in collaboration with Bruce Rosen

Jerusalem January 2013

Editor: Naomi Halsted

Layout and print production: Leslie Klineman

The author, Eliana Meirowitz Nelson, is a Masters student
at the Boston University School of Public Health. The study was conducted
during her internship at the Myers-JDC-Brookdale Institute in 2011.

Myers-JDC-Brookdale Institute
Smokler Center for Health Policy Research
P.O.B. 3886
Jerusalem 91037, Israel

Tel: (02) 655-7400
Fax: (02) 561-2391

Website: www.jdc.org.il/brookdale

Executive Summary

Background

Approximately 180 physicians made aliyah from the US, Canada and England from 2002-2010, the majority of them (approximately 90%), American. In 2011, the Myers-JDC-Brookdale Institute carried out a qualitative survey of American physicians who had immigrated during that period, to learn about their experiences of the aliyah process and of working as physicians in both the Israeli and American healthcare systems. The study was carried out in cooperation with Nefesh B'Nefesh (NBN) – a nonprofit organization that encourages and facilitates aliyah.

Study Goals

1. To explore the relative strengths and weaknesses of the Israeli and American healthcare systems as perceived by physicians who have made aliyah. This information could serve as valuable input into efforts to improve both systems
2. To learn about the challenges faced by immigrant physicians in the immigration process and the extent to which, or manner in which, they succeeded in navigating that process. This information could assist NBN in its efforts to encourage immigration and facilitate the successful integration of the immigrants.

Study Methods

The study consisted of in-depth interviews with 22 American physicians who had arrived in Israel since 2003. The respondents were recruited through an advertisement published via the NBN e-mail distribution list of immigrant physicians. The main issues explored in the interviews were the strengths and weaknesses of the American and Israeli healthcare systems and the experiences of making aliyah as a physician.

After the qualitative interviews had been completed, a demographic survey was sent to the same physicians, to elicit information about medical specialty, age, type of work environment, gender and other variables.

Study Findings

The physicians in this study matched the broad demographics of the NBN physician population. Three-quarters of them were male, the average age was 47, and the majority were primary care physicians.

Perceived Strengths and Weaknesses of the Israeli System

The physicians held strong views about both the Israeli and American systems. Many praised Israel's universal insurance coverage, effective insurance regulation and standardized medical

records. Most agreed that Israeli physicians provide a comparable quality of care to that provided by their counterparts in the United States. Several praised the independent and well-informed Israeli patients who do not need constant access to their physicians, allowing physicians to have a better work/life balance in Israel. On the other hand, most were frustrated with their Israeli salaries, noting that payment levels were insufficient to maintain the quality of life to which they were accustomed in the US. Several physicians complained about the nursing shortage, which required them to perform tasks that they would not be called upon to do in the US. Many complained about the complicated relationships between the public and private medical systems in Israel. They believed that the current healthcare landscape motivated poor public care and was starting to generate unnecessary costs and provide counter-productive incentives for physicians.

Perceived Strengths and Weaknesses of the American System

In many ways, the physicians spoke of the American healthcare system as though it were the opposite of the system in Israel. A frequent refrain was that the greatest strength of the American system – seemingly limitless resources – could ultimately lead to its downfall. Physicians praised the speed with which they could get clinical orders filled in the US, the availability of the highest quality treatments and their high salaries. Simultaneously, they fretted about defensive medicine brought about by excessive malpractice lawsuits, burdensome medical-school loans and evasive insurance companies. The lack of universal coverage, the convoluted and poorly regulated insurance system and the vast disparities in access to care in the United States had been a disappointment to many of the immigrant physicians. They were sharply divided in their opinions of the Patient Protection and Affordable Care Act – the new American healthcare law – with several saying (some with praise and some with anger) that it would lead to socialized medicine.

Perceptions of the Aliyah Process

When discussing the process of making aliyah, there was a great deal of agreement among the physicians that the process was arduous. Most of the respondents complained about the process of licensure with the Ministry of Health (MOH), but only a few were upset about specialty recognition from the Israel Medical Association. Respondents were split over the required period of working under supervision: Some appreciated the opportunity to familiarize themselves with the Israeli system, while others viewed the oversight as an affront to their expertise. Once they had been licensed, though, the physicians resented the opaque and varying Israeli career ladders, often complaining of secret incentives or ambiguous routes to success. Overall, the physicians were grateful for NBN's help and wished that the aliyah process could be more efficient and transparent.

Directions for Action

Several possible further steps emerge from this pilot study. Israeli policymakers could explore the possibility of adapting the positive elements of the American system that were highlighted by the respondents – effective nurse practitioners, high availability of treatments and transparent career ladders. The MOH in Israel could work to simplify the medical licensing process and NBN could help prepare physicians for the differences in the Israeli medical system. American policymakers could draw inspiration from the Israeli system and work towards an American variant of universal coverage and standardized electronic medical records, as well as more effective regulation of the insurance companies.

This study could serve as a starting point for a comprehensive, large-scale survey of American physicians or other healthcare providers who have made aliyah. Researchers could also conduct complementary surveys – of Israeli physicians who have moved to the US, or of physicians who choose to live in Israel but work in the US. This study also prompts issue-specific research that would explore in greater depth such topics as US-Israel differences in salaries, payment structures, treatment availability and nurse-physician relations, as well as the reasons for which the American physicians make aliyah.

Conclusion

As the Patient Protection and Affordable Care Act ushers in changes in the American healthcare system and as the Israeli populations and regulations shift, there will be continued opportunities to conduct comparative studies of these two countries. As with other partnerships between Israel and the United States, a continued dialogue will help researchers and policymakers in each country improve strategies and services for its citizens and work toward improving their quality of life. Each country has successes to share and weaknesses against which it could advise. We hope that this pilot study stimulates future research and motivation to improve both systems.

Acknowledgments

We wish to thank all who helped us with this study – in particular Daniella Slasky and Rachel Berger of Nefesh B'Nefesh, for their support and for providing us with information in the planning, designing and recruitment stages of this study.

We are equally grateful to all the immigrant physicians who were kind enough to spend time with us and provide us with their thoughts and constructive insights into the aliyah process.

Finally, we thank our colleagues at the Myers-JDC-Brookdale Institute – Prof. Jack Habib for supporting the study, Irit Elroy for her advice and support during the data analysis process, Naomi Halsted for editing the report, and Leslie Klineman for the graphic design and preparation for publication.

Table of Contents

List of Tables in Appendix

1. Introduction

1.1 Background

In recent years, both the Israeli and American healthcare systems have undergone structural changes. In September 2010, following in-depth analysis of the differences and similarities of the two systems, Bruce Rosen of the Myers-JDC-Brookdale Institute in Jerusalem and Keith Kanel of the Jewish Healthcare Foundation in Pittsburgh published a booklet entitled ***Healthcare in the US and Israel: Comparative Overview***. The current study is a natural successor to their work, providing a first-hand perspective of these differences and similarities through the eyes of American physicians who have made aliyah. The study team conducted in-depth interviews with 22 American physicians who had arrived in Israel since 2003, to learn about their experiences of adjustment and integration, and how they see the strengths and weaknesses of the two systems.

The study was carried out with assistance from Nefesh B'Nefesh (NBN) – an organization that aims to revitalize aliyah and increase the number of future immigrants by removing professional, logistical and financial obstacles that may prevent many of them from realizing their dreams. NBN works with immigrants with a variety of professional backgrounds from all over the world and guides them through the aliyah process. The organization provides written resources, individual and group counseling, and financial assistance. NBN estimates that 180 physicians have made aliyah from the US, Canada and England since 2002 – a large proportion of them American.

1.2 Objectives

This study was designed with two objectives:

1. To explore the relative strengths and weaknesses of the Israeli and American healthcare systems as perceived by physicians who have made aliyah: This information could serve as valuable input into efforts to improve both systems.
2. To learn about the challenges faced by immigrant physicians in the immigration process and the extent to which, or manner in which, they succeeded in navigating that process: This information could assist NBN in its efforts to encourage immigration and facilitate successful integration of immigrants.

1.3 Methods and Analysis

This study was designed as a pilot qualitative study that could serve as a basis for future research. NBN published an advertisement on its e-mail distribution list of immigrant physicians, asking interested candidates to contact the study director. This list includes all physicians in the NBN database, which means that they had all made aliyah since 2002. Pre-arranged interviews were conducted with those who were interested and available.

The interviews included the following three main questions:

1. What do you see as the strengths and weaknesses in the American healthcare system?
2. What do you see as the strengths and weaknesses in the Israeli healthcare system?
3. Can you tell me about your experiences of making aliyah as a physician?

Altogether, 22 physicians were interviewed over the course of six weeks. All the interviews were conducted over the phone and lasted 15-45 minutes, with an average of around 35 minutes. The interviews were transcribed onto a computer in real time and all the quotations in this report are from the transcriptions. The transcription efforts were rather thorough and the quotations are presented as close to verbatim as possible, though some have been slightly re-worded at times, to improve clarity.

After the qualitative interviews had been completed, we designed a survey to obtain demographic information. All the physicians who were interviewed also responded to this e-mail survey, and the answers are summarized in the appendix. The qualitative data were primarily analyzed without reference to the demographic information but, in cases where they could shed some light, relevant demographic details were added to the report. It is possible that these data could be analyzed by medical specialty, age, type of work environment, gender, or other variables but, at this stage, these variables have not played a significant role in the analysis. Instead, efforts were made to treat all responses equally and avoid any bias or preconceptions based on those types of variable. After the interviews were completed, the data from the interviews were coded and analyzed.

In presenting the findings regarding perceptions of the two health care systems, we have grouped the material into the following sections: Patient care issues (section 2), financial and professional issues (section 3), and cultural, social and lifestyle issues (section 4). Each section begins with perceptions regarding the US, which is followed by perceptions regarding Israel and concludes with a brief summary. Section 5 focuses on the findings related to the second major topic of the study – the physicians' perceptions of the aliyah process. Section 6 presents some concluding thoughts.

2. Patient Care Issues

2.1 United States

2.1.1 Introduction

When speaking about the American healthcare system, most of the issues raised by the physicians related to quality, cost, training and access to care. There were very few consensual issues and physicians often held diametrically opposed beliefs.

There was general agreement on several issues: the US provides excellent healthcare to its patients; American physicians receive high quality training; the US healthcare system has tremendous resources for patient care and innovation; support systems for physicians, e.g., nursing and administrative staff, are very helpful; not all Americans have health insurance. Physicians evidently disagreed on the details and importance of these basics, but there did seem to be underlying commonalities across the sample.

2.1.2 Quality of Care

When discussing quality of care, there were diverging opinions about the details. With the US healthcare system in the process of structural reorganization and legal battles over the Patient Protection and Affordable Care Act, respondents expressed very different beliefs about whether things are getting better or worse in America. Issues of expanded access and technology arose – sometimes with hope and sometimes with frustration. Several respondents reminisced about a time when physician-patient relationships were more trusting and personal, and some lamented that these times were fading because of managed care and/or President Obama.

The physicians discussed the high standards of customer service within all levels of patient care – from secretaries to nurses to physicians. Some physicians credited this to the reimbursement systems, saying that since there was a competitive marketplace and patients could take their business elsewhere, healthcare professionals had to work hard to please their customers. One physician noted, "The American system is based on income, and if you treat people poorly, you won't have a lot of referrals." Others had a more cynical view and talked about overtreatment because of reimbursement incentives.

Overtreatment was also discussed in the context of concerns about malpractice. Several physicians noted that they thought that malpractice lawsuits and insurance were creating an atmosphere of defensive medicine in the US, in which physicians ordered too many tests and covered too many bases out of fear of future litigation. As one emergency medicine specialist noted, "The malpractice situation is such that you can't use judgment when judgment is warranted. You have to over-test and create a paper trail, and can't afford to let some smart aleck lawyer ten years from now say that something hasn't been done and the burden of proof is on you to prove it shouldn't have been done." Many physicians complained about the burdens of a culture of malpractice litigation and how it led to too many procedures.

On the other hand, some respondents felt strongly that the US was not doing enough to encourage preventative care or upkeep of health. As one physician put it, "[The] American system does not reward good outcomes." A physician originally from Canada, who trained and worked in the US, explained what he saw with shock, "Lack of health, like obesity, and old people who were so sick that it was shocking – 300-pound [136 kg] kids, a 900-pound [408 kg] man! To get to that level takes hard work. It's not just that the doctor didn't come in to see his patient on a Tuesday. That's been going on for 30 years on every level." Another noted that even when the

care worked, the patients could not consistently afford the treatment they needed to keep them healthy. She said, "They come to the hospital and you take care of them, and they get healed in the hospital, and then they go home and can't afford their meds, and then they're back where they started." This kind of sadness and frustration came up in several conversations.

2.1.3 Cost of Care

When discussing the American cost of care, many physicians made the point that America's greatest strength could also become its downfall. They noted that the US was using its extraordinary resources at such high levels that the system was inflating itself into unsustainable levels of cost. While some physicians justified the costs of the system by saying that it was financing life-saving research and innovations, others viewed it from the patient's point of view and spoke of individuals not being able to afford their own treatment, while others took a macroeconomic view and said that skyrocketing costs were bankrupting the American healthcare system. It seems, from the point of view of cost, that the respondents did not disagree about the facts, but chose to take different viewpoints and place different moral judgments on its successes.

2.1.4 Quality of Training

When the respondents spoke about the quality of medical training in the US, they seemed to agree about the facts. Medical training is hard, thorough, long and expensive, and it produces very good physicians. The system progresses clearly, and the steps are predictable and consistent. Some physicians described the grueling nature of the training as "a bit inhumane" and perhaps not the ideal way to train. Others thought that the regulations for medical students and residents were sufficient and reasonable – and superior to those in place in Israel. Some physicians also spoke about the variability of foreign medical schools and their suspicions about the qualifications of foreign physicians.

2.1.5 Access

The sampled physicians mostly seemed to agree on issues of access to care as well, with a few exceptions. They agreed that most Americans can access care, though it may be variable in quality, and they acknowledged that there was a sizable uninsured population. Some physicians discussed lack of insurance as though it were the biggest problem in American healthcare, while others mentioned it as a small reality that did not take up much of their time. The physicians who seemed most concerned about uninsured patients referred to it frequently, as it related to their quality of care and access to preventative care. A few of the respondents seemed to think that the number of people who truly could not access care was very small, and blown out of proportion in the discourse. It may be that the variation in the opinions expressed had to do with variation in the patient populations served by the respondents.

2.2 Israel

2.2.1 Introduction

When discussing the Israeli healthcare system, the respondents were deeply divided. Some were very enthusiastic about Israel's technology, access and preventive care. Others were dismayed by the lack of patient and physician support, and by inconsistency and competing incentives between public and private care. There seemed to be general agreement that universal coverage and electronic medical records were generally good, though those issues were reportedly valued more by some physicians than by others.

2.2.2 Quality of Care

Many physicians spoke very highly of the quality of care in Israel, but many others were disappointed with it. Those who praised it spoke of sophisticated training: As one respondent put it, "The standards in academic medicine in Israel are excellent, possibly rivaling or surpassing the US." Physicians were often disappointed, however, by the way that the treatment played out at the patient level. Many physicians spoke about low motivation to provide high quality care, often linking this to the reimbursement system. One physician remarked, "There's no system that truly incentivizes productivity or care, especially in the hospital framework. In the health plan, they are paid per patient per quarter, so a patient who needs to be seen more than that, is not seen. You're incentivizing one visit per three months. In the hospital, they get paid a fixed fee per day, so they try to do as little as possible in the hospital system but keep the patient there as long as possible."

In this context, many physicians spoke about the differences between the public and private systems. Physicians said that there was little motivation to provide high quality care in the public system, when one could earn much more money – often discussed as though it were the actual fair wage – as private physicians. Many expressed frustration with their colleagues who seemed to be waiting until the end of the public workday so that they could go to their private clinics; they said that daytime care suffered because of it. One anesthesiologist discussed this in somewhat extreme terms: "In the Israeli [public] system, they don't care about people. You're just a slab of meat, let's get you through and get you done by 3 p.m. In Israel, they don't care, from the top to the bottom." This sentiment came up when discussing medical care given without compassion. Physicians did not seem to think that there was a value on customer service and politeness in the Israeli healthcare system. Several respondents noted critically that Israeli physicians often do not even touch their patients during visits, even in pediatric care.

Money issues were of concern in a broader context than physician reimbursement. Many physicians discussed the lack of resources in the Israeli healthcare system. They spoke somewhat nostalgically of a time in America where they could order a test and it would be administered, analyzed and billed for, in a timely fashion. A cardiologist with experience in urban teaching hospitals in the US and Israel said, "In America, we had three times the amount of equipment. So if

you request a test or a procedure, you get it. Here if you request it, you don't necessary get it. Here you have to find out whom you have to talk to, and beg and plead. Here I write an order and it doesn't happen. You have to learn how to be efficient and get things here. In the US, if someone's absent, you have someone to fill in. Here if someone's out, they just don't provide that service until that person's back – one week, two weeks, a month. That's the culture." Some physicians discussed this issue from the patient's perspective – long waits, lack of treatment – and others expressed it as a point of frustration for the physician – lack of administrative support, inability to treat to the best of his/her ability – but both sides seem to base the issue on a lack of resources.

Some respondents attributed the lack of resources to the lower per capita income in Israel than the US, but others spoke scornfully of the role of government and the health plans in rationing care and limiting services. Several physicians were most concerned about their patients missing out on the best medications because they were not included in the health benefits package; others were more frustrated by the lack of coverage for certain diagnostic tests. A few physicians blamed the entire private healthcare system for encouraging the downgrading of public care quality. One physician said, "Most senior doctors have a vested interest in the system not working so they can work privately and charge more. Essentially, that's what it comes down to. Medicine is run by a small clique of people who have a vested interest in the system not working, and that's a problem." This distrust and disappointment in the structures of care came up in many conversations.

On the other hand, some physicians had very good things to say about the quality of Israeli healthcare. Many praised the universal coverage, but they did not discuss its importance in much depth; the value of universal coverage seemed implicit. Many physicians also applauded the consistent availability of electronic medical records (EMRs). They said that in Israel it made a big difference in the quality of care, by reducing redundant tests, and they wished that the US had such technology and infrastructure. One physician remarked that the EMRs reduced the frequency of oral communications among physicians for purposes of care coordination, because printing out the record was so easy, but she also said it increased patient education. Several physicians commended other aspects of Israeli care, especially preventive and emergency care.

Some of the physicians appreciated Israeli quality of care – with reservations. One emergency medicine physician noted, "The weak points are that the system does not work well unless you're a very good consumer or you're very healthy. If you have one isolated problem and you want to see one doctor, that's fine. If you have something that's really complex and you need to see several doctors and coordinate it, you're screwed." That said, a pediatrician noted, "I've heard that the ER system here is excellent. The time from when you first feel chest pains from a heart attack to when you end up in the catheterization lab is among the best in the world." Another pediatrician reported that care in the Tipat Chalav mother-and-child clinic system was well

coordinated and comprehensive for the first five years of the child's life, after which it became less reliable.

Many physicians complained about their incomes in Israel. While this issue is explored primarily in the section addressing financial and professional issues, it is noted here because some of the respondents related it to quality of care. Some physicians noted that because of low physician salaries, only the most committed physicians were in the workforce, while others argued that the low remuneration created a brain drain, taking the most talented physicians elsewhere.

2.2.3 Cost of Care

Issues of Israeli healthcare cost are bound up in the issues of quality and access. In addition to the issues mentioned above, some respondents mentioned the costs of co-payments and prescriptions. When discussed, some praised their low costs to patients, but a few still viewed them as a burden and as possibly blocking access to care.

2.2.4 Quality of Training

Physicians had different opinions about the quality of training of Israeli physicians. Some said that the training was exemplary, on a par with American training, while others were suspicious of its quality. One physician, discussing pediatrics, said, "The quality of the training and care in the center of the country is exceptional, and higher than in the US. Physicians who pass board certifications here, on average, are smarter and better trained than in US." This same physician also noted, "But there's a big range in quality of training. It's different in peripheral areas. If you walk into an ER in the periphery, you don't know whom you're getting. A lot of them are in perennial training programs and never finish. A lot of care isn't up to the standard of care; it's not horrible, but the gap between best and worst here is wider than in US."

Several physicians complained about the way that residents were treated in Israel. They discussed lack of regulations about on-call hours, claiming that residents would be overtired and this would affect the quality of care. One physician noted, "Residency training is not done well in this country. The chairmen of the department are way too powerful, can do whatever they want with their residents, feel very little interest in their residents' educations, don't place much value on educating their residents, and take advantage of their residents. Lots of hospitals would love to take advantage of their residents in the US, but there's a residency review process and the program would be yanked." Another noted, "In the US, rules are rules and there's enforcement and oversight. In my program, you had to be out of the hospital at the 30th consecutive hour of a shift, or the hospital could lose its license to train residents. There are hospitals in Israel that have residents on call every other night. There's no enforcement of hours regulation. You wouldn't want someone to fly an airplane every other night. Why would you want someone to treat your child every other night?"

Physicians also talked about a lack of clear hierarchy of roles and tasks. One said, "The system here is more horizontal. Attendings [i.e., board-certified physicians] here do what we consider residents' work and nurses' work in the US. The nursing union has made it so that doctors do what nurses do in the US – drugs, IVs, blood draws. Nurses in Israel are responsible for very little. This is a big weakness. This goes up the chain. Fellows' work is equivalent to doing another round of residency instead of fellowship being at a higher level. When a fellow is on call with residents in the US, the fellow oversees the residents, the residents do a lot of the work, and there's resident-level work. Fellows spend time teaching, and residents do the notes and review what they wrote. There's even standardized notes. But in Israel, residents and fellows all do the same work."

2.2.5 Access

Much of the praise for access to care is because of universal coverage. That said, physicians noted that the periphery has a lower level of quality and care. Additionally, many physicians complained about very long wait times for any testing that is not deemed an emergency. Several physicians also complained about the lack of access to certain drugs that are not covered in the health benefits package.

Several physicians noted that access to tests could often be simplified by going to a private physician. One physician noted, "They do rationing in Israel. My kid is waiting 3 months for a test. But if you pay $250 to a private physician, you can get it this week. What do you think people will do if they can afford it?!" It seems that many of the physicians interviewed believe that paying more money for private care is the practical solution to a slower rate of service.

2.3 Conclusions Regarding Patient Care Issues

There was greater consensus among the respondents regarding patient care than the issues discussed in later sections. Overall, the respondents perceived high quality of care in both the US and Israel, for most patients, most of the time. Deficiencies in service, cost issues, access, quality and training appear in different places in Israel and in the US, but there seem to be problems in both systems. The respondents' reports indicate that while American patients are less likely to get affordable or preventive care, Israelis may be less likely to receive timely care or the most cutting-edge treatments. Because of the considerably different regulatory, insurance and financial structures in the two countries, the incentives and limitations given to physicians seem to differ. In the next section, we will learn more about how these financial and professional issues affect physicians.

3. Financial and Professional Issues

3.1 United States

3.1.1 Introduction

The physicians interviewed had a wide range of perspectives on issues regarding financial and professional development and success in the United States. While it was agreed that physicians could earn much more money in the US, opinions regarding other topics were not unanimous. Physicians differed on issues such as the importance of earning a high salary, private practice, treating under-served populations and/or working in academic medicine, the ease of career development and the kinds of bureaucracy that were the biggest hindrance to practicing medicine.

3.1.2 Income

Almost all of the physicians agreed that they made enough money in the US, though none apparently noted that they earned more money than they deserved. One physician did claim that "Doctors don't get paid enough to compensate for the time and responsibility they have to take," but her comment was exceptional. The high payment for physicians was attributed to several causes. Some discussed payment as a means for compensation for taking large risks, in terms of performing surgery or other procedures. Others noted that the high salaries were necessary to pay for debts incurred during medical school and training. Some claimed that their incomes should be commensurate with their levels of expertise, and expressed frustration when the system did not reward advanced training and education. In addition, several talked about payment as an incentive for higher quality care (quality issues are discussed more in the section on patient care issues). In short, physicians discussed payment as a way of promoting high customer service and efforts towards encouraging patient loyalty – justifications that make sense in a capitalist system. Like other risks of capitalism, though, some physicians noted that fee-for-service payment systems may encourage overtreatment and over-testing.

Several physicians were so dissatisfied with their Israeli incomes that they chose to continue working in the US after making aliyah. They noted that in America, they could earn in a week or two what they would earn in a month or two in Israel. One physician who had earned over $250,000 per year in the US and was earning less than $100,000 per year in Israel, complained about Israeli salaries as follows, "Healthcare education in America – it's $300,000. You can't expect someone to spend that much on education and not be paid well when they're done. College is more expensive; you have to live. You're close to half-a-million in debt and you can't expect someone to accrue that much debt and then be paid only $80,000 when they come out." Although these physicians wanted to live in Israel, they saw the financial advantages of an American salary to be somewhere between a seductive option and an imperative to maintain their quality of life.

3.1.3 Public/Private Practice

Since the insurance systems in the US and Israel are so dramatically different, the issues related to public and private practice are hard to compare. American physicians discussed private practice as a system where they could have personal interactions with their patients and set their own terms of service. Those who had private practices in the US often remembered them with a sense of pleasure – as a time when they could really treat patients as people and develop long-term relationships removed from "meddlesome care managers and administration." That said, some discussed the administrative and financial difficulties of being in charge of a private practice. One physician told his story as follows, "Is the traditional model of a doctor a sustainable reality in America? If there's any competition in the market, it's difficult to keep the office in the black even though it used to be a thriving practice. I was offered the chance to take over and buy my practice, and I realized it's not necessarily a viable option and it's a liability."

Some physicians who worked in large hospitals in the US spoke of private practice as an unfair system that provided quality care only to populations with good insurance or disposable income, while physicians in the hospitals and urban clinics treated patients who often did not have the benefit of preventive or comprehensive care. The physician who declined to buy his private practice expanded on his experience, "It's driven very much by money. I had a private practice in a middle class neighborhood in New Jersey; they all had decent access to care; I ran a good office and people were able to get care. But for a large segment of the population, there's very poor access to medical care; I also spent half my time in a pediatric ER and it had patients from a wide variety of economic classes. Lower-class patients had very poor access to their doctors – poor continuity of care. The rich do quite well. The poor have it much worse." However, some of the respondents noted that emergency rooms would always take the best possible care of patients, regardless of their ability to pay. One physician said, "Even if parents didn't take a kid to primary care, if kids go to the ER, they get most of what they need."

A few physicians spoke of public insurance like Medicare and Medicaid as proof that most people get insurance in the US, while others talked about the difficulties and barriers that those systems put up. Some, however, did not distinguish between the barriers to Medicare and Medicaid and those to other insurance companies. An experienced radiologist who worked with HMOs, Medicare, Medicaid and private insurance spoke about the relationships between these different insurers and the potential problems for patients. "The pricing regulation is disorganized and not standard. For example, reimbursements by insurance companies are based on Medicare rates, which are a government standard. They're allowed to control the costs. Hospitals can charge whatever they want, they won't get paid by the insurance companies, and then patients on private [non-Medicare/Medicaid] insurance are charged the difference. They overcharge and then the private patients pay lots of unreimbursed costs out of their pocket."

It is not clear how affected the physicians were by the change in their patient population when they made aliyah. Some of the physicians interviewed went from a private practice in the US to

public hospital work in Israel, or vice versa. Therefore, when reading their opinions, it should be remembered that they may not have had experience with the same type of practice in both countries.

3.1.4 Career Development

Most physicians seemed to be pleased with the predictability of career tracks in the US. A recent medical school graduate noted, "As a trainee, it's formalized. You know on day 1 what you will be doing in month 48. It doesn't matter what hospital you go to, the process is the same. There's an amazing amount of competition, and it'll age you or you won't get your foot in the door, but you know what to expect. There's no one who'll jump out of the closet and tell you new things and tell you it'll make you a real American." His final sentence seemed to contrast with the Israeli system, which will be discussed later in this section.

Several physicians spoke with pride about US academic medical centers in which they had trained. Conceptions that the American system has the best hospitals and best training in the world were common. That said, some physicians thought that the American system was overly punitive and arduous. To quote one of them: "The system is so big and such a leader in healthcare in the world; they lead, don't follow. It has the most money, newest techniques and leaders. So self-analysis, on some level, will never happen. So things that haven't happened for one hundred years will still go on, and methods of training and belief and respect will keep going. It's like the army, but you're not fighting an enemy. It's a very penal type system. It beats you down. It's very difficult to live and remember why you're doing it. No question, you turn out a well-trained physician, but I think there are 12 ways to do it and they're stuck on the worst way." This understanding cites the American quality and size as a double-edged sword: It is so powerful that, until recently, policymakers did not spend enough time questioning it or trying to reform it.

One physician interviewed explained why he was commuting to the US. In addition to the superior income, he felt that he was better able to use and develop his skills there. He noted that emergency medicine was not a valued specialty in Israel and there was not much for him to do when working in an Israeli ER. In contrast, the American ERs provide exceptional amounts of exciting and varied work, so he was commuting to the US to keep his skills fresh and in use.

Even though the respondents came from a variety of backgrounds and career tracks, they did not discuss their career advancement in the US beyond their training. This could be an area for future study.

3.1.5 Bureaucracy

There are several kinds of regulation and bureaucracy in the US medical system that upset physicians. The respondents complained about: managed care and insurance companies, malpractice lawsuits and insurance, licensing, and overall administrative waste. In sum, the physicians did not have much praise for the different bureaucracies governing patient care. One

physician summed it up thus: "One of the biggest problems in the US is the amount of money spent on bureaucracy. There's a tremendous amount of waste going into bureaucracy; manipulating patients so the insurance companies don't have to pay for care; wasting lots of money. It's unethical. Estimates are that 50%[1] of the money Americans spend for medical care doesn't go to medical care."

Some physicians said that it was very difficult to get reimbursement from insurance companies, both because the insurers tried to avoid paying for things and because a large staff was required to bill all the different insurers. Some physicians said they worked with dozens of insurance companies at the same time, each with its own paperwork and procedures. A surgeon who worked with HMOs, Medicare, Medicaid, private insurance and uninsured patients said, "Health insurance companies are smart and keep thinking of ways to mess with doctors. Health insurance companies are pure evil and all they care about is making money and saving money." In many cases, there seemed to be no love lost between the physicians and the insurers.

Physicians discussed the American malpractice situation as a big hindrance to efficient and comfortable working. Several of them reported that they had to make clinical decisions with an eye towards future lawsuits, risking placing defensive medicine above the best interests of the patients. They said that tort reform was necessary because the system was becoming impossible to work in. One physician with 25 years' experience added, "The expense is very, very high now. The legal liability for the doctors is very bad and it makes doctors very defensive when treating, and they sometimes order way too many tests."

While complaints about American licensing were nowhere near as prevalent as complaints about Israeli licensing, there were still gripes about redundancy. Because each state licenses its own physicians, working in several states can become cumbersome. One physician said, "In terms of licensing, it's highly formalized and ritualized, and that's a big difference from Israel. It's a good thing up to a point. When it starts getting ridiculous, it's no longer a good thing. When each state independently verifies information that's been verified by other states several times, it gets kinda' stupid." It is clear that the American bureaucratic system is not ideal for the physicians.

3.2 Israel

3.2.1 Introduction

The American immigrant physicians, overall, were not pleased with Israeli income levels and professional customs and structures. The assessments of the situation seemed to vary from "not too bad" to "horrible." The opinions of the respondents about how low the salaries were differed, their

[1] Note that most estimates of healthcare overhead costs are much lower than 50%.

condemnations of the public versus private options had different value judgments behind them, and complaints about career development and bureaucracy ranged from the slightly frustrated to the completely indignant.

3.2.2 Income

Satisfaction of the respondents with the incomes available to them in Israel varied widely, falling into two broad camps: 1) The incomes are unreasonably low and talented physicians will work elsewhere; and 2) The salaries are not really much lower than American salaries and they attract physicians who are committed to treating patients rather than attracted to wealth.

Those who said that Israeli salaries were not actually very low seemed to be pleased with their decision to make aliyah. One respondent, who had done some residency training in the US and was finishing it in Israel, said, "People complain here that you make less money. You don't really make that much less money. It's like NIS 1,000-2,000 a month less. It's not that big a difference. And if you want to/have to work privately to supplement your income, knock yourself out." Another – who had gone from earning around $150,000 per year in the US to less than $50,000 per year in Israel – agreed in part, "The salaries are manageable but low. This is a strength. So that the people who go into medicine here know they'll be working hard and enjoy it. I haven't come across anyone who's bitter and burned out."

On the other hand, some physicians were rather upset about the salaries but believed that to be part of the price that one pays for the privilege of living in Israel. One surgeon, who was earning in Israel less than half of what he earned in the US, said, "It makes no sense to come here for this kind of difficult work for almost no money. This is the worst thing I've done professionally up until now. If I looked at this from a purely professional view, I never would have done this." Afterwards, this same respondent added over e-mail, "I remember when I first got here, I met a physician who had made aliyah a number of years ago, who was very encouraging. He told me 'it's a small country; one person can make a big difference.' I think that this is probably one of the things I think of most, because it is really true. In this country, more so than in the US, one person can make a difference and you are contributing to the Jewish state, which is quite wonderful." While several respondents exhibited pride in building the Jewish state, that did not stop some of those same respondents from comparing their salaries to those of bus drivers or school teachers, with apparent disgust.

In contrast, there were also physicians who thought that the salaries were so low that it simply did not make sense to work in Israel much at all. These physicians were commuting to the US so that they could earn a salary they thought reasonable and worth the cost of travel. Some said it took a big toll on their families but that they thought it was the best option they had. Some only commuted during the licensing process – though several respondents expressed such frustration with the licensing process that they were even considering not working as physicians in Israel at all.

Several physicians talked about ways of getting around the low salaries. They spoke of add-ons, private clinics, and consultations. One physician described it as, "When you start working in Israel, salaries are low and standard and then, when you become more senior, you come up with all these add-ons that you work out with the hospital system and it depends on who you know and what you know. There's a lot of greasing the wheels. That's how people do well here. There's a lot of incentives that come out of thin air; not quite under the table, but not transparent either. The pay isn't transparent and you don't know what a doctor of a certain level should be getting paid. There's what the official payment should be and then there's what they're getting after all these add-ons." Another said, "Doctors are so poorly paid that it makes bad medicine. People do things to make more money because they need to. But it's not unethical. Some physicians wanted me to give a second opinion in Haifa. I've never heard of going to another hospital. I said the patients could come here. But that's how it works. You're invited to another hospital, charge $1,000 and give another opinion. It's what people do."

NBN and the Ministry of Immigrant Absorption offer programs to provide income assistance to physicians while they get settled. Those who received the money without complications were very appreciative, but those who had experienced bureaucratic difficulties were more dissatisfied, understandably, with the system. Several physicians mentioned the financial burden of having a gap in employment, while others made it clear that they had prepared for that situation and had saved enough money to be able to afford to be unemployed for many months during the transition. These issues are discussed in greater detail in the section on the aliyah process.

3.2.3 Public/Private Practice

The physicians interviewed seemed to have many diverging judgments about the public and private systems, though the underlying facts were not disputed as much: the public system provides a good baseline of care, but patients often purchase private care anyway. Two themes emerged about motivations for the private system: 1) It is a way for physicians to get around the low salaries of public work; 2) It is a way for patients to get around the delays, rationing and inefficiencies of treatment in the public system.

Many respondents talked about the gross inefficiencies of the Israeli public system, expressing variations of shock, horror, frustration and anger. Many talked about the ways in which the American system would never be so inefficient. Considering that the American system, in many ways, is not known as a paragon of efficiency, this is a significant reaction; it may be related to a perception that while the US health system carries out too many tests and procedures, each test and procedure is done in a timely fashion and without unnecessary manpower. One ER physician said, "The director of an organization here said that in the US, emergency medicine was developed because it's efficient. But here, if you have one doctor doing the work of five, then you have four unemployed doctors and that's not acceptable." Another physician noted, "In a free market, someone would come up with a better model and they would compete in the system.

But here, you can't compete because the Ministry of Health doesn't allow people to compete, because they're closely associated with the people who run the HMOs."

As discussed in the section on patient care issues, many physicians said that the public system did not incentivize providing a high level of care, and so the quality faltered. In addition, some physicians thought that Israel's universal health coverage was extraordinary and vitally important, but others complained about the inefficiencies that "socialized medicine" put in the way of the physician and the patient. One physician said, "By virtue of Israel having a socialized system, it just takes longer to get things done – unless it's an emergency in which case you can get things done quickly. Otherwise, patients really have to wait for results of testing." Conversely, the private system functions by rewarding quality care with patient loyalty and popularity, and therefore, the respondents noted, there was a vested interest in providing poor care in the public system and good care in the private system. Some physicians saw this as proof that the public system – and socialized medicine – was unsustainable, while others sought to improve the public system.

Some physicians talked about what happened after all the private clinicians went to their own offices in the afternoons. A physician who did not have a private clinic told me, "Every doctor thinks about money. Hospital physicians all leave at 3 p.m. except the people on call, and those people are the residents or the Russian doctors who aren't certified, and then everyone goes to their private office to make money. Every doctor needs two to three jobs to make money. People look at me like I'm crazy because I don't cancel patients because it might run until after 3 p.m."

3.2.4 Career Development

The physicians interviewed had many stories to tell about their efforts to get jobs in Israel. Issues relating to the aliyah process are covered in the section on the aliyah process. This section discusses general reactions to professional growth in Israel. Some respondents were very pleased with their situations, while others seemed to be unhappy, or even miserable.

Respondents seemed to have very different experiences with the working environment: Some spoke glowingly about the patience of Israeli professionals and the welcome extended to new immigrants, while others felt totally shut out and rejected. One physician said, "It's terrible to work here and it's very unpleasant. People like to see you fail and they make it hard for you. Part is just Israeli culture, and it's all a screaming, yelling fight and I hate it and it's a waste of energy and time. I hate it very much. It's unpleasant and counterproductive. Israelis communicate very poorly." While another had the opposite experience, "Everyone's really accommodating to immigrants. No one acts as if I'm taking anyone's job or anything. There's no animosity towards foreign-born physicians who don't speak the language, but I could imagine that being hard in the US." These diverse attitudes could reflect the different experiences of particular respondents in their new work environments.

Some of the respondents' frustrations with the system had to do with their expectations of how soon they would start working after making aliyah. A neurologist who has been practicing in Israel for six years said, "I had the improper assumption that when I came, I would start working the next day." While another couple, both of them physicians, noted, "We came here a little older, weren't planning to retire but weren't rushing to work in the first year," so their delay in getting their jobs started was not upsetting.

Many of the physicians interviewed were recent immigrants and did not have many years of work experience in Israel, but those who did, provided some stories. One physician who had exhibited a general frustration with the system, talked about the confusion he had experienced working with Israeli methods of negotiation – a cultural difference that several physicians mentioned. "Intra-hospital politics are very odd for me. At [a hospital] there's a rehab hospital and an acute hospital. Since I have several specialties, I picked one and did *histaclut* [a period of supervised work that immigrant physicians must go through before they receive specialty recognition] at the rehab hospital. They were stringing me along and then offered a halftime position, which is ridiculous, because it's like NIS 4,000–5,000 a month, which is what I'd make in a day in the US. So I found a different position, and the rehab people didn't like it, so they threatened me and said I had to stay there, instead of offering me a better position. I said no. To keep me there, they threaten me?! In America, they offer you something more. That's odd. I don't know if that's a function of that individual. I can't blame a whole country. But it's par for the course."

Regarding commuting to the US, the interviews did not find any physicians who were pleased with the process, though some thought it was worth it. One physician noted benefits in addition to the increased income, "I think the negatives outweigh the positives, but it's a necessity… Everything you're trained to do, you can do, and you can take more responsibility. Those are the positives. The negatives are being away from my kids so much, and travelling is not fun. You get sick of it pretty quickly. If I could be wealthy and didn't need the money, I'd probably work in the US a couple times a year to use my skills and keep them up, which I couldn't do here, but not nearly as much as I do." For him, commuting to the US was not just a route to a higher income, but a means to maintain his clinical skills, which was an opportunity he found lacking in Israel.

3.2.5 Bureaucracy

With few exceptions, the physicians interviewed were very frustrated with the inefficiencies in the Israeli healthcare bureaucracy. As noted in the section on patient care issues, many were happy with universal coverage, electronic medical records and quality of care for most patients, but when it came to the bureaucratic hoops that physicians have to jump through, there was much dissatisfaction. One physician noted, "The system here is maddening. It's so frustrating. I'd already been here for several years and it still knocked me off my feet, even with experience and Hebrew. Everyone makes a decision to come here with idealism that allows you to get over some other difficulties. But still, it's amazing, the inefficiencies, and I don't know if they just accept it or they think it's better, but it's maddening." Many physicians also expressed frustration with the

bureaucracy of licensing and specialty recognition; these will be addressed in the section on the aliyah process.

Some physicians were frustrated with hospital administration. One physician tried to explain the root of the situation, "The way people become administrators is by rising through the ranks of the army. A significant number of directors in administrative positions in the MOH and hospitals were recruited out of the army when they reached a certain rank, and then they went into civilian life in a senior position in a hospital or MOH. There's no training to make them good people; some of them are good people just because they're good people. There's nothing in the army that teaches them what to do. There's nothing in the army that gives them good training. The training and background is not suited to what they'll be doing and everyone comes from that background. People go back and forth from these jobs. People go back and forth from the MOH and hospital administration, and then the hospital administration has too much power over regulation."

Other physicians spoke about the frustrations involved in treating patients in Israel. One said, "In America, if people want a test done, they're set in a day or two. Here it takes longer because it's all regulated." Another explained, "The amount of bureaucratic paperwork for the patients and doctors slows everything down. You need a stamp and a form for everything. And because it's a system where everyone (unless you're at a private doctor) takes a number and waits in line, you see a patient you may not have seen before; there's no real follow-up."

3.3 Conclusions Regarding Financial and Professional Issues

Overall, when it comes to professional advancement and their incomes, the physicians had mixed feelings about the American system, and they had rather negative ones about the Israeli system. It seems that the qualms that physicians had with American healthcare were similar to the complaints noted in the section on patient care issues: Bureaucracy makes efficient and quality care difficult; payment and malpractice concerns incentivize overtreatment; and the health insurance system allows for unjust disparities in care. Very few of these issues appear in complaints about Israel. Instead, the complaints about the Israeli system were that it paid far too little money, that career development was convoluted, and that the tug of war between the private and public systems was damaging to both. Of course, some respondents indicated satisfaction with either or both systems – mostly regarding high quality of care, qualified physicians and acceptable incomes.

4. Cultural, Social and Lifestyle Issues

4.1 United States

4.1.1 Introduction

When these physicians were discussing cultural, social and lifestyle issues relating to the American healthcare system, they often had less to say than when discussing the Israeli system. It may be that the American system functions as an unconscious baseline for several topics, such that they did not need to expound on its merits and demerits. However, it does seem that there's a narrative emerging of physicians being hardworking, well-meaning individuals whose considerable skills and efforts are being hampered by noncompliant or distrustful patients and insurers and regulations that limit what the physicians are allowed to do. While no one explicitly discussed his/her career as resembling martyrdom or victimhood, this narrative nonetheless implies that valiant efforts are being blocked by various impositions and difficulties. Several of these issues are discussed in the section on patient care issues, but the aspects of the conversation that are not directly related to patient care are summarized below.

4.1.2 Work/Life Balance

While physicians were pleased with their income levels in the US, this did not seem to correlate with happiness in their work/life balances. Only a few physicians talked about it explicitly, but some spoke of the exhausting nature of training and residency, though others disagreed and praised the predictable nature of rotations and shifts. One physician also spoke about an American mentality that patients should be able to call their physicians at all hours. She said, "Patients are very demanding, requiring doctors to be available 24/7. People would demand to speak to senior doctors in the middle of the night. Maybe it's because they were paying more and expecting more." This seems to be linked to a general idea that the American healthcare system is more customer/service-oriented and, therefore, patients should be able to have access to their providers whenever they want.

4.1.3 Patient Involvement

Physicians complained about a lack of collaboration between the clinician and the patient in the US, longing for a relationship that involved more communication. Those who discussed it mentioned issues of mistrust, noncompliance or, conversely, too much reverence for physicians. As one pediatrician, who worked in a suburban private clinic and teaching hospital, put it, "There's a tremendous amount of mistrust of doctors – mistrust of authority and of the medical institution in particular. The physician is not necessarily trusted by patients and is often put on the defensive. There's a lot of unreimbursed time that docs have to spend explaining ABCs that they wouldn't have had to spend 20 years ago… Independent patients have gone from joint decisions with doctors to a tug of war. I like to partner with my patients' parents, and I have gotten a lot of mistrust from them." Another physician discussed the opposite end of the non-communicative spectrum. "In the States, it's reverent. If I had graduated in the States two days ago, patients

would do anything I said. Patients would benefit from being less polite and more communicative." Another physician noted that often there was no strong family continuity in the US and patients rarely went to their parents or grandparents for medical advice, so they called their physicians.

4.1.4 Politeness and Bedside Manner

Aside from quality of care issues, the respondents did not spend much time talking about American bedside manners. One physician, though, had very strong feelings about how patients were being treated: "From a patient standpoint, that was probably one of the reasons I came here [to Israel]. I looked at the physicians I was learning from – great men and women whom everyone was supposed to look up to – but the way they treated their patients was complete rubbish. There was no connection. They didn't yell or swear. But there were times I was embarrassed to say I represented someone. There's no communication. And it was a decent/good hospital, but I'm not sure I would have recommended someone to go there. It's probably like that everywhere." He credited this lack of demonstrated respect with encouraging him to leave the American healthcare system. But no other respondents mentioned this issue.

4.1.5 Physician Power and Commitment

The respondents generally painted American physicians as being very committed to their patients. Those who spoke negatively of the physician commitment to patients were referring to managed care, malpractice concerns and regulations tying physicians' hands. Several noted that rules and regulations limited the power of physicians to do everything needed according to their clinical judgment. One veteran physician said, "Full service physicians seem to be disappearing with the growth of extensive HMOs." These issues are discussed in greater depth in the sections on patient care issues and on financial and professional issues.

4.1.6 Language

American physicians, being native English speakers, did not have much to say about language barriers in the US healthcare system. The one comment recorded was in comparison with Israel. In praising the patience of Israelis with her developing Hebrew, one of the physicians noted that if a physician came to the US speaking only Hindi, she would not expect colleagues and patients to be as kind.

4.2 Israel

4.2.1 Introduction

As with the other issues regarding the Israeli healthcare system, the respondents often diverged considerably in their levels of satisfaction with cultural, social and lifestyle issues. Some found life to be easier and less stressful in Israel, while for others, the Israeli system was frustrating. Some physicians were pleased to get fewer calls in the middle of the night, while others were frustrated by a lack of patient participation in their own care. Some had experienced very welcoming and pleasant patient-care situations, while others were continually aggravated by Israel's culture of

argumentativeness. It would be interesting to know how many of these variations in viewpoint had to do with individual temperament and baseline stress and comfort levels, rather than to objective differences, but this study cannot accurately assess this. The following is an account of the range of views expressed on cultural, social and lifestyle issues.

4.2.2 Work/Life Balance

The physicians who had made aliyah had some positive things to say about the work/life balance when working in Israel. When talking about patient care issues, they were not impressed with the Israeli norm of physicians leaving public clinics at 3 p.m., but when it came to a work/life balance issue, they saw it as an advantage. Some physicians also noted that better access to care meant that patients did not have to rely on their physician specifically at inopportune hours. One physician said, "I don't have to carry a pager and I like that. You can if you want to, but most doctors in outpatient medicine don't get calls at night. It's not the culture. Most US pages weren't emergencies; they were just unnecessary reassurance. But it was standard. But in Israel, people manage. In the city I live in, should I feel a responsibility to make myself available? Ninety percent of patients live within 5 minutes of a 24-hour urgent care center." He also said, "I had to take a modest pay cut in salary, but I work a bit less too. And it's a quite easier lifestyle and no less fulfilling." Those physicians who were most upset about the salaries may have been more upset about the lifestyle as well, especially if they were still commuting to the US. But those who moved to Israel content with the idea of a pay cut and happy with the Zionist goal of living in Israel seemed rather satisfied with their lives.

4.2.3 Patient Involvement

Several of the physicians interviewed had something to say about the ways in which Israelis involved themselves in their own medical care, and their perspectives on this varied. Some noted that Israeli patients were sometimes very educated about their own medical situations, because they were empowered by accessible medical records, and that they were very demanding. One physician said, "Here people are more argumentative and straightforward and frank. From a communications standpoint, they could use more 'yes sir,' 'please,' and 'thank you.'" Another reported that he was shocked when a patient rejected his well-considered weighing of possibilities and instead requested a black-and-white diagnosis; the physician expected more appreciation for the nuance and variability of clinical care.

Some physicians noted that Israelis did not go to their physicians for minor health concerns, relying instead on other people in their community. One attributed this to the way that Israeli physicians spoke to patients: "There's a big problem with the way doctors talk to patients here. The relationship is really foreign. Patients go to rabbis to have someone to talk to, since there's a vacuum where the doctor-patient relationship should be. In the US, if I don't talk to my patient, the patient goes to another doctor. Here they go to the rabbi and the rabbi tells them whom to see. This is a culture thing, not a medicine thing." Another physician discussed his experiences with

patients going to their own parents instead of calling him in the middle of the night. He said, "Sociologically, in the US, there's not as much continuity of families over generations, whereas in Israel there's more continuity, so it's very easy to call Grandma or ask her advice when the kid gets sick. People in the US didn't have as much family support and were much more at a loss, and so they felt the need to call the doctor. In the US, it's much more like fast food. In Israel, people know they can survive and know they'll be all right. They've been in the army. Americans have a lot harder time handling that. They're not as confident or independent." This Israeli independent streak was brought up from many angles in these interviews.

4.2.4 Politeness and Bedside Manner

The respondents had some very strong feelings about the ways Israelis – patients and clinicians – interacted. Like many of the opinions in this survey, they were often contradictory. Some physicians said that their colleagues were very nice or that their family had experienced very friendly and competent treatment as patients, whereas others spoke about the cultural norms of arguing, and seemed frustrated by them. One physician gave his opinion of the communication problem, "The difference is in a lack of patience and lack of bedside manner. This is an outgrowth of societal norms. This translates into harried and half-baked treatment." Several physicians complained about what they perceived as lax treatment (see Patient Care Issues).

4.2.5 Physician Power and Commitment

Respondents were very divided on the question of whether or not physicians were empowered and/or committed in the Israeli healthcare system. As discussed in the section on financial and professional issues, many of the respondents were frustrated with the apparent lack of incentive to work hard for patients in the public system. In addition, some thought that the physician shortage gave physicians more power to dictate their situations. One said, "Israel needs doctors. If you're in Israel and you're good, they can't afford to abuse you or you'll go somewhere else." Additionally, as mentioned in the previous section, some physicians saw a benefit in the low salaries, saying that they think the lower incomes attract physicians who are more committed to serving the public than they are to the money.

In contrast to the perceived strengths of the Israeli healthcare system, some physicians had complaints about the ways in which physicians are disempowered. Because of the heavy regulation and the powerful health plans in Israel, some physicians felt that they did not have the freedom to treat their patients in the way they saw best, much like their complaints about the American system. One physician said, "In the Israeli system, the health plan makes more of the healthcare decisions and can overrule what the physician wants to do, so that takes power away from the physicians." Another complained about the work that senior physicians are expected to do, in part because of the strong union regulations, "The system here is more horizontal. Board-certified physicians here do what we consider residents' work and nurses' work in the US. The nursing union has made it so that doctors do what nurses do in the US – drugs, IVs, blood draws. Nurses are responsible for very little." Similar resentment was expressed by several physicians, often

with the feeling that their time and skills were not valued, and that they were being asked to do more secondary tasks that are considered unworthy of physicians' efforts in the United States.

4.2.6 Language

Language barriers and access were significant issues in some physicians' discussions of their quality of life in Israel. Not surprisingly, some physicians came to Israel with very strong Hebrew skills; others with low proficiency. Several physicians were pleased that their patients were not upset at them when they tripped up, though others felt guilty about not speaking perfectly. Physicians occasionally categorized clinics as catering to English-speakers, Hebrew-speakers, Russian-speakers, etc., indicating that the language spoken in the clinic is both an important identifier and variable. Issues regarding learning how to function in a Hebrew system and dealing with Hebrew forms will be discussed more in the section on the aliyah process.

4.3 Conclusions about Cultural, Lifestyle and Social Issues

When speaking about cultural, social and lifestyle issues, physicians generally compared the two countries, rather than evaluating each on its own merits. Respondents had disparate opinions about whether life as a physician was easier in Israel. While some appreciated having less demanded of them, others felt additional stress from Israel's different work ethic and ways of communicating. Some did not feel more relaxed, because they had to perform tasks that in the US are reserved for nurses and other staff. Experiences with Israeli communication – often viewed as more confrontational and aggressive – wore on some physicians' patience much more than others, while some seemed to spend their time with friendly physicians and patients. Overall, these cultural differences were much harder on some of the respondents than on others.

5. The Aliyah Process

5.1 Introduction

The respondents had two kinds of stories about their experiences of making aliyah. There were those who expected the processes (making aliyah, being licensed, getting specialty recognition and getting a job) to be terrible and were pleasantly surprised, and those who expected them to be terrible and found that they were right. Several of them charted the whole process in detail. They may have remembered so much because they documented their struggles in order to argue with the authorities. (One physician even sent the author a copy of a letter that he had sent several members of the Knesset, with the aim of influencing how the process runs.) Respondents seemed to hope that their participation in the study could have an influence on changing the system, as well. In our analysis of the interviews, we have attempted to elicit common themes and not specific narratives, both to give a big picture of the situation and to protect the anonymity of the respondents.

5.2 The Contribution of Nefesh B'Nefesh

Many physicians said they were extremely grateful to NBN for its help. Some had taken advantage of the NBN information on the steps to making aliyah; several respondents who had an easier aliyah said that as long as immigrants followed NBN's instructions exactly, they should not have a tough time. Some talked about the financial assistance that NBN provided to them. Several extolled the assistance of several NBN staff members by name – specifically, Lizi Martin and Daniella Slasky. One physician who made aliyah in 2009 praised all of these elements at once, "I wouldn't have done it without them. The physician fellowship was crucial. I'm a young physician and didn't have much to go on. I got all my good information through them and the financial help was necessary. Medical training in the US is a tremendous cost and the decision to make aliyah has to take into account the prior costs of the medical training. They gave me all the contacts. And Daniella Slasky gets kudos for all of this." One physician tempered his excitement with some disappointment with the limitations of NBN's ability to work the system, "The people who were trying to be helpful were helpful, but they're fighting the same bureaucracy as everyone else is."

A few physicians – mostly those who were already utterly frustrated with the bureaucracy – had suggestions of how to improve the NBN process with the MOH. One man said, "Right now I'm doing it through a lawyer. If it were just me, I'd be pulling out my hair. I think the only reason I've heard anything from the MOH is because of the threat that I'd sue them. NBN is great, but it'd be great if there were staff within the MOH who were as customer-focused as NBN; who would answer their phones and be experts in the process. Apart from a whole overhaul of the system, that's the only way I can see it getting better." Several respondents made similar suggestions about getting a specialized employee who would work within the MOH and NBN, to unite the procedures. It is a compliment to NBN that physicians suggested that the customer service be remodeled to mirror NBN's structure.

5.3 Licensing with the Ministry of Health

Acquiring a license from the MOH to practice as a physician was certainly the most exasperating part of the entire aliyah process for the vast majority of the physicians who participated in the study. Before delving into the details of their troubles, we present some of the strategies implemented by those who did not have a hard time. The first hurdle is that physicians have to make aliyah before they can file their licensing paperwork. One respondent skirted this difficulty with ease: He was planning to immigrate with his family in August, several years ago, but decided to make his "official" aliyah the previous March, to get a jumpstart on the licensing process. He came to Israel as a new immigrant, started his paperwork and then went back to the US to rejoin his family. By the time they arrived together in August, the MOH had finished the paperwork and he (and his wife) had their licenses. He said it could not have been easier.

Some respondents suspected that the process might be easier for those whose specialties were in greatest demand. Several also said that they got advice from other immigrants. One man's attitude seemed to allow him to experience the process as fairly easy, "If you recognize, respect and follow through with the bureaucratic demands, it works."

Although several respondents had had easy licensing experiences, those with bad experiences certainly had a lot to complain about. Many physicians, including those who were not traumatized by the MOH, wished that the licensing process could be started before making aliyah and expressed significant frustration regarding the policy. The next complaint was regarding the submission of the paperwork. The physicians noted that they had to get all of their original documents translated into Hebrew and notarized by an Israeli notary, and that this process could cost thousands of shekels. Respondents were frustrated by the expense as well as the added bother of having to do this in Israel. After that annoyance, they had to mail their original documents to the MOH. Several respondents reported that they had wanted to hand-deliver the documents to make sure they arrived and were received by the correct staff members. One man noted, "We're told to mail in our applications for license to the MOH. I was going past the MOH office and wanted to drop off the application. They wouldn't let me in. I called up and they peppered me with questions. They said they didn't have time to meet with me and said to put it in the mail even though I was in the building. The guard took it and put it in the inter-office mail. I just wanted to hand it to someone." Physicians were rather nervous about using the postal service, given the value of these documents.

Once the respondents had managed to send their paperwork to the MOH, another level of anxiety took root. These physicians – used to American customer service and accountability – expected to be able to follow up on the status of their application. Apparently, this is not a service that the MOH offers. Many respondents reported that the office simply did not answer its phones and rarely responded to e-mail. They were rebuffed when asking how long the processing would take, and everyone seemed to have a different account of their waiting time. Once they did hear from the office, they were often told that their applications were incomplete: Several respondents were certain that they had handed in the missing documents in question and were very frustrated by having to obtain new translations at an additional cost. (One physician wryly observed, "That you have to pay to have all documents translated by a translator recognized by the Health Ministry is a little annoying, because obviously everyone in the Health Ministry speaks English.")

One of the respondents described the process as follows, "I made copies of all my documents and waited and waited for a response. They never answered their phone. But they said I was missing a document, and I checked my copies and I know they received it. I asked them to double-check, and they said that was too much work and asked me to send it again. I had to pay for more translation and notarizing. I made an appointment to bring the document to him. I hitchhiked to Jerusalem, got there, and they said they did not take appointments and I had to

argue for half an hour to get to go upstairs to drop off my form. And then, when I got upstairs, the woman opened my file and the top paper was the form I had been told to get re-notarized."

During this time of uncertain waiting and irritation, physicians cannot work as doctors in Israel. Individuals experienced different levels of anxiety over this indeterminate delay. As explained in the section on financial and professional issues, some physicians had arrived in Israel ready and eager to work immediately, some expected to get to work quickly, and some could not afford to be temporarily unemployed. On the other hand, some had made aliyah towards the middle or end of their careers and were not frustrated with an extended break from medicine, since they had saved money for this. In the end, waiting times for licensing seemed to vary from a few weeks to over a year. As with all other elements of the Israeli healthcare system, respondents varied in the extent to which they viewed this as a hardship or annoyance, but very few encountered no difficulties at all.

5.4 Specialty Recognition with the Israel Medical Association

Across the board, physicians were less frustrated with getting their specialty recognition from the Israel Medical Association (IMA) than they were with licensing. First of all, this process can be started before making aliyah, which was a better fit with their ideas of appropriate customer service and efficiency. One physician contrasted it thus, "In terms of specialty recognition, that was easier. They respond to e-mails. They keep paperwork. They know who you are when you call." His relief when speaking about it was palpable.

Physicians also had comments on the actual job of the IMA. Unlike the MOH, it seems that the IMA is responsible for actually evaluating the experience and skill level of the physicians. They prescribe how long physicians have to work in *histaclut* – the period of observation before receiving recognition in their specialty. Opinions about the period of observation were mixed. Some appreciated a chance to study the Israeli system. One physician accepted it as an annoyance and said, "It was a little strange to do *histaclut* in your 50s, when you've been practicing for so many years, but everyone has their rules." Other physicians seemed to think that it was an affront to their accomplishments and experience to require that they be observed by Israelis. As one said, "Being in *histaclut* is definitely an issue. It's a little bit demeaning. I don't feel like it added anything. It's humiliating, demeaning and ridiculous. If I practiced medicine for ten years in the United States, why do I need to be a resident for six months?" The reactions to the specialty recognition process seemed to be wrapped up in issues of pride and independence.

5.5 Getting a Job

Once physicians are licensed and recognized, they are eligible for employment. Our findings did not reveal a strong infrastructure for helping new immigrants find work. Some respondents told stories of sending job inquiry letters out to hospitals to find positions for employment under observation. It seems that such positions sometimes turn into full-time positions, but not always.

One physician reported "When I finished my 6 months of *histaclut*, I was told that [a health plan] put a freeze on hiring any new board-certified physicians and it had nothing to do with whether they liked me. They received instructions that they couldn't take me. That was very stressful. Everyone knows there is a physician shortage. I was in the periphery. And at the same time, they take doctors from Romania, who may not be as well trained as physicians trained in Western countries. And here you have a board-certified subspecialist in [a periphery area] and people like me." His story continued with many bouts of unemployment due to different health-plan and hospital cutbacks and restrictions.

Physicians also experienced confusion and frustration about the kinds of administrative demands that take a long time to fulfill and those that are ignored. One older physician reported that he needed to prove that he had been vaccinated before working in a hospital, but some of the vaccinations, like PPD, had not been introduced when he was a child. He had to get a vaccination, but no one told him where he could do so. He said, "I had to go to my HMO and personal doctor. My personal doctor doesn't do this in the office. He doesn't do anything in the office but type in a computer and swipe your card. So I had to make an appointment for the PPD elsewhere. They don't answer the phone. I had to make a trip just to get the appointment and then I had to get to the appointment a week later. Now, after you get the skin test you have to go back 48 hours later, wait in line, and take a number to get it read. If you don't already have TB, you'll get it from the people in the waiting room." He added that he wished he had known about these requirements in advance so that he could have been vaccinated in the US.

Other respondents expressed frustration about the difficulty of getting paid during the period of supervised work. One woman who was otherwise very upbeat about the process said, "I will complain to anyone who'll listen with regards to *histaclut*. I heard *histaclut* wasn't a paid position. When I started speaking to the hospital, I learned that you can receive payment from the MOH, but I was told there was a complication with the immigrant benefits package and I couldn't receive both. You receive this money for the 8 months after you move here, starting the day you make aliyah. It's set aside to help you get on your feet. The funding you get for your *histaclut* is through the MOH, but it's actually from the Ministry of Immigrant Absorption. But the Ministry of Immigrant Absorption won't double dip and give you the immigrant benefits package and *histaclut* money. My husband travels for work a lot, and as soon as his passport was scanned two weeks after we moved, it stopped the Ministry of Immigrant Absorption payment. It took me 2 months to notice. It delayed the Ministry of Immigrant Absorption and *histaclut* payments. I had to go through an appeals process and needed a letter from the hospital. That took 2 months, 4 months from the beginning. And I had a baby in the middle. I did half of the *histaclut* without payment and am now going back and should be getting paid. And if they have this rule about not paying twice, then why did they approve the appeal?" Everyone's story was a little different, but many respondents shared these kinds of frustrations.

5.6 Cultural Adaptation

In terms of being acquainted with the Israeli healthcare system once working in it, respondents wished there were more mechanisms for acculturation. One woman said, "It would be helpful to have a briefing on the system and the things that are required. You don't have a secretary to get the MRI, and so you have to know which forms to give your patients and tell the patients where to make their appointments. It's not user-friendly for patients. There are many forms to fill out for medicines that aren't in the health benefits package. There's a lot of bureaucracy. And you need to know what's expected and not expected." Several physicians complained that their Hebrew was not fluent enough and wished that there were an ulpan (intensive Hebrew course) for physicians. A married couple (both physicians) said that they had found a medical ulpan and appreciated it greatly, but no one else seemed to know of its existence. Some respondents noted that such an ulpan would need to tailor to different medical specialties for optimal utility. Several mentioned getting Israeli colleagues and/or friends and family to help them complete their paperwork at each step of the process. Overall, it didn't seem that there was a unified way of getting the proper training, aside from what physicians get while under observation.

5.7 Conclusions Regarding the Aliyah Process

In general, there is some confusion as to why the aliyah process is so challenging for immigrant physicians. Many respondents talked about getting conflicting messages from different offices, or even from the same offices, and some suspected that there was little communication between and within the various bureaucracies. Words like "inconsistency" and "inefficiency" kept appearing in the interviews. Some physicians were convinced that the only way to get through the process was to follow the rules to the letter, while some believed that the only way to survive was to get help from NBN and other immigrants. Others noted that there was no way to get through the process easily because the rules keep changing.

6. Final Thoughts

6.1 Limitations

This study can only represent the perceptions and points of view of the 22 respondents, based on their own experiences. It is possible that there was a responder bias – i.e., that people with very strong feelings were preferentially motivated to volunteer for the study. They may not have had background knowledge on the reasoning behind the bureaucratic structures, and few of them were experts in healthcare systems. Their own experiences of healthcare systems were mostly limited to frontline work in their particular specialties. Their experiences in the two countries may also have differed, in part due to different levels of seniority or because they worked part-time in one country and full-time in the other. Still, we believe that their perspectives are important to hear. The impending physician shortage in Israel and the importance of recruiting new physicians make it essential to consider the experiences of immigrant physicians.

All the respondents in this study made aliyah through NBN and the study cannot account for the experiences of those who made aliyah in another manner, including those who made aliyah

before NBN was established in 2002. It may be that experiences from prior decades or through other mechanisms differed from this and those could be areas for future study.

6.2 Future Research

There is much potential for further research on the subject matter and population that were the focus of this study. The physicians seemed very interested in talking and it appears likely that they would be amenable to further research efforts. In addition, recruiting 23 subjects only took one recruitment advertisement, so it is likely that efforts that are more aggressive could yield a larger sample. NBN estimates that 180 physicians have made aliyah from the US, Canada and England since 2002 and a large proportion of these are American.

The present study could be taken further in several directions. Any number of variables could be isolated for analysis – time spent practicing in the US or Israel, medical specialty, age, primary patient population, etc. Subjects have consented to a follow-up quantitative survey. If such a survey were sent out, the qualitative answers discussed in this report could be re-analyzed in light of any of the variables of interest. This study also could be the launching point for many kinds of larger studies – from a longitudinal study following physicians' acclimations in Israel to a study charting how the medical and aliyah systems have changed over time.

6.3 Conclusion

Physicians seem quite divided in their opinions on the Israeli system, the American system and the process of making aliyah. While there are a few basic facts that seem to be agreed upon, for the most part the details of their experience, and the value judgments attached to them, seem widely variable. The trajectories of the Israeli and American systems also seem to be in dispute, with a roughly equal number of physicians thinking that the American system is failing and the Israeli system is improving, and vice versa. There were agreements on many basic facts including: the American system does not provide universal health coverage and the Israeli system does, and American physicians earn much more money than Israeli physicians do. Perhaps more surprisingly, there were also agreements on more subjective matters such as: the process of making aliyah has the potential to be harrowing, and both the Israeli and American systems provide rather high quality care most of the time for most of the people. Most other items are up for debate.

As the Patient Protection and Affordable Care Act ushers in changes in the American healthcare system, and as the Israeli populations and regulations shift, there will be continued opportunities to study these two countries in a comparative context. As with other partnerships between Israel and the United States, a continued dialogue will help researchers and policy-makers in each country improve strategies and services for its citizens and work toward improving their qualities of life. Each country has successes to share and weaknesses against which it could advise. While this report is only an introductory look at these issues, the hope is that it will make a contribution, in its own right, as well as encourage future research that could be used to improve both systems.

Appendix: Demographic Information

After conducting the qualitative interviews with the physicians, the study team designed and distributed a survey with 40 multiple-choice and short-answer questions to all respondents. The survey elicited general demographic information, as well as a short snapshot of the physicians' careers in the year before making aliyah, as well as their current employment in Israel. The key findings are highlighted below.

Comparison with NBN Data

The study sample was drawn from the NBN database of all physicians who made aliyah from the US in the years 2003-2011. In order to determine the extent to which the sample is representative of the population of physician immigrants from the US during that period, we compared the age, sex and specialty distributions of the sample with that of the population from which it was drawn.

The average age proved to be the same in the two groups (47) and gender mix was apparently very similar (approximately three-quarters male). The data on medical specialties are not exactly comparable because the NBN data do not have specialties listed for 52% of its immigrants. Nonetheless, it is noteworthy that in both the NBN dataset and in this study, pediatricians and internists were the largest groups, with cardiology and surgery not far behind.

Basic Demographics

In this study, the average age of the physicians was 47. Thirty-two percent were under age 40, 41% were between ages 40 and 50, and 27% were over age 50. The "average" physician:

- Graduated medical school in 1992 (about 20 years ago)
- Finished residency in 1996 (about 15 years ago)
- Practiced medicine, post-residency, for almost 12 years in the US
- Made aliyah in 2008
- Has been practicing in Israel for almost 2 years.

Eighty-two percent of the physicians went to medical school in the US, and 18% went to school in Israel. All of them did a residency in the US, with only one (5%) also doing some residency training in Israel.

Lifestyle

- Overall, the respondent sample in this study was a very religious group. Only one person (5%) described herself as non-observant. Table 1 shows the affiliations.

- All the respondents identified themselves politically as somewhere between moderate and far-right wing. No one self-identified as left wing or far-left wing.
- 82% of the physicians were married while living in the US, and 77% were married at the time of interview.
- Most of the respondents were parents, with the percentage increasing from 78% in the US to 86% at the time of interview.
- 23% of the physicians had a new baby in the family around the time of making aliyah, and one person (5%) divorced during that period. Besides that, no one had significant changes in their household during the time of making aliyah.

Table 1: Religious Affiliation (Percent)

Ultra-Orthodox	14
Ultra-Orthodox Zionist	9
Orthodox	54
Traditional	18
Non-observant	5

Financial Differences between Life in the US and Israel

Some of the greatest disparities between respondents' experiences in the US and Israel came up when they were asked about money issues. The demographic survey included multiple-choice questions for salary in the US and in Israel. The lowest option was "less than $50,000/year" and the highest was "greater than $250,000/year." The options were presented in increments of $50,000. The earnings are laid out in Table 2.

Table 2: Annual Earnings

Earnings/year ($)	US	Israel
Physicians earning <$50,000	5%	50%
Physicians earning >$250,000	36%	0%
Average annual earning for those between $50,000 and $250,000	$142,000	$85,700

Eighteen percent were not working in Israel and their lack of salary was not included in the average, but it is possible that some of the reported salaries included money earned in the US. Because the precise amounts of the salaries below $50,000 or above $250,000 are not known, it is impossible to calculate overall average salaries. Nonetheless, the picture is clear that the immigrant physicians were earning far less in Israel than they had been in the US.

Importantly, several physicians were not fully employed (some by choice) or were working in the US. Table 3 shows the physicians' opinions as to whether their incomes were sufficient to support their lifestyles. Table 4 gives a brief account of home and car ownership in each country, as a way of demonstrating wealth.

Table 3: Income Sufficiency (Percent)

Is your income sufficient to support your lifestyle?	US	Israel
Yes	77	14
Yes, combined with spouse	14	9
No	9	69
Unsure/Information not available		8

Table 4: Home and Car Ownership (Percent)

	US	Israel
House	55	26
Apartment/condominium	5	14
Car	86	54

Workplace Information

The survey asked for respondents to identify all applicable settings in which they were working or had worked, both in the US and in Israel. These are noted in Tables 5 and 6. In the US, most physicians worked in teaching hospitals, with a large share in private clinics and private hospitals as well. In Israel, almost half worked in public hospitals, with a quarter working in teaching hospitals, public clinics, and/or private clinics. As noted above, 18% of respondents (4 people), were not employed in Israel; the percentages given for Israeli employment are for the whole group, including those not working in Israel or not working at all.

Table 5: Place of Employment (Percent)*

Workplace	US	Israel
Public hospital	27	46
Private hospital	46	9
Teaching hospital	77	27
Public clinic	5	23
Private clinic	41	27
Other	9	5

*More than one response allowed

Table 6: Location of Workplace (Percent)*

Setting	US	Israel
Urban	58	89
Suburban	55	33
Rural	9	5

*More than one response allowed

In both the US and in Israel, 59% of physicians had teaching responsibilities, and 41% were conducting research. While living in Israel, 18% of physicians were practicing medicine in the US – some instead of working in Israel and some in addition to it.

Payment and Insurance Data

Respondents had many thoughts as to the way physicians were paid in the US and Israel. The survey asked how patients paid for their medical care and how physicians were compensated, to provide context for these opinions. A surprising finding was that many physicians did not know how their patients paid for their care. Twenty-seven percent of respondents did not know how care was paid for in the US, and 50% did not know how their Israeli patients paid, or did not have Israeli patients. This reduces the amount of information that can be extracted from the responses on insurance reimbursement, because it is not known what kind of respondent bias exists. The full responses are in Table 7.

Table 7: Patient Payment Methods (Percent)*

Type of payment	US	Israel
Full payment	23	9
No payment	36	14
Private insurance	55	9
HMO/Health Plan	59	32
Medicare	64	N/A
Medicaid	36	N/A
Don't know/no patients	27	50

*More than one response allowed

Though there was a diversity of ways in which physicians were reimbursed, the majority of them, in both countries, received salaries. These are shown in Table 8.

Table 8: Physician Reimbursement (Percent)*

Type of reimbursement	US	Israel
Salary	73	68
Fee for service	27	9
Paid per shift	9	14
Diagnosis-related group	5	0
Capitation	5	9
Other	5	0
No payment	5	18

*More than one response allowed