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Telemedicine Services in Outpatient Clinics of Clalit Health Services Hospitals

Rachel Nissanholtz-Gannot Tami Brosh
Tal Norman Ella Katz

Editor (Hebrew): Ronit Cohen Ben-Nun
English editing (Abstract): Suzanne Brown
Graphic design: Efrat Speaker

The study was funded with the assistance of the Israel National Institute for Health Policy Research and with the support of the Ministry of Health.

Myers JDC Brookdale Institute

P.O.B. 3886, Jerusalem 9103702, Israel

Tel: 02-6557400

brookdale.jdc.org.il/en | brook@jdc.org

Jerusalem | December 2025

Abstract

Background

In 2017, the Ministry of Health launched the National Digital Health Program, with a central focus on promoting telemedicine services – the provision of medical services through communication technologies without physical presence – in order to improve public health, quality of life, and the efficiency of the healthcare system.

The outbreak of the COVID-19 pandemic in 2020 accelerated the use of telemedicine services worldwide. In Israel the use of telemedicine became more prevalent both in community settings and in hospitals, leading to increased patient satisfaction across various medical fields. However, telemedicine in Israel developed primarily in the community, while its implementation in hospitals progressed at a more moderate pace. The Israel-Hamas war that began in October 2023 further underscored the need for additional telemedicine services.

The Hospitals Division of Clalit Health Services (hereafter: “Clalit”) asked the Myers-JDC-Brookdale Institute to examine the use of telemedicine services in outpatient clinics in Clalit hospitals.

Based on activity data of outpatient clinics, this study examines patterns of telemedicine use and seeks to provide actionable insights for decision-makers to support the expansion of services, their adaptation to diverse population groups, and their integration into hospital workflows.

Objectives

The study aimed to examine the following aspects:

- Characteristics of the patients who used telemedicine services (telephone/video visits)
- Characteristics of the clinics in which telemedicine services were used
- Patients' satisfaction with telemedicine services and their preferences
- Physicians' attitudes toward remote care
- The extent of telemedicine usage and visit characteristics across three visit modalities (in-person/telephone/video)
- The impact of the COVID-19 pandemic and the Israel-Hamas war on patterns of telemedicine use

Methods

The study employed mixed-methods research combining quantitative and qualitative data. The quantitative component included analysis of administrative data on visits to outpatient clinics in Clalit hospitals, as well as analysis of data from online surveys conducted among physicians and patients. The qualitative component consisted of semi-structured, in-depth interviews with patients, physicians, and policymakers from Clalit Health Services and the Ministry of Health.

The administrative data included information on visit, patient, and clinic characteristics from January 2021 to December 2024. The physician survey was conducted between July and September 2024 and included 190 physicians from 14 hospitals, who provided telemedicine services in outpatient clinics. Patient surveys were conducted in February 2024 and included 959 patients who had participated in at least one remote visit in an outpatient clinic between September and December 2023, and 1,298 patients who had participated in at least one in-person visit during the same period. The data were weighted by age, gender, and the socioeconomic cluster of the place of residence and analyzed using *R*, STATA, and SPSS software, applying χ^2 tests, ANOVA, Pearson correlations, and logistic and linear regressions, at a significance level of $p < .05$.

The qualitative component included 43 interviews. The interviews were recorded, fully transcribed, and analyzed using thematic analysis, enabling identification of central patterns in the interviewees' attitudes. The study received approval from the Brookdale Institute Ethics Committee.

Main Findings

Patient and clinic characteristics by visit modality

Analysis of administrative data encompassing more than three million scheduled outpatient visits revealed significant differences between in-person and remote visits. Compared with in-person visits, remote visits were characterized by higher proportions of women, patients in the youngest (18–40) and oldest (81+) age groups, Jewish patients, Israeli-born patients, and patients either without comorbidities or with high levels of comorbidity.

Predictors of remote visits

Multivariate logistic regression models showed that positive predictors of conducting a remote visit included being female, residing more than five kilometers from the clinic, and affiliation with the Eilat and Tel Aviv-Jaffa districts. Negative predictors included age 41–80 years, belonging to the Arab population, residence in localities with low or medium socioeconomic status, and visits to outpatient clinics in small or medium-sized hospitals.

Visit characteristics by modality

Of all visits conducted, 88% were in-person, 11.5% were telephone visits, and 0.5% were video visits. Attendance rates were highest for telephone visits (93%), compared with video visits (87%) and in-person visits (83%). Average waiting time was shortest for video visits (40 days), compared with in-person and telephone visits (56 days). Average visit duration was longest for in-person visits (18 minutes), shorter for video visits (16 minutes), and shortest for telephone visits (15 minutes).

Findings of physician survey and interviews

Physicians estimated that, on average, 18% of their encounters were conducted remotely, and 56% believed that the use of telemedicine services should be expanded. Most respondents indicated a preference for telephone visits over video visits. Usage rates were higher among psychiatrists and internists and lower among surgeons. Physicians' overall experience with telemedicine services was rated, on average, as "good" and was positively associated with usage rates. Key advantages cited included time saving and improved accessibility for remote patients, while key challenges included the lack of physical examination, impaired communication, and low digital literacy among some patients.

Findings of patient survey and interviews

Most patients who participated in remote visits did so by telephone. The majority reported high satisfaction, a sense of comfort, and clarity of instructions for further treatment. Seventy-eight percent reported that the remote visit spared them a trip to the clinic, particularly residents of peripheral areas and individuals with low or medium levels of education. Twenty-one percent indicated a preference for remote visits over in-person visits, and 51% felt that the experience was similar across both types of visits. Key advantages cited included time saving, convenience, and reduced travel. Key disadvantages included impaired communication, reduced quality of care, and the absence of physical examination. Willingness to continue using telemedicine services in the future was higher among younger patients (18–40) and among those who reported high satisfaction with their most recent visit.

Interviews with policymakers

Interviewees emphasized the potential of telemedicine to expand access, improve healthcare system efficiency, and strengthen system resilience in emergency situations, alongside regulatory, economic, and infrastructural barriers. The need for planned implementation, professional support, and adaptation of technology to clinical and organizational needs was also noted.

Recommendations

Recommendations for policymakers (Ministry of Health)

It is recommended to develop economic models and incentives that encourage hospitals to expand telemedicine services in areas where they offer clear added value. In addition, it is advisable to promote inter-organizational frameworks for shared learning, knowledge exchange, and exposure to technological solutions, as well as to initiate dedicated research to develop quality indicators and targets that will incentivize the use of these services.

Recommendations for the Hospitals Division of Clalit

It is recommended to upgrade the internet infrastructure and allocate dedicated rooms for telemedicine, to conduct structured training for medical staff as part of the implementation process, and to improve service accessibility for populations with low digital literacy through adapted interfaces and dedicated support systems. It is further recommended to implement integrated systems that enable scheduling, documentation, and continuity of care within a unified work interface.