Health care for the poor—An exploration of primary-care physicians’ perceptions of poor patients and of their helping behaviors

Menachem Monnickendama,a,*, Shlomo M. Monnickendamb,c, Chana Katzd, Joseph Katan e

School of Social Work, Bar Ilan University, Ramat Gan, Israel
bDepartment of Family Medicine, Sackler School of Medicine, Tel Aviv University, Israel
cMaccabi Healthcare Services, Tel Aviv, Israel
dDepartment of Public Policy and Administration, Sapir Academic College, Israel
eBob Shapell School of Social Work, Tel Aviv University, Israel

Available online 17 January 2007

Abstract

This paper explores the ways in which primary-care physicians in Israel perceive and help poor patients. Our findings are based on a qualitative study that utilized a focus group and in-depth interviews with 16 primary-care physicians who qualified both in Israel and in the former Soviet Union, and who work in community clinics one Health Maintenance Organization serving poor populations of diverse cultural, ethnic and socioeconomic backgrounds (immigrants from the former Soviet Union and from Ethiopia, Bedouin, ultra-orthodox Jews, the chronic poor, and the ‘new’ poor). It was found that the physicians presume causality between poverty and health, identify and distinguish between different types of poverty, and make associations based on the type of poverty and type of patient problem. Their thinking on poverty is patient-oriented rather than socially oriented. An analysis of these findings resulted in a conceptualization of five types of physician helping behavior: emotional and personal instrumental, reinforcing socially desirable behavior, preferential help and bending the rules, rights realization and working the system, and minimal community involvement. The components of this conceptual model depict and chart issues affecting the helping behavior of the primary-care physician, i.e., type of poverty, type of problem, administrative context and, particularly, physician attributes, such as gender and country where notable. Our findings reveal little social consciousness on the part of the physicians, and we conclude with remarks on the potential for change in this area.

Keywords: Israel; Primary-care physicians; Poverty; Doctor–patient communication/interaction; Health-education

*Corresponding author. Tel.: +972 2 9931547; fax: +972 2 9931547.
E-mail addresses: monnick@mail.biu.ac.il (M. Monnickendam), monnicke@post.tau.ac.il (S.M. Monnickendam), chanak@sapir.ac.il (C. Katz), yoseph@post.tau.ac.il (J. Katan).

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doi:10.1016/j.socscimed.2006.11.033

The quality of primary-care services to the poor is of constant concern to the medical profession and to the public at large. Two main actors are involved—the patient and the primary-care physician (PCP). As the latter determines the help provided, any effort to improve these services must take into
account whether and how their perceptions of the poor patient affect their actions and helping behaviors extended to the patient. Studies have shown that poor people have more illnesses, consume more medical services, and show a higher mortality rate (Kuh, Hardy, Langenberg, Richards, & Wadsworth, 2002; Lurie & Buntin, 2002; Watt, 2002), especially women (Kawachi, Kennedy, Gupta, & Prothrow-Stith, 1999). Research has suggested that they postpone visits to the doctor, other than those deemed essential, because of co-payments (Weingarten & Monnickendam, 1985), and are forced into non-compliance (Lee, 1996). Poor children’s access to health care is compromised (Olson, Tang, & Newacheck, 2005; Starfield, 2001). Poor patients’ interactions with institutions and their representatives are often powerless (Narayan, 2000). Research has shown that the manner in which the PCP serves the poor directly affects the latter’s health (Barratt, 2001; Gross, Tabenkin, & Brammli-Greenberg, 2000). Thus any effort to improve medical services to the poor must consider the encounter between the poor patient and the PCP (Beck, Daughtridge, & Sloane, 2002).

The main channel of communication between doctor and patient is the consultation. This encounter has been dealt with in the research and descriptive literature with reference to a wide range of areas relating to poor patients: quality of care (Choudhry, Fletcher, & Soumerai, 2005), referrals to specialists (Chan & Austin, 2003), doctor–patient race concordance (Laveist & Nuru-Jeter, 2002; Napoles-Springer, Santoyo, Houston, Perez-Stable, & Stewart, 2005), cancer screening (Remennick, 1999), dementia (Werner, Gafni, & Kitai, 2004), prescription of opioid analgesics (Tamayo-Sarver et al., 2003), power and paternalism (Goodyear-Smith & Buetow, 2001), trust (Keating, Gandhi, Orav, Bates, & Ayanian, 2004), altruism (Jones, 2002), ethics (Kinghorn, 1999), and GPs’ attitudes to deprived patients (Willems, Swinnen, & De Maeseneer, 2005).

The picture emerging from these studies is that on the part of the physician, the encounter is a composite manifestation of perceptions: the way in which the encounter is conducted is an expression of the physician’s perception of the socio-medical situation as presented. This includes the patient and his/her environment, the medical issue, the administrative setting, and the physicians themselves.

The patients are perceived within a social background shaped by the characteristics of the community in which the clinic is located, its cultural group, religion, and ethnicity (Keating et al., 2004). Thus, in the USA a low socio-economic level may lead to the offering of fewer service options (O’Malley & Forrest, 2002), and patients in the highest 9% of wealthy neighborhoods in Ontario, Canada, receive 4% more referrals than patients in other neighborhoods (Chan & Austin, 2003). North American Physicians who perceive poor patients as being trapped within a poverty culture tend to treat them differently from the way they would treat patients perceived as being temporarily poor (Benson, 2000); indeed, these behaviors are in part influenced by the degree of similarity between patient and physician attributes (Keating et al., 2004). In the USA, doctor–patient race concordance was found to be predictive of patient satisfaction (Laveist & Nuru-Jeter, 2002), with ethnicity related to trust (Keating et al., 2004). Similarly, cultural factors such as language, social class discrimination, immigration status, value systems, manifest customs, stereotypes, and class differences between patient and physician, all influence the quality of the medical encounter. The ways in which the physician perceives a specific patient are in part the product of his/her views on wider social issues. Social awareness is regarded today as an important part of medical education (Clark, Melillo, Wallace, Pierrel, & Buck, 2003; Coulehan, Williams, Van McCrany, & Belling, 2003), however, it is as yet unclear how awareness to the broader social and structural context of poverty affects the medical encounter.

The consultation takes place in the clinic within an administrative framework dictated by the modus operandi of the Health Maintenance Organization (HMO). All citizens in Israel are legally members of one of four national HMOs, which provide for all healthcare needs according to the National Healthcare Law (1995). The perceived values of the physician may or may not correspond with those of the HMO (Beach, Meredith, Halpern, Wells, & Ford, 2005). Thus in conflict situations physicians may use unsanctioned practices to meet their perceived responsibilities to the patient despite HMO directives. These range from working the system and choosing liberal interpretations of patient problems, to preferential treatment, miscoding and bending the rules. Whether or not such conduct is ethical and should be condoned has been debated extensively; however, in the US at least, these are widespread practices (Allen, Griffiths, & Lyne, 2004; Kinghorn, 1999).
Self-role perception is the physician’s conception of vocation realization, shaped by both personal and professional attributes. Personal attributes may include socio-economic level, age and gender, and professional attributes will include in particular medical education and experience (Choudhry et al., 2005; Cohen, Freudigman, Schonfeld, & Leventhal, 2000). These attributes often impact on the physician’s behavior (Werner et al., 2004). When physicians, trained to assume that they should provide only the best medical treatment with full patient compliance, become aware of the sizable gap between realities such as non-compliance on the one hand and their self role perceptions on the other, they may either avoid treating poor populations from the outset (Komaromy & Lurie, 1995), and/or adopt participative or paternalistic modes of behavior during the medical encounter (Goodyear-Smith & Buetow, 2001). Participative behavior may be manifested through compassion (De Moor, 2003), listening and involving patients in decision making, both of which lead to higher patient trust, particularly amongst patients from lower socio-economic groups (Andersson & Lyttkens, 1999; Bonds, Long, Dugan, Hall, & Extron, 2003). Conversely, research conducted in Asia, Africa, France and Scotland, indicates that the perception of the patient as both negligent and disenfranchised may elicit blame and perfunctory treatment, whereas the perception of the poor patient as empowered but a victim of social circumstances might lead to understanding and a higher level of care (Narayan, 2000; Parizot, Chauvin, & Paugam, 2005; Richards, Reid, & Watt, 2002).

This qualitative study aims at exploring and providing insight into the ways PCPs in Israel perceive and help poor patients.

**Method**

**The setting**

Israel is a multifaceted society with a population of about seven million. It is multicultural in the sense of having absorbed over half its population as immigrants; about 20% of its citizens are non-Jews (largely Arab Muslims and Christians), and 5–6% are ultra-orthodox Jews (Central Bureau of Statistics, 2006a). The issue of poverty surfaced during the winter of 2003/2004, when this research was conducted. Israel was at the peak of a severe economic crisis, accompanied by a real cut in social expenditure, dramatically increased unemployment (10.7% in 2003) and poverty in the weakest population groups (Central Bureau of Statistics, 2006c; Kop, 2005).

Poverty amidst the approximately 1,000,000 Jewish immigrants from the former Soviet Union (FSU) who have resettled in Israel since 1990, raised much concern. These immigrants, who increased the country’s population by some 15% (Central Bureau of Statistics, 2006b), brought with them a culture strongly influenced by seventy years of Communist rule. Similarly affected are the approximately 70,000 Ethiopian Jews who have immigrated to Israel within the last twenty years, and today constitute a significant minority (Central Bureau of Statistics, 2006b). Ethiopian Jews are black and racially distinct from other Israelis. They have experienced great hardships in acculturating into Israeli society, and continue to suffer from low socio-economic status. The inability of many of the Ethiopian immigrant parents to speak and write Hebrew and their emphasis on non-verbal communication, indirect expression, silence and soft-spokenness, contribute to these difficulties and have frequently led to misunderstandings with Israeli caregivers and mental health professionals (Ringel, Ronell, & Getahune, 2005). In itself the Arab minority within Israel comprises several religious groups, the largest of which is the Muslim Arab group. Amongst these the Bedouin are by far the poorest. They live in remote desert areas and concentrate in small towns. The level of health care in desert areas is much lower than in the towns (Swirsky, Kanaaneh, & Avgar, 1998). The ultra-orthodox Jewish population live in self-segregated, highly organized communities, are politically sophisticated, largely poor, and receive significant state support (Bartram, 2004; Berman, 2000; Whitehead, Burstrom, & Diderichsen, 2001). The economic crisis also created what the media labeled as the “new poor”, unemployed academic and highly skilled IT workers, as distinct from low skilled “chronic poor”, whose unemployment was often perceived as expected and normative (Latet, Israeli Humanitarian Aid, 2006).

National Health Insurance (NHI) in Israel has been effective since 1995. Health services, excluding dental services, are provided to every citizen, irrespective of age, ethnicity, socioeconomic status, or religion. An important part of primary health care is delivered through community health clinics throughout the country. Clinics may be staffed by a medical director, PCPs, specialists, nurses, social
workers, para-medical workers, and administrative staff. The NHI law stipulates the provision of a standard set of care services in conjunction with quarterly user fees ranging from 6IS to 16IS (comparable to the cost of a Coke or a small 150gr burger, respectively) payable for doctor visits, and co-payments for medications on the approved drug list and for some services. Co-payments for listed medicines for chronic diseases are capped at about 200IS per month (Gross & Harrison, 2001). However, several expensive treatments such as chemotherapy and dialysis are provided free of charge. The NHI allows for voluntary purchase of supplementary insurance for services excluded from the standard package. Between 1997 and 2004 the proportion of out-of-pocket health expenditures relative to the total national health expenditure per person increased from 24% to 30%, with the largest increase found in the two lowest income deciles (Kop, 2005).

Participants
We used a purposive sample design of physicians working amongst the abovementioned population groups, i.e., immigrants from the former Soviet Union and from Ethiopia, Bedouin, ultra-orthodox Jews, chronic poor, and new poor in communities ranging amongst the lowest seven (out of 10) clusters on the local authorities’ socio-economic index (Central Bureau of Statistics, 2006d). The participants were administrative physicians and PCPs employed in community clinics of one Health Maintenance Organization serving about 1.6 million. One characteristic of this HMO relevant to this research is that senior management, including the CEO, have time and again formally supported a policy urging HMO middle management to be creative and resourceful in overcoming excessive bureaucracy, specifically where it hinders service provision to the poor. Consequently, medical middle management has discretionary authority allowing it to disregard certain rules and stipulations in order to expedite service provision. However, they are required to report their decisions and may be called upon to justify them. As participation in this study required considerable time resources on overloaded PCPs, the research team narrowed the sample. Prospective participants were selected by their expected consent to participate. They consented for one or more of the following reasons: prior acquaintance with one of the authors, regarding the study as an opportunity to raise awareness on behalf of their poor patients, and organizational expediency vis-a-vis HMO senior management. The sample included sixteen physicians, comprising nine PCPs and seven physicians in administrative positions working in addition as PCP. One participant was trained in Italy, seven in the Former Soviet Union (FSU), and eight in Israel. Their ages ranged between 35 and 66, with nine female and seven male participants. References to the training background and current working practices of each interviewee accompany all interview data below; however, references to the gender of those interviewed have been removed in an effort to retain their anonymity.

Procedure
A thematic analysis was adopted to facilitate an investigation of issues that surfaced in our literature survey on the one hand, and to uncover novel content on the other. From the outset we convened a focus group. Based on a literature search and our own familiarity with the community clinics, we prepared a thematic list of areas of inquiry and a series of leading questions to be incorporated in the focus group convener’s manual. The main themes related to physicians’ views on the implications of poverty on their patients; on the problems poor patients present; on their responses to the patients’ problems; the HMO’s responses to the patients’ problems, and on physician involvement in communal poverty-related activities. The focus group session included nine physicians, lasted 3 h, and was conducted by the authors. An in-depth interviewer handbook was subsequently prepared based on the focus group manual, and on any novel issues raised (Krueger, 1994). No main themes were added, but directions were given to explore specific helping behaviors, and the implications of medical conditions, population and physician attributes on helping behaviors. In-depth interviews lasting between 1 and 2 h were subsequently conducted with seven physicians in their offices. The interviewers encouraged the participants to explore their views and to add any content they deemed relevant, even if it did not appear in the thematic list of areas of inquiry or did not pertain to additional population groups. The focus group session and the interviews were audio recorded, transcribed (Svenson, 1989), and cleaned (Jones, Miles, & Read, 1996). So as to minimize “coloring of analysis”, conversion into units of meaning was performed by two experienced research assistants, both social workers familiar
with the health system, and working independently. Each unit of meaning was either classified by the appropriate thematic unit or by a newly created one in the course of content analysis (Denzin & Lincoln, 1994). As one unit could have more than one meaning, it could be classified in up to four thematic units (Huberman & Miles, 1994). In the case of divergence, the final classification was determined in consultation with one of the researchers.

Results

The qualitative analysis of relationships between the thematic units produced two integrated conceptual models, which when considered in unison constitute a whole. The whole is depicted in Fig. 1; however, for the sake of clarity, each model will be presented individually.

Physicians’ conceptual model of poverty and health

The conceptual model suggested by virtually all the physicians was found to presume causality between poverty and health (See Fig. 1).

[Poverty] can bring on not only depression but real organic diseases: stroke, hypertension, cardiovascular problems. [Israeli trained primary care physician, working with the Ethiopian poor.]

Additional medical conditions mentioned were suicide, food insecurity, obesity, diabetes, and smoking. One participant however deviated from this pattern and remarked:

There is no proof to date of a cause and effect [relationship] between health and poverty, although there is a relationship. If I make them healthier they do not become less poor. [Israeli trained physician in an administrative position, working with the ultra-orthodox poor.]

This remark was made by the sole physician demonstrating prior formal professional knowledge about poverty as such, and its significance within the medical context.

The physicians identified several types of poverty by ethnicity, culture and/or socioeconomic background and associate these with the patient’s state of health. This typification was in accord with that presumed by the researchers; despite prompting, no new types were suggested. When talking about the “the poor” in general, the physicians referred to “chronic poor” as distinct from the poor belonging to specific groups. The term “chronic poor” was used stereotypically in reference to veteran Israelis of oriental descent living in development towns or

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**Fig. 1.** Diagram of conceptual model of poverty, health and help.
city slums. These poor were regarded as an unfortunate, albeit unavoidable, social condition, and elicited no particular reaction. This was radically different from their reference to specific groups. Ethiopians were considered difficult to get to know and to understand. The poor from the Former Soviet Union were seen as different from the chronic poor, in that they complain less, use fewer services, use anti-depressants and stay at home. Bedouins were considered extremely poor, and assertive in their requests for services and payment reductions. The ultra-orthodox Jewish poor were characterized by intergenerational poverty, choosing to be poor, and having access to an extremely effective communal aid network. Like the Bedouin poor they are considered assertive and consistently ask for dispensation on payments. Similarly, the “new poor” are seen as a very problematic population unaccustomed to poverty, culturally different from the chronic poor, and used to a high standard of living.

Characteristics typical of each group were associated with specific health problems: Food insecurity was linked to the Ethiopian poor because of difficulties in communication hindering physicians’ efforts to explain and educate about the nutritional needs of, for example, diabetes patients:

I need both translation and explanation in order to understand them and know what they eat. For this I need the [Ethiopian] social worker.

[Physician in an administrative position, trained in the Former Soviet Union, working with the Arab and Ethiopian poor.]

One participant added that communication difficulties were so severe that even house visits did not lead to improvement. Chronic poverty was viewed as intensifying conditions such as retardation, and developmental problems. Patterns of health problems amongst the ultra-orthodox poor, with their typically large family sizes, were linked to incidents of continual illness in the family, it was the physicians’ experience that often at least one child in the family is ill. Hypertension and suicide were linked to the new poor, specifically

... when two partners are [newly] unemployed,
... then become dysfunctional [and to whom] you have to give much more attention [than chronic poor] [FSU trained primary care physician, working with the FSU and ultra-orthodox poor].

The salient situational factor was lack of money, even of very small sums. This was perceived as the primary cause leading to non-compliance, to under-use of medical services, and ultimately to impaired health. The respondents unanimously agreed that the poor make compromises on their health, either by not taking medications, by taking lower doses, or by taking only one for a condition for which several were prescribed. Although small, the co-payment was quoted as an impediment to the purchase of some vaccinations and medicines:

They [the poor] often say: let’s wait till the end of the month until I get income maintenance. [However] if they don’t buy medicines their condition worsens [FSU trained physician in an administrative position, working with the chronic poor].

In this context special emphasis was placed on children, for whom poverty was considered a major health hazard. Parents’ inability to buy medicines was mentioned in conjunction with asthma, contraceptives for teenage girls, and the appalling results of the lack of dental treatment which is not covered by the NHI. The lack of money also caused service under-use. For some even the very low user-fee for a doctor’s visit constitutes an obstacle: necessary blood tests were forgone because the money was lacking for the bus ride to the HMO laboratory. In addition to an evident absence of money was also the fear of inducing debts so that justified visits to the emergency room were refrained from, even in cases where full reimbursement was assured. It should be mentioned that one physician maintained that all necessary services and medicines are made available in life-threatening emergency situations.

Physicians’ conceptual model of helping behavior and self-role perception

The helping behavior utilized by the physicians is shaped in part by their background, self-role perception, and the administrative setting on the one hand, and their conceptual model of poverty and health on the other (see Fig. 1). Within the framework of this model the physicians utilized several kinds of helping behavior.

Emotional and personal instrumental help

By and large the physicians sympathized with the poor. This was manifested on both the interpersonal and the instrumental level. On the interpersonal
level the PCP occasionally refers them to the resident social worker just to have a warm and sympathetic talk, which is perceived as lacking in the alienated environment of the poor. Most physicians also employed compassionate listening:

The client has to feel that I am with him, not that I have pity or that I am just being courteous [but impersonal], even-though I cannot change the fundamental situation. [Israeli trained primary care physician, working with the chronic poor.]

Compassionate listening, as distinct from pity, is seen as a sincere and empathic professional response to a fellow human in need of help. Moreover, particularly, the “new poor” received a great deal of empathy and warranted more attention than others:

Specifically to these people you have to give much more attention [than to the other poor]. [FSU trained primary care physician, working with the new poor.]

Whereas these interpersonal helping behaviors were accepted and perceived positively by all, some interpersonal instrumental helping behaviors were not. Several female physicians who originated from, and/or studied in the FSU noted that on more than one occasion they did not ask for the 6 IS user-fees. Since collection of the user fee is made by the physicians, non-collection results in a deduction of that sum from their salaries. When asked to elaborate they explained that they felt close to poor FSU patients, as they too had been poor new immigrants from the FSU. This practice was not uniformly accepted and Israeli physicians of both gender, and male FSU physicians thought it wrong. They argued that this type of private help is uncalled for and unprofessional, that poor FSU patients are undeserving, and that with hard work they too could elevate themselves.

One physician illustrated his realization that many poor patients suffer from food insecurity with the following anecdote:

The social worker and I met with this poor woman in the office. On the table were some cookies from a previous meeting. She immediately asked our permission to take the cookies for her children. [Israeli trained primary care physician, working with the chronic poor.]

He then proudly proceeded to detail two projects conducted under his leadership. The first was a small fund for the poor maintained by the clinic’s team and put at the social worker’s disposal and discretion. The second was an initiative to regularly obtain food for the needy. These personal instrumental practices, though apparently not widespread, attest to a blurring of the divide between the personal and the professional.

**Reinforcing socially desirable behavior**

The sick note entitles the patient to paid leave of absence from work. In addition to its formal medical use, the sick note also functions as a time-honored means of utilizing the physician’s tacit cooperation to get a day or so off from work. However when a physician says:

When they ask for a sick note, I tell them, listen, you should go to work, although you are sick, otherwise they will sack you. [I do this] despite patients getting angry that they aren’t getting a sick note. [FSU trained primary care physician, working with the FSU poor.]

He is imposing his paternalistic self-role perception on the patient. When prompted to expand, the physician explained that although the patient was sick, he could still work and he [the PCP] was not prepared to collude with the patient in using his illness as an excuse to stay home, given the risk of being laid off. Although the conviction that the poor should work was shared by most physicians, non-FSU physicians were of the opinion that it was not their role as physicians to impose socially desirable behaviors on patients.

**Preferential help and bending the rules**

To receive this type of help the patient must be categorized, at the discretion of the physician, as a special case. The recurring type of preferential help was the distribution of medical samples specifically saved for the poor. In addition, two main types of rule bending were identified: unauthorized reimbursements of reductions on co-payments and dispensation of sick-notes even if unjustified medically. Within the context of the community clinic, preferential treatment involves “legitimate” breaking of the rules so as to ease poor patients’ conditions despite the likelihood of some form of administrative sanction. Our impression was that such a likelihood was perceived as more of a nuisance than a serious concern.

As these types of help involve a reduction or waiver of payments, the issue of dishonesty was often raised in this context. Several physicians
considered the routinely requested waivers of co-payments as small sums (up to 30 IS—the approximate cost of a Big Mac burger), and therefore sufficient proof of real poverty. As a result they do not consider it necessary to investigate whether patients cheat or not.

We noted a sharp distinction between the FSU and ultra-orthodox poor. The former complain about payments and often discontinue supplementary insurance. The ultra-orthodox population seldom discontinues supplementary insurance, but at the same time try to get reductions wherever possible:

We experience misuse. They have neighborhood representatives, and when we [rightfully] do not authorize reimbursements [...] they phone top management and we are ordered to authorize the payment. We feel powerless [FSU trained primary care physician and administrator, working with the FSU, chronic and ultra-orthodox poor].

That physicians are coerced into bending the rules demonstrates the importance of the larger service context on service delivery. It alludes to conflicts between the role perceptions of the partners comprising the service context, i.e., community clinics, the physicians, and HMO management.

Rights realization and working the system

Rights realization refers to enlisting the aid of social workers and other relevant personnel, in order to reduce non-realization of entitlements and available services from Social Insurance, the HMO, and from municipal social services. Rights realization was specifically mentioned with regard to the Ethiopian poor who are entitled to many types of aid, but because of their reticent behavior need assistance in unearthing the types of aid available and in implementing access to them.

The main types of aid mentioned in conjunction with working the system were: securing a waiver of ambulance and emergency room payments, home delivery of medicines for those unable to come to the clinic, and transportation of poor patients to the community clinic in selected cases—the latter two services prevalent amongst the Bedouin poor.

Effective rights realization necessitates working the system and thorough familiarity with it. In many cases administrative physicians used their knowledge of the system to help, but only one PCP did. It quickly transpired that many PCPs and, by varying degrees, even administrative physicians, are ignorant of the rights and services available to the poor within the HMO. It should be noted however that when administrative physicians are really convinced of a need they will do their utmost effort to help, including fighting management if necessary.

The helping behaviors mentioned above are all in-house and relate to specific cases, and thus beg the question of how community clinic physicians perceive their role vis-à-vis the community.

Minimal community involvement

Most of the participants showed very little enthusiasm for participating in local poverty-related activities, although some could envisage in principle a community role for the HMO. They stressed however two obstacles: (a) their lack of time and excessive workloads, and (b) that any success is dependent on HMO senior management’s commitment of sufficient resources.

In contrast with the above, the community clinic in general and specific physicians in particular, especially in smaller localities with a low socio-economic rank, occupied a prominent position with considerable political clout, to the extent of successfully pressuring local politicians on ad hoc bases. It was speculated that in such cases this political pressure might provide needed leverage for advancing poverty-related community activities.

An additional reason for the low level of community involvement might be the physicians’ self-role perception regarding poverty.

Physicians’ self-role perception vis-à-vis poverty

This physician attribute refers to the ways in which they perceive the relationship between their role as PCPs and poverty, if at all. For some, the participation in the focus group or the in-depth interview prompted thinking on an issue previously uncontemplated. For most, the basic issue was the extent of their responsibility on poverty issues, if at all. Some perceived the physicians’ role as singularly medical, suggesting that physicians as such and the HMO as a health provider bear no responsibility for poverty. Others saw a somewhat wider, albeit unspecified, role. Still others specified that role:

We are responsible for providing knowledge, explaining and helping, and being more aware of rights and possibilities to help [and] to inform the public, [but] we are not responsible for the poor. [FSU trained physician in an administrative
position, working with the Arab and chronic poor.

It was our impression that a measure of discrepancy and confusion existed between HMO management and physicians on this apparently touchy issue. One participant even refused to answer any question dealing with the ways the HMO copes with the poor. Another stressed the point that, in contradiction to popular medical view, physicians cannot solve poverty problems and should be more modest about what they can achieve.

Discussion

This study explores and provides insight into the ways PCPs in Israel perceive and help poor patients within the medical encounter in the community clinic. Our findings show that the participants presume causality between poverty and health, identify and distinguish between different types of poverty, and observe links between types of poverty and types of patient problem. Classification of articulations made by the focus group and during in-depth interviews produced a conceptualization of five types of helping behavior. The classification process also led to the creation of a conceptual model, the components of which depict and chart the issues affecting the helping behavior of the PCP, revealing also that their thinking on poverty is patient rather than socially oriented (see Fig. 1). Although many of these issues are well known, for the most part they have been treated as isolated processes, and outside the context of the medical encounter as a whole. The inclusive and integrative approach presented here highlights their meaning and interlocking nature with regard to the treatment of poor patients.

The conceptual model highlights the centrality of physician attributes as the sole component relating to the type of help both directly and indirectly provided via the other components. The self-role perception of the PCPs participating in this study demonstrates their compassion towards their poor patients as expressed by the help they provide them. Help behavior was initially defined as “any action that the PCP regards as help to the poor patient”. While conducting the focus group it transpired that in practice, “helping behavior” refers concurrently to action and non-action. However, participants evaluated specific actions or non-actions differently. Notably, participants disagree on whether waiving user-fees for visits, sick notes and paternalism could be construed as help, and some specifically avoid and even condemn such behaviors. In practical terms this means that some, but not all, are prepared go quite a distance, even when the type of help entails private donations, or engaging in “dubious” practices. The waiver of user-fees for visits, the poverty fund and food donations are acts for which the physicians ultimately pay out of their own pockets. In addition, physicians were willing to give preferential treatment to a few of the poor patients and to bend the rules. As our study is, to the best of our knowledge, only the second documentation of physicians’ out-of-pocket cost-reduction practices, and physician-induced cost-reduction practices unknowingly paid for by the HMO, these practices might be more widespread that previously conjectured (Willems et al., 2005). Many regarded bending the rules as normative and necessary, provided the reasons are perceived as justifiable.

The aid made available to the poor patient is also the result of the physicians’ perception of the type of poverty and of their similarity to the physicians’ background attributes. They distinguished between the chronic poor and poor patients belonging to special groups, where the latter receive special consideration and a higher chance of preferential treatment. Given the universal access to health care under the NHI, this tendency has been explained by information gaps, cultural barriers, differences in ethnic group origin and socioeconomic factors between the immigrants, the medical system and its employees (Cwikel & Segal-Engelchin, 2005; Remennick & Ottenstein-Eisen, 1998). The classification of a poor patient as belonging to a specific group depends on the presence of different types of prominent attributes. Ethiopians were classified by language, immigration status and ethnicity, FSU patients by immigration status and culture, Bedouin patients by socioeconomic status, culture and ethnicity, new poor by socioeconomic status, and ultra-orthodox by socioeconomic status and culture.

The similarity or dissimilarity between type of patient and physician background may affect helping behaviors. Thus paternalism and the rejection of a physician-patient collusion of silence regarding sick notes, and augmenting socially desirable behaviors were more common under FSU physicians. Nevertheless, with regard to the waiver of user-fees, female and male FSU physicians differed,
depending on the type of self-role perception (Balint & Shelton, 2002; Remennick & Ottenstein-Eisen, 1998). In the case of the Ethiopian poor, even real efforts such as house visits to overcome large cultural and language differences resulted in frustration and were considered ineffective.

The health and service difficulties quoted all relate to a potential and obvious deterioration owing to money shortage. The help offered are in-kind services in lieu of unavailable money, e.g., medical samples instead of money for medicines, food instead of money for food and home delivery of medicines instead of money for public transportation. The fickleness of these types of help is well known (Irvine & Gratzer, 2002). Lack of rights knowledge on part of the patient combined with the same lack of knowledge by the physician ultimately leads to impaired health care.

The administrative context had an effect on the helping behavior as was noted in several instances. Despite opposition to preferential treatment towards ultra-orthodox patients which was perceived as inequitable, the physicians succumbed to management pressure. Fighting management and granting unauthorized reductions on co-payments on behalf of poor patients points to a degree of ambiguity between physicians’ self-role perception and HMO management, and raises doubts about the effectiveness of the HMO’s endorsement of creative problem-solving in the eyes of the participating PCPs. A somewhat similar situation exists regarding the community role of the physicians. Such ambiguity along with the objection to answering questions on this issue hints that management might have implemented poverty related measures unknown or unaccepted by local physicians.

The effect of the administrative context on helping behavior was also apparent with regard to rights realization and working the system. Generally physicians were not knowledgeable on rights or services potentially available to poor patients. Although social workers were frequently mentioned in that context, there was a strong impression that the subject was outside the physicians’ realm, particularly amongst PCPs rather than administrative physicians.

Close examination of the conceptual model shows that by and large physician thinking on poverty is quite limited. They relate to poor patients as individuals but not to poor patients as an entity or to poverty as a social problem. They relate to poor patients’ illnesses but not to poverty related illness, to compassion but not to the role of PCPs vis-a-vis poverty. By and large the social consciousness and social activism of the participants was low. Consequently, the helping behaviors were on the single client level, detached from larger poverty related health issues, and patient problems were not examined within a wider social context of poverty. The participants uniformly displayed non-action with respect to community involvement. We did not detect any attributes distinguishing between socially and non-socially aware PCPs. It is often argued that community health care is an interdisciplinary endeavor, to be practiced by health professionals committed to social consciousness and social activism for the benefit of underserved populations (Stefanacci, 2004). This raises the issue of whether PCPs are educated to social consciousness and incorporate that awareness in their self-role perceptions (Fournier, 1999). Self-role perceptions such as “my job is medical”, the quoted lack of time and the necessity for considerable management commitment and investment as a condition for community activity, may constitute an additional manifestation of the tension between direct service professionals and management, or a narrow self-role perception or both. In the Israeli context community involvement is not remunerated and may be considered a form of charity. It would seem that the general decline in voluntary activities on the part of salaried physicians, as occurred in the US, would apply to Israel as well (Mulligan, 2001). Further research should clarify under which conditions physicians become involved in wider poverty related and community activities.

This study should be considered within the inherent limitations of any qualitative research. The interviews were carried out at the height of the economic slump and the rediscovery of poverty in Israel. This might have colored perceptions accordingly. The familiarity of the authors with the community clinics and the fact that they conducted the focus group session might have influenced the elicited answers, despite their being aware of the danger of influencing respondents. However the in-depth interviews were carried out by assistants. As we utilized a purposive sample of limited size, within only one HMO, we cannot estimate whether our sample was representative of all physicians of the HMO or of other HMOs. On the other hand their wide diversity and the cross-section of communities within which they worked provided a multifaceted image.
Conclusions

The fundamental issue is whether helping behaviors of physicians are amenable to change. Recent research contends that physicians have managed to change their attitudes to the poor, and by so doing, have fulfilled their traditional mission (Coulehan et al., 2003; Haq, Cleeland, Gjerde, Goedken, & Poi, 1996). Teaching methods have proven effective in educating both students and qualified medical personnel towards a positive approach to working with the poor and providing services in poor communities; it has been argued that involving students and interns in primary medicine in the health services of needy communities has a positive effect on their future behavior patterns (Clark et al., 2003). One innovative training program in England had members of poor communities participate in teaching physicians about the role of the health system regarding poor clients; implementing this program succeeded in improving their state of health (Jackson, Blaxter, & Lewando-Hundt, 2003). The applicability of such programs to the Israeli context should be explored.

Acknowledgments

This research was funded by the Rafi Rotter fund for Medical Research, Maccabi Healthcare Services, Israel. The authors wish to thank the reviewers for their helpful comments.

References


