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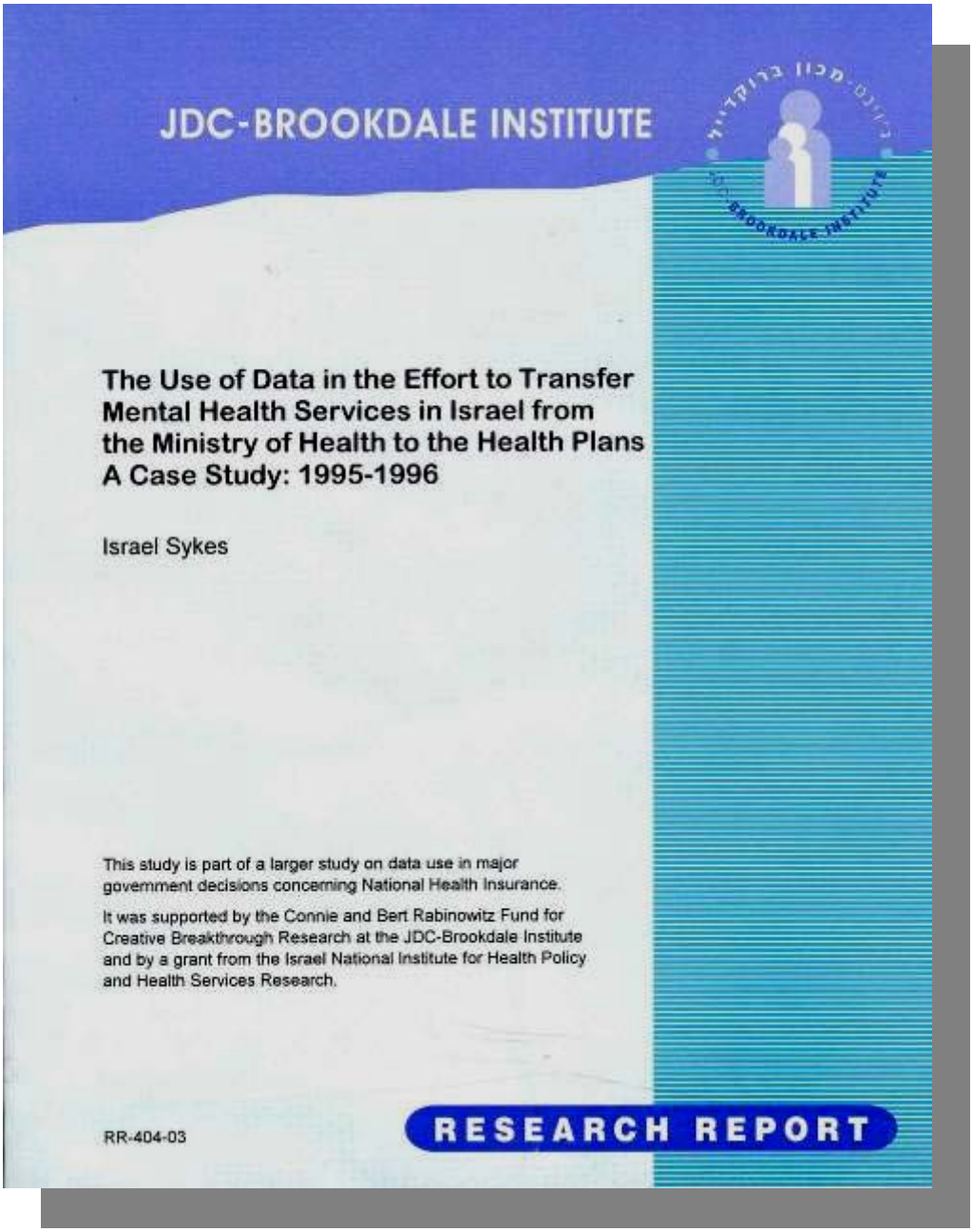

Executive Summary

Introduction and Background of the Study

The present document is a case study of the use of data in the effort to transfer mental health services from the Ministry of Health to the health plans. It is part of a multi-year study of the role of data in decisionmaking on key issues related to national health insurance.

The study highlights the activities that took place during 1995-1996, when the transfer of mental health services to the health plans was the subject of intense negotiations among the health plans, the Ministry of Health, and the Ministry of Finance. Although in the end, failure to reach a consensus among all of the parties led to a stalemate, this time period was chosen because it represents a distinct chapter in mental health policy in Israel, which has not yet been systematically studied. It is hoped that the study will generate insights that could contribute to future endeavors of a similar nature in Israel or abroad.

The present study focuses on a specific policy decision, rather than on a particular study or data base, and relies heavily on primary documentation for its data. Initial interviews with key decisionmakers were essential in enabling the researcher to gain a preliminary familiarity with the core issues faced by health policy decisionmakers. Much of the analysis, however, is derived from a thorough review of primary documents.

To place the events of the period studied in context, we first present an overview of three historical lines of development in related areas that had a direct impact on the transfer effort and on the use of data and research by decisionmakers: mental health reform in Israel; developments in the use of data in decisionmaking regarding mental health care in Israel; and research on mental health needs and services in Israel.

Significant Decisions in the Effort to Transfer Mental Health Services

While the case study initially focused on analysis of a single decision – the decision to transfer mental health services from the Ministry of Health to the health plans – as it progressed, it became increasingly clear that this decision was comprised of many decisions. These "sub-decisions" were found to differ in nature, and included questions such as: *whether*, *how*, *how much*, *by what formula*, *which ones*, *for whom,* and *by whom.*

1. ***Whether to Transfer:*** Should mental health services be included in the basket of services provided by the health plans?
2. ***Scope of Transfer:*** What will be included in the basket of services, what will continue to be the responsibility of the Ministry of Health, and what will be taken over by a different ministry?
3. ***Vulnerable Consumers:*** Who should be responsible for the care of the most vulnerable consumers?

4. ***Financing Level:*** How much money will be made available to the health plans for financing mental health services?
5. ***Earmarking:*** Should money provided to the health plans be given as part of a global budget, or earmarked specifically for mental health services?
6. ***Capitation:*** How will money be distributed among the health plans?
7. ***Hospital Prices:*** What should be the prices of services that health plans will purchase following the transfer?
8. ***Integration of Care:*** How, specifically, will mental health care be integrated into the general health care system?
9. ***Transition Mechanisms:*** What mechanisms need to be in place in order to support the transition from the previous system to the new one?

Each of these questions was analyzed with regard to the data required to make a decision, the data and information that were available or missing at the time the decision was made, the bases upon which a decision was actually made, and the extent to which data and information influenced that decision.

Finally, the study reviews developments in negotiations among key stakeholders since the period studied. Progress made in this area from 2001 onward indicates that important lessons have been learned from earlier efforts. These lessons and their practical implications are presented.

Findings

The study found that during the years reviewed, there was substantial use of data in decisionmaking at all levels of the mental health system. This was made possible both by the prior existence and development of the National Psychiatric Case Registry, and by the decentralization of computerization initiated by the Department of Information and Evaluation of the Mental Health Services of the Ministry of Health in the early 1990s. Our respondents indicated that the use of data increased during these years, as those in the system prepared for the anticipated transfer of services. The proactive and responsive provision of data services by an analytic/statistical unit within the Ministry of Health dedicated specifically to mental health issues undoubtedly contributed to this development.

Furthermore, data played a significant role in five of the nine decisions we analyzed. For example, the decision regarding capitation benefited from substantial data from two different sources on the relationship between personal characteristics and health care expenditures. Similarly, deliberations about who should be responsible for the care of the most vulnerable consumers benefited from data on the number of highly vulnerable persons, their diagnostic profile, and their care utilization patterns.

Nonetheless, even when decisionmaking involved substantial data use, important data were missing. For example, the process of setting hospital prices involved the use of financial data on spending in psychiatric hospitals, but did not generate data on the actual cost of providing specific services. Similarly, in discussions about the level of financing for the transfer of mental health services to the

health plans, current financial data were available and used, but gaps in information about current utilization of services, the extent of unmet need, and consumer preferences led to widely varying projections of future demand, which severely limited their usefulness for budgetary planning. The lack of systematic efforts to produce data regarding the likely effect of the transfer on demand for outpatient mental health services – a key unknown – was perhaps one of the main factors contributing to the ultimate impasse in negotiations

This last example illustrates a more general point. As might be expected, the system did a much better job of gathering and using information on the costs and benefits of the current system of care than it did projecting the likely costs and benefits of proposed changes in the system of care. In general, formulating reliable projections requires a major investment of time and resources – for example, to plan and implement demonstration projects or carefully tailored surveys. Such projects require sufficient lead time to enable them to yield enough information to inform decisions. In the current case, while in theory there was enough lead time (as the National Health Insurance Law allowed three years for carrying out the transfer), decisions were made under intense time pressure, which greatly shortened the time frames.

The following findings relate to the roles played by different types of data and information:

1. There was one central ***data base***, the National Psychiatric Case Registry, which was used extensively for data analysis. A second data base, the National Insurance Institute data base on individuals with psychiatric disability, was introduced during the time studied as a complementary source of information.
2. One of the weak links in the chain of data was ***data on the general population, its mental health problems and service needs***. Such data could have helped predict the changes in demand that might result from the transfer – an important unknown variable. Several studies were initiated to enhance available data on service needs and utilization, but these fell far short of a necessary epidemiological survey. An important contribution was made by a study conducted by the JDC-Brookdale Institute on the needs and utilization of services among recipients of disability benefits, many of whom have psychiatric disabilities. This study provides information on an important population segment that was not previously available. Another encouraging endeavor is a planned national survey on mental health in 2003/4.
3. ***New studies*** were performed for the purpose of addressing policy decisions about vulnerable consumers, capitation, and the inclusion of mental health services in the general health system.
4. ***Financial data*** on the current and expected costs of mental health care, the extent to which capitation will compensate the health plans, and the extent to which the pricing system will support the survival of existing services were prevalent in discourse and informed several of the sub-decisions.
5. ***International experience*** seems to have played a role in some facets of decisionmaking, while being irrelevant in others. Mental Health Service personnel were in contact with staff of the WHO, visited other countries, brought back relevant documentation, reported on their experiences, and organized trips for others. On the other hand, no evidence was found that

this information was systematically gathered and analyzed for its relevance to Israel, so that the policy community could debate and grapple with it. Expert consultation from abroad played an important role in two areas: the integration of mental health services into the general health system, and the development of mechanisms to support the transition into the new system. For each of these issues, foreign experts collaborated in the design and experimental implementation of new systems.

6. Given the considerable ambiguity concerning the results of expected system change, ***computerized simulations***, especially based on manipulation of the data in the Psychiatric Hospitalization Case Registry, were common. For example, in order to set prices for services that would enable the psychiatric hospitals to maintain their budgets, simulations were run with different levels and combinations of prices.
7. Another type of simulation was performed nationally for the purpose of ***generating and improving information and communication systems*** to be used for billing, reporting, and assuring continuity of care. This simulation might have had an important systemic impact if it had not been stopped prematurely because of the impasse at the policy level that prevented the transfer from taking place.

Ministry of Health decisionmakers believed that enough information was available to make a decision in favor of the transfer, despite the inevitable level of uncertainty in decisions about major system changes. When their initial attempts to implement the transfer unilaterally met with opposition in the Knesset Labor and Social Affairs Committee, they had no choice but to seek consensus, especially with the Ministry of Finance and the health plans. In this context, the ways in which data were developed and shared among organizations became a critical factor.

The study also explored the nature of this "data discourse" (the ways in which data were communicated among organizations) among those involved in decisionmaking. An effective data discourse, involving constructive information sharing and a collaborative effort to distinguish between disagreements about facts and disagreements about values, can promote trust and collaboration. In contrast, the data discourse was found in this case to have been problematic; as a result it promoted mistrust and mutual allegations. Several alternative explanations for this phenomenon are discussed in the body of the paper.

Looking to the Future

- The study's findings were presented to the management of the mental health services in the Ministry of Health and were presented at the 2002 National Institute for Health Policy conference. The findings generated a lively discussion of the events surveyed and of the implications of the findings for future developments.

It is encouraging that in recent years, the Ministry of Health, in conjunction with the JDC-Brookdale Institute and with the support of the Ministry of Finance, has undertaken a demonstration project of the provision of community-based rehabilitation services for the mentally ill. However,

the scope of this study has been limited by considerations of confidentiality, which impeded access to critical data.

The transfer of mental health services to the health plans resurfaced in 2001-2 as a high priority on the country's health policy agenda, and the study was brought to the attention of top policymakers involved in efforts to implement the change. In this second round, policymakers developed a clearer conceptual framework for the decisions facing them, had a better understanding of how data could help in the decisions, and took steps to make the necessary data available. In addition, the data discourse appears to have been more open and effective than it had been in the mid-90s.

In January 2003 the government made a decision, in principle, to effect the transfer, but various issues still need to be resolved before implementation can procede. It is expected that the study's findings will promote more systematic and collaborative utilization of information and data to support and accompany the transfer's implementation.

This study's findings also have several implications for future action beyond the mental health area.

- Efforts to improve the use of data in decisionmaking should look beyond ensuring that relevant data are available to decisionmakers; the data discourse within and among the organizations involved in decisionmaking also needs to be improved.
- For decisions that lead to major system change, data about the current system are important, but not sufficient. In order to make projections about how a proposed model of service provision will function, assumptions and extrapolations are required. Demonstration projects, structured analyses of international experience, and specially tailored surveys can provide vital information on the likely costs and benefits of proposed changes.

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