



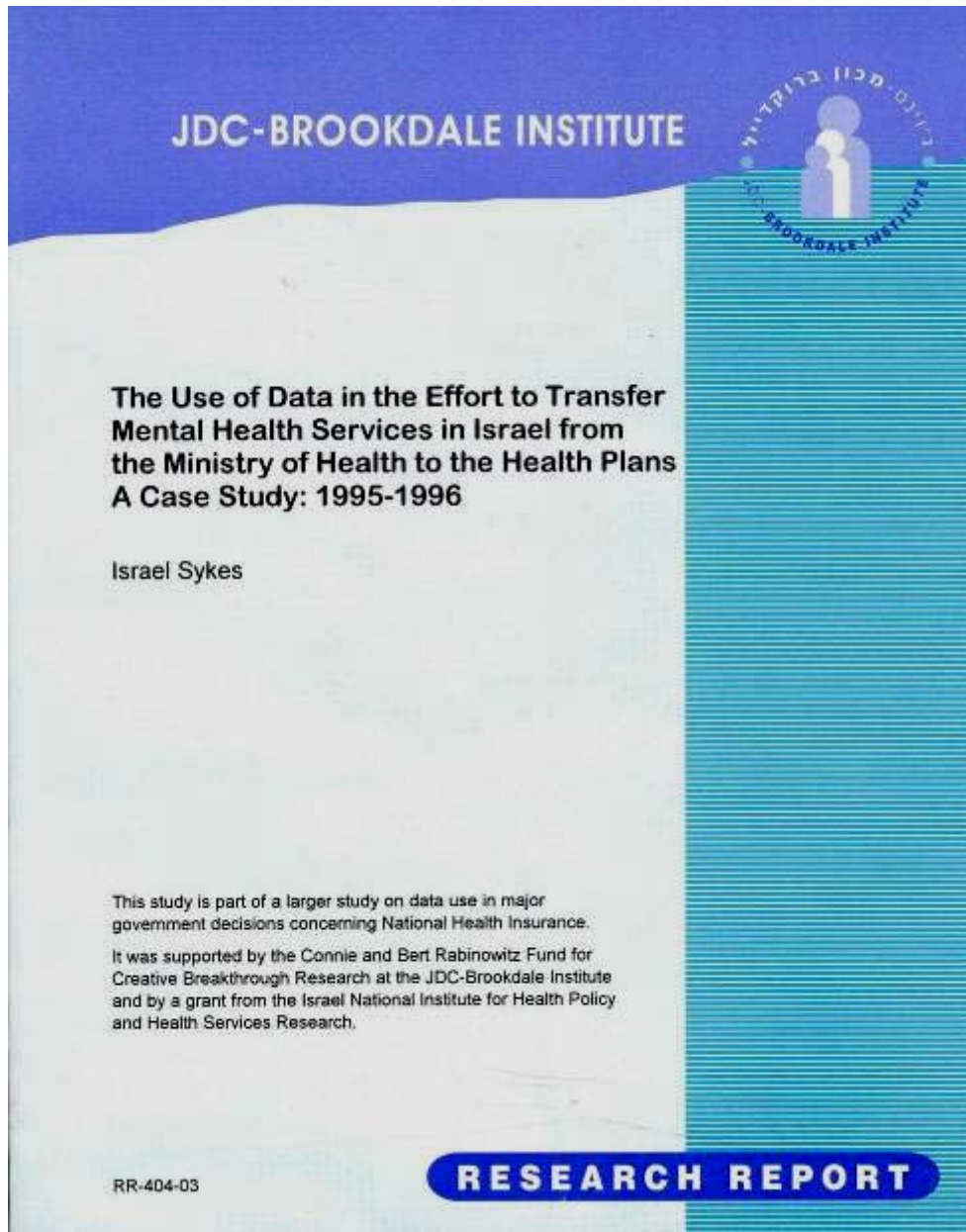
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The Use of Data in the Effort to Transfer Mental Health Services in Israel from the Ministry of Health to the Health Plans A Case Study: 1995-1996

Israel Sykes

This study is part of a larger study on data use in major government decisions concerning National Health Insurance.

It was supported by the Connie and Bert Rabinowitz Fund for Creative Breakthrough Research at the JDC-Brookdale Institute and by a grant from the Israel National Institute for Health Policy and Health Services Research.

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Related JDC-Brookdale Institute Publications

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- Rosen, B.; Schwartz, R.; Sicron, M.; Sykes, I.; Berg, A. *Data Use in Major NHI Related Governmental Decisions*. RR-401-03.
- Rosen, B.; Altman, S.; Cohen, M.; Haklai, Z.; Ivancovsky, M.; Mohilever, M.; Nevo, Y.; and Yisraeli, A. 2002. *Hospital Utilization And Expenditure On The Part Of Israeli Sick Funds In An Era Of Health Care Reform: Year 1 Report*. RR-399-02.
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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 proceed. 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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Chapter 1: Introduction

Background to the Study

The present document, a case study of the use of data in the efforts to transfer mental health services from the Ministry of Health to the health plans, is part of a multi-year study of the role of data in decisionmaking on key issues related to national health insurance. The study explored whether and how data have played a role in the health policymaking process in recent years. It also explored such issues as whether existing data have been used appropriately, and what data have been felt to be missing for policymaking purposes. In addition, the study sought to interpret questions such as: why relevant data were not available, why available data were not used, and what accounts for the substantial impact that data had in some areas, but not in others?

The larger multi-year study has two major components:

- ♦ A “macro” view or overview, of the role of data in health policy decisionmaking, including a detailed review of the use of data – derived from interviews with key decisionmakers – in ten important decisions in the years following implementation of the National Health Insurance Law.¹
- ♦ A “micro” or in-depth examination of four case studies: the first two case studies examine specific decisions related to national health insurance, while the other two case studies use as their starting point data sets relevant to decisions required for ongoing implementation of national health insurance.

The present study was the first of the case studies undertaken by the research team.

Methods

Methodologies Utilized in Similar Studies

A review of the literature on the utilization of data and of study findings by decisionmakers² found that research tends to differ along two key dimensions, namely, the focus of the research and the methodologies used to gather data. Two strategies are commonly used to define the focus of research:

1. The most common approach is to examine whether a *specific study* (or *group of studies* in a particular field) or *data base* were used in a range of decisionmaking processes.
2. A less common approach is to choose a *specific decision* or *series of policy decisions* and examine whether and how a range of data or findings were utilized.

The most common methods for gathering data are structured or semi-structured interviews with researchers and/or decisionmakers. Much less common is the examination of primary

¹ Preliminary findings from this macro study are available on the study’s internet site, www.jdc.org.il/brookdale/ddm.

² The literature review can also be found on the study’s web site.

documentation – letters, protocols, reports – produced by decisionmakers in their effort to grapple with the issues at hand.

Sources of Information for the Present Study

The present study uses the less common formats described above: It focuses on a specific policy decision, rather than on a particular study or data base, and it relies heavily on primary documentation for its data. Initial interviews with key decisionmakers (see Appendix 1) 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.

Early in the study, the then director of Mental Health Services, Dr. Motti Mark, offered the research team access to the written documentation available through his department. Following approval of an application to the Quality Assurance Division of the Ministry of Health – in accordance with procedures established by the Freedom of Information Act – access was gained to the files containing all correspondence related to “service organization” that passed through the office of the director of Mental Health Services during 1995-1997. From these files, the researcher marked all documents relating to the transfer of mental health services to the health plans, and had these copied by Mental Health Services staff. In addition, access was gained through the Knesset library to the protocols of meetings of the Knesset Labor and Social Affairs Committee that addressed the transfer.

One limitation of the research materials is that while they provided access to much of what was relevant to our study, they did not provide access to much of the less formal use of data and information which do not get documented or filed, such as presentations or comments made at meetings. Thus, for example, when analyzing the use of data in making the component decisions, it was not always clear from the documents what data were sought by decisionmakers. In such cases, an effort was made to reconstruct the relevant data needs, but no claim can be made that the reconstruction reflects data that were actually sought.

Choice of the Time Period to be Examined

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 between the health plans, the Ministry of Health, and the Ministry of Finance, that ended without a final decision.³ Choice of this time period was based on feasibility, given the resources of the study and on the perception that this period represented a distinct chapter in mental health policy, a chapter during which a great deal of important work was done, regardless of the end result. While analysis of this period could be a source of learning important to future efforts in Israel and abroad, such an effort has not yet been

³ Prof. Mordecai Shani, director general of the Sheba Hospital and former director-general of the Ministry of Health, when interviewed, was of the opinion that the study should focus no less on developments in recent years which, in his opinion, reflected much learning from difficulties encountered in 1995-1996.

systematically undertaken, in part due to the intense frustration and disappointment that characterized the end of this period. This case study is an initial effort to fill this gap.

At the same time, because the issues discussed in this report remained alive and continued to engage the mental health policy community, we conclude the report with an afterword discussing relevant developments since 1997 – particularly those that demonstrate that many of the lessons highlighted by the study have in fact been learned and put into practice.

Choice of the Framework for the Study

During 1995-1996, the mental health system was involved in two interrelated processes of major reform, which were frequently confused with one another: 1) inclusion of psychiatric services into the National Health Insurance Law, and 2) a long-term reorganization of services.⁴ Given the framework of the larger study of which this case study is a part, an effort was made – in both the interviews and the search for documents – to isolate the first reform from the second, and to sharpen the focus on the process of including psychiatric services in the benefits package offered by the health plans. To a certain extent, this created a distortion, since other concurrent processes that were often intertwined with those analyzed here, were sometimes omitted.

Stages of the Case Study

The process of exploring and writing this case study can be divided into several distinct, though overlapping, stages:

1. Interviews with key decisionmakers and the collection of relevant literature from Israel and abroad enabled the researcher to gain familiarity with core issues, and to begin to construct a narrative of two parallel stories: the story of the attempted reform of the mental health field in Israel, and the story of the development and use of data in Israel's mental health system.
2. Through analysis of primary documents, a second level of description emerged: an explication of specific decisions that had to be made as part of the larger effort to design policy. At this point, it became clear that the decision whether to transfer mental health services to the health plans was composed of a number of distinct component decisions.
3. Explication of the component decisions made possible an analysis of the use of data and information in making them: To what extent were data available? Where were data sought, and how were they generated? To what extent did data play a role in specific decisions?
4. The focus on the use of data led to a systematic review of studies conducted in Israel in psychiatric epidemiology. These provided an important context for the use of data during the period under study.

⁴ The protocol of the 9.12.96 meeting of the Knesset Labor and Social Welfare Committee records that Prof. Chanan Munitz emphasized the importance of recognizing this distinction.

An essential aspect of the research process has been the sharing of drafts of reports with members of the research team, members of the study's steering committee, and respondents and others in the field of mental health. Their comments and suggestions have been crucial to assuring that the researchers' understanding accurately reflects the complexities and subtleties of the policy arena during the time under study.

Chapter 2: The Historical Context: Developments in Three Related Areas

The present study examines events that took place in 1995-1996 from a very specific angle: The use of data and information in decisionmaking related to the effort to transfer mental health services from the Ministry of Health to the health plans. These events took place in a multitude of contexts: Political, economic, professional, historical, etc. It is beyond the scope of this study to examine the influence of these broader social contexts. However, developments in three key areas related to the organization of mental health services had direct impacts on the transfer effort and on the use of data and research by decisionmakers. This chapter will provide brief overviews of each of these areas: mental health reform in Israel; the use of data in decisionmaking regarding mental health care in Israel; and research on mental health needs and services in Israel.

Mental Health Reform in Israel

Historical Background to Reform: 1972-1994

In 1990, a State Commission of Inquiry into the Functioning and Efficiency of the Health System (the Netanyahu Commission) published majority and minority reports recommending fundamental reform of the health system in Israel. With regard to mental health services, the same set of recommendations was endorsed by both documents, including realignment of the roles, responsibilities, and functions of the Ministry of Health and the health plans in providing and financing a range of mental health services. Prior to this time, the Ministry of Health provided most mental health services through its psychiatric hospitals and mental health clinics, and Clalit Health Services, Israel's largest health plan, provided the rest. The Committee recommended the following:

- ♦ To make the health plans responsible for providing the full range of mental health services – inpatient, ambulatory, rehabilitation, and drug and alcohol detoxification – to be funded by a capitation system.
- ♦ To integrate mental health services, both hospitalization and community care, into the general health care system.

On January 1, 1995, the National Health Insurance (NHI) Law, based upon the recommendations of the Netanyahu Commission, was passed. The law adopted the basket of services of Clalit Health Services as the baseline for insurance coverage. Three areas of care were not included in the basket of services covered at the time by Clalit Health Services or by the three other, smaller health plans: Family health centers, mental health services, and geriatric services. In order to expedite passage of

the law, determination of the parameters of insurance coverage in these areas – and subsequent transfer of responsibility and risk for provision of these services – were postponed to an unspecified date within the three years of passage of the law.

The decision to transfer responsibility and risk for mental health services to the health plans paralleled similar decisions in the United States. As of 2000, 25 States had passed some significant portion of risk for Medicaid “behavioral health” benefits to managed care organizations (Croze, 2000).

The decision also overlapped and gave an impetus to efforts in Israel to promote far-reaching reform of the mental health system, which had been on the table for over 20 years -- at least since a 1972 Ministry of Health report had mapped out a program of reform based on the division of the country into catchment areas (Tramer, 1975). This plan was formalized in 1978 in an agreement between the Ministry of Health and Clalit Health Services, which aimed to “guarantee provision of comprehensive mental health services to all of the country’s citizens without exception... on a regional basis and in accordance with medical indication”(Ginat, 1992). According to this agreement the Ministry of Health would directly finance a broad range of mental health services provided in either government or health plan facilities, which would be provided on the basis of need, free of charge.

The 1978 agreement was never actually implemented, as it was never recognized or supported by the Ministry of Finance. In hindsight, while it was well-intentioned, Ginat (1992) has claimed that the agreement probably caused more harm than good, as it left a great deal of “unfinished business” regarding the division of responsibility for mental health services between the Ministry of Health and Clalit Health Services.

The reorganization of mental health services called for by the NHI Law shared core objectives – such as the promotion of accessibility and continuity of care – with the earlier plan for reform, but sought to achieve them through a different strategy: greater privatization, and transfer of responsibility and risk for mental health services from the Ministry of Health to the health plans. The idea was that the plans would be allocated capitated funds – that is, an overall budget for mental health services would be set, with each plan receiving an amount of money calculated to approximate its portion of the total population of mental health clients, and therefore its proportional expected costs. Meanwhile, the Ministry of Health would negotiate with other ministries to divide responsibility for non-medical services for people with mental illness and their families. Specific directions for reform included the following (Mark et. al, 1995):

1. Differentiation and clarification of the roles of the Ministry of Health, service providers, health plans, and other government ministries:
 - a. The Ministry of Health was to let go of its conflicting roles as service provider and direct financer of services, and to develop ministerial functions, at the national and regional levels, such as planning, regulation, licensing, and quality control.

- b. Service providers (inpatient, outpatient, rehabilitation) were to become economically autonomous units funded on a per-service basis by the health plans.
 - c. Health plans were to offer a base level of mental health services in their mandatory basic benefits package. Some services would be provided in-house while others would be purchased from autonomous providers.
2. Development of a service delivery system organized by region, for the purpose of promoting uniform availability of services throughout the country.
 3. Progressive decrease in expenditures for hospital care by lowering hospitalization rates and reducing the lengths of psychiatric hospitalizations. The funding made available would be reinvested in developing community outpatient and rehabilitation services.
 4. Development of inter-ministerial task forces to promote solutions to issues beyond the domain of the Ministry of Health (especially labor and social affairs, housing, and education).

Years of Intense Activity, Anticipation, and Ambiguity: 1995 and 1996

The legal mandate for reform of mental health services as described above launched the entire mental health system into a period of heightened complexity, instability, and anxiety. On one hand, there was no denying that reform of the system was necessary and essential. On the other hand, as the end of the old system came into view, many groups became painfully aware of what they had to lose if the reform were in fact enacted, or if its enactment caught them unprepared or unprotected. These groups, and their causes for concern, included the following:

- ♦ *The administration of the Ministry of Health* stood to lose both its control of the hospitals, as well as discretionary control of funding for mental health services, as these funds would now bypass the ministry and go directly to the health plans. This was especially significant because the ministry had already lost discretionary control of funds for all the other types of care covered by the law (i.e. other than mental health, public health, and geriatric services).⁵
- ♦ *The managers of the health plans* were concerned that the capitation formula being offered by the government would leave them under-funded, especially considering the need for investment during the transition, and the expected increase in demand as a result of the transfer.⁶
- ♦ *The management and staff of state psychiatric hospitals* faced both the probability of downsizing and loss of jobs, and the prospect of being held economically accountable by the health plans.⁷
- ♦ *The management and staff of Ministry of Health outpatient services* feared that excessive control of finances by the health plans would lead to health plan interference in

⁵ Interview with Prof. Yigal Ginat, March 27, 2001.

⁶ Letter from Dr. Avigdor Kaplan, executive director of KHC to Knesset member Maxim Levy, chairman of the Knesset Committee on Labor and Social Welfare, December 23, 1996.

⁷ Interview with former director of a psychiatric hospital.

professional considerations, and the replacement of professional considerations with financial considerations (Feldman et al, 1996).

- ♦ *Mental health practitioners* working in the hospitals faced the prospect of losing the special financial benefits of hospital work. Others, who supplemented poorly paying jobs in the community with lucrative private practices, faced the likelihood that the availability of non-stigmatic, affordable, and reasonably high quality services from the health plans would drive down demand for private services and cause a significant loss of income.⁸
- ♦ *Mental health service consumers*, who were just beginning to organize at the time, feared that the transfer of mental health services to the health plans, and the consequent emphasis on financial considerations, would put those at greatest risk – the severely and chronically mentally ill – in danger of losing their places in the hospitals while being offered no viable alternatives in the community.⁹
- ♦ *Enosh*, the non-profit organization that was contracted by the Ministry of Health to provide mental health rehabilitative services, was in danger of losing its privileged position when new non-profit organizations began to be engaged by the health plans to develop and provide services in the community.¹⁰

The three years following passage of the law were filled with debate in the professional community.¹¹ Some of those who were opposed to or concerned about the effects of the change spoke out in public or internal forums. An example of this was the active lobbying of Knesset members by professional organizations, labor unions, consumer organizations, and Enosh.¹² Others, such as the directors of state psychiatric hospitals and unions representing hospital employees, who had much to lose by the proposed shift from hospital to community services, lobbied within the system to prevent changes that would require cut-backs in hospital budgets.¹³

At the same time, those in favor of the transfer of mental health services to the health plans were busy laying the groundwork for the new system, as new units were created within the health plans, research and information systems were established, and specific services prepared themselves for the change. Simulation studies were undertaken to try to predict the effects, costs, and pricing of the new system, and to build administrative mechanisms to facilitate the transition.

Even though a three-year period was allotted for making the transition, the Ministry of Health took upon itself to shorten this interim period and initiate the more immediate implementation of the

⁸ Interview with consumer advocate.

⁹ Position paper of the Action Committee of Families of People with Mental Illness, signed by Israel Eldar, chairperson, December 9, 1996.

¹⁰ Interview with Prof. Yigal Ginat, March 27, 2001.

¹¹ Documentation of a public dialogue on the reform that took place on 15.1.96, with presenters Yigal Ginat, Mordecai Shani, Gabi Shefler, and Uri Aviram is published in *Society and Welfare, Quarterly for Social Work*, Special Issue on Mental Health Services: Trends and Issues, 18 (1), 1998.

¹² Interview with former hospital director.

¹³ Interview with former hospital director.

transfer. On the day before the transfer was first to take effect (June 1, 1995), the plan was brought before the Knesset Committee on Labor and Social Affairs, at the time under the chairmanship of MK Yossi Katz. During this meeting it became apparent that the law was ambiguous as to whether the Ministry of Health had the authority to decide unilaterally on the conditions of the transfer (as claimed by the ministry's legal advisors), or, alternatively, whether the ministry could only implement the transfer if its terms were agreed to by the Knesset Committee on Labor and Social Affairs, the Ministry of Finance, and the health plans. Yossi Katz insisted upon the latter interpretation, and when he discovered that the smaller health plans had severe reservations about the plan, he insisted that the transfer be delayed, pending further planning and future deliberations in the committee.

Two more deadlines were set by the Ministry of Health and brought to the Committee for approval: May 1, 1996, and finally January 1, 1997. Committee meetings in advance of these dates were attended by representatives of the Ministry of Health, Ministry of Finance, Ministry of Labor and Social Affairs, the four health plans, hospital and community services, professional unions, and consumer advocates. While there was a consensus that reform was necessary, considerable concern was expressed that if not done carefully, it could do more harm than good – if, for example, not enough resources were allocated to the community; the funding allocated the health plans for taking over responsibility for mental health services was insufficient; and other government ministries, especially the Ministry of Labor and Social Affairs, did not accept responsibility for non-medical, rehabilitative care of people with mental illness and their families in the community.

In the last meeting of the committee, to discuss transfer plans prior to the January 1, 1997 deadline, chaired by MK Maxim Levy, the transfer was blocked by health plan opposition to the level of funding they were being offered.

Developments in the Use of Data in Decisionmaking Regarding Mental Health Care in Israel¹⁴

Early Years of the National Psychiatric Case Register: 1950-1990

National data on all admissions to psychiatric hospitals or psychiatric wards in general hospitals have been kept in the National Psychiatric Case Register by the Ministry of Health since 1950. Reporting to this Case Register is required by the 1950 Treatment of the Mentally Ill Law.

The National Psychiatric Case Register was kept manually by the Ministry of Health until 1975, when computerization was introduced. From that point on, it was maintained by the Automation Unit of the Ministry of Health, which operated alongside the ministry's Statistics Department. When an expanded computer system was incorporated in 1980, the Automation Unit became the

¹⁴ This section is based on Danielli and Ben-Natan (undated) and interviews with staff of the Unit for Information and Evaluation of the Mental Health Services.

Department of Information and Computerization. Upkeep and analysis of the Case Register became the task of a separate Unit for Information and Evaluation within the Department of Mental Health Services of the Ministry of Health.

Over the years, the Unit for Information and Evaluation has published many reports based on statistical analyses of the National Psychiatric Case Register. Prior to 1985, reports were published irregularly. Between 1988 and 1990, the Unit began to publish information frequently, regularly, and in large quantities (for examples see Popper, 1982, 1983; Popper and Horowitz, 1988, 1990; Popper and Lerner, 1991).

During these years, the staff of the Unit for Information and Evaluation decided – on the basis of requests and what seemed to be of interest to the public – which analyses to make and which reports to publish. At that time, policymakers showed little if any interest in the use of data to support their decisions.

Computerization of Psychiatric Units: 1991-1993

During the early 1990s, the Ministry of Health decided to augment the centralized computerization of the National Psychiatric Case Registry by computerizing the records of individual patients and of the psychiatric departments and units in 10 hospitals and 40 clinics around the country. This initiative grew out of the administrative concerns of the ministry's senior managers. At that time, the idea of computerization – or, for that matter, of organizing information as part of ongoing management – had not yet become part of hospital managements' thinking. Computerization met with considerable hostility and resistance, as it was seen as cumbersome and alien to psychiatric work.

Effects of National Health Insurance Law on the Use of Data: 1993-1996

While computerization was underway, the new NHI Law was passed. When the new law took effect – even though it did not yet apply to mental health care services – professionals realized that in order to survive in the future they would need to be able to document their work in order to bill the health plans. Suddenly the computerized system became an essential asset, through which they could keep their hospital or clinic in business. As a consequence:

- ♦ The proportion of raw data that were computerized climbed to above 80%.
- ♦ Staff began studying the data reports, and making helpful comments and suggestions.
- ♦ Staff began using stored, organized data in decisionmaking.
- ♦ Staff began constructively criticizing the computerization.

During 1995 and 1996 the Unit for Information and Evaluation was flooded with requests for information and for analyses, to which they did their best to respond. The sense in the Unit, however, was that not nearly enough thought had gone into either the definition of information needs or into efforts to ensure the quality of information – for instance through the uniform definition of variables. The data base tended to be used to substantiate preconceived decisions, rather than as a resource for improving the quality of decisionmaking.

Research on the Mental Health Needs and Services in Israel

The previous section described the evolution of the use of data in administrative decisionmaking about mental health services in Israel, with an emphasis on the central role of the National Psychiatric Case Registry. The present section will provide an overview of academic studies of mental health needs and services in Israel. Lerner (1992) has described these studies as belonging to the field of “psychiatric epidemiology”.

Studies in psychiatric epidemiology in Israel may be classified according to the following four categories: Studies based on analyses of administrative data (primarily the National Psychiatric Case Register); community surveys of populations in mental health treatment; community surveys of the general population that include mental health indices; and studies that combine data from multiple sources.

Studies Based on Analyses of Data from the National Psychiatric Case Register

An overview of the National Psychiatric Case Register and its history was provided in the previous section. In addition to statistical reports put out by the Unit for Information and Evaluation of the Mental Health Services in the Ministry of Health, numerous studies based on Case Register data have been published. The first of these summarized data collected during the Case Register’s first 30 years (Rahav, Popper, and Nahon, 1982). Later studies attempted to evaluate theory-based hypotheses of the effect on rates of hospitalization of neighborhood of residence (Goodman, Rahav, Popper, 1982); socioeconomic status (Rahav, Goodman, Popper, 1986); and education (Levav et al, 1987).

Another focus of academic study has been longitudinal patterns of utilization of inpatient services. Lerner et al. (1989) and Zilber et al. (1990) detailed the results of a nationwide random sample of psychiatric patients admitted for hospitalization in Israel in 1980, who were followed up until the end of 1984. Two main patterns of hospitalization were discerned: a single short-term hospitalization, vs. repeated long term hospitalizations. A similar study of hospitalization trends during 1984-1991 served as a basis for predicting the need for psychiatric beds up to 1995 (Popper, Lerner, 1991).

Community Surveys of Populations in Treatment

A nationwide survey of all public mental health facilities was conducted by the Ministry of Health in 1986, and presented a comprehensive and detailed picture of the content of care provided by public services (Feinson, Popper, and Handelsman, 1992; Feinson et al, 1997). The data set included all persons (13,500) who received any type of mental health treatment in hospitals, ambulatory clinics, or day care units during a one-week period (May 27 through June 2, 1986). Survey questionnaires completed by professional staff for every visit by a client included detailed clinical, demographic, and socio-economic information. Accuracy was exceptionally high, as data were collected through a carefully monitored, uniform process, with a 100% completion rate.

The following are some of the findings reported from analyses of these data:

- ♦ Being a woman and being single or divorced correlated positively with service utilization, while being older and non-Jewish correlated negatively with service utilization (Feinson, Popper, and Handelsman, 1992).
- ♦ Clinical status is the strongest determinant of the type of treatment provided to ambulatory clients, but gender and age are also important predictors of type of treatment. In contrast, clinical status is relatively less important for explaining the duration of treatment, and makes virtually no contribution to explaining the frequency of treatment, for which having more education and being younger are the most important predicting factors (Feinson et al, 1997).

An additional 1986 survey focused on long-term clients of all community mental health clinics in Jerusalem (Lerner et al, 1991). Long-term clients were chosen because they place a particularly heavy burden on the economic and human resources of mental health services. It was found that, for the two-thirds of patients suffering from major psychiatric disorders, long-term utilization rates were similar across catchment areas, but higher in socio-economic groups that are also reported to have high rates of prevalence of psychiatric disorders. For those without major psychiatric disorders, long-term utilization rates varied among clinics, apparently reflecting differences in the extent to which long-term psychotherapy is used as a treatment modality.

Community Surveys of the General Population

Since most individuals suffering from emotional disorders are not patients of mental health services, surveys of populations in treatment give little indication of the prevalence of emotional disorders in the general population. Two common methods for obtaining relevant diagnostic data about individuals in general population samples have been utilized: questionnaires, and clinical diagnostic interview (Lerner, 1992). Questionnaires are presented to all members of a sample, with each subject's self-report rated on a continuum of mental health-mental illness, with defined clinical and normal ranges. These self-report measures have been criticized as being poorly related to diagnostic criteria for mental disorders. This has led to the development of increasingly sophisticated semi-standardized psychiatric diagnostic interviews, which are more expensive to implement but whose results are regarded as a more accurate reflection of the prevalence of diagnosable disorders in the population.

Lerner, in a review of psychiatric community surveys done in Israel, notes that these surveys had limited practical value because most of the samples were local, and more advanced screening and diagnostic instruments were not utilized. The one community study in Israel characterized by a rigorous sampling procedure and data collection methodology was that of Levav et. al. (1993). This study found that, over a ten-year period, approximately one-fifth of the population had had, at least one point in time, a mental disorder that met accepted psychiatric criteria

Studies that Combine Data from Multiple Sources

Aviram et al. (1998), in an effort to estimate the number and characteristics of chronically mentally ill individuals in Israel, utilized multiple data sources. Criteria for inclusion in the category of

“chronically mentally ill” were based on an analysis of data from three data sets: the National Psychiatric Case Registry (hospitalization history); data from the National Insurance Institute on chronic functional disability; and the findings of the Jerusalem survey of long-term users of mental health clinics (Lerner et al. 1991). The use of multiple data sets made it possible to maximize the use of existing data, while taking into account and differentiating between various dimensions of the lives of those being studied.

Conclusions

Over the years, a significant amount of research has been conducted into the population of people with mental illness in Israel, from a variety of perspectives and contexts. Much, though not all, of this research has been facilitated by the existence of mental health research frameworks such as the Unit for Information and Evaluation in the Mental Health Services in the Ministry of Health, and the Falk Institute for the Study of Mental Health and Behavioral Sciences.

This field of research has produced some rich data sets, as well as insight into the prevalence and patterns of emotional distress and mental illness in the Israeli population, and into the provision and utilization of inpatient and outpatient psychiatric services. While many of these studies profess to have practical implications for decisionmakers, it is unclear to what extent they have actually been useful to administrators and policymakers.

Chapter 3: The Use of Data in the Effort to Transfer Mental Health Services in Israel from the Ministry of Health to the Health Plans

Introduction

The present study examines the extent and the ways in which data informed the effort in 1995-1996 to carry out the transfer of responsibility for mental health services to the health plans. As noted, no final decision was actually made. Nevertheless, during this period, when it seemed that this policy change was likely, a great deal of effort went into the attempt to design the parameters of the transfer. The study examines the role of data in these processes.

Three levels of questions were identified as having been addressed by decisionmakers at the time. The first level was the global policy question:

- ♦ Should mental health services be included in the mandatory basic basket of services provided by the health plans?

The second level of questions, found to be prevalent in decisionmaker discourse, related to the design of the parameters of the new policy, especially with regard to the division of responsibilities and the distribution of resources. Included in this group are:

- ♦ Which services will be included in the basic basket, which will continue to be the responsibility of the Ministry of Health, and which will be the responsibility of a different ministry?
- ♦ Who should be responsible for the care of the most vulnerable consumers?
- ♦ How much money will be made available to the health plans for financing mental health services?
- ♦ Should money be given to the health plans as part of a global budget, or earmarked for mental health services?
- ♦ What capitation formula will be used to distribute money among the health plans?
- ♦ What should be the price of services purchased by health plans following the reform?

A third level of questions that were addressed during this period were more peripheral to the decisionmaker discourse. They related to the development of administrative and training mechanisms that would be essential to the successful implementation of the transfer. These included:

- ♦ How, specifically, will mental health care be integrated into the general health care system?
- ♦ What mechanisms need to be in place to support the transition from the previous system to the new one?

This chapter will present an analysis of each of the above nine questions in light of five considerations:

1. Significance of the decision
2. Important analytical questions/data required
3. Available sources of data
4. Missing data
5. Basis of the decision

The discussion of each question will be followed by a summary table and discussion that evaluates the use of data related to that question according to two dimensions: Kinds of data used, and the extent of utilization of data/information. The chapter concludes with an analysis of the findings on the use of data as they are reflected in a composite assessment of the component decisions.

Decision 1: Should mental health services be included in the mandatory basic basket of services provided by the health plans?

Significance of the Decision

The primary decision upon which all others depended was the decision whether to include mental health services in the basic basket of services that the health plans are obligated to provide their members. This would mean, on one hand, that the health plans would be obligated to provide specified mental health services to their members. On the other hand it would mean that they would be provided by the government with a global budget, based on a capitation formula, for this purpose.

On the whole, it was hoped that the inclusion of mental health services in the basic basket of services provided by the health plans would promote the following outcomes (Mark et. al., 1995):

- ♦ *Improved quality of care* for people with mental illness, by preventing unwarranted and expensive long-term hospitalizations and enhancing medical and psycho-social support for living in the community;
- ♦ *Decreased stigmatization*, by putting an end to segregated mental health treatment and integrating mental health care in the general medical services;
- ♦ *Improved efficiency*, by transforming a monopolistic government system into a market-based system in which competition would drive both service development and efficiency;
- ♦ *Enhanced continuity of care*, as the physical and mental health components of medical care would be provided under the same organizational auspices; and
- ♦ *Cost-containment* as health plans would be motivated by their own self-interest to operate within agreed upon budgetary constraints.

The risks and consequences of failure to operate within the budget – if, for example, the demand for services were to rise significantly with their increased availability – would fall on the health plans, which would not have recourse to deficit financing. One possible result of this assumption of risk would be that the health plans would be motivated to increase efficiency in order to hold down costs. An alternative or supplementary scenario was that the health plans would be motivated to organize in ways that would keep down demand, for instance by instituting co-payments, benefit limits, supplementary benefits packages, or otherwise limiting accessibility.

Analytical Questions/Data Required

The proposal to include mental health services in the basic basket of services provided by the health plans is grounded in a number of assumptions about the likely effect of this action on the system – the desired outcomes listed in the previous section. The link between the proposed strategy (inclusion in the basket of services) and the hoped-for outcomes should be challenged and viewed in light of available evidence. For example:

1. What evidence is there that the present system needs to be changed?
2. What has been done in other countries to achieve desired results, and what have been the outcomes?
3. What evidence is there confirming the assumptions underlying the reform strategy, that it will:
 - a. lead to improvements in care for consumers of mental health services?
 - b. decrease stigmatization?
 - c. enhance continuity of care?
 - d. improve efficiency?
4. How much can demand be expected to increase?

Available Sources of Data

Evidence that the current system needed to be changed

Descriptions and evaluations of the current system indicating a need for change were available in both the Netanyahu Commission Reports and the 1991 State Comptroller's Report. For example,

these reports pointed to disparities in service availability between the major cities and the periphery, separation between the psychiatric and medical systems of care, poor coordination between hospital and community care, poorly developed prevention and rehabilitation services, and a lack of data concerning both the prevalence of mental health problems in the general population and the utilization of outpatient and rehabilitation services.

Similarly, numerous reports and articles were published by the Department of Information and Evaluation of the Mental Health Services of the Ministry of Health, the Falk Institute for Mental Health and Behavioral Studies, and academics specialized in the area of psychiatric epidemiology (see chapter 2). These studies, though less focused on directions for change, provided descriptive analyses of selected issues and trends in the utilization of a variety of services by a variety of populations.

Experience in other countries

1. Interviews with staff of the Mental Health Services revealed that the changes taking place in Israel were well informed by similar efforts to reform mental health services elsewhere in the world. Israeli senior mental health staff visited numerous sites in the United States (especially New York State) and Canada (especially Ontario Province) and throughout Europe (England, Germany, the Netherlands, Belgium, Finland, and Norway) to learn about how other countries had dealt with de-institutionalization and the financing of mental health care. Mental health services staff were also in close contact with the WHO, which is involved in mental health reform throughout the world. They collected articles and un-published internal documents about programs and their results, which they brought back to Israel and, in some instances, had disseminated. They also organized meetings, workshops, and conferences for personnel from the ministry and the health plans, to introduce them to one another and to discuss alternative models implemented elsewhere. The substantial input from abroad seems to have been influential in the processes that took place during this period. However, no evidence was found that this input or its effects were systematically documented.

Missing Data

Efforts do not seem to have been made to garner specific evidence that would confirm the assumptions underlying the reform strategies and the projected outcomes of its implementation (i.e. improved accessibility, reduced stigmatization, enhanced quality of care). These were regarded, at this stage, more as axioms than as questions for empirical examination.

Basis of the Decision

The documents reviewed for the current study revealed a broad consensus both on the need for reform of the Israeli mental health system, and on the strategy of transferring responsibility and risk for mental health services to the health plans – this despite the lack of empirical evidence that this strategy would indeed lead to the desired outcomes. In making the decision, attention was focused less on evaluating whether the transfer should be implemented, or how the transfer would achieve

desired goals, than on how to make it affordable for the government, feasible for the health plans, responsible toward the most vulnerable populations, and administratively operable.

Dr. Meir Oren, who was the director-general of the Ministry of Health at the time, is of the opinion that the Ministry of Health had enough information to make a decision in favor of the transfer.¹⁵ This included information on the likely impact on system costs and on the health and well-being of the mentally ill (particularly the most vulnerable among them). While there was also considerable uncertainty, he pointed out that management and policy decisions – particularly those related to major system changes – require the courage to make and implement decisions despite uncertainty.

Table 1: Should Mental Health Services Be Included in the Mandatory Basket of Basic Services Provided by the Health Plans?

Use of data/information	Exists	Discussed	Impact
Relevant data bases	yes	yes	no
Data on needs and services	partial	yes	yes (lack)
Data on finances	yes	yes	yes
International experience	yes	yes	no
New studies or data bases	no	no	no
Computerized simulations	yes	yes	no
Field experiments	no	no	no
Expert consultation	no	no	no

Regarding the decision of whether to include mental health services in the basic basket of services provided by the health plans, a great deal of information and data existed – especially on hospitalization trends in Israel (from the National Psychiatric Case Registry), finances, and experience in other countries. However there was a notable lack of epidemiological data on the population’s mental health needs, service provision – particularly by the health plans and by the private sector – and projected service utilization. Data from the National Psychiatric Case Registry, data on needs and services, and information from international experience seem to have entered the policy discussion. In the end, financial data, and the **lack** of data on needs for services in the community, had the strongest impact on the positions of decisionmakers.

Decision 2: Which services will be included in the basic basket, which services will continue to be the responsibility of the Ministry of Health, and which services will become the responsibility of a different ministry?

Significance of the Decision

Even with agreement on the general idea that mental health care should be included in the basic basket of services covered by the health plans, there remained a question as to how inclusive the definition of “mental health care” should be for this purpose. The 1995 National Health Insurance Law indicated that a broad range of services would be transferred from the Ministry of Health to the

¹⁵ Interview with Dr. Meir Oren and Dr. Motti Mark, 2002.

health plans, including hospitalization, outpatient care, rehabilitation services, and drug and alcohol treatment. At various points during the negotiations, the Ministry of Health changed its stance as to which of these services would and would not be included in the basic basket, particularly with regard to the status of rehabilitative care.¹⁶

“Social care” versus “medical care”

Part of the ambiguity as to what was to be included in the basic basket of services arose from a lack of clarity regarding the extent to which government ministries other than the Ministry of Health would accept responsibility for providing services to the mentally ill and their families. The need for the Ministry of Health to collaborate with the other ministries was especially relevant regarding rehabilitation services (e.g. supported housing, supported employment, leisure time activities). Although these services were originally to be included in the basic basket of services, they are “social” rather than “medical” in nature, and are therefore beyond the usual domain of the health plans. In fact, for other populations with disabilities, such services are provided by the Ministry of Labor and Social Affairs.

Continuity of care

One critical issue that was brought up by respondents in the health plans was that dividing responsibility among several organizations for different aspects of care (i.e. hospitalization financed by *a*, outpatient care by *b*, rehabilitation by *c*) would lead to serious problems in continuity of care. Consumers are continuously forced to negotiate multiple and often poorly coordinated systems in order to access care. Given this, it would have made more sense to transfer the entire continuum of care to the health plans, rather than parcelling it out, as was attempted.¹⁷

Analytical Questions/Data Required

1. Which services are congruent with the mission and practice of the health plans, and which are beyond the limits of their mission and practice?
2. What are the strengths and weaknesses of the health plans as organizations?
3. Given those strengths and weaknesses, what is it reasonable to expect them to do well, and in what areas is there cause for concern?
4. What are the costs and benefits of consolidating services in one organization versus dividing them among organizations?

Available Sources of Data

No evidence of data was found that addressed the above questions.

¹⁶ Avigdor Kaplan, CEO KHC, in testimony before the Knesset Labor and Welfare Committee on December 9, 1996:” The first time that I got an official document from the Executive Director of the Ministry of Health, printed on Ministry stationery, that stated just what was going to be transferred to the Kuppot, was on the 8th of December, that is yesterday”.

¹⁷ Interview with Clalit Health Services staff.

Missing Data

The question of the mission, strengths and weaknesses of the health plans could have been usefully addressed by a study conducted by a consulting firm that specializes in organizational strategy and strategic planning. Such a study could have analyzed the degree of “fit” between new areas of service, such as mental health rehabilitation, and each health plan. In doing so, it would have addressed such issues as whether the service

- ♦ requires substantive specialized knowledge and, if so, the extent to which the health plans had or could acquire that knowledge;
- ♦ involves a large amount of work with the government and, if so, the interest and capacity of the health plans to work with the government;
- ♦ involves a rapidly changing or relatively stable technology and/or environment, and the inclination of the health plans to work in such technological and/or environmental conditions;
- ♦ requires the health plans to provide outreach services.
- ♦ is geared for the general population or for people with special needs, and the inclinations of the health plans to favor serving one or the other; and
- ♦ provides social or medical care, and the willingness of the health plans to address social needs.

The issue of the cost and benefit of consolidating services in one organization, as opposed to dividing them among organizations could be explored by comparing different areas of service in which each strategy has been implemented – in Israel or abroad.

Basis of the Decision

While the original recommendations called for the inclusion of psychiatric hospitalization, mental health ambulatory treatment and rehabilitation services, and drug and alcohol treatment, from the outset it seems there was consensus that hospitalization and ambulatory treatment would be included in the basket, while drug and alcohol treatment would be excluded.

Early on, it was expected that responsibility for rehabilitation services would be transferred to the health plans, which would then contract them out to Enosh – historically the main provider of rehabilitative mental health services in Israel. The management of Enosh protested this plan, preferring to maintain its direct contracting with the Ministry of Health.¹⁸ Under these circumstances, the health plans were reluctant to accept responsibility for these services, and preferred that they remain in the Ministry of Health, or be given to the Ministry of Labor and Social Affairs.

During the years studied, rehabilitation services were a central focus of the work of an inter-ministerial committee which attempted to renegotiate and clarify the responsibilities of a number of

¹⁸ Interview with senior mental health official.

ministries for different aspects of care for mental health care. Thus there was ongoing ambiguity as to the future of rehabilitation services, frustrating the efforts of the health plans to predict future costs.¹⁹

Table 2: Which Services Will Be Included in the Basic Basket of Services?

Use of Data	Exists	Discussed	Impact
Relevant data bases	partial	no	no
Data on needs and services	partial	partial	no
Data on finances	yes	yes	little
International experience	no	no	no
New studies or data bases	no	no	no
Computerized simulations	no	no	no
Field experiments	no	no	no
Expert consultation	no	no	no

As reflected in Table 2, regarding the question of which services to include in the basic basket of services, few data were available, such that data played a very small part in the discourse of this question, and had little if any influence or impact upon decisions.

Decision 3: Who should be responsible for the care of the most vulnerable consumers?

Significance of the Decision

Analyses of the National Psychiatric Case Registry identified about 4,000 consumers with chronic mental illness who were in long-term hospitalization. They were seen as least likely to respond to rehabilitation in the community²⁰ and were viewed as being at greatest risk of harm if the transfer were effected. The question arose as to who would be responsible for their care if indeed it were effected?

The issue of identifying the most vulnerable consumers was important from two perspectives:

1. Concern for their well-being and protection;
2. Drawing a line between those whose care would be funded by the Ministry of Health, and those whose care would be funded by the health plans.

Concern for the well-being and protection of the most vulnerable consumers

One of the prime arguments of opponents of the transfer of mental health services to the health plans was that it would put at risk the most vulnerable population – that is, the treatment-resistant

¹⁹ Dr. Avigdor Kaplan, in the Knesset Committee for Labor and Welfare meeting of December 9, 1996, said “We don’t know clearly what is included in the basket of services, we don’t know its cost as estimated by the government, we don’t know the capitation formula, and we don’t know the final prices according to which the health plan will operate opposite the public and government hospitals.”

²⁰ This number was taken from a letter from Prof. Gabi Barbash, director general of the Ministry of Health, to Member of Knesset Maxim Levy, chairperson of the Knesset Labor and Social Affairs Committee, on October 13, 1996.

chronically mentally ill. This argument was threefold. First, there was concern that the health plans would receive government money through the capitation formula for mental health services, but would then spend it elsewhere, such that mental health care financing would actually decrease.

Second, it was argued that the health plans, which operate on the basis of economic decisionmaking, would seek to replace expensive forms of care with cheaper alternatives. On the one hand, this tendency is an advantage, as it would decrease reliance on expensive hospital care in favor of community-based alternatives, which are frequently in consumers' best interests. On the other hand, for the most severely mentally disabled, it could cut off access to necessary care and protection. The plight of the mentally ill homeless in New York and other cities, who had undergone "de-institutionalization", provided a vivid example of this.

A final cause for concern was that severely dysfunctional mentally ill would be unable to voice their needs and concerns. Thus, if not specially protected in the new system, they would be unable to be advocates for themselves, and could easily be victimized.

Drawing a line between those whose care would be funded by the Ministry of Health, and those whose care would be funded by the health plans

In light of the above concerns, the Ministry of Health proposed that it maintain responsibility for a small portion of the chronically mentally ill – those considered "without hope of rehabilitation". A funding mechanism was to be established for this purpose called the RUT Fund (Revacha VeTikva – Welfare and Hope). This proposal raised the important question of where to draw the line between this group and other intensive users of mental health services, whose treatment would be financed by the health plans with the money from the capitation. This distinction was crucial, because these categorizations would be permanent once made.²¹

An initial proposal suggested that the treatment of all those who had been hospitalized for the entire previous year would be covered by the RUT Fund. This was later revised to include only people who had been hospitalized for the entire previous two years. The establishment of this parameter created concern that, since it would be in the interest of the health plans to pass on responsibility to the Ministry of Health, they would have an incentive to extend hospital stays so that consumers' insurance status would change.

Analytical Questions/Data Required

1. Who will be most at risk if responsibility for mental health services is transferred to the health plans?
2. What is the cost of a reasonable level of care and protection for these individuals?
3. What strategies have been used in other countries to protect such individuals, and what have been the outcomes?

²¹ This section is based on the interview with a former director of a psychiatric hospital.

4. What are the costs and benefits of transferring responsibility for these individuals to the health plans, or alternatively, of leaving them the responsibility of the Ministry of Health?

Available Sources of Data/Information

The main sources of data/information about the most vulnerable chronically mentally ill – who they are, their treatment history, where they were residing – was the National Psychiatric Case Registry, and the analyses performed on that data base by the Department of Information and Evaluation of the Mental Health Services of the Ministry of Health, and by the Falk Institute.

In addition to the descriptive information available from the National Psychiatric Case Registry, during 1994-1995 a study was conducted by the Ministry of Health in which an interdisciplinary team evaluated the functional status and prospects for rehabilitation of 4,000 people with chronic mental illness who had been hospitalized in a psychiatric hospital for one year or more. The team examined each person and considered alternatives to hospitalization, recommending that 1,241 of them be transferred to housing in the community.²² Initial attempts were also undertaken to monitor the outcomes for members of this group who had been released to the community.²³ No formal documentation was found of either of these two studies.

The decision process was also supported by exposure, through professional contacts and written documents, to strategies of mental health reform used in other countries, and the effects of these strategies on similar populations.

Missing Data

One of the issues disputed during the decisionmaking process was the level of funding required for the care of the group of individuals who were likely to remain in long-term hospital care. No documentation was found of studies to systematically determine the cost of an acceptable level of care.

Similarly, no data were available from Israel to inform the decision as to whether this group would be better off in the care of the Ministry or of the health plans.

Basis of the Decision

During the early stages of the process, it was assumed that responsibility for all mental health services consumers – including those with severe and chronic mental illness – would be transferred

²² This study was reported in the 1998 State Comptroller's Report (49), with the added comment that the vast majority of this group remained hospitalized nonetheless in 1998 due to lack of housing alternatives in the community.

²³ See a document from Yechiel Shereshevsky, director of hospital alternatives in the Mental Health Services, entitled "First findings in the survey of the Rut consumers released to the community", from September 25, 1996. It was found that there was little if any follow up care in the community, which left patients at severe risk for rehospitalization.

to the health plans. When the plans resisted taking responsibility for this most vulnerable and costly population, and after ministry staff had learned that, throughout the world, this population remains the responsibility of the state, the decision was made that a portion of the mental health budget would be set aside in a special fund within the Ministry – the RUT Fund – for the care of this population.²⁴

Once the health plans realized that this change would result in their losing out on a sizeable portion of the funds from the capitation formula, they began expressing more interest in accepting responsibility for serving this population. Disagreements then arose between the Ministry of Health and the health plans as to whether or not the health plans could be entrusted with their care. Health plan representatives insisted on numerous occasions that they be given overall responsibility for individuals covered by the RUT Fund, as well as the budgets set aside for their care.²⁵ The policy of the Ministry of Health changed over time, sometimes leaving this group solely under its care, and sometimes leaving it under the care of the health plans. In the last ministry proposal prior to the 1997 deadline, care of the group had been transferred to the health plans.²⁶

Table 3: Who Should Be Responsible for the Care of the Most Vulnerable Consumers?

Use of data/information	Exists	Discussed	Impact
Relevant data bases	yes	yes	yes
Data: Needs and services	yes	yes	no
Data: Finances	yes	yes	yes
International experience	yes	yes	yes
New studies or data bases	yes	yes	yes
Computerized simulations	no	no	no
Field experiments	no	no	no
Expert consultation	yes	yes	yes

As reflected in Table 3, the efforts to identify the most vulnerable consumers and to consider how they could be best cared for was significantly informed by data and information. First, the National Psychiatric Case Registry was analyzed to identify the most vulnerable individuals. In addition, a new study was conducted evaluating the capacities of those considered most vulnerable, and monitoring the progress of those of them who had been released to the community. Finally, learning about how these individuals are cared for in other countries affected the stance of the Ministry of Health during most of the negotiation period.

²⁴ This section is based on an interview with a senior mental health official.

²⁵ Letter from Gila Saadia, Director of Mental Health in Maccabi, to Dr. Zeev Kaplan, director of Mental Health Services, Ministry of Health, from July 31, 1996.

²⁶ See letter from Prof. M. Shani to Y. Keranot, deputy legal counsel of the Ministry of Health, from November 20, 1996.

Decision 4: How much money will be made available to the health plans for financing mental health services?

Significance of the Decision

Underlying the bulk of negotiations between the Ministry of Finance, the Ministry of Health, and the health plans was the question of how much money should be made available to the health plans. Or, put differently: How much money would the health plans require in order to carry out – at a satisfactory level and without destructive cost overruns – the responsibilities entailed in the transfer of mental health services to their auspices. Differences in perspective on this question were at the root of repeated failures to decide on transferring mental health services to the health plans.

Differences between the Ministry of Health and the health plans were based upon different perceptions of three factors: projected increase of demand for mental health services as a result of the transfer; savings in costs of care that the health plans would gain as a result of the transfer; and whether the costs should be entirely funded by the Ministry of Health, or the health plans should cover some of the costs by increasing the efficiency of their service.

Projected increase of demand for mental health services as a result of the transfer

It was widely expected that provision of mental health services within non-stigmatic, community-based frameworks would increase the likelihood that people in need of treatment would actually seek it, thus leading to a rise in demand. Projections as to extent of this effect, and its subsequent cost for the health plans, varied widely, being minimized by the ministry and maximized by the health plans.

In negotiations conducted prior to the January 1997 deadline, the health plans raised this issue, asking for a funding agreement that would have the flexibility to monitor and adjust to emerging realities; however, this request was unacceptable to the Ministry of Finance.²⁷

Savings in costs of care that would result from the transfer

Decisionmakers in the Ministry of Health claimed the transfer would actually create savings for the health plans in two ways. First, the reform was to be accompanied by a shift in the balance of services from the hospital to the community, which would be accompanied by reductions in the rate of psychiatric hospitalization. Health plans would be compensated at the level of cost adequate to finance rates of hospitalization at the time of the transfer, and this rate would be maintained even as these rates would decline – thus leaving the health plans with a surplus. Second, proper care of mental health problems could have an indirect effect of bringing down general costs of health care.²⁸

Should the costs of care be entirely funded by the Ministry of Health

There was sharp disagreement between the Ministry of Health and the health plans on the question of whether all of the costs for provision of mental health care should be funded by the Ministry of Health. Meir Oren, former director general of the Ministry of Health, took a strong stand that some of the health plan operations were wasteful, and that there were numerous steps that they could take

²⁷ Letter from Dr. Avigdor Kaplan, Director of KHC, to Maxim Levy, from December 2, 1996.

²⁸ Interview with Dr. Meir Oren and Dr. Motti Mark, 2002.

in order to mobilize the funds necessary to supplement the amount of funding that the ministry was offering. Representatives of the health plans, concerned about already growing deficits, rejected this expectation.

Analytical Questions/Data Required

1. What do services cost now?
2. What expansion of demand is likely to result from inclusion of each item (inpatient care, outpatient care, rehabilitation, drug and alcohol), separately and together, in the basic basket?
3. What are projected costs, given a change in demand and utilization patterns and the need to develop new services and administrative systems?
4. What savings can be expected from the reduction of hospitalization rates, and from the provision of mental health services as an integrated aspect of health care?
5. How much money can the health plans mobilize through increased efficiency measures?

Available Sources of Data

The simplest of the above questions is that of the cost of current levels of service, which was addressed by financial data from the ministry and the health plans. The question of the expected change in demand in response to both the lowered cost of obtaining services and to the non-stigmatic nature of service delivery within the general health system – which was one of the core unknowns, was addressed by a number of relevant sources of data.

- ♦ A nationwide survey of 13,500 persons receiving services in public mental health facilities during the week of May 27 - June 2, 1986 (Feinson et. al. 1992; Feinson et.al. 1997), and a follow-up of this study in 1994 (Levinson et. al., 1996.)
- ♦ Data on current utilization of outpatient and rehabilitation services from the Department of Information and Evaluation of Mental Health Services of the Ministry of Health.
- ♦ An epidemiological study by Levav et al (1993) which found that, over a ten-year period, approximately one-fifth of the population had had, at least one point in time, a mental disorder that met accepted psychiatric criteria.

In addition to the sources of data already available, a study was initiated by the Ministry of Health in collaboration with the JDC-Brookdale Institute (Gross et.al., 1997). The stated aim of the study was to contribute to the ability of national policymakers and the health plans to determine the population's mental health service needs, as a basis for allocating resources and developing new services. The study tapped into the JDC-Brookdale Institute's 1995 national survey of a random sample of 1,394 adults in Israel (age 22 and over), which was part of an evaluation study of the National Health Insurance Law. This survey provided the first Israeli data on the extent of perceived mental health need (27% of those surveyed had at some time in their lives experienced "emotional distress or mental health problems which they had difficulty coping with alone"); and actual use of mental health services (38% of the above group sought help). It also explored why people do not seek assistance, to whom people turn for help, the extent to which the duration of treatment meets people's needs, and the relationship between mental health needs and the consumption of general health care.

Missing Data

While the above sources contained generally relevant data, several types of data were missing. These included the following:

- ♦ Systematic epidemiological data on mental health needs in the Israeli population.
- ♦ Data on current utilization of private sector and health plan outpatient services.
- ♦ Assessment of the percentages of people currently not utilizing mental health services who would utilize them if they were offered by the health plans, and of the effect of various conditions of service provision (e.g. co-payments, caps) upon this choice.
- ♦ Pilot projects in which the transfer could be implemented on a small scale in order to inform projections of its future effects on demand and costs.

Basis of the Decision

In light of the concern that the transfer of mental health services to the health plans would spark a sharp increase in demand for services, especially among those in the general population who were not previously intensive users of psychiatric services, and given the lack of any empirical basis predicting or controlling this course of events, the Ministry of Finance took a strong stance regarding the need for cost containment. The general principle dictated by the Ministry of Finance was that the amount of money in the Ministry of Health's budget used to finance mental health services before the law took effect would be put at the disposal of the health plans. Financial data were used to ascertain these financing levels. There was little if any consideration of alternative sources of financing, such as co-payments. Once this baseline had been accepted, the questions posed regarding projected extra expenses resulting from the transfer no longer played a role in the decision.

While there was agreement about most of the financial data, there was disagreement as to how to relate to a NIS 39 million deficit in the mental health budget. The Ministry of Health claimed that since the deficit was a direct product of a legal change established by the National Health Insurance Law, which cancelled the financing of psychiatric hospitalization by the patient's family (causing a change in income but not in expenditures), this amount should be included in the capitation formula that would be used to allocate money to the health plans. The Ministry of Finance did not accept this stance, and advocated a lower level of funding. Disagreement over this issue made it impossible to approve the transfer by the target date of May 1, 1996.²⁹

Once the Ministry of Health and the Ministry of Finance reached agreement, with the help of the government legal advisor,³⁰ it was possible to work toward a new target date: 1/1/97. A similar disagreement, not with regard to actual numbers but with regard to the meaning and implications to be derived from the numbers, ultimately created the impasse between the Ministry of Health and the health plans (primarily Clalit Health Services, the largest of the plans) in this next phase of negotiations. While there was agreement on financing levels for the services that would be

²⁹ See letter from Dr. Meir Oren, then director general of the Ministry of Health, to Chaim Peltz, deputy director of budgets, Ministry of Finance, from April 30, 1996.

³⁰ See letter from Member of Knesset Yossi Katz, Chairman of the Knesset of Labor and Social Affairs Committee, to Michael Ben Yair, legal counsel to the government in the Ministry of Justice, soliciting his involvement in the dispute between the two ministries.

transferred to the health plans, there was disagreement as to what to do about the mental health hospital and outpatient services that had long been provided by Clalit. Funding for these services had been disputed ever since the Ministry of Health had promised to fund them in 1978, and one year later had retracted that promise, leaving Clalit Health Services to provide the services and bill the Ministry ever since.

The core of this disagreement was whether the services already provided by Clalit Health Services, which for many years it had financed on its own while claiming that financing should come from the Ministry of Health, should now be financed through capitation, or whether they should remain the funding responsibility of Clalit. The two parties were unable to reach an agreement on this issue, which led to the failure to approve and implement the transfer on January 1, 1997, and to a long pause in activity while Clalit brought its claims to the Supreme Court for ruling.

Table 4: How Much Money Will Be Made Available to the Health Plans for Financing Mental Health Services?

Use of data/information	Exists	Discussed	Impact
Relevant data bases	no	no	no
Data on needs and services	yes	yes	yes
Data on finances	yes	yes	yes
International experience	yes	no	no
New studies or data bases	no	no	no
Computerized simulations	no	no	no
Field experiments	no	no	no
Expert consultation	no	no	no

The picture reflected in Table 4 shows that with regard to the core issue for this question – the effect of the transfer on future demand and costs – data existed and were discussed, but lacked components that would have made them useful in decisionmaking. Given the prevailing ambiguity and fears of sharp increases in demand, decisionmakers fell back on containing costs at current levels. Thus, financial data about past spending were the only data that seems to have had any impact on the amount of money that was to be made available to the health plans for financing mental health services.

Decision 5: Should money provided to the health plans be part of a global budget, or earmarked for mental health services?

Significance of the Decision

The decision of whether to earmark the money provided to the health plans for mental health services relates primarily to the degree of autonomy and discretion the health plans would have with the funds being transferred to them from the mental health budget. One of the primary concerns of opponents of the transfer from within the mental health field was that a significant portion of the money, once it had been transferred to the health plans, would be used to meet their other pressing needs, and would thereby be lost to mental health services. Earmarking the money would preserve it for mental health services, but would diminish the health plans' autonomy and increase the need for administrative controls.

Analytic Questions/Data Required

1. What are the risks, costs, and benefits of earmarking money for specific services, as opposed to granting it unconditionally?
2. What strategies have been used in other countries, and what have been their outcomes?

Available Sources of Data

No data was available to decisionmakers during the years studied.

Missing Data

In addressing the above questions, studies could have been sought that analyze experience in Israel and abroad with alternative strategies in a variety of administrative fields that specifically address past experience between government and health plans. Also, a small-scale experiment could have been performed and monitored, or a decision could have been made to perform a system-wide experiment, whose evaluation would affect a policy decision at a later stage.

Basis for the Decision

No evidence was found of this decision being systematically addressed during the years being studied. It seems to have been assumed that money would not be earmarked for mental health care, despite a great deal of concern expressed repeatedly in different forums as to the fate of the money that would be transferred to the health plans.

Table 5: Should Money Provided to the Health Plans Be Part of a Global Budget or Earmarked for Mental Health Services?

Use of data	Exists	Discussed	Impact
Relevant data bases	no	no	no
Data on needs and services	no	no	no
Data on finances	no	no	no
International experience	yes	no	no
New studies or data bases	no	no	no
Computerized simulations	no	no	no
Field experiments	no	no	no
Expert consultation	no	no	no

As reflected in Table 5, the decision of whether to provide the health plans with money as part of a global budget or to earmark it for mental health services, does not seem to have been explicitly on the agenda of decisionmakers. Thus, while data may have been available from international experience or from other service contexts, these data were not sought out and did not inform the decision.

Decision 6: What capitation formula will be used to distribute money among the health plans?

Significance of the Decision

The capitation formula established in the National Health Insurance Law divides resources among the health plans on the basis of the number of members of each health plan, weighted by age. This formula is problematic for financing mental health services, as the intensity of care is unrelated to age, but is affected by other factors, some of which are measurable. It was clear that people with chronic mental illness would require a relatively intensive investment of treatment resources, and

that a majority of these were members of Clalit Health Services. In contrast, there was much ambiguity with regard to the distribution among the health plans of current consumers of health plan and private mental health services, and of members who would use mental health services once they were financed by the health plans. Thus it was necessary to design a different formula that would take these factors into account and divide resources accordingly.

Analytic Questions/Data Required

1. How are mental health services consumers distributed among the different health plans, with reference to numbers and intensity of treatment?
2. How can the costs to be incurred by the health plans from providing mental health services to their members be effectively predicted, so that the capitation formula will in fact reimburse them for their expenses?
3. For purposes of calculating the capitation formula for each health plan, what information will need to be transmitted to whom, and how will this affect confidentiality?

Available Sources of Data

Ginsberg, Lerner, Mark, and Popper (1997), using data from the National Psychiatric Case Registry, developed a formula based on the combined use of age, days of usage during the past five years of hospital-based inpatient or day-hospital services, and diagnosis of individuals with chronic mental illness. This combined formula was found to explain almost all of the variance in the utilization of hospital-based services.

While the formula was technically successful, it had two limitations that seem to have prevented its implementation. First of all, the formula was based only on analysis of mental health consumers who had been hospitalized, and was not at all sensitive to the distribution of consumers who had not been hospitalized but who received services in the community.

The second limitation was that use of the formula would have required communication of data on individuals, and this raised serious confidentiality concerns. Specifically, the National Insurance Institute, which collects health insurance funds and distributes them to the health plans under the National Health Insurance Law, was willing to distribute funds on the basis of the proposed formula only on condition that it have access to the individual-based data from which the formula was derived. The Ministry of Health saw providing this information as a breach of patient confidentiality.³¹

An alternative formula was sought that would combine accuracy and confidentiality. A committee chaired by Gabi Bin Nun proposed relying on a data base that was already accessible to the National Insurance Institute: that of people who receive disability payments for a psychiatric disability of 50% or above. This criterion was chosen as it was found that people with this level of psychiatric disability were most likely to require inpatient services.³² It was proposed that 85% of the funds from capitation be distributed based on the number of people receiving disability

³¹ This information was taken from an undated draft of a Ministry of Health document: "The Capitation Formula for Transferring Responsibility for Mental Health to the Health Plans: Principles".

³² Taken from an interview with a senior official of the Mental Health Services.

payments in each health plan, with the remaining 15% distributed according to the ordinary capitation formula (that is, based on age).

After this second formula was adopted by the Ministry of Health, it was nonetheless a focus of conflict on three counts. First, health plan representatives complained that the new formula did not generate fair distribution of funds.³³ Second, since they were not given access to the NII files, they were unable to calculate how they would be affected by implementation of the formula.³⁴ Third, following the failed negotiations prior to the planned transfer of January 1997, the Ministry of Health apparently unilaterally shifted the proportions of the regular versus mental health capitation formulas, from 15%-85% to 25%-75%, a move that was hotly protested by the health plans.³⁵

Missing Data

There was no systematic data on the current distribution of users of mental health services, especially outpatient services, among the health plans. Similarly, there were no systematic attempts to evaluate how implementation of the reform would affect utilization of mental health services by members of each of the health plans, so that this could serve as input into the capitation formula.

Basis of the Decision

While a study was performed for the purpose of deriving a capitation formula on the basis of analyses of data that existed in the National Psychiatric Case Registry (Ginsberg, et al, 1997), the formula derived was not implemented. The capitation formula chosen relied upon a different data base, one that existed within a separate organizational framework (the National Insurance Institute), and that was based on evaluations of functional capacity rather than on hospitalization history. Concerns about a lack of adequate information sharing were raised, particularly in this area, by the health plans.

³³ Interview with Rachel Kaye, Maccabi Healthcare Services, October 31, 2001.

³⁴ Shuli Shai, director of Mental Health Services in Clalit Health Services, in a letter from December 19, 1996 to Dr. Avigdor Kaplan, director of Clalit Health Services: The health plan should be given information about the number of people with mental illness in the country "who received disability payments according to section 9 of the National Insurance Law (1956) for medical handicap of at least 50% in accordance with section 4(a) of the addendum to the National Insurance Law, and from that information should cull the total number of those insured by Clalit. This is the basis for the capitation formula and we have no official data on this."

³⁵ Avigdor Kaplan, director of Clalit Health Services, in a letter to Gabi Barbash, director-general of the Ministry of Health: "Just the other day I was told that the capitation formula that had been initially formulated for allocating resources for financing psychiatric services was based on the setting of weights of 85% for a percentage of those members of our health plan receiving disability insurance out of the total number of people with mental illness receiving disability insurance, and 15% according to the general capitation formula. Now, unilaterally, and without even informing us after the fact, these weights have been changed to 75% and 25%, respectively. It is difficult for me to describe in words how we feel about the way this matter was handled, and it is superfluous to say how this action will affect our stance on the matter."

Table 6: What Capitation Formula Will Be Used to Distribute Money among the Health Plans?

Use of data/information	Exists	Discussed	Impact
Relevant data bases	yes	yes	yes
Data on needs and services	no	no	no
Data on finances	yes	yes	yes
International experience	yes	no	no
New studies or data bases	yes	yes	yes
Computerized simulations	yes	yes	yes
Field experiments	no	no	no
Expert consultation	no	no	no

As reflected in Table 6, data and information of a number of different kinds played an important part in determining the capitation formula. Two data bases were utilized, each during a different phase: The first was the National Psychiatric Case Registry, and the second was the National Insurance Institute's data base of individuals with psychiatric disabilities. Most noteworthy for utilization of data is the study by Ginsberg et al (1997), based on computer simulations using National Psychiatric Case Registry data, specifically designed for developing a formula that would be useful as a basis for capitation.

Decision 7: What should be the prices of services purchased by the health plans following the reform?

Significance of the Decision

For many years, the Ministry of Health has declared that one of its fundamental objectives is to shift the balance of mental health services from the hospitals to the community. Despite this espoused goal, hospital care has remained predominant, a fact reflected bluntly in budgetary data provided by the Ministry of Health: In 1995, 77.6% of the mental health budget went to inpatient services, while only 11.2% went to community-based services (with most of the remainder going to finance the Mental Health Services headquarters).

The imminent transfer of mental health services to the health plans provided a unique opportunity to design a system of financing that would create incentives for developing the espoused community-based orientation. If in the previous system services were not specifically paid for, but rather were covered by an overall budget historically provided by the Ministry of Health, the inclusion of mental health services in the basic basket of services would mean that service providers would charge the health plans for the services they provided to the plans' members.

At this stage, a fee-for-service pricing system had to be initiated that would be acceptable to providers, insurers, and consumers. Such a pricing system had, on one hand, to enable service providers to survive in the new system and, on the other hand, to create incentives that would shape the behavior of the health plans in the direction desired by policymakers – inducing them, for example, to reduce hospitalization rates and increase alternatives in the community.

Analytic Questions/Data Required

1. How can prices be set to reimburse existing services fairly, on the one hand, and to create incentives for desired change, on the other?
2. What mechanisms, or combinations of mechanisms, can be used to derive pricing?
 - Market mechanisms?
 - Micro-costing, to estimate the true cost of specific services?
 - Structuring incentives to produce desired system changes?
 - Pricing to protect and maintain existing services?
3. Which services may be at risk of financial loss during this transition, and how can they be supported?
4. Which services may be at risk of closure during this transition, and how should this be addressed?

Available Sources of Data

Available sources of data included the National Psychiatric Case Registry, financial data at the national and institutional levels, and computerized simulations based upon them.

Missing Data

No studies were found that estimated real costs incurred in the provision of a range of mental health services.

Basis of the Decision

Popper (1998) reported that the National Psychiatric Case Registry was used as the basis of a simulation exercise designed to establish levels of pricing that would create a reasonable fit between predicted income and the existing budget. Prices established for hospital services differentiated among categories of service (emergency, active, rehabilitative, and chronic long-term) and age groups (10-20, 20-64, 65+). Full data were available on these parameters for each of the hospitals from the National Psychiatric Case Registry, making it possible to analyze the level of income expected according to different pricing levels. With the help of these data, decisions were made that enabled the psychiatric hospitals to maintain their existing budgets.

In effect, the resulting pricing system reflected a strategy of preservation embedded within a strategy of reform. While the rhetoric of the reform advocated a shift in priorities from the emphasis on hospitalization to an emphasis on community-based services, a key objective of the pricing system as reported by Popper was the protection of the budgets of the psychiatric hospitals. Maintaining hospital budgets, at a time when the overall mental health budget remained unchanged, essentially froze the existing imbalance between hospital-based and community-based services. Instead of utilizing the pricing system as a means for creating incentives for shifting resources to the community, pricing was used as a way to maintain the status quo.

Table 7: What Should Be the Prices of Services Purchased by the Health Plans following Reform?

Use of data	Exists	Discussed	Impact
Relevant data bases	yes	yes	yes
Data on needs and services	yes	yes	no
Data on finances	yes	yes	yes
International experience	no	no	no
New studies or data bases	no	no	no
Computerized simulations	yes	yes	yes
Field experiments	no	no	no
Expert consultation	no	no	no

As reflected in Table 7, data and information from three sources had a critical impact on pricing decisions: the National Psychiatric Case Registry, financial data at the national and institutional levels, and computerized simulations based upon them. Pricing was not based on estimates of real costs, and no mechanisms were built into the pricing system to structure incentives for systemic changes.

Decision 8: How, specifically, will mental health care be integrated into the general health care system?

Significance of the Decision

The Netanyahu Commission noted that, although psychiatry is a branch of medicine, historically and organizationally it has remained, in Israel as in most other countries, largely segregated from general medical care – to the detriment of people needing psychiatric care. A central and guiding principle of the Netanyahu Commission’s recommendations with regard to mental health was that mental health services be integrated into the general health system. The transfer of responsibility for mental health services to the health plans was, in effect, a core strategy for achieving this objective, although it is only the first step toward the integration of mental health care into the general health system. In practice, the strategy needed to be put into operation based on the following considerations:

- ♦ What would be the roles and responsibilities of primary care physicians, and what training would they need in order to perform them?
- ♦ Who would be responsible for care coordination, a primary care physician or a mental health specialist?
- ♦ What would be the division of responsibility and the nature of relations between primary care and specialty mental health care?
- ♦ What would be the relationship between general hospitals and psychiatric hospitals?

Analytic Questions/Data Required

1. To what extent are primary care physicians already involved in providing mental health care?
2. What are the costs and benefits – to consumers, providers, and insurers – of primary care physicians being the “gatekeepers” for mental health care, as opposed to consumers having direct access to specialists?

3. What training and work conditions would be required for primary care providers to be effective “gatekeepers”?
4. What barriers exist in the general health system to the integration of mental health services?

Available Sources of Data

The first question relates to the need to evaluate the extent to which people with mental health conditions present themselves to primary care providers, and the extent to which these conditions are diagnosed and treated by the physicians. A number of studies based on the self-reports of patients in primary care clinics in Israel have been performed during the past decade (Benjamin et al, 1992; Maoz, 1998; Maoz et al, 1991; Shiber et al, 1990). These studies have found that between 50-69% of the individuals who turned to a primary care provider were suffering from a “mental health problem”, with these problems being recognized in 13%-26% of the cases.

A recent Israeli study (Rabinowitz et al, 1998) addressed the question through analyses of data on the treatment of depression from a nationwide survey of 677 primary care physicians in Israel. Among these physicians, 58.6% reported that they “always” or “usually” treated depression, 28.6% reported that they “sometimes” treated depression, and 12.6% reported that they “never” treated depression. Those who treated depression were found to be more likely to treat a broader range of medical issues, to see themselves as having more contact with psycho-social problems, to meet more with social workers, and to have been trained in family medicine.

The issue of the requisite training for primary care physicians benefited from the exposure of Ministry of Health staff to experience in other countries – particularly those that had successfully integrated mental health into their general health systems. Through the WHO, contact was made with colleagues in Germany, who trained primary care physicians in Israel during this period.

Missing Data

The question as to advantages and disadvantages of having primary care physicians function as gatekeepers, versus allowing direct access to specialty care, could have been addressed through comparisons of different health systems that implement different strategies. This issue is relevant for all areas of health care, but may have specific nuances for mental health. No evidence was found of the use of such studies.

The issue of barriers to the integration of mental health care into the general health system could have been addressed through a survey of providers and consumers in the general health system, which could explore the prevalence of stigmatic perceptions and attitudes toward mental health consumers. No evidence was found of such a study.

Basis of the Decision

The increased reliance upon primary care physicians seems to have been axiomatic to the planned transfer. No evidence was found of debate surrounding this issue, although a considerable amount of effort was invested in laying the groundwork for this change. Following the failure to reach an agreement prior to the January 1997 deadline, plans to prepare primary care physicians for a new role in mental health care vanished from the mental health agenda.

Table 8: How, Specifically, Will Mental Health Care Be Integrated into the General Health Care System?

Use of data	Exists	Discussed	Impact
Relevant data bases	no	no	no
Data on needs and services	yes	yes	no
Data on finances	no	no	no
International experience	yes	yes	yes
New studies or data bases	yes	yes	no
Computerized simulations	no	no	no
Field experiments	no	no	no
Expert consultation	yes	yes	yes

As reflected in Table 8, data and information played some role in efforts to deal with the question of how to integrate mental health into the general health system – especially information based on experience in other countries dealing with the same issue, and expert consultation given by individuals who were involved in such efforts. Some data were available on the functioning of primary physicians in this area, and at least one new study was initiated.

Decision 9: What mechanisms need to be in place to support the transition from the previous system to the new one?

Significance of the Decision

As can be seen by the present analysis, the transfer of responsibility for mental health services to the health plans was an extraordinarily complex endeavor. It essentially involved transforming an entire system – including all its component parts, the relationship among all these parts, and the relationship between this system and the general health system – from one paradigm of service organization to another. Compounding this complexity was the tremendous ambiguity as to what would actually take place, and what would be the consequences of change, including the risks for all involved parties.

Thus, it was essential, if the endeavor were to succeed, that policymakers take an active stance toward laying the groundwork for the new system. This would mean engaging in a large amount of detailed planning, creating and implementing procedures for billing, reporting, collaborating, sharing information, and instituting monitoring where none had existed before.

Analytic Questions/Data Required

1. What channels of communication are essential to the new system, and what should be the content of this communication?
2. What information systems will be required to support communication?
3. What barriers exist to effective collaborations among organizations, and how can they be overcome?
4. How will sub-populations be differentially affected by implementation?

Available Sources of Data

Experience with similar processes in other countries provided some tools and directions for these processes, but also led to a recognition that a great deal would have to be invented to suit the local

context. At the insistence of foreign consultants and with their assistance, the Ministry of Health set in motion a large-scale national simulation of the reform, in order to prepare the system for anticipated changes and to gauge more carefully the effect of the reform on differential sub-populations.

Missing Data

No missing data was identified.

Basis of the Decision

During 1996, in anticipation of the implementation of the transfer, the Ministry of Health and the health plans collaborated on an extensive simulation exercise that aimed to create and test billing procedures, and to enhance predictions of needs. Providers were asked to bill the health plans at pre-designated levels for services provided to their members, while the health plans reported to the Ministry in ways that would determine their own financing.³⁶ The simulation was underway when negotiations for the transfer broke down in January 1997, such that it never came close to reaching its potential value. One key finding at this early stage was that the requirement of reporting procedures frequently created the risk of a breach of confidentiality, as information about specific individuals was being computerized and communicated. This issue remained unresolved.

Table 9: What Mechanisms Need to Be in Place in order to Support the Transition from the Previous System to the New One?

Use of data	Exists	Discussed	Impact
Relevant data bases	no	no	no
Data on needs and services	no	no	no
Data on finances	no	no	no
International experience	yes	yes	yes
New studies or data bases	no	no	no
Computerized simulations	no	no	no
Field experiments	yes	yes	yes
Expert consultation	yes	yes	yes

As reflected in Table 9, international experience and expert consultation played an important role in preparing the mechanisms that needed to be in place to support the anticipated transition from the previous system to the new one. In consultation with experts from abroad, a national field experiment was launched by the Ministry of Health, in collaboration with the health plans, psychiatric hospitals, and community based services. This experiment established and put into initial practice a complex network of data-based lines of communication, reporting, and billing. The experiment was halted mid-way when it became clear that the transition was not going to take place; therefore, it fell short of producing new data or systematic learning.

³⁶ See letter from Dina Feldman, senior assistant to the director of the Mental Health Services, to Dr. Meir Oren, director-general of the Ministry of Health, April 23, 1996, describing the progress of work on the simulation.

Conclusions

The Use of Data in the Component Decisions

Table 10 presents an overview, by decision, of the most relevant data that either were or were not available during the decisionmaking process. It is apparent that while some of these data were available for nearly all decisions, in most cases additional data, which were no less relevant, were lacking. In addition, the extent to which data played a role in each decision varied: In three decisions, data played little role; in two decisions, only financial data played a role; and in three decisions, there was extensive use of data. In the decision on transition mechanisms, rich data were being generated by the nationwide simulation; however, when the simulation was disrupted, this potential resource was lost. Thus, data played an important role in five of the nine decisions analyzed.

As noted, even in those decision processes that involved substantial data use, important data were missing. For example, the process of setting prices for services (#7) involved the use of financial information on spending in psychiatric hospitals, but not of data on the actual cost of providing specific services. Similarly, in discussions about the level of financing necessary for the transfer of mental health services to the health plans (#4), current financial data were available and utilized, but widely varying projections of demand severely limited the usefulness of these data for budgetary planning.

Table 10: Overview of the Use of Data in the Component Decisions

DECISION	Highly Relevant Data That Were Available	Highly Relevant Data That Were Missing	Role Played by Data in Decision
1. Whether to effect the transfer	Existing problems	Examination of the assumptions underlying strategy	Extensive use of data (primarily financial)
2. Scope of transfer	Current division of labor	Costs and benefits of consolidating versus splitting; analysis of alternative divisions of labor.	Data played little role
3. Vulnerable consumers	Who they are, what their health needs are, costs of care	Risks and benefits of alternative arrangements	Extensive use of data
4. Funding level	Current spending (though data and their interpretation were disputed)	Current utilization of health plan and private outpatient services. Projected changes in demand and cost	Extensive use of data (primarily financial)
5. Earmarking	Little	Risks and benefits of alternative arrangements	No use of data
6. Capitation	Link between costs and consumer characteristics	Distribution of current and potential users of mental health services among the health plans	Extensive use of data
7. Prices for services	Macro expenditure data for hospitals and community mental health centers	Micro-level data for cost of specific services	Extensive use of data
8. Integration of care	Current problems	Analysis of barriers to integration	Little use of data
9. Transition mechanisms	Similar processes in other countries; simulation	Simulation disrupted	Simulation disrupted

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 existing system of care than it did projecting likely costs and benefits following proposed changes in the system of care. In general, reliable projections require a major investment of time and resources, for example in the planning and implementation of demonstration projects. Such projects require considerable lead time and a long enough time frame to allow them to come to fruition, so as to inform decisions. In the current case, while in theory there was enough lead time for such processes (as the NHI Law provided three years for carrying out the transfer), decisions were made under intense time pressure that minimized their use.

The Roles Played by Different Types of Data and Information

Looking at the nine questions analyzed from the perspective of the role played by different types of data and information, the following conclusions can be reached:

1. One central *data base*, the National Psychiatric Case Registry, was used intensively for data analysis. A second data base, that of the National Insurance Institute on individuals with a psychiatric disability, was introduced as an alternative policy tool.
2. One of the weak links in the use of data and information was *data on the general population and its mental health problems and service needs*. Such data could have contributed to efforts to predict changes in demand that would result from the transfer – a key unknown factor. Several studies were initiated that aimed to enhance available data on service needs and utilization (including Feinson et. al. 1997; and Gross et. al. 1997), but these fell far short of an epidemiological survey.
3. In a number of other areas, *new studies* were performed to address policy needs. This was the case for decisions about vulnerable consumers, capitation, and inclusion in the general health system. While some of these were documented and/or published, others seem to have been aborted before reaching this stage.
4. *Financial data* on current and expected costs of mental health care, the extent to which capitation would compensate the health plans, and the extent to which the pricing system would support the survival of existing services were prevalent in discourse and central to several of the sub-decisions.
5. *International experience* seems to have played a role in some facets of decisionmaking, while being irrelevant to others. Mental Health Service personnel corresponded with the WHO, visited other countries, brought back relevant documentation and reported on their experiences, and organized trips for others. However, no evidence was found that this information was gathered and analyzed systematically 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: in the integration of mental health services in the general health system, and in the development of mechanisms to support the transition to the new system. In each of these cases, foreign experts collaborated on the design and experimental implementation of proposed systems.
6. Given the considerable ambiguity concerning the results of proposed system change, *computerized simulations*, especially based on manipulation of the data in the National Psychiatric 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 the information and communication systems* to be used in billing, reporting, and assuring continuity of care. This simulation might have had an important impact on the system had it not been aborted prematurely because of the impasse among policymakers.

Chapter 4: The Data Discourse

From Decisionmaking to “Design System”

When we contemplate a decisionmaker making decisions, we evoke an image of a high-ranking official or manager who is faced with a problem or question, who gathers relevant information, considers and evaluates alternative action, chooses the action that seems best, and then dictates his decision to those under his responsibility in the system. The extent to which this rational process actually takes place may be questioned, but the term “decisionmaker”, and the image it evokes, are generally accepted.

During the course of events described in this case study, many decisions were made – by ministers and senior administrators in the Ministry of Health, the Ministry of Finance, and the Ministry of Labor and Social Affairs; by administrators in each of the health plans; by hospital directors; by Knesset members; and by committees. Yet in the end, all of these decisions were nullified since no final decision was made.

In order to understand this process of decisionmaking, or to understand the role of data and information in it, a language is required that captures its non-linear, non-hierarchical nature. Schon and Rein (1994) refer to this process as the workings of a “design system”. In designing, something is being made under conditions of uncertainty and complexity, so that it is not initially clear what the problem is or what it would mean to solve it. In a design system, a complex and emergent design process is carried out by multiple actors who represent different constituencies. Each actor is in “conversation” with an evolving “policy object”, with other players, and with his own constituencies. If the design system works well, a policy can be jointly crafted that is acceptable to all parties by consensus. If the system breaks down, no decision will be reached, or the decision reached will be unacceptable to major stakeholders.

The Data Discourse

The previous chapter examined the extent to which data were available to decisionmakers and influenced decisions related to the transfer of responsibility for mental health services to the health plans. However, that analysis fails to convey an important and controversial aspect of the use of data, which became evident from both interviews and the documents reviewed. This can best be referred to as the quality and nature of “the data discourse”. By this term I mean *how data and information are utilized in communications among members of a policy design system*. “Data discourse” refers to the quality and transparency of data-based communication and, more particularly, to the extent to which this communication promotes effective collaboration and better decisionmaking or, conversely, promotes mutual suspicion and defensive positioning.

If the decisionmakers in the Ministry of Health had been able to implement their decision to transfer mental health services to the health plans, it would have been enough for them to decide on their own. However, opposition -- from the Knesset Committee on Labor and Welfare, from the Ministry of Finance, and from the health plans themselves – forced the Ministry of Health to negotiate the terms of the transfer, and to achieve the agreement of the other parties. Data was an important medium for communication in these negotiations.

Content of the Data Discourse

Before looking at a number of comments that allude to the quality of the data discourse concerning the events studied, it is useful to consider an initial categorization of the content of data-based communication. This categorization should answer the following question: In multi-party processes of policy design, what types of information does one party communicate to another through data or information? The current study brought to light the following categories:

1. Information presented about an existing or previous situation.
2. Projections of the effect of proposed steps.
3. Decisions by one party that the other party needs to factor into its decisionmaking.

The first category concerns the extent to which one party believes that the other is being truthful in its presentation of “objective” facts. The second category concerns the extent to which projections are seen as either trustworthy, or distorted (in line with one party’s interests). The third category relates to the extent to which each party’s decisions and considerations are transparent to the other, or guided by agendas that are not openly communicated.

Indications of the Nature and Quality of the Data Discourse between the Ministry of Health and the Health Plans

During the course of the interviews, as well as in the documents analyzed, there was a great deal of evidence that the data discourse, particularly between the Ministry of Health and the Clalit Health Services, promoted more suspicion and defensiveness than collaboration. Time and again – in interviews, letters, and official protocols – high-level administrators of Clalit indicated that they were deeply disturbed by how data and information were being communicated to them by their counterparts in the Ministry of Health.

The following comments by Clalit Health Service officials, which express their deeply felt reactions to the data discourse with Ministry of Health officials. These quotes are organized according to the above categories.

Content Category 1

“They (the ministry) have succeeded in fundamentally confusing us with numbers.... Even the budget that I get from the director general of the Ministry of Health, which is supposed to represent the budget available for mental health, is not all of the budget, as there is a reserve for inflation that applies to this issue, but that is not included.”³⁷

The health plan should be given information about the number of people with mental illness in the country who receive disability payments of at least 50% ... and about the total number among this group who are insured by Clalit. This is the basis for the capitation formula, and we have no official data on this.”³⁸

³⁷ Avigdor Kaplan, director of Clalit Health Services, in Knesset Labor and Social Affairs Committee hearing on December 9, 1996.

³⁸ Shuli Shai, director of Mental Health Services in Clalit Health Services, in a letter from December 19, 1996 to Dr. Avigdor Kaplan, director of Clalit Health Services.

Content Category 2

*Again and again, [with each revised proposal] they tried to convince us with the numbers that the transfer was in our best interest [despite our concerns]. After a while we stopped trusting anything they said.”*³⁹

Content Category 3

*“We don’t know clearly what is included in the basket of services, we don’t know its cost as estimated by the government, we don’t know the capitation formula, and we don’t know the final prices according to which the health plan will operate opposite the public and government hospitals.”*⁴⁰

*“Unilaterally and without even informing us after the fact the weights [in the capitation formula] were changed [from 85% and 15%] to 75% and 25% respectively. It is difficult for me to describe how we feel about the way this matter was handled, and it is clear how this action will affect our stance in the matter.”*⁴¹

These comments indicate suspicion, mistrust, and even a sense of betrayal. The intensity of these negative reactions seems directly related to their being identified as part of a consistent pattern, one in which the “facts” presented to them were unreliable, in which projections were biased, and in which considerations, decisions, and agendas were being concealed from them.

These comments were not responded to directly by Ministry of Health officials during meetings or in correspondence. In interviews of some Ministry of Health officials, the impasse in the negotiations with the health plans was attributed to the health plans’ resistance to accepting responsibility for the stigmatic mental health population – a claim that was repeatedly denied by health plan officials in both interviews and written documentation. Other Ministry of Health officials interviewed provided off-the-record confirmation that the reactions of Clalit Health Services officials were understandable, in light of what they remembered of the data discourse at the time. For example:

*“Information wasn’t shared, because there was an interest in hiding information to present a better picture than existed in reality. In many cases, information was hidden as a tactic, in order to achieve a goal. It turned out that at the strategic level, this failed.”*⁴²

*“In reality, what happened was that they [decisionmakers in the Ministry of Health] reached a decision and then said, ‘let’s find the data that support the decision, and the data that confirm the claims leading to the decision’. And all this took place under terrible pressure.”*⁴³

³⁹ Interview with former director of Clalit Health Services.

⁴⁰ Avigdor Kaplan, director of Clalit Health Services, in Knesset Labor and Social Affairs Committee hearing on December 9, 1996.

⁴¹ Avigdor Kaplan, director of Clalit Health Services, in a letter to Gabi Barbash, director-general of the Ministry of Health.

⁴² Interview with a Ministry of Health official.

⁴³ Interview with a Ministry of Health official.

All of the above point to the existence of a problematic data discourse between two of the major players in the case: the Ministry of Health and Clalit Health Services. It should be remembered that, as noted earlier, an important background to the events studied was a history of problematic relations – relations steeped in suspicion and mistrust – between the Ministry of Health and Clalit Health Services, particularly in the area of mental health services. Therefore it is likely that the data discourse was at least in part a product of these relations.

Nonetheless, analysis of documents points to the possibility that, despite difficult relations in the past, there was a window of opportunity during which both parties were willing to work together to implement the National Health Insurance Law's provisions for mental health services. It seems possible that problems with the data discourse contributed to the closing of this window in early 1997, nearly a year before the official deadline for the transfer.

Alternative Explanations for Problems with the Data Discourse

What might explain the reports, reflected in the quotes above and in many of the interviews, that the transfer effort generated emotional turmoil in the mental health system? How might this be related to the ways in which data were used in the process? This section will present alternative explanations, one focuses on the effects of different perspectives on what information is required for decisionmaking; a second relates to the tumultuous nature of the transfer process; and a third considers the effects of strategies that seem to have been adopted by key personnel in the Ministry of Health.

Who determines what data needs to be produced and for whose needs?

Dr. Meir Oren, director general of the Ministry of Health during most of the period under study, emphasizes that the Ministry had enough information to make an informed decision with regard to the transfer:

“We did a thorough job of identifying patients who would be at risk. We carried out a study that ensured monitoring on the individual level, including a mapping of the mentally ill population, a diagnostic reevaluation of every one, an evaluation as to which of them had the potential for rehabilitation in the community. We knew about the individual case – who was going where. There was monitoring on the individual level in order to inform the process and in order to reassure the public.”

In this quote, Dr. Oren emphasizes that the Ministry of Health indeed made impressive efforts to produce the data that it viewed as necessary both for its decision and for the monitoring of the decision's implementation. Underlying this position is an implicit stance that the Ministry of Health is in a position to determine the data needs of any policy decision and to act unilaterally in producing those data.

The above stance would perhaps be operational if the Ministry of Health were in a position to act unilaterally. As we have seen, however, the Ministry found itself dependent upon the decisions of other parties – the Ministry of Finance, the health plans, the Knesset Committee of Labor and Social

Affairs. Each of these parties viewed the same policy decision from its own perspective and in light of its own concerns. As these concerns were largely outside of the data framework that Dr. Oren described above, representatives of these parties could either produce the data themselves (when possible), convince the ministry to produce them, or develop collaborative mechanisms for their production. All of these in fact took place. Nonetheless, the sense that the Ministry's data focus was too narrow and not inclusive of the data needs of the health plans was probably a significant factor in the development of the problematic "data discourse" between them.

Effects of Turmoil, Ambiguity, Complexity, and Fluidity on the Data Discourse

This case study has focused on events during a period of intense *turmoil* and *ambiguity*, as one mode of organization and activity seemed to be coming to an end before the next one had been determined. Anxiety was high on all sides, as each party considered what losses it might face in the new system. Under such conditions, it is normal for involved parties to be on guard and to fear being harmed by processes that are beyond their control. Thus the data discourse took place in a highly charged field, one heavy with suspicion and defensiveness.

Moreover, the situation was extremely *complex*, with many actors working within multiple organizational frameworks; and *fluid*, with many variables being considered and negotiated. Despite the need for solid, objective information, often such information did not exist or was inaccessible. Often, the same situation was viewed from different perspectives, generating contradictory conclusions. Different people in the same organizational framework had different and even contradictory perspectives; sometimes the same people changed their position on an issue over time.

All of the above conditions, compounded by a history of mistrust between the Ministry of Health and Clalit Health Services, contributed to a data discourse dominated by mutual suspicion. In fact, it seems fair to say that in the absence of a deliberate effort to develop trust, this was an inevitable outcome, independent of the specific strategies taken by each party.

Communication Strategies Chosen by the Ministry of Health

Although the data discourse was heavily influenced by contextual effects, it is nonetheless relevant to attempt to understand the communication strategies chosen by the Ministry of Health that so disturbed Clalit Health Services officials.

The strategies chosen by officials in the Ministry of Health, who promoted the transfer of mental health services to the health plans, can be described by a military metaphor that points to their underlying theories of action (Argyris and Schon, 1974). The metaphor of *military intelligence* reflects the rich military background of many of the senior administrators in the ministry and in the Mental Health Services. In the theory of action drawn from this metaphor, in order to achieve one's objective one must overcome the resistance of the "other side". This objective, however, cannot be attained solely by force, because it ultimately requires the cooperation of the other side. Thus the other side must be coerced into deciding to agree to terms that are contrary to its interests. For this purpose, it is legitimate to use data as "intelligence information" which on one hand can be tactically withheld from the other side, and on the other hand, can be used for generating confusion, distraction, and poor decisionmaking on the other side.

On the basis of analysis of primary documents, an additional explanation could be suggested. In the effort to transfer mental health services to the health plans, key actors in the Ministry of Health were in effect struggling to find a way out of a metaphorical vise, generated by pressures being imposed from multiple directions:

- ♦ The National Health Insurance Law required the Ministry to transfer mental health services to the health plans.
- ♦ Within the Ministry itself there were strong voices that opposed the transfer.
- ♦ The Knesset Labor and Social Affairs Committee, and particularly chairman MK Yossi Katz, was refusing to let the Ministry implement the transfer unilaterally, instead insisting that agreement on the terms of the transfer be reached with the Ministry of Finance and the health plans.
- ♦ The Ministry of Finance wanted to severely restrict the budget that would be transferred to the health plans.
- ♦ The health plans were insisting that they would not accept the transfer if they could not be assured that their costs could be reasonably covered.

In fact, it seems to have been as clear to some in the Ministry of Health as it was to the health plans that, given the budgetary restrictions imposed by the Ministry of Finance, the transfer was unrealistic and would lead to large deficits. Those in the Ministry of Health could have proceeded in a number of different directions:

- ♦ They could have insisted that, given the budgetary limitations, the transfer was not a realistic option, National Health Insurance Law notwithstanding.
- ♦ They could have pressured the Ministry of Finance, perhaps together with the health plans, to increase the allocated budget or to develop additional sources of income.
- ♦ They could have pressured the health plans to take the transfer upon themselves, despite the problematic conditions.
- ♦ They could have designed a process for limited implementation in the form of a field experiment that would generate the data for a better-informed large-scale transfer later on.

It seems that, given the relatively weak position of the Ministry of Health vis a vis the Ministry of Finance, those in the Ministry of Health were unable to negotiate better terms. The option of a limited, systematic, jointly designed field experiment does not seem to have been seriously considered. Instead, they chose to try to impose a very problematic package on the health plans, all the while arguing that it was in their best interest. Thus data and information became a tool not for a joint search for the best design but rather for imposing a unilaterally determined objective. The desired outcome might have taken the pressure off the Ministry of Health, but would have left the health plans “holding the bag”. Despite the pressure and the tactics employed, the health plans held their ground, blocking the decision and leaving mental health care the responsibility of the Ministry of Health (to the satisfaction of those in the ministry who had not wanted to give it up in the first place).

Conclusions

This chapter has introduced the concept of the data discourse – that is, how data and information are utilized in communications among members of a policy design system. Several content categories

were identified, and quotes from primary documents and interviews were presented which both concretized these categories and portrayed the problematic nature of the data discourse between the Ministry of Health and Clalit Health Services as revealed by the study.

The concept of data discourse highlights an aspect of inter-organizational communication that can, as seen in this case, be both a symptom of pre-existing mistrust and suspicion, and a factor that generates and escalates them. This is particularly likely to occur in situations of considerable complexity, ambiguity, and threat.

Ultimately, and more importantly, the data discourse can, if deliberately and effectively addressed, provide leverage for the development of trustworthy relations among inter-dependent parties. On this basis, they can work collaboratively and transparently to design policies that take into consideration the legitimate needs and concerns of all stakeholders.

Chapter 5: Conclusions

Introduction

The decision to transfer mental health services to the health plans was nothing less than an attempt to design and implement – with severely limited resources – the transformation of a complex, segregated, and well-entrenched system, and to include it in the broader health system. Thus this case study has offered an opportunity to learn about essential questions addressed by those engaged in systemic reform of public services, about the role that data and information can and cannot play in such reform, and about factors that can enhance or block the constructive use of data in reform.

This study initially took as its focus of analysis the decision to transfer mental health services from the Ministry of Health to the health plans. As the study progressed, it became increasingly clear that this decision was in fact composed of many sub-decisions, and that these sub-decisions differed in nature, and included questions of whether to, how, how much, by what formula, and which ones, as well as for whom and by whom. Understanding the multifaceted nature of this decision provided a framework for exploring the role of data and information in the decisionmaking processes.

Summary of Findings

A first finding of this study is that substantial use was made of data in decisionmaking at all levels in the mental health system. This was made possible both by the development of the existing 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 the years under study, 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, which was dedicated specifically to mental health issues, undoubtedly contributed to this development.

Second, data played a significant role in five of the nine decisions we analyzed. For example, the decision regarding the capitation formula benefited from substantial information from two different data 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 greatly from data on the number of highly vulnerable persons, their diagnostic profile, and their care utilization patterns.

Third, even in those decision processes that involved substantial data use, important data were missing. For example, the process of setting hospital prices used solid financial information 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 to be provided to the health plans, current financial data were available and utilized. However, gaps in information about current utilization, the extent of unmet need and consumer preferences led to widely varying projections of demand and costs, which severely limited the usefulness of these data in 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 that contributed 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 cost and benefit of the existing system of care than it did projecting the likely cost and benefit of proposed changes in the system of care. In general, four basic ways of reducing such ambiguity can be identified: 1) Learning from experience in other countries; 2) using past trends to predict future trends; 3) including hypothetical questions in a survey; and 4) implementing intended changes on a relatively small scale in pilot projects.

None of the above strategies were systematically implemented in the current case. The first three strategies require a relatively minor investment, but they do require foresight and organization if they are to identify and make use of learning opportunities. The fourth strategy, that of pilot projects, requires a much more intensive investment of time and resources.

Conclusions

In conclusion, it seems appropriate to look at the “big picture”, and address two essential questions:

1. How “good” or “bad” was the stalemate that blocked implementation of the transfer of mental health services to the health plans?
2. Did data make a difference in the decisionmaking process?

How “good” or “bad” was the stalemate that blocked implementation of the transfer of mental health services to the health plans?

As noted, the transfer of mental health services to the health plans faced clear restrictions imposed by the Ministry of Finance: The budget after the transfer was not to exceed the mental health budget prior to the transfer, and the health plans were not to be provided with a safety net for the first year(s) following the transfer, in case their deficits were prohibitive. These restrictions were, at the time, non-negotiable.

Decisionmakers in the Ministry of Health did not feel that these restrictions warranted the postponement of the transfer, and did their best to push it through. They pointed to the savings that the health plans would accrue, to the cut-backs that the health plans could make in other areas, and

to the impossibility of certainty when promoting systemic change. They felt that the level of uncertainty was manageable and that there was a window of opportunity that should not be missed.

Others, in the Knesset Labor and Social Affairs Committee and in the health plans, viewed the situation differently. In their view, these restrictions left the health plans with an untenable risk. They dictated that there would be no funds available for any of the necessary development that the health plans would need to undertake, such that they would have to focus on cutting their expenses for mental health services so as to avoid prohibitive deficits. They would not be provided with a transition time within which they could experiment and learn how to achieve both quality of care and cost efficiency.

Croze (2000), in her review of managed behavioral health care in the public sector, concluded emphatically that “no amount of good will, public spirit or managed care technology can overcome an ill-conceived benefit design or inadequate financing” (p.30). Was the funding being offered inadequate? Ministry of Health decisionmakers thought no. Others thought yes.

If the funding was indeed severely inadequate, it seems likely that the outcome of the transfer would have been highly problematic. Many of the feared dangers of managed care were likely to have become widespread: limitations that block access to care for low-income or high-intensity consumers, efforts to cut costs of care provision by hiring less expensive staff, increased administrative involvement in professional decisionmaking. Rather than creating the improved system that the Netanyahu Report had envisioned, the existing system would have been replaced by an alternative system driven by economic values, with no safety net for those who are most in need and vulnerable.

Did data make a difference in the decisionmaking process?

It is clear from this study that data played a part in the events examined. But did data make a difference? This is much less clear.

The events presented in this case study can be looked at from at least two perspectives, each of which leads to an opposite conclusion as to whether data made a difference.

One could argue that the dynamics of the decisionmaking process were largely dictated by the play among three limiting conditions: the insistence of the Knesset Labor and Social Affairs Committee that the transfer could not be implemented unilaterally by the Ministry of Health; restrictions imposed on financing by the Ministry of Finance; and the fear of the health plans that cost overruns would be devastating. From this perspective, while data were part of this dynamic, they could not affect any of these limiting conditions, and therefore their impact on the process was marginal.

It is possible, however, to look at the same course of events from a very different angle, by posing the question of whether data, had it been produced, might have been able to have an impact upon these limiting conditions, and particularly upon the ability to reach a consensus among stakeholders.

As noted, one of the major unknowns of the transfer was the extent to which the provision of non-stigmatic, high-quality mental health services would lead to an exponential increase in the demand for services, particularly outpatient therapy. While there were attempts to make projections, these

varied widely, leaving decision-makers with good reason to fear the worst. The reluctance of both the Ministry of Finance and the health plans can be seen as a rational response to this high level of ambiguity and risk.

It is possible that if systematic research efforts based on the implementation of small-scale pilot projects had been undertaken early in the process to reduce this ambiguity and to develop mechanisms for decreasing risk, the Ministry of Finance might have been more open to increasing allocations, and the health plans might have been less fearful of the outcomes of the transfer. Thus, such research, had it been undertaken, might have radically changed the course of negotiations.

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 proceed. 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.

Bibliography

- Argyris, C; and Schon, D. 1975. *Theory in Practice: Increasing Professional Effectiveness*, Jossey-Bass Publishers, San Francisco.
- Aviram, U.; and Rosenne, H. 1998. "Mental Health Policy and Services in Israel – the Planned Reform Following Enactment of the National Health Insurance Law". *Society and Welfare, Quarterly for Social Work*, Special Issue on Mental Health Services: Trends and Issues, 18(1): 161-190. (Hebrew)
- Aviram, U.; Zilber, N.; Lerner, Y.; and Popper, M. 1998. "Chronically Mentally Ill Persons in Israel: Estimations of Their Number and Characteristics". *Social Security* 53: 92-105. (Hebrew)
- Benjamin, J.; Maoz, B.; Shiber, A.; Antonovsky, H.; and Mark, M. 1992. "The Prevalence of Psychiatric Disorders in Primary Care Clinics in Beer Sheba: Assessment by the General Health Questionnaire, General Practitioners and Research Criteria". *General Hospital Psychiatry* 14: 307-314.
- Croze, C. 2000. "Managed Behavioral Healthcare in the Public Sector". *Administration and Policy in Mental Health* 28 (1): 23-36.
- Feinson, M.C.; Lerner, Y.; Levinson, D.; and Popper, M. 1997. "Ambulatory Mental Health Treatment under Universal Coverage: Policy Insights from Israel". *The Milbank Quarterly* 75 (2): 235-260.
- Feinson, M.C.; Popper, M.; and Handelsman, M. 1992. *Utilization of Public Ambulatory Mental Health Services in Israel: A Focus on Age and Gender Patterns*. Mental Health Services, Ministry of Health, and JDC-Brookdale Institute, Jerusalem.
- Feldman, D.; Gross, R.; Nirel, N.; and Barash, M. 1996. *Staff Attitudes toward the Reform of the Mental Health System in Israel: Findings from a Survey of Participants at a National Conference on Mental Health (March, 1995)*. RR-260-96. JDC-Brookdale Institute, Jerusalem. (Hebrew)
- Ginat, Y. 1992. "The Organization of Psychiatric Services in the State of Israel and their Financing Arrangements". *Harefua* 123(7-8): 264-268. (Hebrew)
- Ginsberg G.; Lerner J.; Mark M.; and Popper M. 1997. "Prior Hospitalization and Age as Predictors of Mental Health Resource Utilization in Israel". *Social Science and Medicine* 44 (5) 623-33.
- Goodman, A.B.; Rahav, M.; and Popper, M. 1982. "A Social Area Analysis of Jerusalem: Implications for Mental Health Planning and Epidemiologic Studies". *Israel Journal of Psychiatry and Related Sciences* 19: 185-197.

- Gross, R.; Feldman, D.; Rabinowitz, Y.; Greenstein, M.; and Berg, A. 1997. *Perceived Emotional Distress and Mental Health Characteristics in the Adult Population in Israel: Characteristics of Users and Patterns of Use of Mental Health Services*. RR-285-97. JDC-Brookdale Institute, Jerusalem. (Hebrew).
- Lerner, Y. 1992. "Psychiatric Epidemiology in Israel". *Israel Journal of Psychiatry and Related Sciences* 29 (4): 218-228.
- Lerner, Y. Popper, M.; and Zilber, N. 1990. "Patterns and Correlates of Psychiatric Hospitalization in a Nationwide Sample: II. Correlates of Length of Hospitalization and Length of Stay Out of Hospital". *Social Psychiatry and Psychiatric Epidemiology* 25: 144-148.
- Lerner, Y.; Popper, M.; and Zilber, N. 1989. "Patterns and Correlates of Psychiatric Hospitalization in a Nationwide Sample: I. Patterns of Hospitalization with Special Reference to the 'New Chronic' Patients". *Social Psychiatry and Psychiatric Epidemiology* 24: 121-126.
- Lerner, Y.; Wittman, L.; Zilber, N.; and Barash, M. 1991. "Long-Term Utilization of Community Mental Health Outpatient Services in Jerusalem". *Social Psychiatry and Psychiatric Epidemiology* 26: 34-39.
- Lerner, Y.; Zilber, N.; Barash, M.; and Wittman, L. 1993. "Utilization Patterns of Community Mental Health Services by Newly Referred Patients". *Social Psychiatry and Psychiatric Epidemiology* 28: 17-22.
- Levav, I.; Kohn, R.; Dorenwend, B.P.; Shrout, R.E.; Skodol, A.E.; Schwartz, S.; Wenk, E.G.; and Naveh, G. 1993. "An Epidemiological Study of Mental Disorders in the Ten-year Cohort of Young Adults in Israel". *Psychological Medicine* 23: 691-707.
- Levav, I.; Zilber, N.; Danielovich, E.; Aisenberg, E.; and Turetsky, N. 1987. "The Etiology of Schizophrenia: A Replication Test of the Social Selection vs. the Social Causation Hypotheses". *Acta Psychiatrica Scandinavica* 75: 183-189.
- Levinson, D.; Popper, M.; Lerner, Y.; Feinson, M.; and Mark, M. 1996. *Ambulatory Mental Health Services in Israel: Rates and Patterns of Use – An Analysis of Data from a National Survey (May 1986) and from a Follow-Up Study in 1994*. Department of Information and Evaluation, Mental Health Services, Ministry of Health, Jerusalem. (Hebrew)
- Maoz, B. 1998. "Psychiatry and Primary Medicine in Israel". *Society and Welfare, Quarterly for Social Work*, Special Issue on Mental Health Services: Trends and Issues 18(1): 65-74. (Hebrew)
- Maoz, B.; Levy, S.; Brand, N.; and Halevy, H. 1966. "An Epidemiological Survey of Mental Disorders in a Community of Newcomers to Israel". *Journal of the Royal College of General Practitioners* 77: 267-284.
- Maoz, B.; Rabinowitz, S.; Mark, M.; Antonovsky, H.; Ribak, J.; and Kotler, M. 1991. "Physician Detection of Psychological Distress in Primary-care Clinics". *Psychological Reports* 69: 999-1003.

Mark, M.; Feldman, D.; and Rabinowitz, Y. 1996. "From the Netanyahu Report to the National Health Insurance Act – Implementation of Mental Health Reform in Israel", *Society and Welfare* 16, 185-197. (Hebrew)

Mental Health in Israel: Annual Statistics 2000, Department of Information and Evaluation, Mental Health Services, Ministry of Health, Jerusalem. (Hebrew)

Nahon, D.; and Ben-Natan, E. (undated). ***The Influence of Computerization on Israeli Government Mental Health Service Units***, unpublished document, Ministry of Health, Jerusalem. (Hebrew)

National Health Insurance Law, 1994, Law Code 1469, 156.

Popper, M. 1998. "Case Registry: A Tool for Implementing the Mental Health Reform in Israel". *Society and Welfare* 18 (1): 191-202. (Hebrew)

Popper, M. 1983. ***Length of Hospitalization of Patients Discharged from Psychiatric Hospitals in 1981. Statistical Report Number 4.*** Mental Health Services, Ministry of Health, Jerusalem. (Hebrew)

Popper, M. 1982. ***Hospitalized Psychiatric Patients in Israel on 31.8.81, by Sex, Age and Hospital. Statistical Report Number 1.*** Mental Health Services, Ministry of Health, Jerusalem. (Hebrew)

Popper, M.; and Lerner, Y. 1991. ***Psychiatric Hospitalization in Israel: Trends 1986-1990; Predicted Trends through 1995.*** Mental Health Services, Ministry of Health, Jerusalem. (Hebrew)

Popper, M.; and Horowitz, R. 1990. ***Length of Psychiatric In-patient Stay in Selected Years. Statistical Bulletin Number 2.*** Mental Health Services, Ministry of Health, Jerusalem. (Hebrew)

Popper, M.; and Horowitz, R. 1988. ***Trends in Psychiatric Hospitalization: 1975-1987. Statistical report Number 6.*** Mental Health Services, Ministry of Health, Jerusalem. (Hebrew)

Rabinowitz, Y.; Feldman, D.; Gross, R.; and Burma, Y. 1998. "Which Primary Care Physicians Treat Depression?" *Harefua* 135 (5-6): 183-186. (Hebrew)

Rahav, M.; Goodman, A.; Popper, M.; and Lin, S.P. 1986. "Distribution of Treated Mental Illness in the Neighborhoods of Jerusalem". *American Journal of Psychiatry* 143: 1249-1254.

Rahav, M.; Popper, M.; and Nahon, D. 1981. "The Psychiatric Case Register of Israel: Initial Results". *Israel Journal of Psychiatry and Related Sciences* 18: 251-267.

Schon, D.; and Rein, M. 1994. ***Frame Reflections: Toward the Resolution of Intractable Policy Controversies.*** Basic Books, New York.

Shiber, A.; Maoz, B.; Antonovsky, A.; and Antonovsky, H. 1990. "Detection of Problems of Emotional Distress in the Primary Care Clinic". *Family Practitioner* 7: 159-199.

State Comptroller's Report 1991. *Annual Report 41 for 1990 and the Fiscal Year 1989*. Government Printing Office, Jerusalem. (Hebrew)

State of Israel. 1990. *National Commission of Inquiry into the Functioning and Efficiency of the Health System in Israel, Majority and Minority Reports*. Government Printing Office, Jerusalem. (Hebrew).

Tramer, L. 1975. "A Proposal for the Reorganization of the Mental Health System – An Integrated Systemic Plan". *Public Health* 18: 536-547. (Hebrew)

U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*. Rockville Maryland: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

Appendix 1: List of Interviewees

Prof. Uri Aviram, The Paul Baerwold School of Social Work, The Hebrew University, Jerusalem

Dr. Gabi Bin-Nun, Assistant Director, Ministry of Health, Jerusalem

Dr. David Elisha, Director of Outpatient Services, Mental Health Services, Ministry of Health, Jerusalem.

Dina Feldman, Former Assistant Director, Mental Health Services, Ministry of Health, Jerusalem

Prof. Yigal Ginat, Former Director, Talbiya Hospital, Clalit Health Services, Jerusalem

Dr. Rachel Kaye, Assistant Director, Maccabi Healthcare Services, Tel Aviv

Prof. Yaacov Lerner, Director of the Falk Institute for Mental Health and Behavioral Studies, former Director of Kfar Shaul-Eitanim Psychiatric Hospital, Jerusalem

Prof. Yitzchak Levav, Director of Research, Mental Health Services, Ministry of Health, Jerusalem

Dr. Moti Mark, Former Director, Mental Health Services, Ministry of Health, Jerusalem

Daniella Nahon, Director of the Department of Information and Evaluation, Mental Health Services, Ministry of Health

Dr. Meir Oren, Former Director General, Ministry of Health, Jerusalem

Gila Saadia, Former Director of Mental Health, Maccabi Health Care Services, Tel Aviv

Shuli Shai, Director of Mental Health Services, Clalit Health Services, Tel Aviv

Prof. Eli Shamir, Chairman of Otzma: National Forum of Family Members of People with Mental Illness, Jerusalem

Prof. Mordecai Shani, Executive Director, Sheba Medical Center

Yechiel Shereshevsky, Director of Rehabilitation Services, Mental Health Services, Ministry of Health, Jerusalem

Appendix 2: Overview of Decisions and the Place of Data/Information

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
1. Should mental health services be included in the mandatory basic basket of services provided by the health plans?	<p>Will transfer improve care? Decrease stigma? Increase accessibility? Enhance continuity of care? Improve efficiency? How much can demand be expected to increase? What are the risks? Can the risks be managed?</p>	<p>Problems in the current system, from Netanyahu report and State Comptroller reports</p> <p>Psychiatric epidemiology studies in Israel</p> <p>Comparisons of utilization, accessibility, quality with other countries</p> <p>International literature on mental health policy reforms, financing in mental health, managed behavioral health care.</p>	<p>Predictions of shifts in demand for outpatient and rehabilitation services.</p> <p>Predictions of health plan behavior under the new system.</p> <p>Epidemiological data on mental health needs of the general population.</p> <p>Data on outpatient utilization in the health plans and in private sectors.</p> <p>Data on the prevalence and effects of stigma.</p>	<p>Attention was focused less on evaluating whether the transfer should be implemented, or how the transfer would achieve desired goals, and mostly on how to make it affordable for the government and feasible for the health plans.</p>

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
2. Which services will be included in the basic basket of services, which services will continue to be the responsibility of the Ministry of Health, and which services will become the responsibility of a different ministry?	What services are congruent with the mission and practice of the health plans, and which are beyond the limits of their mission and practice?	Description of current division of responsibilities	Organizational analyses of the health plans to assess their capacities for adapting to the required changes	Unclear on what basis this decision was made, sometimes including rehabilitation and sometimes not. Was left open for much of the time, frustrating health plan efforts to predict future costs.
	What are the strengths and weaknesses of the health plans as organizations?	Data on current utilization of outpatient and rehabilitation services	Predictions of effects of consolidating versus splitting services across organizations	
	Given those strengths and weaknesses, what is it reasonable to expect that they will do well, and in what areas is there cause for concern?	Descriptions of division of aspects of mental health care in other countries		De facto the decision was made by failure to reach agreement with ministries or health plans, leaving all areas the responsibility of the Ministry of Health.
	What are the costs and benefits of consolidating in versus splitting across organizations?			

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
3. Who should be responsible for the care of the most vulnerable consumers?	Who are to be considered most vulnerable and in need of protection?	Epidemiological data on chronically mentally ill in Israel from the Case Registry and community studies.	Evaluation of alternative mechanisms of protection	Initial plans included this population in the transfer to the health plans.
	Where are they now?	Ministry of Health 1994-95 multi-disciplinary evaluation of 4,000 long-term hospitalized.	Predictions of behavior of the health plans with regard to this population if they were allotted responsibility	Health plans objected under the assumption that they would pose too heavy a burden. On the basis of learning from other countries, the Ministry agreed to take on responsibility for this group, leaving the financing for their care out of the capitation (what was called the Rut Fund). Health plans changed their stance and advocated that they be given responsibility.
	How might the transfer put these individuals at risk?	Follow-up of individuals discharged to the community from long-term hospitalization.		
	Is their risk greater if responsibility for their care is transferred to the plans?	Lessons from the experience of de-institutionalization in other countries.		
	What mechanisms can best protect them?			In the last proposal prior to the January 1997 deadline the Ministry agreed to transfer responsibility and financing to the health plans for this group.

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
4. How much money should be made available to the health plans for financing mental health services?	What are costs of current levels of services?	Current financial data from the Ministry and from the health plans	Data on expected costs related to changes in demand,	Decision seems to have been solely based on Finance Ministry's concern for cost containment by maintaining current level of government spending on mental health, without factoring in expected changes or compensating plans for services they were already providing.
	Should funding cover services already provided by the health plans and not funded by Ministry?	International literature on mental health reforms and their effects on costs	necessary development, administrative and overseeing costs.	
	What is projected change in demand?			
	What are projected costs for development of new services, data and billing systems, monitoring and supervision?			
	What savings can be expected from the provision of mental health services as an integrated aspect of health care? From the shift in emphasis to community-based care?			

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
5. What capitation formula will be used to distribute money among the health plans?	How are psychiatric patients distributed among the health plans?	Case Registry	No systematic data on the current distribution of users of mental health services among the health plans.	Capitation formula recommended by Ginsberg et al was rejected because of confidentiality concerns.
	How can patient distribution be weighted so that capitation approximates treatment costs incurred by each fund?	National Insurance Institute (NII) data base of individuals with psychiatric disabilities	No systematic attempt to evaluate how reform would differentially effect utilization of mental health services by health plan members	Instead a formula was proposed by the Bin-Nun Committee based on NII disability.
	How can capitation be used to minimize risks of “cream-skimming” and “quality skimping”?	International literature on use of capitation in other countries, factors used to predict utilization and risk Study (Ginsberg et al) based on analysis of the Case Registry, recommended combined use of prior hospitalization, age, and diagnosis. Bin-Nun committee analysis, recommending the use of NII disability data base.		

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
6. Should money provided to the health plans be part of a global budget, or earmarked for mental health services?	What are the risks, costs, and benefits of earmarking money for use in a specific area, as opposed to giving it as an unconditional grant?	No serious attempts to analyze these questions seems to have been done.	Analysis of experiences in Israel and abroad with alternative strategies.	It seems that earmarking was not seriously considered as an option at the time, even though considerable concern was expressed at possible misuse of the funds.
	What strategies have been used in other countries, and what have been the relevant outcomes?		Small scale or system-wide experimentation with alternative strategies	
	What administrative controls would be required in order to enforce earmarking?			
	Are there alternatives to earmarking that would also protect funds for use in mental health?			

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
7. What should be the prices of services purchased by the health plans following the reform?	<p>How can prices be shaped to reimburse existing services fairly, on the one hand, and to create incentives for desired changes on the other?</p> <p>What mechanisms, or combinations of mechanisms, can be used to derive pricing?</p> <p>What services may be at risk for financial loss during this transition and how can they be supported?</p> <p>What services may be at risk for closure during this transition, and how should they be addressed?</p> <p>How might prices be used to limit demand for services?</p>	<p>Budgetary data of the Mental Health Services, health plans, hospitals and clinics.</p> <p>Simulations based on Case Registry, oriented towards maintaining hospital budgets.</p> <p>Reports from other countries</p> <p>Strategies used in other countries to manage the effects on hospitals of de-institutionalization.</p>	<p>No efforts seem to have been made to design incentive schemes to promote the shift toward community services.</p>	<p>While a core espoused value of the reform was the shift from the hospitals to the community, in practice fear of the consequences for the hospitals and their employees, and the influence of hospital directors, prevailed. Prices were set so that they would support the continued functioning of the psychiatric hospitals, with no incentives built in to encourage a transition to community-based care.</p>

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
8. How, specifically, will mental health care be integrated into the general health care system?	To what extent do primary care physicians already provide mental health care?	Studies of prevalence based on self-report of patients and on report of primary care providers	Studies of costs and benefits of use of primary care providers specifically for mental health	The increased reliance upon primary care physicians seems to have been axiomatic to the planned transfer.
	What are the costs and benefits of primary care physicians as “gatekeepers” to mental health care?	Studies of costs and benefits of use of primary care providers as gatekeepers for general health services	Studies of barriers to inclusion of mental health services and consumers in the general mental health system.	
	What barriers exist in the general health system to inclusion of mental health?	Learning from experience in other countries, including availability of training.		
	What training and work conditions would primary care providers need to be effective “gatekeepers”?			

Appendix 2: Overview of Decisions and the Place of Data/Information (cont'd)

Decisions on Agenda	Analytical Questions/ Data Required	Available Data/Information	Missing Data/Information	Basis of the Decision
9. What mechanisms need to be in place in order to support the transition from the previous system to the new one?	What channels of communication are essential to the new system, and what is the content of this communication?	Learning from similar processes in other countries, including access to specific models and administrative tools	Since the simulation stopped mid-way, much of the potential learning from it has not been actualized.	The system was in the process of “booting up”, when failure to reach agreement at the policy level regarding the transfer led to its sudden halt.
	What information systems will be required to support communications?	System-wide simulation of the new system prior to its actual adoption.		
	What barriers exist to effective collaborations across organizational boundaries, and how can they be effectively addressed?			
	How will different sub-populations be differentially effected by the implementation?			