THE ISRAELI MENTAL HEALTH INSURANCE REFORM:
THE NEED FOR A PLANNED, SYSTEMATIC EVALUATION EFFORT

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The State of Israel is preparing to transfer legal responsibility for mental health care from the government to the country's four, competing, non-profit health plans. The reform seeks to improve the health and well-being of the mentally ill by establishing a legal right to care, increasing the level of government funding for mental health care, and improving the accessibility, availability, and efficiency of services. The expectations of service improvements are due in large part to two key elements of the reform - the application of managed care elements to mental health and the integration of mental and physical care – that are relevant to many countries considering reforms in their mental health systems. However, it is unclear whether these changes will indeed result in a service system that is more effective and efficient. Hence, a thorough evaluation of the reform can contribute to policy development both in Israel and abroad.

The objectives of this paper are to underscore the potential contributions of a planned, systematic evaluation of this reform, highlight key issues that should be addressed in the evaluation, and discuss various challenges facing the evaluation effort. The assessment of evaluation needs draws primarily on a structured analysis of the Israeli reform, including its context, objectives, key components, and attendant concerns. The assessment is also informed by prior efforts in other countries to monitor performance of mental health systems, with particular attention to those involving elements of mainstreaming (i.e., integration of the financing/delivery of mental health care and physical health care) or managed care. The paper seeks to generate a discussion involving experts from Israel and other countries about the appropriate goals and methods for evaluating the Israeli reform.

The structure of the paper is as follows. Section 1 presents an overview of Israeli health care and its system of mental health services, along with a discussion of some of the main problems facing that system. Section 2 describes the objectives of the reform and presents some of the concerns that have been voiced to date regarding the reform. Section 3 identifies several issues that should be given priority in the evaluation effort, along with promising strategies for doing so, while Section 4 notes several major challenges facing the evaluation effort. Section 5 places the Israeli
reform in an international context, and explores the relevance of performance measures developed abroad for evaluating the Israeli reform. Section 6 summarizes the main points of the paper; it underscores the importance of articulating evaluation foci and strategies, and encouraging a multi-disciplinary, international discourse about them, already at an early stage in the reform effort.

1. Overview of Israeli health care and its system of mental health services

In 2005, Israel had a population of approximately 7 million people and per capita GDP was approximately 15,000 Euro ($21,000). Since the introduction of National Health Insurance (NHI) in 1995, Israel has had a universal, health insurance system that is predominantly tax-financed and that ensures access to a broad package of benefits. All residents are entitled to enroll in any of four competing, non-profit health plans. The health plans receive capitation payments from the government, which reflect the number of members in each plan and their age mix. Many residents also purchase supplemental insurance, from either the health plans or commercial insurers.

Health care accounts for approximately 8% of Israel's GDP and amounted to 1,130 EURO per capita. Approximately 31% of total health care expenditures are financed privately, with that figure including household payments for supplemental insurance, out-of-pocket payments for services not covered under NHI (primarily dental and optical care), co-payments for pharmaceuticals and specialist visits provided under NHI, and visits to private physicians. (CBS, 2007)

The mental health system functions, to a large extent, separately from the physical health system in terms of financing, organization, and practice setting. Israel spends approximately 6% of national health expenditures on mental health care and they are financed primarily by general tax revenues. Government is also the largest provider of mental health services, operating both numerous psychiatric hospitals and a network of community mental health centers.

Israel is in the midst of a major reform of its mental health service system. The main objectives of that reform are to improve the quality of life of the mentally ill, and
improve system efficiency (Aviram and Rosenne, 1998). The reform has three main components, generally referred to as the hospitalization reform, the rehabilitation reform, and the insurance reform. This paper focuses on the insurance reform (which will be described in the next section), but as the three components are inter-linked, we will also provide a brief background on the other two components.

The first component – the hospitalization reform - was initiated at the beginning of the 1990s. It sought to reduce the use of inpatient psychiatric care and shift services from hospital to community settings. That effort has been largely successful, with beds per 1,000 population dropping from 2.13 in 1990 to 1.17 in 1996 and 0.77 in 2005, and inpatient care days per 1,000 declining in parallel (Nahon, 2006; Haklai et al, 2006). The decrease in the inpatient population has not created major dislocations such as a significant homeless population, and a growing proportion of the mentally ill are functioning reasonably well in community settings (Shereshevsky, 2006). There has also been a shift in the composition of psychiatric hospitalizations, from long-term admissions to short-term admissions and day care.

As of 2006, approximately 63% of direct government spending for mental health care went for inpatient services¹. Israel officially had approximately 5,400 psychiatric beds, of which only 3,500 (0.50 per 1,000 population) are considered active beds. Only 7% of all psychiatric beds were in general hospitals, and 93% were in psychiatric hospitals (Ministry of Health, 2006).

Israel has about 90 community-based public mental health clinics. Over half of them (55) are operated by the Ministry of Health, and they provide services free of charge; they are financed via general government revenues. In addition, 25 clinics belong to Israel's largest health plan, Clalit, while the remaining public clinics are operated by other non-profit agencies. In addition, a large number of private, independent mental health practitioners provide community-based mental health services, either in conjunction with the health plans, or on a completely private basis.

¹ At present, the government does not cover community-based mental health care costs incurred by the health plans, such as psychotropic medications.
The decline in psychiatric hospitalizations noted above is probably due, in part, to the second component of the reform, the development of community-based rehabilitation services. The right to such services was established by law in 2000, which also provided for government funding of the services. The services include assistance with employment, housing, and leisure time activities, and the supply of these services has expanded greatly over the past decade in response to the new funding available. At present, approximately 12,000 Israelis are receiving assistance under this law. It is generally recognized that there continues to be significant unmet need for these services (ref).

Some of the main problems currently facing the mental health system, according to various researchers and observers, are the following:

- Mental illness and mental health care are stigmatic for the mentally ill themselves, their families, care providers, and the general population (Struch et al., 2007)
- There is a great deal of unmet need for ambulatory mental health services (Levinson et al, 2007); in part, this is because many people in need do not seek care (Rabinowitz et al, 2003)
- Moreover, persons seeking ambulatory care from MOH clinics must often endure long waiting times. This may be due in part to inadequate staffing levels and in part to sub-optimal allocation of available staff time.
- Private mental health services can be quite expensive, and are not financially accessible to many low- and moderate-income persons
- The linkages between physical and mental care are inadequate. As a result, the physical health needs of patients under psychiatric care often go untreated, and primary care providers are not as effective as they might be in diagnosing, treating and referring mental illness.
- Insufficient attention is being given to mild and moderate psychiatric problems, as the vast majority of system resources are focused on the relatively small number of seriously mentally ill
These problems have led to efforts to transfer responsibility for mental health care from the government to the health plans (Rosen, 2003), as described in the section that follows.

2. The insurance reform

This section reviews the objectives of the insurance reform, its key elements, and attendant concerns.

Objectives

The main goal of the insurance component of the mental health reform, in keeping with the goals of the broader three-part reform of mental health services, is to improve the health and well-being of the mentally ill. Policymakers have also articulated a series of more specific objectives and measures for the insurance component of the reform that are intended to advance that goal, including:

- Establishing a right to mental health care with legally enforceable access standards, so that the availability of services will no longer be constrained by budget limitations;
- Improving access and availability of services (and reducing the extent of unmet needs) by reducing waiting times and financial barriers to care, and by reducing the stigma associated with mental health care and mental illness;
- Improving the link between mental and physical care by enhancing primary care physicians' (PCPs) capacity to diagnose and treat mental illness, and by strengthening the consultation and referral relationships between the PCPs and mental health specialists.

The insurance reform also has a number of secondary objectives including:

- Improving the efficiency of mental health services by making them the responsibility of competing, non-governmental health plans that have a tradition of pursuing efficient care modalities. The plans are expected to seek ways to continue the trend of shifting mental health care from hospital to
community settings and to promote those community based treatment approaches which are most cost-effective

- Enhancing the **status** of mental health professionals, particularly psychiatrists, through the tighter linkage with general health care
- Securing **greater levels of government funding** for mental health services
- **Changing the role of government** from direct service provision to regulation and planning

Many of the primary and secondary objectives listed above are designed to address an important crosscutting objective of the reform: to increase the amount of professional attention and budgetary resources dedicated to mild and moderate psychiatric problems (such as anxiety and depression)

**Key elements**

According to the reform plan, the National Health Insurance Law will be expanded to include mental health services. These will be established as a right of all residents of the State of Israel, and the specific mental health services to which they will be entitled will be spelled out in the legislation (in terms of both types of services and the amount of services\(^2\)). The law will stipulate that the health plans will be required to provide these services to all members who need with reasonable timeliness and accessibility.

The health plans will have responsibility for securing for their members both ambulatory care and inpatient psychiatric care (which they will purchase from psychiatric and general hospitals at rates established by the Ministry of Health). Responsibility for rehabilitation services will not be transferred to the health plans; this responsibility will remain with the Ministry of Health.

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\(^2\) A particular patient's entitlement to services is a function of his diagnosis and his need for care, as determined by his clinician, subject to various caps. For example, an adult patient with an affective disorder (i.e., with an ICD of F-30 to F-39) is entitled to up to 6 counseling sessions per year, as needed. If the clinician believes that more than 6 sessions are needed, an application for additional sessions can be made to an appeals committee.
The law also calls for the Ministry of Health to divest itself of its public clinics, along with a target date for the completion of that process. The expectation is that some of the clinics will be closed, while others will be transferred to particular health plans, a non-profit association that is loosely affiliated with the Ministry of Health, or others to private entrepreneurs.

The health plans will have a substantial degree of freedom in determining the mix of professionals, contractual arrangements, treatment modalities, and practice settings through which they will deliver mental health services. As long as MOH continues to operate mental health clinics, the health plans will be free to purchase some or all of the community-based services for their members from those clinics, but will not be under any obligation to do so.

The mental health services to be provided by and through the health plans will be financed via government general revenues (i.e., predominantly via progressive taxation). In the first year of the reform, the government will add approximately 200 million EURO ($280 million) in new additional funds to be distributed among the health plans to compensate them for their new responsibilities in the mental health area. Approximately three-quarters of this sum will be taken out of the budget of the Ministry of Health's Mental Health Service (which is expected to gradually close down its mental health clinics) and approximately one-quarter constitute new monies for mental health. The funding will be in the form of capitation payments, reflecting the number of members in each plan and their expected use of mental health services. These payments will be in addition to the capitation payments currently made to the health plans for physical health care, and will, naturally, be based on a somewhat different set of parameters.

The health plans will not be required to use the new mental health capitation payments solely for mental health care, nor will they be required to use the traditional capitation payment solely for physical care. The two payment streams will be integrated and the health plans will be able to use the monies as they see fit. At this stage it is not clear whether the mental health care monies will be used by the plans to
cross-subsidize physical health care, or vice versa. However, during the first few years after the reform the health plans will be required to track their expenditures for mental health care and report this information to government regulators. As this could influence future government funding levels for mental health care, this does reduce the health plans' incentives to limit mental health care – at least during the initial years of the reform.

In addition to the capitation payments received from the government, the health plans will be allowed to charge regulated user fees. In cases where the patient seeks care from a mental health professional who works in a health plan clinic on a salaried basis, the fee is very low (approximately 3 EURO or $4) and is the same as the user fee for visits to other medical specialists (such as ophthalmologists or urologists). If the patient seeks care from an independent provider who works with the health plan on a contractual basis, the plan is allowed to charge a higher fee. To offset the resulting incentive to the health plans to rely primarily on independent providers, the law requires the plans to make a clinic option geographically accessible to all members.

**Concerns raised by the reform effort**

The planned reform has raised a number of serious concerns that have been articulated by various participants in public discussions. One group of concerns relates to the incentives, motives and actions of the health plans, while another group is related to way in which the government structures and implements the reform.

**Concerns related to the nature of the health plans**

Many of the concerns currently being voiced by consumer and professional groups derive in large part, from an awareness of the significant contextual and organizational differences between the health plans and the Ministry of Health's Division of Mental Health Services (DMHS). The DMHS's sole line of work is mental health care, while the health plans would be adding a responsibility for mental health care to a long-standing responsibility for physical health care. In addition, the health plans are non-governmental agencies operating in a competitive environment,
while the DMHS is a governmental agency which currently serves as the sole (monopoly) provider of public mental health services.

Of course, some of these characteristics of the health plans played an important part in the motivation to transfer the responsibility for mental health care to the plans. Their involvement in physical health care makes it possible to better integrate mental and physical care. The competitive environment in which they operate increases consumer choice and creates incentives to seek out efficient modalities of care. The non-governmental nature of the plans gives them greater flexibility and frees up the DMHS to work on policy, planning and quality monitoring.

And yet, at the same time, these very same characteristics create concerns and risks. While the health plans are non-profit entities and are generally perceived as functioning under a mix of public service and self-serving motives, there is a general feeling in Israel that the self-serving motives have become more dominant in recent years.

Some Israeli observers have suggested that the health plans will have an incentive to avoid and/or under-serve the most seriously ill patients3. They suggest that while a sole governmental provider may also have had such an incentive, the risk that it will be acted upon is greater in the case of competing non-governmental health plans. The international literature suggests that the risk of cream-skimming and skimping are much greater if the capitation formula does not adequately compensate health plans for their greater level of need (Frank and McGuire, 2006). Moreover, as the monies for mental health are not earmarked, the health plans have the ability, as well as an incentive, to shift some of these funds to physical care of those types of members who are more attractive to the health plan.

Similarly, health plans will have a greater incentive than did government to limit care in order to reduce expenditures. This could take the form of reduced volume of services (e.g. fewer visits per patient) and/or the use of less expensive treatment modalities (e.g. medications instead of long-term counseling) and/or reliance on less

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3 While the reform does seek to increase the amount of care provided for the less serious mental illnesses (such as depression and anxiety) the hope is that this increase will be funded by the new monies being provided by government for mental health care, and will not come at the expense of services for the seriously mentally ill.
expensive professionals (e.g. BA level social workers instead of masters or doctoral level clinical psychologists). While these alternatives can sometimes be clinically appropriate, this is not always the case.

In addition, because of the predominance of physical health care in the work of the health plans, and their more medical mindset in comparison with the DMHS, health plans have a further impetus to emphasize medications in the treatment of mental illness (at least in comparison with the DMHS). This professional orientation combined with the economic incentives could result in over-medication. Furthermore, as the additional monies to be transferred to the health plans in lieu of their added responsibilities are not earmarked for mental health care, there is a concern that some of these monies will be directed to physical health care, the core concern of the health plans.

Two additional concerns relate to the non-governmental nature of the health plans. First, as non-governmental providers, it may be more difficult for them than for the DMHS to interact, and coordinate care, with the agencies responsible for rehabilitative and welfare services. Second, as non-governmental providers, health plans perceive their responsibility as limited to service provision, whereas DMHS has seen itself as also being responsible for preparing the next generation of mental health care practitioners. There is a serious concern that, unless required by new laws or motivated by new financial incentives, the health plans will not invest in the educational endeavor. As a result, in the future Israel could face serious manpower shortages – in terms of quantity and quality - in the mental health field.

Advocates and planners of the reform believe that they have ways to address, or at least mitigate, many of the concerns discussed in this section. For example, they note that concerns about cream-skimming and skimping can be addressed in several ways, including: a good capitation formula, governmental monitoring of the quality of mental health services, and health plans' concerns that inadequate care could result in lawsuits and/or damage to the health plan's reputation. Thus, there exists significant uncertainty as to the extent to which the concerns listed here will indeed materialize – all the more reason to monitor the relevant parameters as part of an overall evaluation strategy.
Concerns related to design and implementation

Another set of concerns relates to the manner in which the government (and particularly the Ministry of Finance) will structure and implement the reform. Most of these relate to financial issues. The Ministry of Finance is quite concerned that, by making mental health services a right, reducing the stigma associated with mental health care, and increasing access to care, the reform will lead to greatly increased consumption of mental health services and even over-consumption relative to need. As a result, the MOF has pushed for, and secured, various limits and controls, such as limits on the number of visits to which patients are entitled⁴ and co-payments for certain types of services (MOH-MOF agreement, 2006).

Similarly, the MOF has been concerned that the health plans will have an incentive to refer patients to rehabilitation services (which are funded by a separate government allocation) in order to reduce their own treatment expenses. Accordingly, the planned reform gives the health plans a financial incentive to refer sparingly to rehabilitation. There are concerns that these incentives may be too strong and that, as a result, many patients in need of rehab services will not get them.

Another concern relates to the future of the DMHS clinics. The MOF seeks to cover some of the additional costs associated with the reform by closing down these clinics as soon as possible. The hope is that they will not be closed down until the health plans have developed alternative sources of care. The concern is that it will take the health plans several years to expand their capacity to provide high-quality mental health services and in the meantime, intra-governmental budgetary pressures will lead to premature reductions in DMHS’ capacity. This could happen exactly at a time when there is a need to expand overall mental health service capacity. The transition period clearly poses significant challenges.

There is a further concern that, even if the initial level of governmental funding to be transferred to the health plans for mental health services is adequate initially, it will

⁴ Thus, the concern that patients will not receive enough visits derives from two sources – the limits on the entitlements (noted in the section) and the sick funds’ incentives to determine that a particular patient need fewer visits than government-established maximum entitlement (as noted in the previous section).
decline over time relative to population need. The government is always scanning its full range of activities and looking for ways and places to reduce expenditures. Countervailing pressures can be applied by the relevant government ministries, non-governmental providers or contractors, and the populations being served. In the case of mental health services, these countervailing forces may not be particularly strong: the MOH and the health plans may focus their lobbying capacity on physical health care, and the lobbying power of consumers of mental health services and their families is limited.

Finally, it should be noted that there are ongoing concerns that the reform will not be implemented at all. Since the introduction of National Health Insurance in 1995 there have been several serious attempts to transfer mental health to the health plans, and they have all failed, for a complex set of reasons discussed elsewhere (Aviram et al, 200; Sykes, 2006). Thus, while the reform planning and preparations have made more progress this time round than ever before, there continues to be room for healthy skepticism.

3. Keys issues for evaluation

 Israeli researchers are currently in the process of mobilizing to monitor and evaluate the reform. Efforts are underway to identify the most important issues to evaluate and strategies for evaluating them. Input is being sought on these issues from experts in other countries. Sources of financing for evaluation are being created and nurtured. Coordination mechanisms are being developed to reduce duplication of evaluation efforts and ensure that all of the most important issues are covered. This section describes some of the key issues identified for monitoring and evaluation, while the section that follows reviews some of the challenges facing the evaluation effort.

The nature of the evaluation

There is a consensus that the evaluation of the mental health reform should be both summative and formative. In other words, it will be important to generate information "along the way" that can help fine-tune the reform as it is being implemented, and in several years time it will be important to assess the overall impact of the reform. For
both summative and formative purposes, it will be important to assess the extent to which the reform achieves its multiple objectives as well as the extent to which the various concerns about the reform materialize. In addition, it will be important to monitor the organizational and policy changes adopted by the key institutional actors, as this can help researchers focus evaluation efforts on where the action is taking place\textsuperscript{5}. This relates to both the timing and extent of the government policy changes (which often depart from the original plan) and the responses of provider organizations. Information on the latter can also help policymakers identify emerging issues that need to be addressed at the policy level. Finally, there is a need for analytic work to develop key tools needed to implement the reform. In this section we will give examples of the issues to be monitored under each of these major headings (objectives, concerns, institutional responses, and tools), along with strategies and directions for evaluating them.

**Evaluation issues related to reform objectives**

With regard to some of the reform's objectives, no special evaluation efforts are needed to assess whether they have been achieved. For example, the reform seeks to create a clear and enforceable legal right to mental health care, and once the relevant legislation has been passed no additional evaluation is needed to assess whether a new right has been created (though questions remain about the extent to which that right is realized and enforced).

The situation is different for objectives such as improving the access, availability and quality of care provided (both to the general population and to the seriously mentally ill). With all due respect to objectives of the reform, and its underlying rationale, it is distinctly possible that access, availability and quality of the services will in fact remain at their current levels or even deteriorate. While the reform does establish rights to care, and provides additional funding for mental health care, it is not certain that the health plans have the capacity and the incentives to improve mental health care.

\textsuperscript{5} As discussed further below, this tracking of system dynamics is also important for exploring whether changes in key outcome variables can reasonably be attributed to the reform.
The primary information sources regarding access, availability and the service dimension of quality should be general population surveys, surveys of mentally ill persons and surveys of care recipients. Clinical databases of the provider organizations (MOH and the health plans) could be valuable sources of information on diagnoses and treatments at the individual level, which can be used to assess the clinical appropriateness of the treatments provided. There already exist international standards for access, availability and appropriateness of care and a variety of tools for assessing compliance with those standards (Hermann, 2006). Researchers will have to adapt those measures to the Israeli context and data sources.

It will also be important to assess the extent to which the reform improves linkages between mental and physical care. Locating responsibility for both in the same organization (the health plans) certainly creates the opportunity for improved linkages, but the situation will improve only if the health plans mobilize to make the linkages. One useful information sources here is in-depth interviews of health plan executives regarding the interventions they have launched to enhance the linkages. It will also be important to carry out surveys of primary care physicians and mental health specialists to assess the extent to which those managerial interventions have influenced what goes on in the field, in terms of capabilities, consultation and referral patterns, and treatment patterns. It might also be useful to look at health care indicators that could be influenced by improved linkages (e.g., measurement of blood sugar for diabetics among the seriously mentally ill).

**Evaluation issues related to concerns about the reform**

One of the main concerns about the reform is that the health plans will neglect the seriously mentally ill. Some analysts have suggested that the plans may well take steps to avoid having them as members and also skimp on the care of those who are members. It will be important to develop reliable tools for assessing whether, and to what extent, such behavior indeed materializes.
Another serious concern is that there will be a major increase in service utilization, part of which will be unnecessary. Accordingly, it will be important to monitor both trends in aggregate utilization levels as well as trends in utilization rates by treatment type, diagnosis and (ideally) severity of illness. Computerized clinical databases in the health plans, and perhaps in MOH as well, could be very useful here. However, as discussed further below, there are serious data accessibility and compatibility challenges which will need to be overcome.

**Organizational and policy changes adopted by the key institutional actors**

It is critically important that researchers explore how the health plans perceive the new system's incentives, obligations and constraints and how they mobilize to meet their new responsibilities for mental health care. One key issue is the extent to which health plan managers feel that the capitation formula adequately compensates them for the seriously ill.

It will be important to be on the lookout for paradigm shifts and the development of new ways to organize and provide care. This could includes changes in the roles that the health plans assign to primary care providers and various types of mental health professionals, the treatment modalities they encourage, the extent and manner in which they monitor practitioner behavior, etc. While provider responses are important to monitor in any evaluation of changes in health care policy, they are particularly important here, as the mental health reform leaves many key organizational decisions to the discretion of the health plans.

Major health reforms are often implemented in ways that depart from the original plans (Gross et al, 1998), and often these changes in the reform necessitate changes in evaluation foci and strategies. Therefore, it will also be important to monitor and analyze how the Ministry of Health implements its part of the mental health reform.

The primary information source here is key informant interviews – particularly in the health plans, but also in the government and the professional associations. Planning
documents and government reports are also valuable information sources. Patient interviews can provide useful information on the organization of care. This sort of information can help policymakers make immediate changes to the rules of the game and can help researchers identify issues requiring more in-depth research.

**The need for analytic work on tool development**

Researchers can contribute to successful implementation of the reform not only through formative evaluation, but also through development of better implementation tools and strategies. One critical task is to provide the strongest possible basis for the capitation formula by analyzing the relationship between individual characteristics and the use of mental health services. This can help with efforts to refine the mental health capitation formula so that it does a better job of allocating monies among health plans fairly (i.e., in proportion to members' needs) and also creates incentives so that health plans will not try to avoid the most seriously ill.

Another area where analytic work can contribute to the design of the reform relates to the structure of the co-payments. On the one hand, co-payments can help address concerns about excessive and unnecessary utilization. On the other hand, they can create barriers to care, particularly for low-income groups and persons with substantial service needs. Here, the challenge is figuring out which diagnoses and services should be subject to co-payments, how high they should be set, and who should receive exemptions or discounts. Analyses of how mental health co-payments have been structured in other countries, and their impact, could be useful here. It will also be useful to examine and extrapolate from Israeli data on the extent to which fees and co-payments currently create financial barriers to medical and physical care for various population groups.

A third area in need of tool development was mentioned earlier. It will be important to adapt international guidelines, quality of care standards and measures to the Israeli context. The adaptations will have to take into account differences in terms of how the mental health system is organized, the available resource levels, the illness patterns, the culture, and the availability of relevant data.
4. Challenges facing the evaluation effort

The evaluation of this complex reform faces numerous challenges, including: incomplete baseline data, difficulties in attributing changes to the reform due to the lack of a control group, uncertainties regarding the timing of the reform and its design, the need to merge data from numerous providers, and the need to mobilize inter-disciplinary expertise. We will discuss each of these in turn.

ASSEMBLING BASELINE DATA

As noted above, the evaluation of the reform has both formative and summative dimensions. Any assessment of the impact of the reform on these issues would require data for the period before the reform as well as for the period after the reform. On several of the key issues, researchers will be able to assemble before and after data, either from surveys or from administrative/clinical databases. This will be important, as information on the impact of the reform could be useful in future policy discussions in Israel on whether to deepen or scale back the reform. Moreover, findings on the impact of the Israeli reform could be useful to decisionmakers in other countries considering similar reforms.

However, the issue of impact is not the only issue of interest. Moreover, it is well that it is so, as baseline data are likely to be lacking on many of the key parameters. Even aside from the issues of changes and impacts, policymakers have an interest in monitoring the levels of key parameters after the reform, and will often be comparing these levels with implicit or explicit benchmarks of desired performance levels.

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6 Israel is fortunate to have baseline data from several excellent general population surveys including the 2003 World Mental Health Survey and the 2007 Myers-JDC-Brookdale survey of consumers’ experiences with the health system (Gross, 2004). The situation with regard to surveys of mentally ill populations and populations of users of mental health services is less sanguine.

7 In some health care reform efforts, information on impacts can also inform decisions on cancellation of reforms and/or whether to take pilot projects and implement them nationwide. Neither of these are relevant in this case, as the reform is already being implemented nationwide and full cancellation is considered very unlikely.
A key issue in the evaluation design is whether, and to what extent, it is important to assemble baseline information on each of the various process and outcome measures of interest. Clearly, this could vary from measure to measure and serious detailed analysis is required to identify those measures for which baseline data are most critical.

A related issue is encouraging researchers to invest the time and monies needed to assemble baseline data. Some researchers are hesitant to do so, due to the uncertainties about whether, and when, the reform will be implemented (particularly in light of repeated delays in the past). Why collect "before" data to assess the impact of a proposed reform, if that reform might well not happen? One approach could be to encourage researchers to design studies that can both contribute to the reform (if it takes place) and can contribute in other ways to the development of mental health services even if the reform is cancelled or delayed.

A final issue to consider is the appropriate date for baseline data. As the insurance reform has been in the air for over a decade, despite repeated deferrals, some of the health plans have been preparing for it for quite a while. Those anticipatory preparations have largely been in the form of contingency plans, but it is likely that they have also led to certain changes in the field as well. In other words, the reform may have had an impact even before it is officially implemented.

ATTRIBUTION OF CHANGES TO THE REFORM
Even in the case of parameters for which before and after data will exist, it is not clear that studies can be designed that can determine the extent to which the changes can be attributed to the mental health insurance reform. Other policy, organizational and environmental changes may be taking place simultaneously that could affect the process and outcome measures of interest. As the reform is nation-wide in scope, no

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As Frank and Glied (2006) demonstrate, these could even include changes external to the mental health system, such as changes in the level and coverage of welfare and disability payments.
control group is available, and in the absence of a control group, it is difficult to isolate the effects of the reform.

Here, it will be important to monitor what other changes are taking place in the environment and to consider their potential impact on the process and outcome variables of interest. It will also be useful to analyze the organizational and policy changes adopted by the key actors, as that can help address attribution issues, against the background of models of how the reform is expected to bring about changes in outcomes (Gross et al, 1998). For example, if the evaluation finds deterioration in the quality of care for the SMI population, it will not be possible, from the outcome data alone, to assess whether this was due to the insurance reform. Interviews of health plan executives could reveal whether they view the SMI population as desirable, and whether they have changed either the amount of resources devoted to their care or the manner in which services for this group are organized and provided. While such information cannot definitively prove or disprove a causal link between the reform and quality of care, they can certainly contribute to our assessment of the plausibility of such links.

Again, it is important to keep in mind, that Israeli policymakers may be less concerned with attribution (isolating the effects of the reform) than with whether the new system works well. However, for policymakers from other countries considering adopting a reform similar to the Israeli reform, the attribution issue remains cardinal. If Israeli policymakers are indeed interested in the causality issue, it may be possible to convince them to introduce the reform in a phased manner (say, by regions) to create the possibility of a pre-post, control group design.

BRINGING TOGETHER DATA FROM SEVERAL PROVIDERS
The evaluation will require combining data from a variety of health plans (regarding the situation after the reform) and combining health plan data with Ministry of Health data (as MOH is the major provider of care before the reform). This will be challenging, as the variables available will differ across providers, as well variable definitions. Moreover, the MOH data information system is somewhat dated and cumbersome to use; in addition, MOH regulations stipulate that data can only be accessed on a clinic-by-clinic basis. It is unlikely that these challenge can be fully
addressed, but they can be addressed in part (through painstaking effort), and the limitations can be carefully documented.

MOBILIZING EXPERTISE

As the Israeli reform seeks to integrate mental and physical care, its evaluation will require the involvement both of experts in mental health and of experts in general health care. As the reform uses legal, organizational and financial tools in the pursuit of improved access and quality of care, its evaluation will require expertise in a wide range of disciplines, including law, organizational sociology, economics, epidemiology, psychiatry, general medicine, etc. In addition, because we need to assess a reform process, not just a new care system in equilibrium, experience and expertise in evaluating reforms is also needed.

At present, Israel has very few researchers whose primary field of work is mental health services research. Accordingly, it will be important to encourage mental health experts, most of whom have focused to date on epidemiological and clinical issues, to get more involved in organizational issues. Similarly, it will be important to encourage general health services researchers to get more involved in issues of mental health care.

There are important opportunities for collaboration here, including greater involvement of experts in mental health services research from other countries. The section that follows highlights some of the lessons that can be learned from research and researchers outside of Israel, as well as why the Israeli reform could be of interest to them.

5. The Israeli reform and its evaluation in international context

The goals of the Israeli mental health reform are similar to mental health reform efforts in other countries. Many other countries have undertaken efforts to improve the well-being of the mentally ill, integrate mental and physical care, reduce stigma, shift care from the hospital to the community, etc. Similarly, many of the practical
elements of the Israeli reform can be found in other countries. For example, the UK, New Zealand, Norway and Denmark have established mental health as a right and provided government financing for mental health care to turn that right into a reality. The US has been acquiring experience with provision of mental health care by managed care organizations. In many countries, the same organizational entity (governmental or otherwise) is already responsible for both physical and mental health care. Some of these countries are experimenting with new ways to integrate mental and physical care at the primary care level. Accordingly, Israel can learn a great deal from monitoring and evaluation efforts in other countries—in terms of both what is most important to measure and what is the best way to do so.

For example, assessments of managed behavioral health care (MBHC) in the US highlight the importance of measuring changes in such variables as the types and duration of the treatments provided and the professional mix of those providing them. They also suggest that managed care can decrease the amount of care provided to the seriously mentally ill, even while it increases the amount of care provided to those suffering from more common but less debilitating mental illnesses—and hence the need to consider the two groups separately. Israeli policymakers are already examining and debating what the US experience teaches us about MBHC and the quality of care.

Similarly, Israel can learn a great deal from studies in various countries of efforts to better integrate mental and physical care at primary care levels. There are lessons here in terms of how best to conceptualize the care models, what processes and outcomes to monitor, and how best to design the studies. For example, Gilbody and Bower’s (2007) distinction between various models of integration (training, consultation-liaison, collaborative, and replacement care) are very relevant to analyses of the Israeli situation, as is their review of the literature on the efficacy of those approaches. With regard to processes, several authors (Knapp et al, 2007; McDaid et al, 2007)

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9 It should be noted that while the move to managed care for mental health in the US was motivated primarily by the desire to control costs, in Israel it is motivated by the desire to increase access.
emphasize the need to look beyond the actions taken within the health system to the actions taken by related social service systems, another issue very relevant to the Israeli reform. Similarly, with regard to outcome measures and study design, Wells' work on efforts to improve depression treatment in primary care is quite relevant to Israel. It highlights the importance of looking beyond clinical symptom manifestations to quality of life and employment measures, and of doing so differentially for different ethnic groups (Wells et al, 2004).

In addition to drawing on evaluation studies from other countries, Israel can benefit from ongoing monitoring tools that have been developed elsewhere. Israel already participates in the WHO's World Health Survey; information from that survey has already informed the plans for the reform and, if repeated in several years, could also contribute to its evaluation. Similarly, as Hermann (2006) has documented, there exist many tools for monitoring the quality of prevention and assessment efforts, access, treatment, coordination, continuity and patient safety. Some of these could be adapted to Israel and used for both ongoing quality monitoring and evaluation efforts.

The experience in other countries also underscores the complexity and challenge of "mainstreaming". In the UK, the NHS as an organization has been responsible for both mental and physical health for decades, but there is still much to be done in integrating the two at the level of the front-line practitioners (ref). In the U.S., while mental health has become much more mainstream in terms of co-payment and benefit package parity, the growth of MBHC has also contributed to the carving out phenomenon, where the care management function is split between mental and physical health (Mechanic, 1998). All this highlights the importance of monitoring how "mainstreaming" will play out within Israeli health plans.

Clearly, Israel has much to learn from practical experience and monitoring efforts in other countries. At the same time, the Israeli reform and the new mental health system that it seeks to create share many elements with other countries, there is something rather unique in the Israeli reform. It could become the first country to provide mental health services for its entire population through a system of government-regulated and
government-financed managed competition\(^\text{10}\). Unlike the situation in most European countries, which do not have health plans, there would be a major role in Israel for competing health plans. Unlike the situation in the US, the health plans would be operating in a system with government-financed universal coverage and entitlements. This unique mix could have important implications for the impact of the reform and for the types of monitoring efforts required.

Another distinctive, though not unique, feature of the insurance component of the Israeli reform is its target population. While the hospitalization and rehab components of the Israeli reform focused exclusively on the seriously mentally ill (SMI), the insurance component also (some would say, primarily) seeks to benefit the non-SMI population in need of mental health care. Almost all of the government-led mental health reforms in other countries that are assessed in the professional literature focus on the SMI population.

Accordingly, the findings from the Israeli evaluation, as well as the tools developed to carry it out, could be very informative for other countries considering nation-wide changes involving managed care, the mainstreaming of mental health care and/or a major focus on the more common mental health problems.

6. Conclusion: the importance of articulating a timely, structured evaluation plan

As the article has spelled out, an evaluation of the Israeli mental health reform is needed due to uncertainties about the extent to which the goals will be achieved and concerns will materialize. The evaluation can be most helpful if it has both formative and summative elements.

The Israeli case also illustrates the importance of thinking through evaluation needs (and policymakers’ information needs more broadly) in advance, articulating them, and sharing them with others for comments. Doing so makes it possible to benefit

\(^{10}\) In January, 2008, will be transferring responsibility for mental health care from the government to the health plans, but at least in the initial phases the government will continue to bear the financial risks (Van de Ven, 2007).
from the input of a range of disciplinary and substantive area experts, and fosters opportunities for cooperation among them. This is especially important for a reform that links the traditionally separate areas of mental and physical health care and that uses managerial and economic tools to promote improved health and well-being.

A well-articulated, timely evaluation plan makes it possible for the governmental and field organizations being studied to contribute to the identification of issues that need to be monitored; they are also often in a position to identify issues which researchers might otherwise not notice. The professional literature (refs) suggests that this contributes both to a better evaluation plan and the willingness of the organizations to cooperate with the evaluation effort (e.g., by providing access to key data). No less important, a clear and compelling evaluation plan can help build the case for adequate funding of the evaluation and related research efforts, particularly if there is a broad consensus about the need for evaluation.

An explicit evaluation plan also creates opportunities for timely learning from other countries. This is very important in our case, as there are significant parallels in other countries to several key elements of the Israeli reform and the new system of care that it seeks to create. Israel can learn from researchers in other countries about both what is most important to monitor and about what are the best ways to do so. Such input could not be possible without a clear statement of the Israeli reform and the evaluation plans being developed by researchers within Israel, as well as timely vehicles for sharing that information with experts from abroad.
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