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PERSPECTIVES

The Israeli Mental Health Insurance Reform

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Abstract

Background: At present, Israel's mental health system functions separately from its physical health system in terms of financing, planning, organization and practice setting. The government is responsible for the provision of mental health care, while the country's four, competing, non-profit health plans are responsible for physical health care. A reform effort is underway to transfer legal responsibility for the provision of mental health care from the government to the health plans.
Aims: The main objectives of this paper are to summarize the key components of the reform, its objectives, and the concerns that it has raised. The paper also seeks to foster interactions between experts from Israel and other countries about the Israeli reform.
Methods: The analysis is based on official government documents, the scholarly literature about the Israeli reform and the relevant international literature about mental health care in other countries, participation in key public meetings related to the reform, discussions with leaders of the reform effort, and discussions with leading mental health experts in other countries.
Results: Two elements of the reform - the application of managed care principles to mental health and the integration of mental and physical care – are shown to be central both to the reform's objectives and to the concerns that have been raised about the reform.
Discussion: These same two elements are relevant to many countries implementing or considering reforms in their mental health systems.
Conclusions: The architects of the Israeli reform could learn a great deal from the experience with mental health care and related reforms in other countries. At the same time, the Israeli reform could offer important insights and lessons for other countries.
Implications for Policy: The Government of Israel should work with the international mental health care professional community to create frameworks that would facilitate cross-national learning.
Implications for Further Research: It will be important to monitor the implementation of the reform and evaluate its impact, in order to assess the extent to which the objectives are met and the extent to which the concerns materialize. Cross-national research collaborations could be very helpful.

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Background

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 clarifying and specifying the 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.

The main objectives of this paper are to analyze the key components of the reform, its objectives, and the concerns that it has raised. The paper also seeks to generate a discussion involving experts from Israel and other countries about the Israeli reform.

The analysis is based on official government documents, the scholarly literature about the Israeli reform as well as relevant international literature about mental health care in other countries, participation in key public meetings related to the reform, discussions with leaders of the reform effort, and discussions with leading mental health experts in other countries.

The structure of the paper is as follows. The first section 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 the current system. The second section describes the objectives of the reform and presents some of the concerns that have been voiced to date regarding the reform. The third section places the Israeli reform in an international context, and gives examples of how both the

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unique features of the Israeli reform and the features it shares with reforms elsewhere, provide important opportunities for cross-national learning. The fourth section summarizes the main points of the paper and encourages international discourse about the reform.

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 in 2005 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.[1]

The mental health system functions, to a large extent, separately from the physical health system in terms of financing, planning, organization, and practice setting. Israel spends approximately 6% of national health expenditures on mental health care.†[2] These expenses are financed primarily by general tax revenues. Government is also the largest provider of mental health services, operating about half of the psychiatric hospitals as well as the largest network of community mental health centers.

Since its adoption in 1995, the National Health Insurance Law has included a long list of mental health services that the government is expected to provide.* However, it also included an overlapping list of mental health services that the health plans are expected to provide. This has resulted in confusion about the allocation of responsibility between government and the health plans, and made it difficult for those in need of mental health care to realize their rights to care.

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,[3] The need for a major overhaul of the mental health system was articulated already in 1990 by The State Commission on the Functioning and Efficiency of the Health Care System, a blue ribbon panel which called for far-reaching changes in the financing, organization and operation of the Israeli health system as a whole. The mental health reform, as it has evolved since then, 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.[4,5] 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.[6] 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 services.* 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.[4]

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.

The success in reducing psychiatric hospitalizations without major dislocations was 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

* Thus, the Israeli health care system is similar to many European systems in that it a publicly financed national health insurance system with universal coverage. The prevalence of managed care is a feature that Israel shares with the Netherlands, and to some extent with the U.S.

† Approximately one-third of the 89 nations that provided baseline data to the WHO's Atlas Project indicated that mental health accounted for more than 5% of federal health expenditures. It is not clear what percentage of national health expenditures went for mental health care in these countries (Saxena *et al.*[2]).

* As with other services included in the NHI benefits package, both the government and the health plans are expected to provide the services free of charge (aside from certain small co-payments) and at reasonable levels of proximity and promptness.

* At present, the government does not cover community-based mental health care costs incurred by the health plans, such as psychotropic medications.

available. At present, approximately 12,000 Israelis are receiving assistance under this law. It is unclear to what extent the full population of those who could benefit from the rehabilitation services are receiving them at present.

The third component of the reform – the insurance reform – would transfer responsibility for mental health care from the government to the health plans. The 1990 State Commission of Inquiry noted above spoke about the need for such a transfer, citing two main reasons: the need to free up the government from operations so that it can focus on policy, and the need to clarify the division of responsibility in this area between the government and the health plans. 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.[7,8] The current effort appears to be more promising, as there is essential agreement on the terms of the transfer between the Ministry of Health, the Ministry of Finance and the health plans. Moreover, the relevant legislation has already passed its first reading in the parliament.

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 stigmatized for the mentally ill themselves, their families, and the general population.[9]
- There is a great deal of unmet need for ambulatory mental health services;[10] in part, this is because many people in need do not seek care.[11]
- 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.
- There are significant disparities in service availability between the center of the country and peripheral regions.
- There is a lack of clarity about the division of responsibility for mental health care between the government and the health plans.
- Investment in the government system has been limited, as a result of a long period of uncertainty about whether the government will continue to be a major service provider.

These problems have led to renewed efforts to transfer the main responsibility for mental health care from the government to the health plans.[12] This time the effort has been associated with a larger set of objectives than that envisioned by the 1990 State Commission of Inquiry, as described in the section that follows.

The Insurance Reform

This section reviews the objectives of the insurance reform, its key elements, and attendant concerns. The key elements are captured in **Figure 1**, which also indicates the key relationships among them.

Objectives

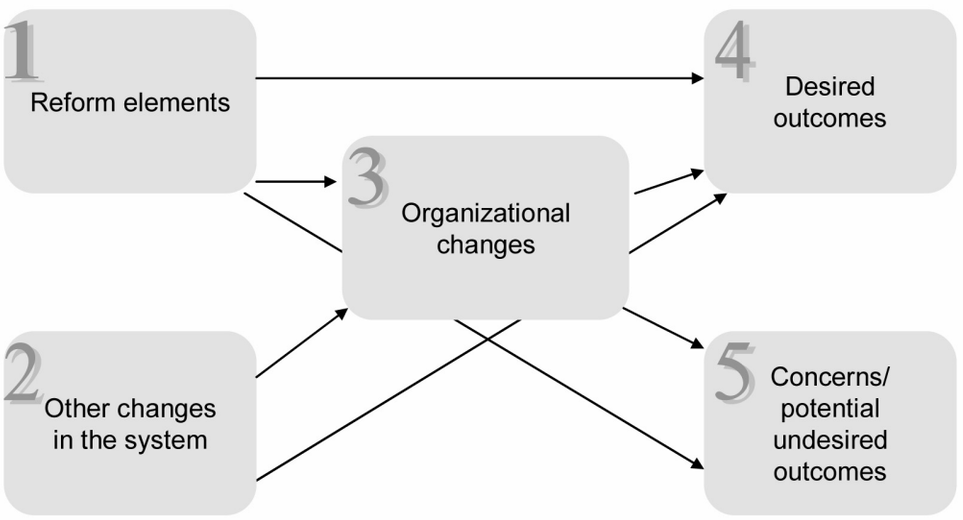
The main goal of the insurance component of the mental health reform, in keeping with the goals of the broader three-part reform of mental health services, is to improve the health and well-being of the mentally ill.[13,14] Policymakers have also articulated a series of more specific objectives and measures for the insurance component of the reform that are intended to advance that goal, including:

- 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.
- Improving *access and availability* of services (and reducing the extent of unmet needs) by:
  - Providing greater specificity regarding the services to which there is a legal entitlement to care
  - Removing the link between government budget constraints and providers' responsibilities to make the right to timely care a reality
  - Making it easier to enforce the right to mental health care
  - Reducing waiting times and financial barriers to care
  - Reducing the stigma associated with mental health care and mental illness;

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.*
- Increasing the amount of professional attention and budgetary resources dedicated to *mild and moderate psychiatric problems* (such as anxiety and depression).

* Note that for some of the key players, such as the Ministry of Finance, this objective appears to be one of the primary objectives, rather than a secondary objective.



1	**Reform elements** • Transfer of responsibility from government to the health plans • Specification of a mental health benefits package • Capitation formula	4	**Desired outcomes** • Improved link between mental and physical care • Improved efficiency, access and availability • Improved status of psychiatrists • Greater levels of government funding • Change in the role of government • Increased attention to mild-moderate MH problems
2	**Other changes in the system** • Structural reform • Rehabilitation reform	5	**Concerns / potential undesired outcomes** A. Concerns related to incentives, motives and actions of health plans • The most seriously ill will be avoided or under-served • Cost-saving efforts will impinge on quality of care • Over-emphasis on pharmaceutical treatments • Insufficient coordination with welfare and rehab services • Insufficient attention to professional training B. Concerns related to the design and implementation of the reform • Barriers to needed rehab services • Government clinics will be closed prematurely • Government funding levels will deteriorate over time
3	**Organizational changes** • Government – mid-course changes in the reform • Health plans o "Make/buy" decisions o Role of primary care providers o Mix of professionals o Mix of treatment modalities		

Figure 1. Key Elements of the Mental Health Insurance Reform.

Key Elements

According to the reform plan, the responsibilities of the health plans under the National Health Insurance Law will be expanded to include all mental health services, aside from rehabilitation care and substance abuse care. The specific mental health services to which residents of the State of Israel will be entitled will be spelled out in the legislation (in terms of both types of services and the amount of services).* The law will stipulate that the health plans will be required to provide these services to all members who need them with reasonable timeliness and accessibility (as is the requirement regarding other services provided by the sick funds for physical health care).

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).

* According to the bill submitted by the government to the Knesset, 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. It now appears that the Knesset may amend the legislation so that it is more flexible with regard to both who can receive care and how many sessions will be covered.

Responsibility for rehabilitation services will not be transferred to the health plans; this responsibility will remain with the Ministry of Health.

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 some mix of the health plans, a non-profit association that is loosely affiliated with the Ministry of Health, and/or 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 Ministry of Health will monitor the performance of the health plans and other operational aspects of the reform; it has set up a special unit (the "reform authority") charged with doing 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 Euro 190 million ($275 million) to the funds to be distributed among the health plans, to compensate them for their new responsibilities in the mental health area.* Approximately 85% of this sum will be taken out of the budget of the Ministry of Health's Mental Health Service (which is will no longer finance hospital care directly and which is expected to gradually close down its mental health clinics). Approximately 15% constitute new monies for mental health, which will be added to the health budget from the government's general revenues. 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. 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 Euro 4 or $6) 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.

To sum up, the key elements of the reform, and their relationship to the reform's objectives, are as follows:

- The assignment of the responsibility for mental health care to the health plans is intended to improve access, quality, efficiency, and integration between physical and mental care.
- The increase in the amount of money available for mental health care is seen as a necessary to finance improve access.
- The introduction of a capitation formula seeks to limit the risk of cream-skimming and ensure that plans with a high concentration of severely mentally ill will be compensated fairly.
- Co-payments are being introduced as a cost containment measure.

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 nature of the health plans, while another group is related to way in which the government is structuring and implementing the reform.

Concerns Related to the Nature of the Health Plans - Structure, Organizational Culture, Incentives, Motives and Operating Style

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.

* At present, the health plans receive approximately 3.5 billion Euro per year from the government in general capitation payments, to cover the cost of general health services. At present (i.e., prior to the mental health insurance reform), the health plans are estimated to spend approximately 20 million Euro per year on mental health care.

Of course, some of these structural 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 legitimate mix of public service motives and organizational interests, some observers feel that the organizational interests have become more dominant in recent years. Other observers counter that organizational interests also influence government agencies, so that it is not definite that the transfer of mental health from the government to the health plans will lead to less attention being paid to the public interest.

Some Israeli observers have suggested that the health plans will have an incentive to avoid and/or under-serve the most seriously ill patients.* 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.[15] 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, as they work in a more competitive environment, and a more business-like organizational culture. This incentive could lead to 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 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.

Accordingly, it will be important to monitor the relevant parameters as part of a multi-faceted evaluation of the reform. Serious efforts are underway to plan and implement a comprehensive and coordinated evaluation effort.

Concerns Related to Design and Implementation of the Reform

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 various limits and controls, such as limits on the number of visits to which patients are entitled* and co-payments for certain types of services.[16]

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

* 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.

* 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). It should also be noted that the Parliament is considering striking these limits on the number of visits from the mental health reform legislation.

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 rehabilitation 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 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, there is a concern that the effort to improve access by detailed specification of the services to which persons with mental health problems are entitled, and to limit entitlement to persons with a defined mental health diagnosis (as expressed in the bill submitted by the government to the Knesset), could reduce access for those patients whose problems do not fit neatly into any of the specific diagnostic categories listed in the law. The Parliament is considering broadening the entitlement to all persons whom the professionals involved believe could benefit from mental health care.

The Israeli Reform 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.[17,18] The US has been acquiring experience with provision of mental health care by managed care organizations.*[19,20] 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.[21,22]

Accordingly, Israel can learn a great deal from the experience in other countries. For example, assessments of managed behavioral health care (MBHC) in the US highlight its affects on the types and duration of the treatments provided and the professional mix of those providing them.[23] 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.[24] Israeli policymakers are already examining and debating what the US experience teaches us about MBHC and the quality of care.[25,26]

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, and what processes and outcomes to monitor. For examples, Gilbody and Bower's[22] 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[17,27] 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.

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.[28] 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.[24] 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 in other countries. At the same time, while 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

* 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. Another important difference between the two countries is that in the US most managed behavioral health care is provided by managed care firms that deal only with mental health care, while in Israel the expectation is that the health plans will deal with both physical and mental health care.

population through a system of government-regulated and government-financed managed competition.* 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.

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 evolving Israeli experience 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.

In light of the wide range of opportunities for cross-national learning that have been noted in this section, the leaders of the Israeli mental health reform, and those involved in its evaluation, are establishing a variety of channels for the exchanges of ideas and experiences. These relate to both the reform itself and to efforts to monitor and evaluate it. Readers interested in taking part in these efforts are encouraged to contact the corresponding author of this article.

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* In January 2008, the Netherlands 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 den Ven, Personal Communication, 2007).