Comments on Zhang, "Strategies Used by Managed Behavioral Health Organizations to Reduce Hospital Care" A Literature Review Submitted to the Myers-JDC-Brookdale/Brandeis Collaboration on Mental Health

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First, there is room to query whether and to what extent the health plans resemble managed-care organizations in mental health in the form that they are presented in the article. In this context, one may point to four main differences:

1. *According to the article: The explicit goal of these organizations in the US is to achieve mental-health care of high quality and **low cost**. While it is clear that the health plans have an interest in maximum economization, their legal obligations and the official position of the state charge them with functioning within their budgetary limits without necessarily prioritizing the lowest possible prices. In this, Israel's health system differs essentially from a fully privatized system.*

2. *Another difference is that managed-care organizations in the US focus solely on providing mental health services to people with serious mental disabilities, whereas Israel's health plans are supposed to provide service also to people with more minor mental difficulties (soft psychiatry) for whom hospitalization is irrelevant, as well as additional services unrelated to mental health. Both these conditions have implications for the way that the health plans are meant to provide services in mental health, and for the various agencies to be taken into account in the planning and regulation of service provision.*

3. *In the present constellation, now that the mental health reform has taken effect, the Ministry of Health serves as service provider (in the area of hospitalizations and ambulatories), as regulator, and as financier of the health plans. Each of these "hats" might translate into different interests.*

4. *Rehabilitation services in mental health are anchored in another law and provided by agencies unconnected with the health plans and the hospitals.*

Points referring to issues raised in the article:

- *As I see it, one important point mentioned by the author is that the reduction of hospitalization is not a goal in itself; were we to reduce the extent of hospitalization (according to the various methods elaborated in the article) without simultaneously developing community services – the consequences could prove disastrous. The system must constantly be examined by this warning light, with mandatory standards created on one side, and means of control, on the other, to ensure – above all – the development of accessible, available and quality community responses. A reduction in hospitalization as a consequence of these is*

preferable to financial-administrative mechanisms, which would reduce hospitalization as a goal in itself. On the other hand, to encourage the development of alternatives to hospitalization, necessary financial incentives should be created along with professional, obligatory standards.

- *Emphasis should be put on developing alternatives to both short-term and long-term hospitalization. The necessary ones (in my opinion) are – crisis intervention within the community, frameworks of day hospitalization and day care (referred to in the article as "partial hospitalization"), Assertive Community Care (ACT), and peer support alongside other familiar models not mentioned in the article.*

The views expressed here are the personal views of the author and do not necessarily reflect the position of the organization in which the author works or of the Myers-JDC-Brookdale Institute.