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The Smokler Center for Health Policy Research

**Data and Decision Making in the NHI Era:  
A Summary Report**

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This study was supported by the National Institute for Health Policy and Health Services Research and by the Connie and Bert Rabinowitz Fund for Creative Breakthrough Research at the Myers-JDC-Brookdale Institute



**RESEARCH REPORT**

RR-467-05



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Berg-Warman, A.; Rosen, B.; and Sicron, M. 2004. *Use of the Central Bureau of Statistics' Health Survey in Decisionmaking in the Health System*. RR-416-04. (Hebrew)

Rosen, B.; Schwartz, R.; Sicron, M.; Sykes, I.; and Berg-Warman, A. 2003. *Data Use in Major NHI-related Governmental Decisions*. RR-401-03 (English). RR-436-04 (Hebrew).

Sykes, I. 2004. *The Use of Data in the Effort to Transfer Mental Health Services in Israel from the Ministry of Health to the Health Plans: A Case Study: 1995-1996*. RR-404-03. (Hebrew)

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## EXECUTIVE SUMMARY

### Introduction

The Myers-JDC-Brookdale Institute conducted a multiyear study of the role that data and research have played in key government decisions related to the implementation of the National Health Insurance (NHI) Law. The project involved a comprehensive review of the role of data in ten major NHI-related government decisions and four in-depth case studies:

1. The use of data in the efforts to transfer mental health services from the Ministry of Health to the health plans
2. The use of data in the work of the Amora Commission
3. The use of data from the Central Bureau of Statistics' Health Survey
4. The use of data from the health plan financial reporting system (the "Witkowsky reports")

### Data Use in Ten Major NHI-Related Government Decisions

With regard to each of the ten decisions that were examined, the study team:

- ◆ Analyzed the policy decision in terms of its context, the sub-decisions which comprised it, the main policy options, and the key considerations for and against the various options
- ◆ Identified the types of information that could have contributed to the decision-making process
- ◆ Analyzed how that data could have contributed to the decision-making process
- ◆ Documented the actual role of information in the decision-making process
- ◆ Analyzed the gap between the potential and actual use of data in the process
- ◆ Explored possible reasons for that gap

The study was based on in-depth interviews with policymakers, managers and researchers. It found that the use of data in Israel health care is substantial and is on the rise. Yet, in all of the decisions examined, policymakers had to make decisions in the absence of important information, primarily because the necessary data were not generated, but also because data that were available were not fully utilized. The study also found that in 1995-1999, health care policymakers rarely engaged in structured analyses of how data could contribute to the decisions they would face in the years ahead. The study team also identified several characteristics of decisions, decision making and leadership styles that had a major influence on the extent to which data played a role in decision making.

The study also found that, in contrast to the American health system, where demonstration projects and social experimentation abound, the Israeli health system does not have a tradition of field-testing new policies. As a result, disagreements about the probable impact of proposed policies often lead to policy gridlock. In addition, the study found that decision makers are interested in receiving more and better forecasts that are grounded in empirical data.

This study has made an important methodological contribution to the evolving international literature on data and decision making. To date, empirical studies in this field have tended to examine the actual use of data in a particular decision, without carefully considering what data might have potentially contributed to the decision. The project team prepared an analysis of potential data needs for ten different major policy decisions. This study demonstrates that important additional insights and additional practical conclusions can be generated when serious attention is given to "what might have been", and not only to "what actually happened". The differences between the two can be particularly illuminating.

### ***Case Study #1: The Use of Data in the 1995-6 Effort to Transfer Mental Health Services From the Ministry of Health to the Health Plans***

The first case study highlights the activities that took place in 1995-1996, when the transfer to the health plans was the subject of intense negotiations among the health plans, the Ministry of Health, and the Ministry of Finance, which ended in an impasse.

The case study initially focused on analysis of a single decision – the decision to transfer mental health services from the Ministry of Health to the health plans. As it progressed, it became increasingly clear that this decision comprised nine distinct "sub-decisions". These included what services should be transferred, how much money should be transferred to the health plans as a group, and how those monies should be distributed among the health plans.

The study found that there was substantial use of data in decision making at all levels in the mental health system. Data played a significant role in deliberations regarding five of nine sub-decisions. At the same time, the lack of systematic efforts to produce data regarding the likely effect of the transfer on demand for outpatient mental health services – a key unknown – was perhaps one of the main factors that contributed to the ultimate impasse in negotiations (alongside organizational interests and political factors).

The study also explored the nature of the "data discourse" (the ways in which data were communicated among organizations) among those involved in decision making. An effective data discourse, involving constructive information sharing and a collaborative effort to distinguish between disagreements about facts and disagreements about values, can promote trust and collaboration. In this case, the data discourse was strewn with problems; as a result, it promoted mistrust and mutual allegations.

### ***Case Study #2: The Use of Data in the Work of the Amora Commission***

The "Amora Commission" was established in 2000 as part of the agreement between employers and the Israel Medical Association that ended a four-month physicians' strike. It addressed a very wide range of health policy issues. Out of a desire to bridge the gaps in the approaches of the interested parties, the Commission took upon itself to formulate general recommendations without going into detail. To this end, it strived for compromise and consensus.

The study found that the Commission's concept of its role had an impact on its attitudes toward the need for empirical qualitative data. Several Commission members (including the chairman), took the position that the Commission had no need for concrete data because, in the interest of promoting consensus, its recommendations were to be restricted to generic pronouncements. In contrast, the study team believes that even if a public commission plans to restrict itself to broad policy recommendations, targeted quantitative data can be useful and influential.

The study also found that the interested parties conducted most of the data collection and wrote most of the position papers. The commission staff was very small and barely collected data. As such, the commission utilized a methodology that is characteristic of the judiciary system, in which the courts rely on the interested parties to determine the issues for discussion and decide what evidence to bring before the court.

As a result, the Commission was inundated with information, with the interested parties submitting a large volume of information, much of which was considered useful. Moreover,

the study found that the position papers, statistical data and background information made available to the Commission figured prominently in its deliberations.

However, despite the large amount of material submitted to the Commission, critical pieces of information were lacking. In addition, data submitted by the various parties were inconsistent. The Commission lacked adequate staff to integrate data from various sources, process data into user-friendly formats, analyze data from existing databases and collect new data on issues that were important to the Commission but were avoided by the interested parties.

### ***Case Study #3: Use of the Central Bureau of Statistics' Health Survey in Decision Making in the Health System***

The Central Bureau of Statistics' Health Survey is one of the principal and most accessible sources of information about health and health care in Israel. Key questions considered in the study include: To what extent does the survey contribute to policy decisions concerning the health system, including those related to NHI? If designed differently, might it contribute more?

This analysis is based primarily on in-depth interviews with users and potential users of information from the survey, and with those responsible for financing, planning, and conducting it. Three types of use of the survey data were examined:

- ◆ *Overall monitoring of the health system:* The survey contributed considerably to the monitoring of the system, and especially to the analysis of access and equity.
- ◆ *Input into policymaking in ten key decisions related to the National Health Insurance Law:* The survey contributed much to one of the ten decisions examined, and somewhat to two additional decisions. However, it made almost no contribution to the other seven decisions.
- ◆ *Evaluation of the impact of decisions related to the National Health Insurance Law:* To date, data from the survey have not contributed significantly to efforts to evaluate the impact of NHI-related decisions.

The survey's brevity, its insufficient frequency, and incomplete efforts to adapt it to policymakers' evolving information needs limited its contribution to the development of policy and evaluation of its impact. Thus, while the survey's contributions may already be sufficient to justify conducting it, this study's findings suggest that it could contribute more, were it designed differently.

### ***Case Study #4: Use of Data from the Witkowsky Report on the Financial Activities of the Health Plans in Decision Making in the Health System***

The initiation of the Witkowsky Report on the financial activities of the health plans was directly related to the introduction of National Health Insurance. With the creation of a government responsibility for financing health care, the government felt a critical need for periodic information on health plan finances.

The main objective of this case study was to evaluate the extent of use of the Witkowsky Report and to explore the reasons for that use. The methodology included an analysis of the Report and related correspondence, along with in-depth interviews of key users of the Report.

Respondents agreed that the Report was extremely useful. They felt it provided the most important financial information required for ongoing monitoring and supervision of the health plans and for governmental decisions about the level of funding of the health plans. The

Report also helps the health plans identify problematic areas, such as relatively high per capita expenses in the pharmaceutical, and as such enables them to identify measures to increase efficiency.

The Report's success and its widespread use can be attributed to a number of characteristics of the Report's design. First, it was planned in response to very concrete regulatory needs. Second, the government had legal backing to require the health plans to prepare complete and accurate reports. Third, despite the legal capacity to dictate the nature of the Report, regulators were wise enough to work collaboratively with the health plans on the design of the Report. Fourth, the involvement of external accounting firms contributed to the Report's reliability. Finally, the report's utility is greatly enhanced by the inclusion of comparative data across health plans and trends over time.

### **Integration**

Seven key conclusions emerge from the project as a whole:

1. Decision-makers throughout the health system – government, health plans, hospitals, etc. - make extensive use of data.
2. The extent of data use appears to be increasing over time
3. The health system could benefit greatly from relatively modest investments in a few key national data systems in areas such as quality of care, health care costs, and health care work force. These systems must be objective, reliable, and current.
4. Policymakers can be inundated with data and still be missing the specific pieces of data needed most in order to make informed decisions.
5. Targeted efforts are needed to ensure that policymakers have the data they need.
6. Analytic staffs have a critical role to play in ensuring that policymakers have the information they need.
7. Policymakers rarely engaged in structured analyses of the decisions they faced and the ways in which data could contribute to those decisions. They also indicated that the kind of structured analysis employed in this study can and should be done at an early stage of the policymaking process.

These conclusions are supported by the findings from the case studies as well as from comparisons among them.

The findings have been widely disseminated, and it appears that the findings have already encouraged Israeli researchers and policymakers to think more systematically and proactively about the links between data and policymaking .

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## INTRODUCTION

The Myers-JDC-Brookdale Institute has conducted a multiyear study of the role research and data have played in key governmental decisions related to the implementation of the National Health Insurance (NHI) Law. The study was funded in part by the Connie and Bert Rabinowitz Fund for Creative Breakthrough Research at the Myers-JDC-Brookdale Institute and by a grant from the Israel National Institute for Health Policy and Health Services Research.

In implementing the NHI law, government policymakers have had to make many major decisions that affect the way health care is delivered to Israel's residents. While data and research alone can never determine governmental policy, they can play a very important role in improving decision making. This multiyear study sought to pinpoint where data have contributed to NHI-related decision making, where they have not, and why.

The project involved a comprehensive review of the role of data in ten major NHI-related government decisions and four in-depth case studies:

1. The use of data in the efforts to transfer mental health services from the Ministry of Health to the health plans
2. The use of data in the deliberations and the report of the Amorai Commission
3. The use of data from the Central Bureau of Statistics' Health Survey
4. The use of data from the Witkowsky Report on the financial activities of the health plans

The first two case studies focus on particular policy development processes and examine how data from a variety of sources contributed to those processes. In contrast, the other two case studies focus on particular data sources and examine how they contribute to a variety of policy issues and processes.

Separate Myers-JDC-Brookdale research reports have been published (or will be published shortly) for each of these case studies. In this summary report, we review the key findings from each of these studies and reflect on some of the inter-relationships among them.

## THE COMPREHENSIVE STUDY: DATA USE IN TEN MAJOR NHI-RELATED GOVERNMENT DECISIONS

The examination of the use of data in ten key NHI-related policy decisions had three major objectives. First, the study sought to identify the data and their use in NHI-related decision making between 1995 and 1999. Second, it analyzed the factors that influenced the extent to which data were used. Third, it considered how, in light of the findings, the relationship between data and decision making in the Israeli health care system might be improved. The primary source of information in relation to these issues was in-depth interviews with health system leaders; key relevant documents were also analyzed.

With regard to each of the ten decisions that were examined, the study team:

- ◆ Analyzed the policy decision in terms of its context, sub-decisions that comprised it, main policy options, and key considerations for and against the various options
- ◆ Identified the types of data that could have contributed to the decision-making
- ◆ Analyzed how that data could have contributed to the decision-making
- ◆ Documented the actual role of information in the decision-making process,
- ◆ Analyzed the gap between the potential and actual use of data in the process, and Explored possible reasons for that gap

That data are, of course, not the only factor in decision making is emphasized in the international literature on policymaking, and was quite apparent in the ten health policy decisions we studied.

Nonetheless, the study found that the use of data in Israel health care system is substantial and is on the rise. And yet, in all of the decisions examined, policymakers had to make decisions in the absence of important information. Primarily this was because the necessary data were not generated, while in some cases data that were available were not fully utilized. The study also found that in 1995-1999, health care policymakers rarely engaged in structured analysis of how data could contribute to the decisions they would face in the years ahead and what data would be needed.

The study also found that, in contrast to the American health system, where demonstration projects and social experimentation abound, the Israeli health system does not have a tradition of field testing new policies. As a result, disagreements about the probable impact of proposed policies often lead to policy gridlock.

On the other hand, the findings of major research centers and governmental decision-making processes appear to be more effectively linked in the Israeli health system than in the U.S. and many other countries. Several factors can account for this finding: Israel is a small country and, as such, most leading researchers and policymakers know each other and interact regularly; some of the leading research centers invest substantial energy in the dissemination of findings; and many health policymakers are interested in making use of data in decision-makings.

In addition, the study found that decision makers are interested in receiving more and better forecasts that are grounded in empirical data. In order to choose wisely among competing policy options, they must make judgments about the likely impact of these options. However, the data typically presented by analysts relate to the past, not to the future. In the interviews the project team conducted, they repeatedly heard pleas for analytically based projections and for better methodologies for translating data about the past and the present into forecasts.

We found that *decisions* that had certain characteristics were prone to more use of data. Data seemed most likely to play a role in decisions that were made periodically, were second tier as opposed to fundamental decisions, and/or were quantitative rather than yes/no decisions.

We also found that *decision-making processes* that had certain characteristics were prone to more use of data. Data seemed most likely to play a role in decision-making processes that were structured, well-organized, well-staffed, and/or involving one or more decisionmakers who approached the process with an open mind.

*Personalities, leadership styles and negotiating styles* also had a major influence on the extent to which data played a role in the decision-making process. When a director-general who was prepared to seek compromises with the Ministry of Finance headed the Ministry of Health, inter-ministerial teams often used data to develop creative compromises. However, when the post was assigned to a less-compromising manager, data use decreased significantly.

This study has made several important methodological contributions to the evolving international literature on data and decision making. To date, empirical studies in this field

have tended to examine the actual use of data in a particular decision, without carefully considering what data might have potentially contributed to the decision. The project team prepared analysis of data needs for ten different major policy decisions and was able to demonstrate that when serious attention is given to "what might have been", and not just to "what actually happened", important additional insights and practical conclusions can be generated. The differences between potential and actual use of data can be particularly illuminating.

The findings of this comprehensive study have been widely disseminated, and policymakers have indicated that the kind of structured analysis employed in this study can and should become a regular part of the policymaking process at the earliest stages, so as to enable them to take steps to assemble the relevant data and integrate them into the process. Moreover, it appears that the findings have already encouraged Israeli researchers and policymakers to think more systematically and proactively about the links between data and policymaking.

### ***CASE STUDY #1: THE USE OF DATA IN THE 1995-6 EFFORT TO TRANSFER MENTAL HEALTH SERVICES FROM THE MINISTRY OF HEALTH TO THE HEALTH PLANS***

The first case study examined the use of information in the decisions whether and how to transfer responsibility for mental health services from the Ministry of Health to the health plans. The study highlights the intense 1995-1996 negotiations among the health plans, the Ministry of Health, and the Ministry of Finance, which ended in an impasse.

The case study initially focused on analysis of a single decision – the decision to transfer mental health services from the Ministry of Health to the health plans. As it progressed, it became increasingly clear that this decision comprised many "sub-decisions". These sub-decisions were found to differ in nature, and included the following questions:

1. *Whether to Transfer*: Should mental health services be included in the basket of services provided by the health plans?
2. *Scope of Transfer*: What will be included in the basket of services of the health plans; what will continue to be the responsibility of the Ministry of Health, and what will be taken over by a different ministry?
3. *Vulnerable Consumers*: Who should be responsible for the care of the most vulnerable consumers?
4. *Financing Level*: How much money will be made available to the health plans for financing mental health services?
5. *Earmarking*: Should money provided to the health plans be given as part of a global budget, or earmarked specifically for mental health services?
6. *Capitation*: How will money be distributed among the health plans?
7. *Hospital Prices*: What should be the prices of services that health plans will purchase following the transfer?
8. *Integration of Care*: How, specifically, will mental health care be integrated into the general health care system?
9. *Transition Mechanisms*: What mechanisms need to be in place in order to support the transition from the previous system to the new one?

Each of these sub-decisions was analyzed with regard to the information that could have contributed to effective decision making, the information that was available and that was missing at the time the decision was made, and the role data and information played in the deliberations.

The study found that there was substantial use of data in decision making at all levels in the mental health system. We found that data played a significant role in deliberations regarding five of the nine sub-decisions. At the same time, the lack of systematic efforts to produce data regarding the likely effect of the transfer on demand for outpatient mental health services – a key unknown – was perhaps one of the main factors (alongside organizational interests and political factors) that contributed to the ultimate impasse in negotiations.

The study also explored the nature of the “data discourse” (the ways in which data were communicated among organizations) among those involved in decision making. An effective data discourse, involving constructive information sharing and a collaborative effort to distinguish between disagreements about facts and disagreements about values, can promote trust and collaboration. In this case, the data discourse was strewed with problems; as a result, it promoted mistrust and mutual allegations.

This study illustrates the importance of a thorough and structured analysis of the decisions at hand and the data needed for informed decision making. Such an analysis is crucial for helping to understand past decisions, and can be an important aid for structuring future decisions.

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

In January 2003, the government made a decision to affect the transfer, but various issues still need to be resolved before implementation can proceed. It appears that the study’s findings have promoted more systematic and collaborative utilization of information and data to support and accompany the transfer’s implementation.

#### ***CASE STUDY #2: THE USE OF DATA IN THE WORK OF THE AMORAI COMMISSION***

The fourth case study analyzed the use of data in the work of the “Amorai Commission” (officially named the Public Commission on the Publicly Financed Health Care System and the Status of Physicians). This public commission was established in 2000 as part of the agreement between employers and the Israel Medical Association that ended a four-month physicians’ strike.

The objectives of the study were:

1. To examine the patterns of use of information in the Commission’s work
2. To understand the characteristics of the Commission’s work that had an impact on its use of information
3. To examine what information was lacking
4. To consider what can be learned from this case study regarding the use of information in public commissions

The study found that, in terms of the breadth of the issues it examined, the Commission went far beyond its original mandate. The areas the Commission was charged with examining were the definition of “public medicine” and “private medicine” and the relationship between the two, particularly the process of providing private medical services in public hospitals

(known by the Hebrew acronym SHARAP); physicians' salaries; and the relationship between ambulatory services and hospital services. In practice, the Commission saw in its work an opportunity to examine the entire health care system. In addition, out of a desire to bridge the gaps in the approaches of the interested parties, the Commission took upon itself to formulate general recommendations without going into detail. To this end, it strived for compromise and consensus.

The commission staff was very small and barely collected data. The interested parties conducted most of the data collection and wrote most of the position papers. As such, the commission utilized methodology that is characteristic of the judiciary system, in which the courts rely on the interested parties to determine the issues for discussion and decide what evidence to bring before the court.

The management of most organizations in the health care system ascribed a high level of importance to the preparation and presentation of their position papers; some established work groups and even sub-work groups to gather material and prepare different chapters. In its position paper, each organization emphasized issues in which it had a particular interest and avoided others it had no wish to address.

The Commission was inundated with information, with the interested parties submitting a large volume of information, much of which was considered useful. Moreover, the study found that the position papers, statistical data and background information made available to the Commission figured prominently in its deliberations.

However, despite the large amount of material submitted to the Commission, critical pieces of information related to the following issues was incomplete: physician salaries, separate accounts ("research funds"), supplementary health insurance, medical equipment, medical specialties in distress, co-payments, and SHARAP. As these issues remain on the health care system agenda, system resources should be devoted to the production of relevant data and databases.

Some of the Commission's members felt the information obtained by the Commission was useful and of high quality. However, others felt that this information was problematic, due to a lack of uniformity in data definitions and the interests of the organizations presenting the position papers. As a result, the Commission devoted a good deal of time to bridging the variation in the data definitions.

It appears that even when a public commission relies primarily on a "judicial approach" involving detailed submissions by interested parties, staff can play an important role. Staffs integrate data from various sources, process data into user-friendly formats, analyze data from existing databases, and collect new data on issues that are important to the commission but are avoided by the interested parties.

We found that the members' perceptions of the Commission's purpose affected their attitudes toward the need for empirical qualitative data. Several Commission members (including the chairman), took the position that the Commission had no need for concrete data because, in the interest of promoting consensus, its recommendations were to be restricted to generic pronouncements. Other members thought the Commission should provide clear and specific recommendations, and therefore data were necessary.

Our own view is somewhat different. We believe that even if a commission intends to restrict itself to broad policy recommendations, specific quantitative data can be influential. Such

data can sometimes shape a commission's understanding of the essence of the problems and their magnitudes. In addition, specific data can sometimes facilitate compromise.

In this study, prior to the examination of the use of data, we looked at the goals the Commission had set for itself; this was important, as the goals had considerable impact on the way the Commission utilized data. Another important facet of study was that in addition to examining the way the Amora'i Commission utilized data and integrated data into its report, they study examined the way the interested parties gathered data and integrated data into their position papers. These two facets contributed to our understanding of the Amora'i Commission's use of data, and generated broader insights regarding better use of information by a public commission for setting policy.

### **CASE STUDY #3: *USE OF THE CENTRAL BUREAU OF STATISTICS' HEALTH SURVEY IN DECISION MAKING IN THE HEALTH SYSTEM***

The second case study focused on the Central Bureau of Statistics' Health Survey – one of the principal and most accessible sources of information about health and health care in Israel. This multi-purpose survey is conducted on a large, representative national sample by the Central Bureau of Statistics (CBS), in cooperation with (and with the financial support of) the Ministry of Health. The survey primarily comprises questions about the use of various health services and the presence of certain chronic diseases; each round of the survey has also included additional questions about one or more special topics.

The Israeli survey is based on a relatively large sample of households and individuals (for example, 30,000 people in 8,200 households were included in the survey in 1997). The survey can therefore provide information about the total population, sub-populations, and differences and gaps between groups with different demographic-social characteristics. Comparison among consecutive rounds of the survey can help identify trends.

The survey is conducted at irregular intervals (due to budgetary limitations in the Ministry of Health). In recent years, improvements and additions have been made to the survey (on the initiative of users such as the Ministry of Health and the CBS). These include data that might help monitor changes in the health status of the population and in the use of health services and that might be used in decision making regarding topics on the health agenda. As a multi-purpose survey, the Health Survey was not originally designed to provide data related to the NHI law. However, the opportunity arose to adapt it to information needs related to the law.

Key questions considered in the study include:

- ◆ To what extent does the survey contribute to policy decisions concerning the health system, including those related to NHI?
- ◆ If designed differently, might it contribute more?

This analysis is based primarily on in-depth interviews with users and potential users of information from the survey, and with those responsible for financing, planning, and conducting it. Three types of use of the survey data were examined:

- ◆ *Overall monitoring of the health system:* We found that the survey contributed considerably to the monitoring of the system, and especially to the analysis of access and equity.
- ◆ *Input into policymaking in ten key decisions related to the National Health Insurance Law:* The survey contributed much to one of the ten decisions examined, and somewhat to two

additional decisions. However, it made almost no contribution to the other seven decisions.

- ◆ *Evaluation of the impact of decisions related to the National Health Insurance Law: To date, data from the survey have not contributed significantly to efforts to evaluate the impact of NHI-related decisions.*

The survey's brevity<sup>1</sup>, its insufficient frequency, and incomplete efforts to adapt it to policymakers' evolving information needs limited its contribution to the development of policy and evaluation of its impact. Thus, while the survey's contributions may already be sufficient to justify conducting it, this study's findings suggest that it could have contributed more, were it designed differently. The study findings are already helping the Ministry of Health and the CBS modify the survey and develop a multiyear strategy regarding the frequency, length, and focus of future Health Surveys.

#### ***CASE STUDY #4: USE OF DATA FROM THE WITKOWSKY REPORT ON THE ACTIVITIES OF THE HEALTH PLANS IN DECISION MAKING IN THE HEALTH SYSTEM***

The initiation of the Witkowsky Report on the financial activities of the health plans was directly related to the introduction of National Health Insurance. With the creation of a government responsibility for financing health care, the government felt a critical need for periodic information on health plan finances.

The main objective of this case study was to evaluate the extent of use of the Witkowsky Report and to explore the reasons for that use. The methodology included an analysis of the Report and related correspondence, along with in-depth interviews of key users of the Report: eight in the health plans, four in the Ministry of Health, four in the Ministry of Finance, and five in universities and research centers. The interviews were conducted in late 2002 and early 2003.

The Witkowsky Report contains chapters on expenditures by type, revenues by source, and deficit. The information is presented by health plan and for the four health plans as a group. Revenues and expenses are presented in total, as well as per age-adjusted member, and they are presented in both nominal and real (inflation-adjusted) terms.

Respondents concurred that the Report was extremely useful. They felt it provided the most important financial information required for ongoing monitoring and supervision of the health plans and for governmental decisions about the level of funding of the health plans. It is a critical and central resource for the Ministry of Health and the Ministry of Finance in their work as regulators. It is also a very valuable resource for the health plans. The Report helps the health plans identify problematic areas, such as relatively high per capita expenses in the pharmaceutical area and, thus, enables them to identify measures to increase efficiency. Various researchers in the areas of health economics and health policy have also used the Report to analyze trends over time and differences among health plans.

The Report's success and its widespread use can be attributed to a number of characteristics of the Report's design. First, it was planned in response to very concrete regulatory needs. Second, the government had legal capacity to require the health plans to prepare complete and accurate reports. Third, despite the legal capacity to dictate the nature of the Report, regulators were wise enough to work collaboratively with the health plans on the design of the Report. Finally, the involvement of external accounting firms contributed to the Report's reliability.

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<sup>1</sup> In 2003, a much longer survey was fielded, including an in-depth look at mental health.

Various characteristics of the Report's content and format also contributed to its utility. The Report is objective, professional, audited, and accepted by the health plans and the government agencies. The availability of comparative data across health plans greatly contributes to its usefulness, and even though it is recognized that the comparisons are imperfect, they are generally viewed as sufficiently valid to be useful, and ongoing efforts are made to improve comparability. The Report is published periodically, which facilitate monitoring trends as well as generating insights into the impact of various interventions.

At the same time, the Report has a number of limitations. For certain regulatory purposes, there is still too much of a lag between the publication of the Report and the time to which it relates. Additional detail regarding revenues and expenses would be helpful. Despite the ongoing improvements in comparability of data across health plans, this continues to be a problem with regard to certain issues (e.g., the boundary between hospital and community care). Finally, as a financial report, by its very nature it does not include comparative information on service volume or quality. The study team has discussed these limitations and possible ways to address them with the producers of the Witkowsky Report.

## **INTEGRATION**

Seven key lessons emerge from the project as a whole:

1. Decisionmakers throughout the health system – government, health plans, hospitals, etc. - make extensive use of data. They use simple tabulations from databases as well as findings from research studies. Data are used to identify problems, choose among possible interventions, and monitor the impact of interventions.
2. The extent of data use appears to be on the rise. As more relevant data are being produced, policymakers are becoming more adept at using data, researchers are becoming better at communicating their findings, and more effective channels are being developed to link data and decision making.
3. To make a significant contribution to policy processes, data must be relevant, objective, current, and reliable. Data sources that permit comparisons across providers and analysis of trends over time can be particularly valuable. The health system could benefit greatly from relatively modest investments in a few key national data systems in areas such as quality of care, health care costs, and health care work force.
4. Policymakers can be inundated with data and still be missing the specific pieces of data needed most in order to make informed decisions. In the efforts to transfer mental health services to the health plans, policymakers did not have basic data needed to project the impact of the transfer on service utilization and costs. Despite the voluminous submissions of the interested parties, the Amorai commission also did not have critical data on physicians' incomes, the impact of Sharap, and the extent of the difficulties facing the various medical specialties.
5. Targeted efforts are needed to ensure that policymakers have the data they need. The Witkowsky Report is extremely useful to policymakers, primarily because it was designed with their data needs in mind. In contrast, while the CBS health survey has the potential to be very useful to policymakers, to date it has not fully realized that potential, in part because of insufficient efforts to focus on the issues that will face policymakers in the years ahead.
6. Analytic staffs have a critical role to play in ensuring that policymakers have the information they need. The work of the Amorai Commission suffered from insufficient staff that could have helped the commissioners by integrating the data from the various sources and by collecting data on issues that the interested parties chose to avoid. Analytic staff members, who are close to policymakers and understand their data needs,

can also play a critical role in ensuring that major data collection efforts are well targeted – as was the case with the Witkowsky Report.

7. Policymakers rarely engaged in structured analyses of the decisions they faced and the ways in which data could contribute to those decisions. They also indicated that the kind of structured analysis employed in this study can and should be done at an early stage of the policymaking process

One of the project's important innovations is that it brought together two different types of case studies: those focused on a particular data source and those focused on a particular policy process. Prior to this study, all published studies in the field of data and decision making have used only one of these types of case study. Our study demonstrates that the two types of case studies can generate complementary insights. Cases that focus on a particular data source enable researchers to explore the relationship between the usefulness of data in policy decisions and the antecedent decisions about what data should be collected and how it should be collected, analyzed, and disseminated. Cases that focus on a particular policy process enable researchers to explore how the political and organizational context of the policy process affect the extent to which data is used and how it is used. Thus, the two-pronged approach employed in this study can substantially benefit efforts to understand the relationship between data and decision making.

## APPENDIX: KEY FINDINGS FROM THE LITERATURE REVIEW

A detailed literature review of data and decision making has been prepared as part of this project and is available on the project website: [www.jdc.org.il/brooksites/ddm](http://www.jdc.org.il/brooksites/ddm).

Here we present only the key findings related to the following issues:

- ◆ Do data contribute to governmental decision making?
- ◆ Which factors influence the likelihood and magnitude of the contribution?
- ◆ At which stages of the policy cycle do data contribute?

The consensus in the literature is that while governmental decisions are clearly not determined solely, or even primarily, by data, data do make an important contribution to the decision-making process. This was not always the consensus view. There were times when the prevailing view was that political considerations are so dominant that they leave little, if any, room for data in the process. In contrast, most modern writers take the position that data at times play a major role, at times a minor role, and at still other times no role at all. Indeed, recent conceptual and empirical writing on the subject focus on the attempt to identify the factors that influence the extent to which data contribute to the decision-making process.

The main factors identified include:

- ◆ *The Nature of the Decision* – Data play a greater role in decisions that are operational and technical than in decisions with substantial ideological components.
- ◆ *The Decision Makers* – The age, managerial style and educational background of decision makers are believed to have an impact on the use of data in decision making.
- ◆ *The Decision-making Process* – When decision-making processes involve public committees and professional staffs that do not operate under extreme time pressure, there are more opportunities to bring data to bear on the decision-making processes.
- ◆ *The Data* – Consistent, relevant Data whose relationship to the policy issues at hand is made clear are more likely to be incorporated into policy discussions.
- ◆ *The Producers and Conveyors of the Data* – The likelihood that the data will be taken seriously increases to the extent that the conveyors of the data are perceived to be objective and professional.
- ◆ *The Political Context* – The broader political context in which the decision is being made has important implications for the extent of data use.

The literature also suggests that data can contribute to public policy at several stages of the policy cycle, including:

- ◆ Identification of a problem and its placement on the public agenda
- ◆ Characterization of the scope and nature of a problem
- ◆ Identification and characterization of possible interventions
- ◆ Monitoring of the impact of interventions

While this study considers all four items on the list above, the emphasis is on the last two: identification and characterization of possible interventions, and monitoring of the impact of the interventions that have been implemented.