Between Policy and Implementation – Two Years into the Mental Health Reform

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Abstract

Background

Israel's Mental Health Insurance Reform (the MH reform) took effect in July 2015, transferring responsibility for the provision of services from the state to the health plans. The step was preceded by two decades of failed attempts at reforming MH services, characterized by waves of preparations and followed by dropping the reform from the public agenda. Since 2007, the Myers-JDC-Brookdale Institute (MJB) has played a key role in designing and conducting a multi-dimensional evaluation of this historic reform; firstly, by describing the pre-reform situation (to obtain a baseline for comparison) and documenting the preparations towards it; and then, by examining its impact on various levels of the health system. The evaluation of policy implementation often rests on an examination of the data and measures deriving from the goals. It is therefore important to examine the proclaimed goals accompanying the decision to promote the MH reform. It is also important to examine how the different players have interpreted these goals and worked to realize them. Should a gap be identified between the conception of the implementers and the intent of the formulators, the goals can be honed and clarified to benefit implementation.

Goals

1. To understand the proclaimed goals of the MH reform
2. To understand how reform planners and implementers perceive the implementation of the goals, the achievements and difficulties
3. To describe the activities of the health plans in realizing the goals of the reform
4. To identify the steps required to promote optimal implementation of the reform

Methods

In the first stage of the study, the study team analyzed the content of key policy documents, meeting minutes, organizational directives, and work programs in MH with an emphasis on identifying the goals of the MH reform. In the second stage, 38 in-depth interviews were conducted with personnel involved in the reform's planning and implementation at the Ministry of Health (MoH), the Ministry of Finance, the health plans and non-profits.

Findings

Although no formal statement of goals was ever published, there is considerable congruence between the goals emerging from the analysis of the policy documents and the goals cited by the interviewees. These included: positioning of MH care as being of equal value to other areas of health care; expanding MH service availability and accessibility; improving the quality of care; integrating physical and mental care; reducing stigma; improving the hospitalization-community continuum; streamlining the MH system; and clarifying the legal right to services. Nevertheless, as there is no formal document, there was no definition of operative measures relating to the reform goals, and this impedes implementation and evaluation.

The study findings revealed that two years into the reform, the health plans are still busy with the deployment of the basic services of psychiatric consultation and psychotherapy, and coping with the difficulty of providing sufficient availability. As a result of the need to focus attention on addressing those basic needs, they have not yet started to develop more specialized services for particular populations.

The interviewees noted two bottlenecks in the expansion of service availability: manpower shortages in certain professions (such as child psychiatry and psychology), and the shortage of funded positions in the health plans for those professions that do not suffer from manpower shortages (such as clinical psychologists and psychotherapists).

The study found that there continues to be lack of clarity regarding what is covered by national health insurance in the area of MH in the in the wake of the reform. This state of affairs obscures the boundaries between MH and related areas (e.g. family medicine, welfare, education). It also creates dissent between the health plans and the service providers over the content of the health basket, notably psychiatric hospitalization.

Policy Recommendations

Define operative objectives for diverse goals of the reform, such as strengthening the relationship with the primary care physician, making information about MH services accessible, providing specialized services, and reducing stigma.

Take steps to expand the pool of MH professionals, mainly for children and the Arab and ultra-Orthodox populations.

Clarify the boundaries between MH and related areas, clearly define the MH service basket, determine the appropriate mix between various service tracks and consider defining a standard for staffing positions at MH clinics.

Executive Summary

Scientific Background

The evaluation of the success of implementation of policy is closely related to the conceptualization of success. A comprehensive, meta-analysis of studies on policy implementation has described two main methods of evaluating the success of implementation of the policy in question. One is self-reporting by policy implementers. The other is a before-and-after comparison of the goals of a new policy including change on selected measures (Durlak & DuPre, 2008). In other words, the evaluation of policy implementation often rests on an examination of the data and measures deriving from the policy goals.

In July 2015, Israel's Mental Health Insurance Reform went into effect transferring responsibility for the provision of mental health (MH) services from the state to the health plans. The decision to implement the reform had been adopted by a government directive in 2012, following almost two decades of unsuccessful attempts to institute the measure. These decades were characterized by waves of preparation after which the topic was dropped from the public agenda. The reform's implementation was meant to improve MH service availability and accessibility. The transfer of responsibility for MH services to the health plans makes the legal right to MH services clear and regulates the budgeting and financing. It was expected that the incorporation of MH into the health plans would integrate mental and physical health and mitigate the stigma associated with receiving MH treatment. In the years leading to the reform's adoption, concerns about negative repercussions of the reform were voiced alongside the expected improvement in MH services. The gist of these concerns was that financial considerations would carry too much weight in health-plan decisions regarding the mix of professionals employed in their clinics, the types of services offered to insurees, and the duration of treatment series; that budgets would be inadequate and, moreover, that the MH budget would be swallowed up by the general budgets of the health plans, especially in light of their financial straits; that patient confidentiality and privacy would be compromised; and that the change would be detrimental to the severely mentally ill, the weakest population least able to claim their rights.

Since 2007, the Myers-JDC-Brookdale Institute (MJB) has played a key role in designing and conducting a multi-dimensional evaluation of the insurance reform, at first by describing the pre-reform situation (to create a baseline for comparison) and documenting the preparations made, and subsequently by examining its impact on the various levels of the health system (Nirel & Samuel, 2013; Samuel & Rosen, 2013; Elroy, Rosen, Elmakias, & Samuel, 2017; Rosen, Nirel, Gross Bramli, & Ecker, 2008(. As part of the evaluation, a model was developed to assess the extent that the reform has achieved its goals and that the abovementioned concerns have been borne

out (Nirel, Ecker, Rosen, Brammli-Greenberg & Gross, 2008). Since the development of the evaluation model, several significant changes have been introduced into the reform program, including in its main emphases and goals. Consequently, to evaluate the success of the reform's implementation, the proclaimed goals accompanying the decision on implementation should be examined along with the way that the various players in the health system have interpreted and worked to realize them. Such an examination makes it possible to identify gaps between the activities of policy implementation and the intent of the formulators, and provides an opportunity to hone the goals for the benefit of implementation. Also, as part of the ongoing evaluation, both the executed and planned actions should be followed, and the difficulties and challenges of the process exposed.

Study Goals

1. To understand the proclaimed goals of the insurance reform as reflected in official Ministry of Health (MoH) documents
2. To understand how MoH and health-plan personnel in charge of planning and implementation perceive the goals, achievements, and difficulties of implementation
3. To describe the actions of the health plans in implementing the goals in the two years since the reform took effect, and the future plans for continued implementation
4. To understand the needs and the actions necessary to promote optimal implementation of the reform from the perspective of the personnel in charge of planning and implementation

Methods

In the first stage of the study, we analyzed MH-related content of key policy documents, meeting minutes, organizational directives, and work programs in mental health of the MoH and the health plans, as well as the content of the health-plan websites. The time frame for our selection and analysis of the documents was from the publication of the government implementation directive (May 2012) to the performance of the study (start of 2017). The analysis of the policy documents focused mainly on the identification of the goals of the insurance reform.

In the second stage (February to November 2017), we interviewed personnel involved in planning and implementing the reform at the head offices of the MoH, the Ministry of Finance, and the health plans – at both national and district levels. We also interviewed directors of state MH clinics and representatives of non-profits active in the area (a total of 38 interviewees). A protocol was developed for a semi-structured interview

that was slightly adjusted to each of the interview groups and probed the following topics: the reform goals, implementation activities, and achievements to date as they compare to the original reform goals, implementation difficulties, plans for the future, and additional action for successful implementation. The interviews were transcribed and analyzed with the assistance of a content-analysis program (Narralizer).

Findings

The review of the policy documents and the interviews showed that the MoH had not written or published an official policy document listing the proclaimed goals of the insurance reform. Nevertheless, we found a collection of documents attributing a variety of goals to the reform. It also appeared from the interviews that, although no official statement of goals had been published, there was considerable overlap between the goals emerging from the analysis of policy documents and the goals cited by the interviewees. The following goals were noted, among others: the positioning of MH care as being of equal value to other areas of health care; expanding MH service availability; increasing accessibility; improving the quality of MH care; integrating physical and mental care; reducing stigma; improving the hospitalization-community continuum and transferring the focus of activity from the hospitals to the community; streamlining the MH system; and clarifying the legal right to services.

Steps taken by the health plans to implement the reform: These steps focused on creating the infrastructure and an operating system, professional development including MH training for primary care staff, developing new models of service delivery, and fostering linkages between MH and primary health care.

Achievements of the reform: As a rule, interviewees broadly agreed that the reform had been the right thing to do and had improved the situation of MH patients. Other achievements cited were the establishment of a MH service within the health plans; the increasing number of patients; reduction in stigma and growing awareness of MH care; greater visibility of the area of MH at the health plans; the clarification of responsibility for providing MH services; greater efficiency; glimmers of better integration of physical and mental health; and greater scope in the supervision of MH care and the quality of care.

Difficulties and challenges in implementing the reform: Most of the difficulties and challenges mentioned by interviewees related to budgets (such as insufficient or non-dedicated budgets and to competition with other medical areas at the health plans, the struggle to recruit manpower and so forth). Additional difficulties related to infrastructure (the construction of new clinics, the shortage of technological systems), or to the interface with the MoH and with service suppliers (more MoH demands alongside a reduction in MoH service delivery, the difficulty of financial and professional control over the activities of suppliers, a lack of clarity about the

boundaries of the MH subdivision and the question of the health-basket content that the health plans must provide, as well as contradictory MoH messages as to the services to be delivered at the health plans). The interviews further revealed the difficulty of developing quality and outcome measures for MH.

Activities required for continued optimal implementation: According to the interviewees, there is a need to expand the existing service system, increase the number of staff positions, and expand the pool of professionals in areas suffering from shortages to improve availability; develop specialized services for complex populations; clarify MoH expectations as to the proper mix between services offered for free at the health plan and the services given by independent practitioners involving co-payment; develop alternatives to hospitalization; improve the hospital-community interface and that between primary physicians and MH; take additional steps to improve the relationship between the primary care staff and MH professionals.

Plans for the near future: Plans include development of specialized services and alternatives to hospitalization; continued investment in training professionals; the development of measures of quality; the broadening of the existing service; variegation of the types of services and professions active in MH; increasing control; and accreditation of the health-plan clinics for specialization in psychology.

Discussion and Conclusions

Reform Goals and the Need to Define Operative Aims

The study findings showed that although the MoH did not publish an official policy document stipulating the goals, it, the health plans, and other stakeholders agree on what the reform is meant to achieve. Yet, in the absence of a formal statement of goals, there was no definition of the operative measures related to the reform goals. Two years into the reform's implementation, the heads of MH at the health plans are still asking for clarifications as to what is expected of them and how to channel their limited resources. The regulator meanwhile has begun to take steps to set standards for waiting times for treatment. There is room for similar standard-setting procedures as regards the other goals, such as improving the connection with primary care, making the information on MH services accessible to different populations, creating a continuum of care, and reducing stigma.

Difficulties and Challenges in Implementing the MH Reform

1. **Availability of MH services** – As indicated above, even though the quantity of services has grown, there are still long waiting times, as the number of patients also increased. Interviewees cited two main bottlenecks in service availability:

a. A severe manpower shortage in certain professions such as child psychiatry and psychology: while this shortage does affect the workings of the health system, it partially originates elsewhere and any solution therefore must be systemic and undertaken in cooperation with other parties such as institutions of higher education, the Ministry of Education and the Ministry of Finance.

b. Shortfalls in health-plan development of staff positions for professions not beleaguered by manpower shortages, such as clinical psychology and psychotherapy: it may be that MH became just "another area" at the health plans prematurely because the change makes it difficult to allocate funds and staff positions. Perhaps, it should have maintained its preferred position for some time still. It may be worth considering having the regulator define a standard for staffing positions at MH clinics, both in regard to the treating professions and to the number of weekly hours. Such a standard would support the allocation of additional MH staff.

2. **Developing specialized services in the community:** From the interviews with health-plan personnel, the recognition emerged of a need to develop specific MH services for particular populations. Despite this recognition, however, two years into the reform the health plans are still preoccupied with disseminating the reform's basic service of psychiatric consultation and psychotherapy, and addressing the difficulty of creating sufficient availability. Interviewees cited a shortage of budgets and manpower as the main reason especially as specific services demand a large investment of resources for small patient groups.

3. **Defining the boundaries of the MH sector:** According to the findings, the question of what comes under MH in the context of the insurance reform has been left vague. This is reflected in three areas:

   a. A blurring of the boundaries between MH and related areas (such as primary care, welfare, education) resulting in disagreement within the health system over the question of the problems to be treated as MH and the problems to receive a response in other systems

   b. A partial definition of the MH basket of services, creating disagreement between the health plans and service suppliers over the content of the basket, mainly as regards what is included in a day's hospitalization in psychiatric hospitals.

   c. The absence of a binding definition of the desirable mix between in-house services at the clinics and independent psychiatrists (involving co-payment)

A Forward Look – Continued Evaluation of the MH Reform

As noted, this study focused on an examination of the perceptions of MoH personnel and health-plan professionals of the implementation of the reform in the community MH system. It may be beneficial to examine the reform's implementation in the hospital system as well. Similarly, further on, it would be important to examine the points of view of additional stakeholders, such as patients, their families, and professionals regarding the issues that came to light in the study. Such an examination would make it possible to learn how service recipients and service providers perceive the functioning of the MH system in order to continue to improve both implementation and the services supplied in the community and the hospital system.

Note that the study shed light on the difficulty of evaluating a reform's implementation without a definition for measurable, binding goals at the national level to serve as measures of success (apart from goals related to the scope of health-plan services such as the rate of patients in the population, and the average duration of treatment cycles). Thus, the ability to evaluate the reform's achievements at the national level will remain limited to the perceptions of the various stakeholders so long as the reform's goals and derivative aims have not been clearly defined.

Policy Recommendations

Define operative objectives for diverse goals of the reform, such as strengthening the relationship with the primary care physician, making information about MH services accessible, providing specialized services, and reducing stigma.

Take steps to expand the pool of MH professionals, mainly for children and the Arab and ultra-Orthodox populations.

Clarify the boundaries between MH and related areas, clearly define the MH service basket, determine the appropriate mix between various service tracks and consider defining a standard for staffing positions at MH clinics.