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How Did The Mental Health Insurance Reform Affect The Financial Hardship Imposed On Israeli Households?

Ruth Waitzberg Tal Norman

Editor: Ronit Cohen Ben-Nun

English translation (Abstract and Executive Summary): Ruth Waitzberg

English editing: Suzanne Brown

Graphic design: Anat Perko Toledano

Myers JDC Brookdale Institute

P.O.B. 3886, Jerusalem 9103702, Israel

Tel: 02-6557400

brookdale.jdc.org.il/en | brook@jdc.org

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Abstract

Background

The mental health insurance reform came into effect on July 1, 2015, and transferred responsibility for financing and providing mental health services from the Ministry of Health to the health plans. The main goals of the reform were to improve the quality, availability, and access to mental health services in the community, including improving economic access (the ability to receive quality services without experiencing financial hardship), as measured by the amount of out-of-pocket expenditure (hereinafter: expenditure). Access was improved by including mental health services in the public benefits basket, with full or partial coverage, and expanding the supply of services in public outpatient clinics. However, until now, the impact of the reform on the financial hardship of Israeli households due to the utilization of these services has not been examined.

Objectives

To assess the trend of financial hardship of Israeli households resulting from expenditure on the use of mental health services in the community, and to examine the impact of the insurance reform on this hardship.

Method

A descriptive analysis of data from the Household Expenditure Surveys of the Israeli Central Bureau of Statistics (CBS) in the years 2008-2022. The dependent variables analyzed were: (1) the share of households with annual expenditure on mental health services in the community (the intervention group) and the share of households with annual expenditure on rehabilitation and child development services (hereafter: development) in the community (the control group) out of all households each year; (2) The average annual expenditure among households with expenditures on these services. Two differences-in-differences (DID) analyses were performed. This analysis assesses the causal effect of an intervention when a randomized controlled trial cannot be performed.

Findings

After the reform was implemented, there was a significant increase in both the share of households with expenditures for mental health services and the level of expenditure. The share of households with expenditures for these services increased significantly more than the share of households spending on rehabilitation and development services (from 2.2 percent to 2.9 percent compared to 1.6 percent to 1.8 percent, respectively).

Therefore, this increase was caused by the implementation of the reform. In addition, the amount of annual expenditure on mental health services increased (from about NIS 7,800 to about NIS 9,000, on average), but the increase was not significantly different from the increase in the amount of annual expenditure on rehabilitation and development services. Therefore, it is not possible to link this increase to the implementation of the reform.

Discussion

The findings of the study are in line with previous data that showed a significant increase in the utilization of mental health services in the community as part of the public benefits basket after the implementation of the reform. Despite the increase in the supply of public services, the share of households with expenditures has increased, indicating that the public system provides only a partial response to the demand. In addition, the increase in expenditure on these services is consistent with previous data that showed that psychotherapeutic treatments are widely sought within the independent or entirely private caregivers' track which entail high expenses. All of this indicates that the reform has not reduced the share of households that need to pay out-of-pocket for mental health services.

Policy recommendations

In addition to the Ministry of Health's efforts to expand the training of psychiatrists and psychologists, it is worthwhile to continue to expand and diversify the workforce skill-mix and train a wider range of professionals. It is also advisable to continue diversifying the provision of services and to offer new models of care beyond individual sessions with a psychiatrist or psychotherapist. This additional provision should be provided free of charge within the public system.

In order to allocate public system resources more efficiently, the Ministry of Health should establish eligibility criteria for mental health services according to diagnosis, with evidence-based treatment protocols for each diagnosis, giving priority to short-term community-based treatments, as needed.

Finally, it is advisable to promote a progressive financing policy and protect low-income individuals in need of services from financial hardship or even from having unmet needs. Cost sharing for mental health services in public clinics or health funds should be avoided. It is also advisable to reduce the co-payments for visits to independent therapists working with the health plans through discounts, ceilings, and exemptions based on income level, for example, for recipients of income support.

Executive Summary

Background

The mental health insurance reform in Israel came into effect on July 1, 2015, transferring responsibility for funding and providing mental health services from the Ministry of Health to the health plans (HPs).

The main goals of the reform were to improve the quality, availability, and access of mental health services in the community. Access to healthcare is the extent to which individuals are able to use services, and it includes three dimensions: a physical dimension related to the ability to use services at a reasonable distance, reasonable waiting time, or during convenient hours of operation; a social dimension (acceptability), which is related to, among other things, the willingness, and the ability to receive the services offered in an appropriate language and in a culturally appropriate manner; and an economic aspect related to the ability to pay for quality health services without experiencing financial hardship, measured by the amount of out-of-pocket expenditure (hereinafter: expenditure).

The State Comptroller's report from 2020 found that not enough treatments are provided in relation to the budget allocated to the HPs for the implementation of the reform, and that there is excessive utilization of treatments provided by the independent providers' track, which involves high co-payment fees, due to the insufficient availability of free services in the HPs clinics. Out-of-pocket expenditure on these services may result in financial hardship and even in having unmet needs. However, so far, the impact of the reform on the financial hardship of Israeli households due to the utilization of these services has not yet been examined.

Objectives

The main objective

To assess the trend of financial hardship of Israeli households resulting from expenditure on the use of mental health services in the community, and to examine the impact of the insurance reform on this hardship.

Sub-Objectives

1. Describe the changes that occurred in 2008-2022 in the following measures: (1) the share of households with any annual expenditure on mental health services in the community; (2) The average annual expenditure of households on mental health services in the community.
2. To examine whether the reform has affected the average annual expenditure of households on mental health services in the community.

Methods

A descriptive analysis of data from the Israeli Central Bureau of Statistics (CBS) household expenditure surveys in the years 2008-2022. The dependent variables analyzed were: (1) the share of households with annual expenditure on mental health services in the community (the intervention group) and the share of households with annual expenditure on rehabilitation and development services in the community (the control group) out of all households each year; (2) The amount of annual expenditure among households with expenditure on these services. Two differences-in-differences (DID) analyses were performed. The first analysis calculated the difference between the odds of all households spending on mental health (the intervention group) and the odds of all households spending on rehabilitation and development services (the comparison group) in the period before the reform (2011-2014) and in the period after the reform (2016-2019), and then calculated the “difference between the differences.” The second analysis calculated, among households with expenditures, the change in the amount of expenditure on mental health and the change in the amount of expenditure on rehabilitation and development services in the period before and after the implementation of the reform and then calculated the “difference between the differences.” This analysis creates a “natural experiment” that assesses the causal effect of an intervention when a randomized controlled trial cannot be performed. According to the assumption of parallel trends, without the intervention, the gap between the two groups would have remained similar.

Findings

The share of households with expenditure on mental health services was 2.2% before and 2.9% after the implementation of the reform. In contrast, the share of households spending on rehabilitation and development services was 1.6% before and 1.8% after the implementation of the reform. The difference between the two types of services in the share of households with annual expenditure was 0.6% before the reform and 1.1% after the implementation of the reform. A multivariate analysis of logistic regression showed that the DID coefficient (δ) was significant ($p = .006$), and that after the implementation of the reform, the difference between the two types of service in the odds of annual expenditure increased significantly by 23.8% compared to the period prior to its implementation.

The odds of annual expenditure were not significantly different in the period after the implementation of the reform compared to the period before the implementation of the reform, both for rehabilitation and development services ($OR = 0.872$, $p = 0.131$) and for mental health services ($OR = 1.080$, $p = 0.363$). The odds of annual expenditure were significantly higher for mental health services than for rehabilitation and development services, both in

the period before the reform ($OR = 1.332, p < .01$) and in the period after its implementation ($OR = 1.648, p < .01$). **In other words, even before the reform was implemented, the odds of annual expenditure on mental health services were 33% higher than the odds of annual expenditure on rehabilitation and development services, but after the reform was implemented, the difference increased to 65%.** The increase in this difference was significant, as evidenced by the significance of the interaction in the model. In addition, it was found that the four control variables – expenditure quintile, academic education of the head of household, residence in the center of the country, and household size – are significant positive predictors of the odds of having annual expenditure. **Therefore, it can be determined that following the implementation of the reform, the share of households with expenditure on mental health services increased more than the share of households with expenditure on rehabilitation and development services.**

The average annual expenditure among households with expenditure on mental health services was NIS 7,827 before the reform and NIS 8,992 after its implementation. In contrast, the annual expenditure on rehabilitation and development services was NIS 4,305 before the reform and NIS 4,759 after its implementation. The difference in the average annual expenditure between the two types of services was NIS 3,522 before the reform and NIS 4,233 after its implementation.

In the multivariate linear regression model, the DID coefficient (δ) was not significant ($\beta = 1.139, p = .157$). **In other words, the rate of increase in average annual expenditure for the two types of service was similar.** However, while the annual expenditure on rehabilitation and development services did not change significantly between the periods ($\beta = 1.201, p = .084$), the annual expenditure on mental health services increased significantly ($\beta = 1.369, p < .01$). In addition, the annual expenditure on mental health services was significantly higher than the annual expenditure on rehabilitation and development services, both before the reform ($\beta = 1.849, p < .01$) and after its implementation ($\beta = 2.106, p < .01$). We found that the quintile expenditure and academic education of the head of the household are significant positive predictors of the amount of annual expenditure, while the size of the household is a significant negative predictor. **Therefore, although the annual expenditure increased significantly in the period following the implementation of the reform only for mental health services, the difference between the two types of services did not change significantly, and therefore it is impossible to determine causality that it was the reform that affected the change in the amount of annual expenditure on mental health services.**

Discussion

The findings of the study contradict the study's hypothesis, according to which a decline was expected both in the share of households with expenditure on mental health services and in the amount of annual expenditure, due to a significant increase in the availability and supply of care in the community that the HPs began to provide free of charge following the implementation of the reform. The significant increase that occurred after the implementation of the reform, both in the share of households with expenditure on mental health services and in the amount of annual expenditure on these services, supports previous findings that indicate an increase in the utilization of care from independent professionals working with the health plans, which involve high copayments.

The reform probably achieved one of its goals - reducing the stigma regarding access to mental health services - and thus led to an increase in demand for these services. However, despite the increase in both the supply and the actual utilization of mental health services in the public system, the reform has not succeeded in reducing the financial hardship imposed on households stemming from the expenditure on the utilization of service. Even after the reform, more households pay out-of-pocket for these services, and their expenses are higher. The data on the financial hardship associated with the utilization of mental health services is complemented by data on unmet needs, mainly due to the cost.

The share of household expenditures on mental health and rehabilitation and development services during the COVID-19 pandemic (2020, during which most of the lockdowns occurred) did not change significantly compared to previous years (2018-2019). In other words, households continued to consume both types of services to the same extent even during the pandemic and lockdowns, possibly because the transition to telemedicine was fairly simple in these types of services. In addition, it appears that at the end of the pandemic, the use of mental health services increased significantly, compared to the use of rehabilitation and development services, apparently due to the impact of the pandemic on mental distress. However, this hypothesis requires further research.

Policy recommendations

In addition to the Ministry of Health's efforts to expand the training system for psychiatrists and psychologists, expensive human resources requiring a long training process, it is advisable to continue to promote policy measures to expand and diversify the workforce skill-mix and to train a wider range of professionals. For example, psychotherapists, social workers, art therapists, mental health advocates, peer experts, and resilience coaches, and to delegate authority to them. It is also recommended to continue to diversify the modes of service delivery

and to offer new models of care beyond individual visits to a psychiatrist or psychotherapist, such as group therapy, remote therapy, or therapy that expresses a combination of models. **This additional supply should be provided within the framework of the public system free of charge.**

In order to channel the resources of the public system more efficiently, the Ministry of Health should establish eligibility criteria for services according to diagnosis, with evidence-based treatment protocols based on diagnosis, prioritizing short-term, community-based treatments, as needed.

Together with workforce and service delivery policies, it is advised to promote a progressive funding policy and to protect low-income individuals who need services from financial hardship or from having unmet needs. Copayments for the utilization of mental health care in public or HP clinics should be avoided. It is also recommended to reduce the copayments for visits to independent professionals working with the HPs through discounts, ceilings, and exemptions according to income level, for example, for income support recipients.