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**Mental Health Reform in Israel:
Challenge and Opportunity**

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Mental Health Reform in Israel: Challenge and Opportunity

Uri Aviram and Sagit Azary-Viesel*

Abstract

In July 2015, the mental health reform went into effect. This reform, which transfers responsibility for hospital and ambulatory mental health services to the health funds, constitutes a major change in mental health services in Israel. This paper examines the opportunities and challenges associated with implementation of this reform. It analyzes the issues that remained unresolved when the decision on the reform was reached and must now be dealt with by the reform's implementers and the state. For example, it is necessary to ascertain whether the estimates regarding the rate of care recipients were realistic, to guarantee that the deployment of services will ensure equal access, and to develop appropriate alternatives to hospitalization which will enable persons suffering from mental health problems to receive suitable treatment and care in the community and avoid unnecessary hospitalizations. In conclusion, the paper lists several recommendations for contending with these issues, and with the problems that might arise in the course of the reform's implementation, including:

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the allocation of administrative and financial resources for research and evaluation and to promoting the reform; the establishment of a special administrative body in the Ministry of Health to oversee its implementation; and strengthening the regulatory bodies established for the purpose of monitoring and control.

Thanks also to Inna Pugachova of the Ministry of Health's Information and Evaluation Division, to Daniel Rotenberg of the Mental Health Services, and to Yulia Cogan for their assistance in collecting and analyzing the data. For the purpose of the study, we interviewed many relevant people and space will not suffice to list them all by name, but we are grateful to them all. We also wish to thank Prof. Dan Ben-David and Prof. Ayal Kimhi, Shores Institute, for their encouragement and assistance in writing this paper.

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Introduction

At the start of July 2015, the mental health reform went into effect. The decision for the reform was taken in June 2012 by means of a government order (Government Secretariat, 2012) after a series of former attempts had failed. Undoubtedly this reform, which transfers the insurance responsibility for hospital and ambulatory mental health services to the health funds¹, constitutes an essential change in mental health services in Israel – in both their structure and service provision.

Although the principle and general direction of the reform were clear to decision makers, at the time the decision was made questions on many issues remained unresolved. The decision was made to go ahead with the reform and contend with the unresolved issues in the course of the three years allocated for preparations towards its implementation or even after the reform went into effect. In light of the various problems such as limited knowledge in the field, a significant level of disagreement regarding the target populations, as well as ideological, organizational and political aspects of the topic, the decision to implement the reform without resolving all the issues in advance was appropriate. In fact, if this step had not been taken and the decision makers had waited until all matters were resolved, it is doubtful that the reform would have been undertaken at all.

The aim of the present study was to examine the advantages and risks associated with the transfer of responsibility for mental health services to the health funds and their integration into the general medical service system. The paper analyzes the issues confronting those in charge of its implementation and the regulators, and recommends the appropriate modifications or ways of dealing with the issues and problems that may arise in the course of the reform's implementation.

The study is of the exploratory (Wholey, 2010) and “formative” assessment type – an evaluation in the course of program implementation with the objective of improving its functioning and outcome (Friedman, 2010; Rossi, Lipsey and Freeman, 2004). It relies on both quantitative data and interview-based qualitative data. The comprehensive interviews (50 in total) included discussions with the various persons connected to

¹ Health funds, Kupat Holim in Hebrew, are similar to HMOs in the United States. According to the National Insurance Law (1994), residents must enroll in one of the four health funds responsible for delivery of health services based on a basket of services according to law and government's orders.

the reform decision and its implementation – including senior health fund officials, officials in the Ministries of Health and Finance and in other government agencies, suppliers of health services, professionals in psychiatric hospitals and in the field, as well as associations of persons coping with mental illness, families of people suffering from mental illness, human rights organizations, and public figures.

The policy paper begins with a brief description of the reform's aims and fundamental components. It then sets out the background leading to the reform and the state of the mental health service system immediately preceding the decision on and implementation of the reform, with an emphasis on the major changes in mental health services in the last two decades since the enactment of the National Health Insurance Law (1994). The document's main part will deal with several unresolved issues and topics that require thought and attention in the course of the reform's implementation. In the concluding section, several recommendations arising from the analysis will be presented.

1. Background

Fundamentals of the Mental Health Insurance Reform

The reform in mental health was meant to implement the provision set by the National Health Insurance Law (1994) which stipulated that the mental health services should be transferred from the state's responsibility to the health funds and be integrated into the general healthcare system. According to planning, after the reform, the situation in the field of mental health services was to be parallel to the accepted arrangements in medical services under the National Health Insurance Law (except for a small number of items). The fundamentals of the reform are detailed in an order from 10 May 2012 (Government Secretariat, 2012) and in an agreement between the Ministries of Health and Finance and the Clalit Health Services² (2012) from 6 June 2012. These documents are based on previous decisions and agreements made since the first attempt to transfer responsibility for mental health services to the health funds in 1995 (Aviram, Guy and Sykes, 2006), but mainly

² Clalit Health Services is Israel's largest health fund (HMO) insuring about 60 percent of the country's population. The other health funds are Maccabi Health Services, Kupat Holim Meuhedet and Leumit Health Fund.

on the proposal enacted by the Knesset (Israeli parliament) in 2007 (National Health Insurance Law, Amendment 41, 2007).

The reform concerns the insurance responsibility and financing arrangements for mental health services, including patient co-payments. At heart it seeks to apply the principles of the National Health Insurance Law – justice, equality and mutual assistance – to the mental health services. It is supposed to realize and extend the principle of availability and accessibility of the National Health Insurance system to the mental health services, and lead to a fair and equitable deployment of these services in all parts of the country and among the various population sectors. Likewise, the reform was intended to bring order to the budgeting and financing of mental health services similar to the accepted arrangements in the general health services.

The primary elements of the reform included the transfer of insurance and therapeutic responsibility for mental health services from the state to the health funds, and the integration of these services in the overall array of health services. The order arranged the funding of the transfer of responsibility to the health funds, stipulating that NIS 1.54 billion³ (in the value at the time of the order's authorization) be added to the health funds' basic annual budget for the inclusion of responsibility for mental health services in the framework of the basket of services to the public. This sum mainly represents the costs of psychiatric hospitalizations, which amount to about NIS 1,034 million annually, and about NIS 506 million for clinical services (Government Secretariat, 2012; *Agreement Between the Ministries of Health and Finance and the Clalit Health Services*, 2012). In effect, since a considerable part of this money is already in the budgets allocated to mental health (which until now were included in the state budget), the reform is supposed to add about NIS 300 million (in 2012 prices) to the annual health budgets. These sums will be added to the health funds' basic budget and will be updated periodically, according to the criteria that apply to the regular updating of the health funds' budgets. As with the arrangements in general medicine set by the National Insurance Law, and as opposed to the situation when the responsibility for mental health services lay with the state, once the reform has been implemented, service users are entitled to sue the health fund if they feel they have not received the services included in the health

³ On June 6, 2012, the exchange rates were US \$1 = NIS 3.887 and €1.00 = NIS 4.863.

basket in whole or in part, within a reasonable time and located at a reasonable distance from their home.

The reform order left three years for preparations and for the system to get organized, stipulating, as mentioned previously, that the reform would enter into effect on 1 July 2015. Likewise, it was agreed that three years from the start of its implementation there would be the first periodic evaluation and the necessary modifications would be discussed.

Since the number of people diagnosed with mental illness insured by the Clalit Health Services is far greater than the number of those with mental illnesses insured by the three other health funds (Ministry of Health, 2012), the government chose to come to an agreement with Clalit Health Services and afterwards the other health funds joined it. These agreements were approved by the Knesset's Finance Committee (Finance Committee, 2013) and were included in the Economic Arrangements Law (2013).

The agreement between the Ministries of Health and Finance and the Clalit Health Services (2012) and the order (Government Secretariat, 2012) detailed which mental health services would be under the health funds' responsibility and which would remain in the hands of the government – community rehabilitation services for people with psychiatric disabilities, hospitalization of those suffering from double illness (physical and mental), services for prison inmates who suffer from psychiatric disorders, and services for addiction and drug rehabilitation. The reform related to a specific list of psychiatric diagnoses and defined the average duration of treatment as well as the terms of payment. From now on, anyone seeking mental health ambulatory treatment or hospitalization will be required to present a financial agreement voucher (Form 17) from the health fund. However, in contrast to the medical insurance arrangements for physical illnesses, in the case of mental illness the order allows referral to private psychotherapeutic services with higher patient co-payments than those for a specialist consultation in the general health services.

The goals of the reform were to integrate the mental health services with the general medical services, to improve the quality of treatment by expanding the ambulatory services, to prevent unnecessary hospitalizations, to increase the number of alternatives to hospitalization, and to offer more options for people with mental illness within the community. Policy makers hoped that the reform would help to remove

the stigma from those in treatment by the mental health services and from people suffering from mental illness and emotional problems in general.

The goal of the reform's planners was to reach 4 percent of the adult population and 2 percent of the child population who will be entitled to and receive mental health services. The plan stipulated an average number of 9 contacts for adults and 12 for children. The assumption was that in the wake of the expansion of these services it will be possible to prevent unnecessary hospitalizations, make the mental health services significantly more efficient, and, of course, improve the health and quality of life of people suffering from mental illness.

The main effort in the intermediate period was invested in expanding the ambulatory services – increasing the number of mental health clinics and their distribution around the country (including in the geographic periphery), as well as preparing the organizational and administrative infrastructure of the health funds for the reform's implementation, as well as the introduction of Managed Care arrangements to the mental health services, similar to the arrangements in the general health services.

Mental Illness and Mental Disability: Extent of the Problem

The World Health Organization has ranked mental illnesses on a par with coronary diseases and malignant diseases in terms of the global burden of disease. They are included among the ten main factors leading to disability in the world (Murray and Lopez, 1996). In addition to the disability and social handicap, people with mental illness suffer from stigmatization and social exclusion (Corrigan, 2005; Goffman, 1963; Link, 1987; Link, Struening, Rahav, Phelan, and Nuttbrock, 1997). These may be the reasons that the problems of the functioning of people with mental illness have not been given proper public discussion, and few are aware of the extent of the problem and its consequences. The World Health Organization estimates that at any given time, about 10 percent of the population suffer from mental illness and mental distress, and between a quarter and a third of the population will require mental health services in the course of their lives. One to two percent of the population suffers from serious and persistent mental illnesses that can cause an appreciable decline in function and serious disability (Aviram, Zilber, Lerner, and Popper, 1998; Aviram and Rosen, 2002; WHO, 2001). In addition to those who suffer serious and persistent mental illness, many of the population suffer from mental problems that harm their

functioning, impact on their livelihood and quality of life, affect their families, and place a significant burden on the health services and on society at large.

Although the reform determines who the target population is, it is far from simple to define, locate and measure the rates and distribution of mental illnesses in the population. Issues related to defining what mental illness is, the psychiatric diagnosis and its validity, and the epidemiology of mental illnesses have already been discussed extensively in the literature (Mechanic, McAlpine and Rochefort, 2013), and it is not necessary to discuss them again.

The lack of uniformity in defining the field and in measurement leads to a wide range of estimates of the dispersal and distribution of mental illnesses in the population. Studies conducted in the United States estimated that in the course of one year, a fifth to a quarter of the country's inhabitants suffer from mental illness, mental problems and addictions (Narrow, Rae, Robins, and Rieger, 2002; U.S. Surgeon General, 1999; WHO, 2001). Other estimates contend that nearly half of the population will at some point in the course of their lives suffer from emotional problems of one kind or another (Leighton et al., 1963; Srole et al., 1962). Despite the great disparity among the results of the various studies that have tried to estimate the rate of sufferers from mental illnesses and mental problems in the community (Dohrenwend, 1975; Dohrenwend and Dohrenwend, 1974), there is a broad consensus that between 1 and 2 percent suffer from serious and persistent mental illnesses, and that every year 3 to 5 percent of the population require mental health treatment. There is no doubt, then, that this is a wide-ranging and serious health and social problem. Furthermore, family members of sufferers from mental illnesses are also harmed both directly and indirectly; not only does it cause anguish and distress, but there is also an impact on family members' economic situation, quality of life and even their physical health (Gallagher and Mechanic, 1996; Gubman and Tessler, 1987).

Mental illnesses are a substantial factor in the national expenditure on health. The overall cost due to mental illnesses and their economic consequences has not been measured to date in Israel. Nonetheless, it is clear that this expense far exceeds the governmental budget devoted to mental health services which today amounts to about NIS 2.5 billion annually (Ministry of Finance, 2014). To this amount need be added, among others, the health funds' budgets devoted to mental health

services; the disability allowances granted by the National Insurance Institute to about 75,000 people with mental disabilities (National Insurance Institute, 2014); the allowances given to disabled persons by the Ministry of Defense due to mental health problems; the funds allocated by the local authorities; the housing supports granted by the Ministry of Housing; and the not insignificant amounts paid for mental health treatment in the private sector (Shamir, 2006). In addition, as mentioned previously, the economic damage caused to families caring for the people with mental illness in terms of workdays lost and other expenses, as well as the emotional and economic price of higher rates of illness among families caring for people with mental illness versus their counterparts in the general population needs to be taken into account as well (Gallagher and Mechanic, 1996). There are also considerations of the financial and organizational burden on the general medical services resulting from treatment of those suffering from mental illness, as well as the harm to the economy as a result of lost workdays and of the non-employment of people with mental illness. On the basis of an estimate conducted in Great Britain of the economic and social cost of mental illnesses (The Sainsbury Centre, 2003), adjusted to the size of the population and the standard of living in Israel (according to per capita GDP – Bin Nun and Kaidar, 2007; Central Bureau of Statistics, 2011), the annual cost of mental illnesses to Israeli society amounts to U.S. \$13 billion. Furthermore, following the results of the study by Kessler et al. (2008) in the United States, the loss to GDP due to the non-employment of people suffering from mental illness in Israel is estimated at \$2.5 billion per annum (Aviram, 2012). Although these estimates are imprecise, they undoubtedly suffice to underscore the high economic price of mental illnesses to society, and the economic and social benefit to be gained from appropriately dealing with them and with the rehabilitation of people with psychiatric disabilities in the community.

According to the international estimates, 3 to 5 percent of the population suffer from various kinds of mental illnesses and mental disorder and require treatment every year, and these may be considered the target population of the mental health reform. Of them, according to different estimates, the number of those suffering from serious and persistent mental illnesses is about 100,000-150,000 (Aviram, 2007a; Aviram et al., 1998; Aviram, 2010; National Insurance Institute, 2014; Struch, Shershevsky, Naon, Daniel, and Fishman, 2009). According to National Insurance Institute data, in 2013, the number of those receiving

a disability allowance due to psychiatric diagnoses was about 74,500. However, this figure is an underestimate, as it includes only those who chose to submit a claim to the Institute and who not only met the criterion of medical disability, but were also defined as persons whose earning capacity was reduced by at least 50 percent. The group of people disabled by mental illness constitutes about a third of the recipients of disability allowances, and is the largest in this category (National Insurance Institute, 2014). It is also the largest group that receives disability allowances at 75 percent or over of the maximum allowance. It should be emphasized that this number refers to only a small portion, albeit those in great need of the services, of the broader target population of the law. To this estimate of those with mental illness who constitute the reform's target, should be added the close family members caring for the disabled and the ill, since the physical, mental, and economic burden involved in caring for these family members is, as noted previously, immense.

According to the Central Bureau of Statistics' estimates of the size of the population and the average household size in Israel, the estimated number of people with serious and persistent mental illness and the persons caring for them is about 350,000-400,000 – about the population of a medium-sized town in Israel (Aviram, 2013). Of course, according to the other estimates discussed previously, the overall number of those suffering from mental illness and emotional problems and their family members is many times higher.

Trends in the Mental Health Services Policy

The attempted reforms in the mental health services in Israel are connected to the new world-wide trends in the fields of treating and caring for people with mental illness. The essential changes that have occurred in the last four decades are deinstitutionalization along with new concepts regarding the structure and methods of treatment (Goldman, 1983; Goodwin, 1997; Grob, 1991; Mechanic, McAlpine, and Rochefort, 2013). Although it is a complicated subject, it can be defined by means of three prominent changes: a drastic reduction in hospitalization rates, the development of community services, and a change in therapeutic approaches.

What led to the change in the mental health service systems in the world? Essentially, it was a combination of circumstances, and not necessarily the outcome of careful, rational planning. The main factors

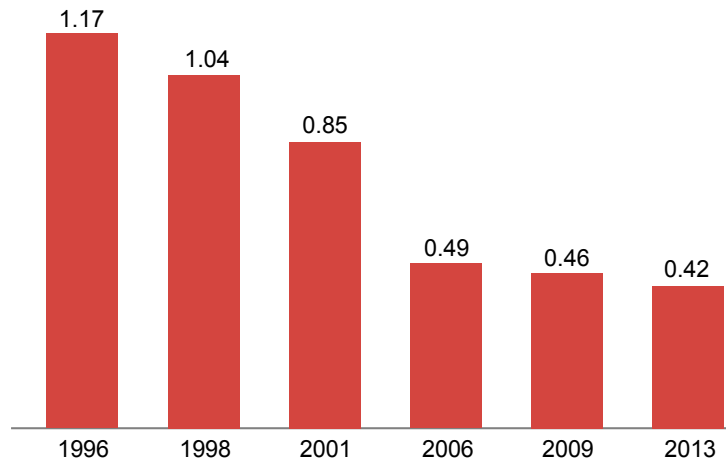
were: the beginning of the use of psychoactive medications; the expansion of the welfare state and the transfer of financial and other supports to the disabled; the immense costs of the system of psychiatric hospitals and the burden on state budgets; and the disappointing results of the psychiatric hospitalization system. That system failed to achieve the three main goals of any mental health system: social control, humane treatment, and low costs. The civil rights movement was also significant among the factors leading to the change (Aviram, 1988; Bassuk and Gerson, 1978; Goodwin, 1997; Mechanic and Rochefort, 1990).

It is impossible to understand the reforms proposed in Israel and the problems and difficulties in the attempts to implement them without reference to the main problems plaguing the mental health service system since the state's establishment. Of course, this system could not avoid the main issues with which any modern mental health system must contend: limited knowledge of the causes of mental illness and emotional distress and the impact of their treatment. Many of the customary therapeutic approaches lack a solid empirical basis, and many of the existing services are not evidence-based. More than in any other medical field, in the mental health field there is disagreement with regard to the problems that the system needs to contend with, the population entitled to service, as well as the range of services that the system should provide (Aviram, 1991; Aviram and Levav, 1981; Mechanic, 1994a, 1994b).

In addition to the global issues, the mental health service system in Israel is faced with three major interrelated problems: limited development of community mental health services, the dominance of the psychiatric hospitalization system, and the medicalization of the mental health services (Aviram, 1996). These problems reflect both organizational and economic issues as well as social-cultural structural factors. The explanations for their continued existence and influence on the system are linked to the historical background of mental health services in Israel (Brill, 1974; Dagan, 1988; Kaplan, Kotler and Witztum, 2001; Miller, 1981; Zalashik, 2008), traditional beliefs and approaches regarding mental health problems and ways of dealing with them, and a series of interests that have sprung up and become rooted over the years (Aviram, 1991; Aviram, 1996; Ginath, 1991).

The insurance reform is supposed to complete two partial reforms that took place in the last 20 years in the mental health services. The first was the structural reform, that is, the reduction in the number of psychiatric beds and a lowering of the hospitalization rates, the number of hospitalization days in the course of a year, and hospitalization duration. This reform began in the mid-1990s. The second was the rehabilitation reform, which was legislated in 2000 (Rehabilitation of the Mentally Disabled in the Community Law, 2000). As shown in Figure 1, in the wake of the reforms the number of psychiatric beds dropped by 65 percent between 1996 and 2013 (from 1.17 to 0.42 beds per thousand people).

Figure 1
Number of psychiatric inpatient beds
 per 1,000 persons, 1996-2013

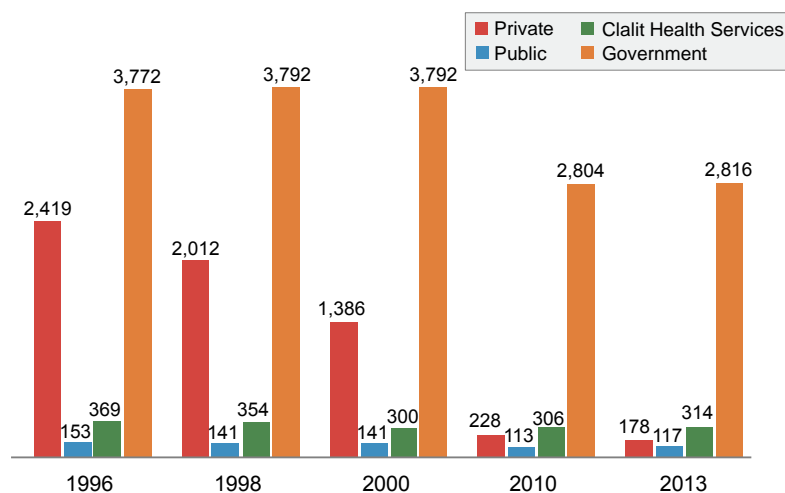


Source: Uri Aviram and Haim Bleikh, Taub Center
 Data: Ministry of Health

The decrease in the number of inpatient beds stems mainly from the closing of private psychiatric hospitals, where conditions and the standard of treatment drew continuous public criticism. Between 1996 and 2011, six of the eight private hospitals in the system closed. In 1996, the number of beds in private hospitals was 2,419, and by the end of 2013, the number was only 178 – that is, most of the psychiatric beds in private hospitals (93 percent) were eliminated, quite a significant accomplishment (Ministry of Health, 2006, 2012; Ina Pugachova,

Ministry of Health, Information and Evaluation Division, personal communication, 1 June 2015). In the same period of time, the number of psychiatric beds in government hospitals dropped by 25 percent – from 3,772 to 2,817 beds – although not a single government hospital closed (Figure 2).

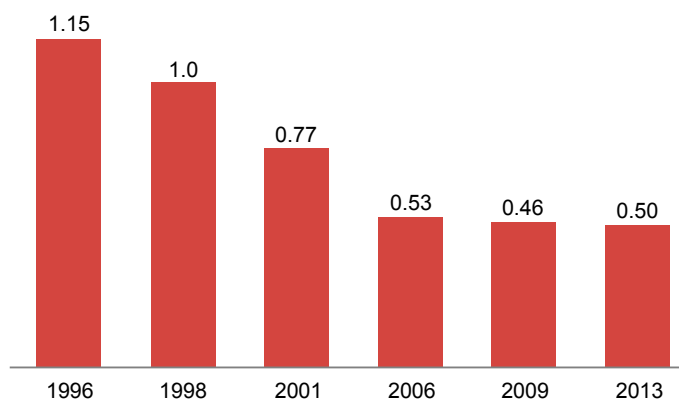
Figure 2
Number of psychiatric inpatient beds by ownership, 1996-2013



Source: Uri Aviram and Haim Bleikh, Taub Center
Data: Ministry of Health

In parallel, there was a drop in the rate of full hospitalizations: from 1.15 hospitalizations per thousand in 1996 to 0.5 in 2013 (Figure 3).

Figure 3
Number of psychiatric hospitalizations
full hospitalization, per 1,000 population, 1996-2013

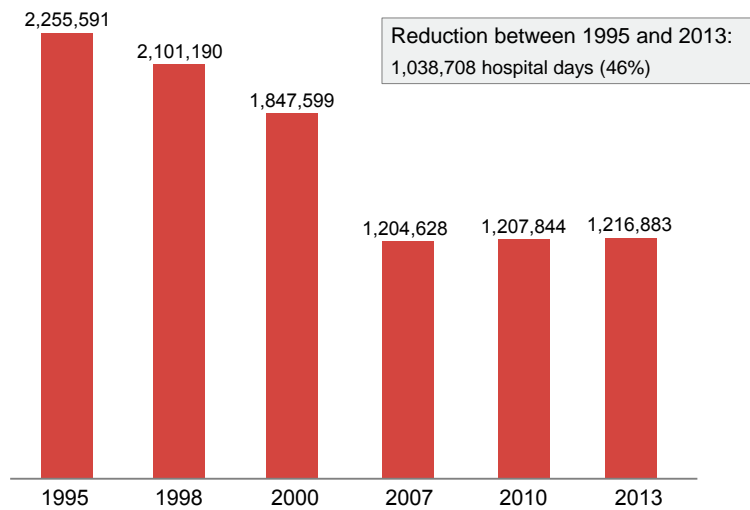


Source: Uri Aviram, Taub Center for Social Policy Studies in Israel
Data: Ministry of Health

Between the years 1995 and 2007, there was a dramatic reduction in the number of annual hospitalization days. Whereas in 1995 the number of hospitalization days amounted to 2,255,591, in 2007, the number of yearly hospitalization days was 1,204,628, that is, a 47 percent drop in a 12-year period. Beginning in 2007, in parallel with the end of the drastic decline in the number of psychiatric beds, the number of yearly hospitalization days stabilized at about 1,200,000 (Figure 4).

Figure 4

Number of psychiatric hospitalization days, 1995-2013



Source: Uri Aviram and Haim Bleikh, Taub Center

Data: Ministry of Health

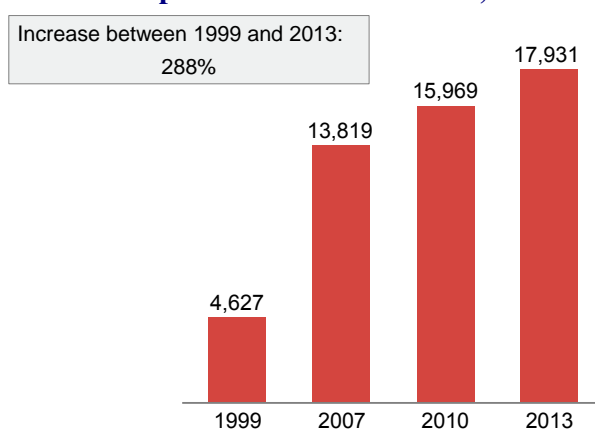
The duration of hospitalization also shortened appreciably during the same period. In 1996, the average psychiatric hospital stay was 151 days, whereas in 2011, the number stood at 68 days – a drop of 55 percent (Ministry of Health, 2006, 2012). It should be noted that until 2000, the average number of annual hospitalization days per person was even higher, ranging between 180 and 339 a year. Since 2001 (the first year of implementation of the Rehabilitation in the Community of Persons with Mental Disabilities Law (henceforth the Rehabilitation Reform Law)), this number has consistently decreased every year (Aviram, 2013; Central Bureau of Statistics, 2006, 2014; Elizur, Baruch, Lerner, and Shani, 2004;

Ministry of Health, 2004, 2006, 2012; Ministry of Health, Department for Reporting and Evaluation, personal report, 2014).

The rehabilitation reform was the second big change that took place in the mental health services in the period under study (Aviram, 2010; Aviram, Ginath and Roe, 2012; Shershevsky, 2006, 2015). The Rehabilitation Reform Law (2000) constituted a breakthrough. Following this law, which was the initiative of former Knesset member Tamar Gozansky, a special allocation was granted for the rehabilitation of persons with mental disabilities in the community, and in 2013, that sum amounted to about NIS 600 million (Ministry of Finance, 2006, 2014; Ministry of Health, 2006, 2012, 2014). In the years since the enactment of the Rehabilitation Law, a network of community services has been put in place in the framework of the mental health services, including supported living arrangements, supported employment, continuing education programs, clubs, and so forth – all of which was just a dream only a few years ago (Aviram, 2010, 2013; Shershevsky, 2006, 2015). At the end of 2013, the community rehabilitation system was providing services to about 18,000 people with mental disabilities, versus only 4,600 in 1999 (Ministry of Health, 2001, 2006, 2012, 2014; Figure 5).

Figure 5

Number of persons in rehabilitation, 1999-2013



Source: Uri Aviram and Haim Bleikh, Taub Center

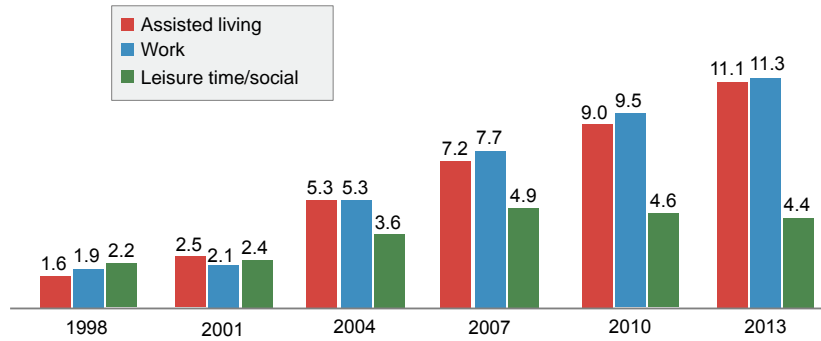
Data: Ministry of Health

The number of people with mental illness in community supported living arrangements has multiplied by six since the law went into effect, reaching 11,300 in 2013 (Figure 6). A similar increase occurred in the field of supported employment (Ministry of Health, 2012, 2014).

Figure 6

Numbers in rehabilitation by main service

thousands, 1998-2013

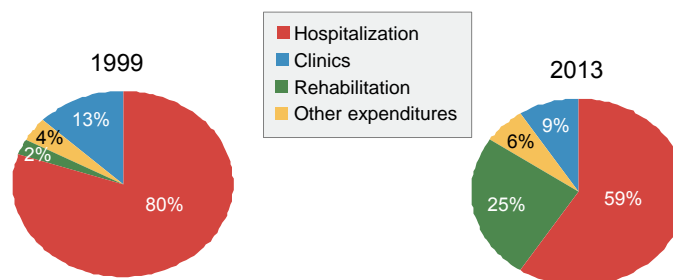


Source: Uri Aviram and Haim Bleikh, Taub Center

Data: Ministry of Health

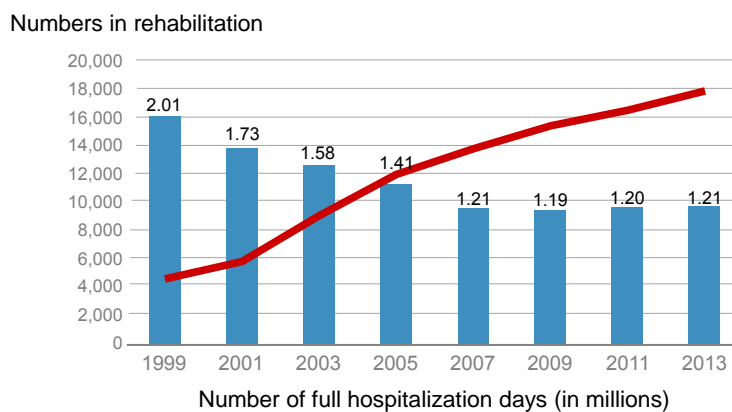
These changes are also seen in the budgetary distribution for mental health services during the period under study. Whereas in 1999, on the eve of the enactment of the Rehabilitation Reform Law, the rehabilitation services accounted for only 2 percent of the government budget for mental health services, by 2013, they accounted for 25 percent. At the beginning of the period, hospitalization services accounted for 80 percent of this budget, but that share dropped to 59 percent in 2013 (Figure 7). It may be assumed that at least in the initial years of the implementation of the reform, there was a connection between it and the decline in the number of psychiatric beds and hospitalization days (Figure 8).

Figure 7
Distribution of the budget for mental health services, 1999 and 2013



Source: Uri Aviram and Sagit Azary-Viesel, Taub Center
 Data: Ministry of Health, State Budget

Figure 8
Hospitalization and rehabilitation days, 1999-2013



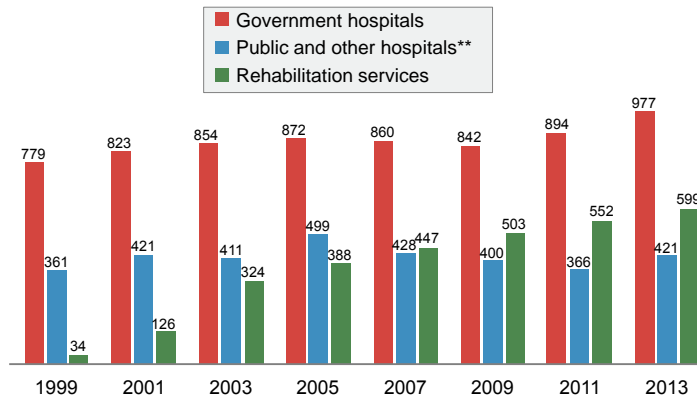
Source: Uri Aviram and Haim Bleikh, Taub Center
 Data: Ministry of Health, State Budget

Despite the drastic drop in the hospitalization rate and in hospitalization days in the 14 years since the enactment of the Rehabilitation Reform Law, as already mentioned, not a single government psychiatric hospital has closed and the overall budget for inpatient services (including costs for hospitalization in government hospitals and payments for hospitalizations in Clalit psychiatric hospitals as well as public non-government hospitals and private psychiatric hospitals) has grown (in fixed values) by about 20 percent between 1999 and 2013 (Figure 9).

Figure 9

Budgets for psychiatric hospitals and rehabilitation services

NIS thousands, 1999-2013*



* Fixed prices by 2013 Health Costs Index

** Including payments to other non-government hospitals and hospitalization alternatives

Source: Uri Aviram and Sagit Azary-Viesel, Taub Center

Data: Ministry of Health, State Budget

Despite the legislator's intention to strengthen the ambulatory services, in the years after the enactment of the National Health Insurance Law the opposite process occurred. Between 1995 and 2007, the budget for government mental health clinics declined by 40 percent (Aviram, 2010), and the availability and accessibility of ambulatory mental health services continued to be far from satisfactory. The distribution of clinics in the country's various regions and in certain sectors (e.g., the Arab Israeli sector) was not uniform and was unequal (Irit Elroy of the Myers-JDC-Brookdale Institute, personal report dated 9 June 2015). Likewise,

the funding of mental health services was far from adequate to meet the population's needs and funding was not updated in the same way that the health funds' general medical services were. Development budgets were also directed mainly to the hospitalization system – 98.5 percent as opposed to only 1.5 percent for the community clinics (Aviram, 2010).

In addition to the Rehabilitation Reform Law, other laws and judicial decisions have had an impact on the system, like the Treatment of the Mentally Ill Law (1991); the Equality of Rights for Disabled Persons Law (1998); the Basic Law – Human Dignity and Liberty (1992); and various judicial rulings in matters pertaining to people suffering from mental illnesses.

However, these changes are far from what is required to meet needs. While 90 percent of persons suffering from serious mental illness are in the community at any given time (Aviram et al., 1998), and among the sufferers from mental distress the rate is even higher, only 35 percent of the mental health services budget is directed to community services, including ambulatory and rehabilitation services (Ministry of Finance, 2014; Ministry of Health, 2006, 2012) (Figure 7 previously). This differs from the situation in the general health services, where half of the system's expenditures are invested in community services. Likewise, even though the structural reform and the decline in the number of psychiatric beds in the mental health services (including those in the government hospitals) led to a relative drop in the share of the budget devoted to hospitals, in numerical terms the budgets of the government hospitals were augmented in the years 1999-2013 and rose by 25 percent, from NIS 779 million in 1999 to NIS 977 million in 2013 (in 2013 prices).

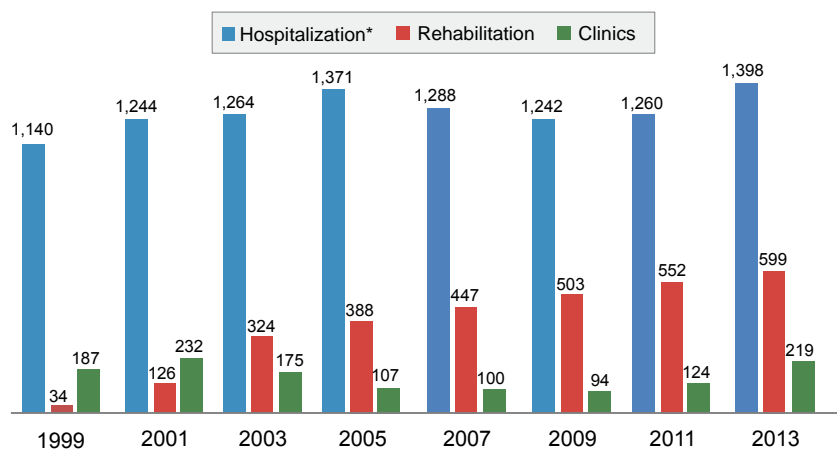
In contrast, there was a drop of about one-third in the budgeting of ambulatory services (clinics) between 1999 and 2011 (Figure 10), from NIS 187 million in 1999 to NIS 124 million in 2011 (in 2013 prices). In light of the planned insurance reform, it would seem more appropriate to strengthen the ambulatory services. The relative share of the budget for clinics out of the government budget for mental health has also declined. Whereas in 1999 it constituted 13 percent of the mental health services budget, in 2013, it accounted for only 9 percent – and this after a special budgetary infusion of over NIS 300 million in the wake of the reform order of 2012. Only after the reform order was issued in 2012 did the budgets allocated to ambulatory services rise, reaching NIS 219 million in 2013 – a 75 percent increase over 2011. As was reported at the

convention of the National Institute for the Study of Health Services and Policy on 13 May 2015, following the decision on the reform, 61 community clinics have been added to the 56 government clinics that existed prior to the decision, and the number of recipients of ambulatory services has doubled in the period under study (Dr. Gadi Lubin, former head of the Mental Health Division, personal report from 13 May 2015).

Figure 10

Mental health services budget by type of service, 1999-2013

NIS millions, fixed prices by 2013 Health Costs Index



* Including payments to other non-government hospitals and hospitalization alternatives

Source: Uri Aviram and Sagit Azary-Viesel, Taub Center

Data: State Budget 1995-2014

The relative share of the mental health services out of the total public expenditure on health services is also lower than in other developed countries. While some Western countries allocate 10 percent of the total health package, in Israel the share allocated to mental health services is approximately 5 percent. This situation forces many of those with mental disabilities and their families to pay privately for mental health services, or even to forego the services altogether (Shamir, 2006; Shershevsky, 2006, 2015). At a recently held conference on the topic, it was reported that the private expenditure on mental health services is appreciably higher than in the general health services. Whereas in the general health services the ratio between public and private funding stands at 60 to 40, in the mental health services the situation is reversed: private funding

accounts for 67 percent and public funding for 33 percent (Dr. Idit Saragusti, director, “Bizchut” Mental Health Project, personal report from 4 May 2015). The decline in the clinics’ budgets, as well as the high rate of private funding in the mental health services, should be reflected in the findings of the studies that have examined the availability and accessibility of mental health services. These studies, which were conducted by the Myers-JDC-Brookdale Institute, found that only a third of the interviewees who had felt mental distress in the previous year sought treatment, that the rate of applicants from the lower socioeconomic clusters (usually including the localities in the periphery) was lower than the rate in the upper ones, and that the rate of treatment-seeking among Arab Israelis who felt mental distress was lower than among Jews (Irit Elroy, Myers-JDC-Brookdale Institute, personal report from 9 June 2015). These data, which attest to the availability and accessibility of the mental health services for the entire population, to the unequal distribution among the various sectors of the population and to the high level of private financing of these services, are undoubtedly troubling.

The data prove how far the mental health service system still is from the planned goal, which is to deliver the majority of the services in the community. What are the reasons for this? Why has the reform not been implemented until now? What are the challenges facing those implementing the reform? To answer these questions, it is necessary to determine who the major interested parties were, what the main issues were when they tried to implement the reform, and what the interested parties’ positions were with regard to the reform. Then it may be possible to deduce what the existing threats are to its current successful implementation. Before conducting that analysis, the five major attempts made over the past 40 years – usually upon the Ministry of Health’s initiative – to implement a substantial change in the mental health services in Israel will be briefly surveyed.

Previous Reform Attempts in the Mental Health System

If the current attempt to make a substantial change in the mental health services in Israel succeeds, it will mark the end of an effort that began over four decades ago. As early as the beginning of the 1970s, the state sought to institute a fundamental reform in the mental health service system, the purpose of which was to transfer the locus of care from a

system based mainly on psychiatric hospitals to a community-focused system. The attempts at a community reform in the mental health field in Israel matched the general trends in the mental health systems of the Western world in the second half of the twentieth century (Goodwin, 1997; Mechanic, McAlpine, and Rochefort, 2013).

Even though fundamental reforms in mental health services are a complex and complicated process, many countries have been successful (Benson, 1996; Cutler, Bevilacqua, and McFarland, 2003; Goldman, 1983; Goodwin, 1997; Mangel, 1985; Whiteford, Thompson, and Casey, 2000). What most of these reforms shared was a significant reduction in the number of persons hospitalized, a reduction in the number of special psychiatric hospitals, the expansion of the supply and accessibility of mental health services in the community, the development of rehabilitation services for those with mental disabilities, the diversification of mental health services and a greater degree of integration of those services with general medical services, as well as a change in budgetary allocations towards increasing the share of the community services in the mental health budgets.

Since the early 1970s, five major attempts have been made at reforming the mental health services in Israel (Aviram, 2005, 2010, 2013; Finance Committee, 2013). The first was the 1972 plan to reorganize the mental health services (Aviram and Dahan, 2007; Ministry of Health, 1972; Tramer, 1981), followed by the second in the form of the Menczel-Doron agreement (1978) between the Ministry of Health and the Clalit Health Services (Aviram, 2005). The next steps were related to the National Health Insurance Law (1994) and the reform plans for the mental health services that followed in its wake (Aviram, Guy and Sykes, 2006; Aviram, 2010; Government Secretariat, 2006a; Mark, Feldman and Rabinowitz, 1996). These included the attempt to transfer responsibility for the mental health services to the health funds in the course of the three years allocated for this purpose in the National Health Insurance Law, legislation from 2007 (National Health Insurance Law, Amendment 41, 2007) which was not completed, and the most recent decision from 2012 by means of government order (Government Secretariat, 2012). Despite some modest beginnings and partial successes (e.g., the Rehabilitation of the Mentally Disabled in the Community Law), and despite official decisions, declarations and government decisions in this matter (e.g., Finance Committee, 2013; Government Secretariat, 2003, 2006a, 2006b),

the attempts at radical reform have not borne fruit (Aviram, 2007a, 2007b; Aviram et al., 2006; Aviram, 2010; Saar, 2006).

The latest attempt, which is now in progress, began when decision makers in the Ministry of Health came to the conclusion that the 18th Knesset would not finish the legislative procedure of the Mental Health Reform Law (National Health Insurance Law, Amendment 41, 2007) before the end of its term or its dissolution. In light of that, they decided on a change of course and saw to it that a decision on reform was taken by means of a governmental order. The government decision from 2012 stipulated that the reform would enter into effect three years from when the order was issued, that is, on 1 July 2015 and indeed, it went into effect on time. It is to be hoped that this attempt will succeed.

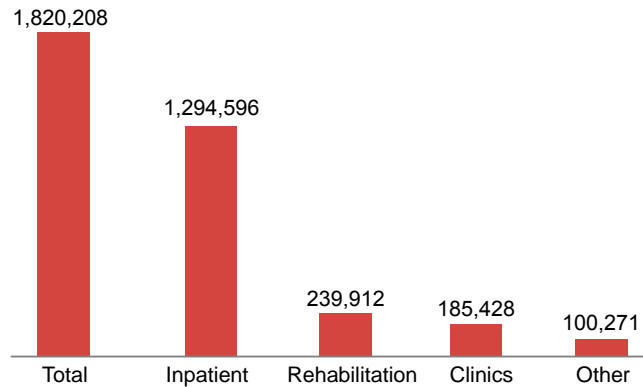
It bears mention that in the framework of efforts to promote the reform, NGOs of people with mental disabilities and their family members, human rights organizations (“Bizchut”) and public figures (former Knesset member Tamar Gozansky and former Minister of Health Nissim Dahan) were active and lobbied to advance the issue. For example, in 2005, a petition was submitted to the Supreme Court to require the government to execute a reform, and in the wake of an interim order issued at that proceeding (Supreme Court, 2005), the government proposed a bill and submitted it to the Knesset in 2007. In order to convince those within the Ministry of Health who still hesitated to support the reform, they were shown the financial loss incurred by the mental health system as a result of its budgets not being updated by the same criteria that the health fund budgets are periodically updated. Indeed, the long delay in completing the reform cost the mental health services considerable sums. As a general estimate, from 1998, the last year in which the reform had been intended to enter into effect according to the National Health Insurance Law (1994) until 2009 – the year in which the Deputy Minister of Health decided to support the reform and take action in the matter (Dead Sea Conference, 2009) – the mental health system lost about NIS 800 million (in 2009 prices). According to another estimate, from 1995 (the first year in which an attempt was made to execute the insurance reform) to 2013 the mental health system lost NIS 1.8 billion (in 2013 prices; Figure 11). This considerable amount of

money could have augmented the mental health budgets and improved the level of services.⁴

Figure 11

Budgets that would have transferred to the mental health system if the reform had been implemented earlier

in shekels, by area, 1995-2013



Source: Uri Aviram and Sagit Azary-Viesel, Taub Center
Data: Ministry of Health

After the decision on the reform by means of governmental order, the government made sure to allocate to the health funds' mental health services NIS 320 million for ambulatory services and NIS 60 million for infrastructures in preparation for the reform (Ministry of Finance, 2013). This designated budgetary allocation helped to expand the ambulatory services. As mentioned, in the course of the period, 61 new clinics were established (in addition to the 56 already functioning), and the number of new recipients of ambulatory mental health services shot up by 140 percent, from about 50,000 to about 120,000 a year (Dr. Gadi Lubin, former head of the Mental Health Division, personal report from 13 May 2015).

⁴ The loss is calculated according to the cumulative differential amount between the cost of the health basket according to the cost factors of the health funds and its cost in nominal terms.

2. Implementation of the Reform – Issues and Problems

In light of the data and familiarity with the system, this section presents essential issues and problems that must be addressed to ensure the success of the reform's implementation and its realization. The issues concern the seven critical elements that define the mental health service system and the functional environment in which they operate (Emery and Trist, 1965):

- A. Clients – users
- B. Areas of intervention
- C. Services
- D. Manpower
- E. Budget
- F. Legislation and regulation
- G. Functional-organizational environment

A. Clients – Users

1. Target population. As noted, one of the reform's goals is to double the rate of those receiving ambulatory mental health services to 4 percent of all adults and 2 percent among children. However, there are those in the health funds who think that this estimate is too low. The overall national rate today stands at half of the declared goals, and it is not distributed equally among all of the country's regions and among the various population groups. Initial data of the health funds indicates that in certain city centers and among well-established populations the rates are already higher than the reform's goal, whereas in other places, especially in the periphery and among specific populations, it is considerably lower.

Furthermore, there are differences between the health funds in the rate of their insured populations with mental illness. Initial estimates indicate that the difference between the health funds is also apparent in the rates of their insured populations with serious and persistent mental disorders; the rate in the Clalit Health Services and the Leumit Health Fund is higher than in the other two health service funds (Maccabi Health

Services and Kupat Holim Meuhedet). The planning and budgeting of services will have to contend with these differences.

B. Areas of Intervention

2. *The nature of problems requiring mental health treatment and division of authority among therapeutic agents.* There is a great deal of disagreement regarding the nature of problems requiring professional intervention by the mental health services, the methods of intervention and their duration, and who is appropriate and authorized to treat persons with mental illness – general practitioner, psychiatrist, psychologist, social worker, occupational therapist, nurse, or others. Likewise, there are disputes regarding the issues that each of these agents is authorized to treat. Additionally, there are the debates over treatment methods; it is well-known, that there are often methods that are considered the “last word” in treatment which, over time, fall out of favor and are even avoided. A low level of reliability and validity in the mental health arena relative to other medical fields also makes it difficult to reach agreement in these matters.

Although the reform has defined the psychiatric diagnoses where intervention is legitimate, the level of precision and agreement in this field is not high, and there are arguments regarding primary and secondary prevention of mental illnesses and the proven levels of intervention. Decision makers need to be aware of these issues and be prepared to deal with them when they arise.

3. *Persons with serious and persistent mental illness.* The customary estimates of the rate of those suffering from serious and persistent mental illnesses range from 1 to 1.5 percent of the population, and approximately one-quarter to one-third of the mental health services’ target population. Experience elsewhere in the world shows that in many cases this group is not at the top of the mental health system’s list of priorities. To avoid the neglect of this population, the supervision and regulatory system, as well as the family members’ organizations and human rights organizations, will have to be vigilant.

Another issue to be addressed will be the population suffering from serious and persistent mental illnesses who are currently hospitalized due to their level of disability. This population, which includes those who have been continuously hospitalized for over a year, occupies about one-third of the hospital beds. It may be assumed that finding alternative

solutions to prolonged hospitalization will be one of the system's goals. The financial consideration constitutes a significant incentive to pursue this course, although finding more appropriate solutions from a therapeutic and humane aspect should also carry some weight in the decision making. Indeed, the Mental Health Division of the Ministry of Health appears to be working on a solution to this problem (Dr. Tal Bergman-Levy, head of the Ministry of Health's Mental Health Division, personal report from 19 October 2014).

Experience in other countries shows that all too often financial considerations and a desire to save on costs override therapeutic and humane considerations, and the arrangements instituted are detrimental to the quality of life of persons with mental disabilities. As a society, we must remain vigilant against the creation of inferior hospitals or institutions in the community, lest there be a return to sights reminiscent of the darker times when private institutions, which were supposed to treat, were in many cases places of deep neglect.

C. Services

4. *Accessibility and availability.* At this stage, the accessibility and availability of ambulatory services in the periphery, in sparsely populated areas and among specific sectors of the population (such as Arab Israelis and ultra-Orthodox Jews) leave much to be desired. Although, as noted previously, in the course of the three years allocated to prepare for the reform's implementation many clinics were added to those which already existed and the annual number of treatment recipients rose by 140 percent. It is still unclear whether the increase meets all the needs and the demand for services, and what the distribution of treatment recipients is according to the country's regions, population groups, or the type of mental health problems they present. The health funds are striving to improve the situation in this regard, but their progress has yet to be examined and verified.

In this context, it is highly important to provide a clear operational definition of the law's requirement that services be provided "within a reasonable time and at a reasonable distance." This is among the reform's conditions that are binding upon the insurers, i.e., the health funds, similar to the requirement in the National Health Insurance Law. This flexible definition has drawn a considerable amount of criticism, and has been noted in the State Comptroller's reports (e.g., State Comptroller,

2015). Without making light of the problem regarding the general population of those insured by the health system, the lack of a clear definition of these concepts is most serious for the population of those with mental illnesses. On the whole, this is an extremely weak and vulnerable group that, in addition to its disability, also suffers from stigmatization and social exclusion. The reform's implementers will have to devote special attention to this topic. The possibility of defining these concepts in a clear manner should be examined, as was done in the case of the law dealing with entitlement to dental treatment (National Health Insurance Law, Amendment – Dentistry, 2010).

5. *Duration of treatment and supervision.* Will the average duration of ambulatory treatment set by the reform, at 9 encounters per adult and 12 encounters per child, meet the needs of this population? There is disagreement regarding this estimated assessment, as well as who should have the authority to determine continued treatment when necessary. The issue of treatment and oversight is also rife with issues, disagreements, and a not inconsiderable level of uncertainty. The reform includes implementation of a supervisory system similar to the one in general medicine. The duration of hospitalization, appropriate ambulatory treatment, or transfer of a patient to other systems for treatment or rehabilitation is supposed to be determined according to professional standards and via administrative principles and supervisors. Nonetheless, there is no doubt that budgetary considerations and other considerations unrelated to the level and quality of treatment will guide various agents, or that the many disagreements among the therapeutic agents and various schools of treatment and care will have an influence on the ability to decide on the nature and duration of intervention. As will be detailed further on, the fact that many of the hospitalization authorities are not owned by the health funds is liable to give rise to conflicts of interest and to disagreements regarding oversight and the nature and duration of treatment.

6. *Choice of hospitalization location.* For some time now, there has been a demand to allow psychiatric hospitalization in the hospital of choice, as is the case in the general hospitalization system. Those in favor of it, mainly NGOs of people with mental illness and various human rights advocates, believe that in addition to the right to choose, the change in the regulation and practice will lead to competition among the institutions and generally improve the quality of the hospitalization

network. The mental health service system opposed this demand and insisted on the importance of maintaining the existing arrangement, according to which persons requiring hospitalization are admitted to a hospital in their area of residence. The main argument turned on professional considerations connected to treatment in the user's community and issues of continuity of care; however, it may be assumed that administrative considerations also underlay the hospitals' opposition to change the status quo. The issue was decided in the Supreme Court, which in principle accepted the petitioners' demand, but since the right of choice was made conditional upon the bed occupancy rate in the chosen hospital, and recently that rate is usually close to 100 percent, in fact this right cannot be exercised most of the time. However, if as a result of the reform, hospitalization rates do in fact decline as well as bed occupancy rates, it will become possible to exercise the right to choose the hospital location – with all the administrative, budgetary and therapeutic implications of this choice.

7. *Option of private treatment.* The reform's designers preferred to have ambulatory services provided in the framework of the public services through a national network of clinics. Nevertheless, due to a tradition of providing mental health services by means of private therapists – primarily in the framework of the Maccabi Health Services – the option of private services was included in the reform. The price is regulated, but it is still appreciably higher than the patient/user co-payment that applies to those opting to use public clinics. It is unclear whether allowing private treatments was a constraint or a compromise, but the fact that this option exists gives rise to a concern that a separate system of ambulatory services for the wealthy may spring up, creating a gap in quality between the therapists in the public system and those in the private sector. Undoubtedly this situation is counter to the principles of the reform, and it is important to follow developments and prevent the creation of special and better mental health services for those who can afford to pay.

8. *Involvement of family doctors in the mental health services.* The reform's working assumption was that it is necessary to connect the family doctors and general practitioners to the mental health treatment network. However, many of those interviewed for this study thought that the family doctors are unprepared or unable to accept responsibility for this task: they lack a sufficient level of knowledge, there is not enough

time to train them for it, nor is enough time allocated per patient to enable them to deal properly with the needs of people with mental illness.

The reform began without the full participation of the family doctors, and they claim that their professional union was not enlisted either. Moreover, it turns out that in the course of the discussions on the reform, the family doctors' association eliminated the compulsory specialization in psychiatry for those specializing in family medicine. In light of all this, the connection to family medicine is very likely to be problematic. Since according to the reform's planning and goals the involvement of family doctors in the mental health system is very important, the professional unions of family doctors and psychiatrists and the Ministry of Health must give special attention to this topic.

9. *Financing community and group interventions.* Modern concepts of community psychiatry view activities that include contact with the community and strengthening the fabric of the community as a vital part of mental health services. In the past, these activities, albeit to a very limited extent, were budgeted in the framework of the overall budget for the hospitals, clinics, or government mental health services. In the wake of the reform, the financing of the professional activity will be dependent mainly on the application and authorization forms of the health funds (Form 17). It is necessary to find ways to finance these vital professional activities that currently are not included in the framework of the form.

D. Manpower

10. *Size and quality of professional and service personnel.* One of the phenomena which appeared during the years of preparation for the reform's implementation was the movement of manpower from the government system, mainly the psychiatric hospitals, to the mental health services in the health funds. The health funds, which needed additional manpower for the mental health services, were able to offer better jobs, higher pay, and more promotion tracks than those available to many professionals in government service. The directors of the psychiatric hospitals complained that many of positions in their hospitals remained vacant, and voiced a concern that they would not be able to fill them with quality personnel (or at all).

Another issue the system has to contend with concerns the required manpower and their professional level. This is one of the topics that was not defined clearly in the framework of the reform. In light of the changes

that are due to ensue and the need to save on costs, there is concern that the system will not fully allocate the budgets required to train the appropriate personnel, or forego incentives to enlist qualified personnel, leading to compromises in manpower – e.g., the employment of insufficiently skilled personnel. Although it is to be hoped that the reform’s implementers will demonstrate responsibility and employ appropriate personnel, it is also important that the regulator, the professional unions, and other bodies such as the Civil Service Commission, as well as users of the system remain vigilant.

E. Budget

11. Budget transfer to the health funds – should the money be “earmarked”? The question of how to ensure that the money transferred to the health funds for integrating the mental health services reaches its destination in full preoccupied the reform’s designers. Clalit Health Services as well as the Ministry of Health insisted that the budget should be handled as it would in any other medical specialization, and that the use of these additional funds should be left to the discretion of the health funds. Others argued that it was necessary to “ earmark the money,” i.e., to ensure that it went only to the mental health services, if only in the initial years of the reform. This was to prevent the transfer of money from the mental health services budget to the budgets of other, stronger or more popular, health service areas.

Ultimately, the opponents of restricting the funds for the mental health services won. Nonetheless, the danger that budgets may escape elsewhere has not passed. In light of the fact that the health funds’ budgeting model leaves them at a deficit, and the customary budgeting model (capitation) does not take poor populations into account, the danger of budget transfers only increases. (Regarding the need to correct the financing of the health funds, see State Comptroller’s Report, 2015, and also Israel National Institute for Health Policy Research, 2015.) Strong medical specializations and considerations of popularity in the competition among the health funds are liable to create an incentive to save as much as possible on mental health services and to provide services at the minimal required investment. Of course, in this situation those persons suffering from serious and persistent mental illness, who lack social-political power, will be the first to suffer.

To prevent this situation, it is necessary to track the use of the mental health budgets and find ways to ensure that the funds allocated for these services in the basic budget are fully utilized. It is important, at least in the initial stages, to employ some sort of “affirmative action” or preferential treatment to this topic.

12. *Reimbursement arrangements for hospitalization services.* One of the issues in dispute, which is a source of uncertainty and concern among those responsible for operating the inpatient service system, involves the reimbursement arrangements of the health funds to the government hospitals for psychiatric hospitalization.

The goal of the reimbursement arrangement that was set was to strike a balance in the system: to prevent unnecessary hospitalizations, but at the same time to protect the psychiatric hospitals. In order on the one hand to protect the health funds from an uncontrolled rise in hospitalization costs, and on the other hand to protect the hospitals from a drastic reduction in the number of hospitalizations which would seriously impact their budgets – and also to prevent health funds from refraining from working with certain hospitals for whatever reasons – it was decided that the health funds would be charged 95 percent of the previous year’s charge, and would be exempt from additional payment for occupancy rates up to 108 percent of the previous year. According to the arrangement, should hospitalizations cross this threshold, payment for the additional hospitalization days will be set at 30 percent of their full cost. The explanation for the reduced charge is that the marginal added cost for longer hospitalizations is much lower than the average cost of hospitalization in the framework of ordinary occupancy (Economic Arrangements Law, 2013; Agreement between the Ministries of Health and Finance and Clalit Health Services, 2012). This arrangement is similar to the provisional arrangements, which are renewed at three-year intervals, in the general hospitalization system.

Despite the arrangement, those connected to the Ministry of Health’s hospitalization system are apprehensive of harm to their budget, and of the difficulty this may pose to the level of service they will be able to offer their users. Likely this will be one of the main topics to be examined in 2018, which according to plan is when an assessment of the reform should be performed.

F. Legislation and Regulation

13. *Transfer of data and protection of privacy.* In light of the structural changes dictated by the reform, a dilemma has arisen regarding transfer of information: on the one hand it is necessary to transfer patient or user information to the new therapeutic agents, but at the same time, appropriate arrangements must be put in place to protect privacy. Due to their nature, greater sensitivity is attached to mental health issues than to other medical issues, and perhaps for that reason the decisions concerning the mode of information transfer and ways of protecting privacy among the various agents were not made until the months just prior to the reform's going into effect. Those concerned with individual rights and personal privacy demanded that the health funds obtain authorization in advance from a user to transfer personal information from the government services to the health funds. In contrast, the health funds argued that information in the field of mental health could not be handled differently from other medical information, and that they would take care to properly ensure the required privacy.

Most recently, the director-general of the Ministry of Health decided it was impractical to obtain authorization in advance from the users, and that information should be transferred to the health funds unless a user explicitly objects to it. This topic undoubtedly will require monitoring and sensitive assessment to examine whether a proper balance is being maintained between the need for essential information in order to provide the proper treatment and protecting the individual's right to privacy.

14. *Regulatory supervision and oversight and the status of the head of the Mental Health Division.* The successful implementation of the reform is dependent to no small degree on the status and power of the regulator and the sanctions that can be imposed on the executive agents in the mental health system. Although the Ministry of Health is not the only agent filling the role of regulator (bodies such as the Ministry of Finance and the Civil Service Commission also play an important role), it has an important part in supervision. Specifically, the Mental Health Division and its head play a central role in supervision, oversight, and charting the reform's course. As previously noted, the Ministry of Health has a basic conflict of interest stemming from its position as regulator and overseer of the rehabilitation of people with mental disabilities in the community network on the one hand, and its being the owner of the psychiatric hospitals on the other hand. Similarly, the status of the head of the Mental

Health Division as an employee of the Ministry of Health also has implications for his or her ability to lead the reform.

The reform's initiators and leaders saw the transfer of insurance responsibility to the health funds as a means of transferring the locus of mental health services from the psychiatric hospitals to a community system. Although there was no intention to give up the hospitalization services entirely, the implementation of the changes in full – strengthening of the ambulatory network, expansion of day treatments, opening of psychiatric wards in the general hospitals, and expansion of the psychiatric rehabilitation network – would lead to a weakening of the senior status of psychiatric hospitals. This has not escaped the attention of the psychiatric hospital directors and other interested parties, such as the staff employed at these hospitals. An example of this was seen in the failure of the attempted closure of Abarbanel psychiatric hospital and its integration with an area general hospital (Wolfson). The closure was prevented due to the opposition of some sectors of the Ministry of Health and the hospital's employees.

Like other Ministry of Health employees, the head of the Mental Health Division is not free of interests which may hamper him or her in properly fulfilling this role. An examination conducted for the purpose of this paper found that almost all the heads of the Ministry of Health's Mental Health Division (12 of 14) from 1970 to 2014 went on to administer a psychiatric hospital after leaving their position as heads of the service. This move appears to have been a promotion in their professional careers, and included significant improvement in pay. According to data of the Ministry of Finance Supervisor of Wages for the years 2011-2014, the average pay of a psychiatric hospital director was 90 percent higher than the service head's pay. The director of a large hospital even earned more than twice the service head's pay. In addition to the financial incentive, the professional status of a hospital director also seems to be higher than that of the service head: the heads of the Psychiatric Association are hospital directors, and those in the senior academic ranks also come from the psychiatric hospitals. By the same token, the data indicate that psychiatrists' promotion track did not include a move from administering a hospital to running the overall system.

Without casting aspersion on the personal and professional integrity of the heads of the Mental Health Division, this situation throws a long shadow over the system's structure, raises doubt as to the professional and administrative power of the service head vis-à-vis hospital directors,

and creates an uncomfortable state of affairs, to put it mildly, for the regulatory and policy making system that is supposed to lead the reform to success.

15. *Research and evaluation.* As noted previously, the reform is supposed to be implemented despite the fact that many important topics have not been clearly defined, and policy makers and those implementing it will be required to set clear goals and evaluation measures on the go. It will be necessary to ascertain whether what was supposed to be done has been done, e.g., an appropriate deployment of the ambulatory services, and whether the intervention outcomes actually improve the health and quality of life of the service recipients.

The Ministry of Health is currently working on defining evaluation measures. This comes late in the day, but better late than never. It is reasonable to assume that the health funds would also welcome research examining costs and the utilization of inputs, since this impacts the financial aspects of the reform. Nonetheless, it is impossible to know whether sufficient attention will be devoted to evaluating the quality of the professional interventions and their outcomes. Therefore, a certain percent of the reform's designated budget should be allocated to research of this kind, and researchers should be encouraged to study the field. To the authors' regret, the reform's planners did not include this in planning the system, and it is highly doubtful that the topic can be promoted in the existing evaluation frameworks.

G. Functional Environment and Conflict of Interests

16. *Conflict of interests.* As noted, the reform (deliberately or unavoidably) left an inherent conflict of interests. Most of the hospitalization services and the rehabilitation services in the community remained in the hands of the state, under the authority of the Ministry of Health. The psychiatric hospitals' budget and the personnel employed by them, and as a consequence also the number and duration of hospitalizations, will continue to be the concern of the state. As noted in Section 14 above, a conflict of interests is liable to arise between the health funds, which from professional and budgetary considerations will seek to reduce the number of inpatients and duration of hospitalization, and the hospitals, which stand to lose from these measures.

Most of the persons who were interviewed about the scale of hospitalization, both among officials of the psychiatric hospitals and mental health officials in the Ministry of Health and among health fund officials, thought that it would not be possible to further reduce the hospitalization rate, since the current rate of psychiatric beds (0.4 beds per thousand population, Figure 1 previously) is already very low. Although the issue is likely not to be pressing in the initial period of the reform's implementation, professional, humane (e.g., the possibility of treatment in the least restrictive environment possible) and budgetary considerations that are liable to arise in the future, as well as experience from other countries, give reason to suppose this issue will become relevant soon enough.

Another possible difficulty concerns the fact that the psychiatric hospitals were left out of the Hospitalization Authority established in the time of Netanyahu's third government, in 2014 (Ministry of Health, 2014). Although it has been claimed that their exclusion is temporary, the temporary, as is well known, often becomes permanent – and what is more, a date has not even been set for including the psychiatric hospitals in the Hospitalization Authority. (Admittedly, this topic may cease to be relevant in light of the new government's freeze on the establishment of the Hospitalization Authority.)

The rehabilitation services for persons with mental disability in the community have also remained under the state's responsibility. Unlike the hospitalization system, where the state remains a direct employer, the rehabilitation service system has been entirely privatized, although the organizational and budgetary responsibility remains in the hands of the state. Here, too, the arrangements set by the reform create an inherent conflict of interests. The health funds will naturally want to transfer the hospitalized individual to the rehabilitation services as quickly as medically possible. In order to ensure that the hospitals will not have an interest in prolonging hospitalization due to financial considerations, in the framework of the reform, the state took it upon itself to pay for the continued hospitalization of users forced to wait in hospital more than ten days after the rehabilitation committee has decided on their return to the community (Agreement Between the Ministries of Health and Finance and Clalit Health Services, 2012, p. 9). Many questions, however, remain open. For example, who will pay for the extra days in the hospital until the patients' transfer out to rehabilitation services – the hospitals themselves, the Ministry of Health or the Ministry of Finance? Will there

be agreement as to who is appropriate for rehabilitation? Who will have the authority to determine that, and what will happen in the case of disagreements between the health funds and the hospitals and the Ministry of Health? Will the rehabilitation network have the means and ability to admit any person released from hospitalization (since this is dependent on the privatized systems and other factors to increase availability, such as budgets and tenders)?

17. *Alternatives to hospitalization.* It may be assumed that the health funds and others who have supported the reform – including governmental and professional agents, NGOs for those with mental disabilities and their families, as well as human rights organizations – will seek ways to develop alternatives to hospitalization, whether their aim is treatment in a less restrictive environment in accordance with the therapeutic needs of the individual or simply to lower the costs. Among such alternatives are institutions for day treatment, as well as the development of psychiatric departments in community general hospitals. Looking at the mental health system in recent decades, it is impossible not to notice that services for day hospitalization have not been developed inside or outside the hospitals, and to date not a single government hospital has been closed. As already mentioned, in recent years, the one attempt to close a government psychiatric hospital (Abarbanel) and merge it with Wolfson Hospital in Holon failed. In light of that, there is no knowing what the state may do in this matter – especially considering the very real conflict of interests and when the power to authorize this development remains in its hands.

18. *Government clinics for mental health.* In the original plan for the reform of mental health, the intention was to close the government clinics and allow the health funds to develop ambulatory services of their own with the encouragement of the Ministry of Finance and policy makers. This could be seen, among other things, in the significant reduction in the budgeting of the government clinics in the period after the enactment of the National Health Insurance Law. This trend aroused stiff opposition among government clinic employees and unease and concern among the leadership of the government hospitals. Consequently, the design of the reform was changed and it was announced that the government mental health clinics would continue to operate as usual. This statement of intent did not allay the concerns of the workers in the government clinics, and recently their professional unions (the Federation of Academics in the

Social Sciences and Humanities and Social Workers' Union) declared a labor dispute in this matter (Bior, 2015).

The government clinics, which are linked to the hospitals or under their organizational authority, are important to the hospitalization system for the purpose of continuity of care and supervision, but almost certainly they also serve as a means of regulating the flow of users out of and into the hospital system. It seems that mainly for these two reasons the psychiatric hospitals subsidized the clinics operating in their framework over the years. In the wake of the reform, this situation may change due to the requirement to obtain an authorized referral and financial agreement voucher from the health fund (Form 17) in order to receive treatment in the clinic, and due to the health funds' control over the flow of users and the choice of the ambulatory treatment facility for their insured users. Beyond that, a situation may arise in which the government clinics treat mainly the cases of those with serious and persistent mental illness, while the "soft psychiatry" cases are dealt with by the health funds' clinics or the private services they offer.

3. Summary and Recommendations

A review of how social reforms have turned out reveals that they have usually been made possible when social and political circumstances come together to create a coalition of interests (not necessarily overlapping) that manages to overcome the status quo-seeking opposition. Usually political and social leadership has been a necessary condition for the success of the coalition. This was true also in the case of the mental health reform. The political element that stood at the head of the Ministry of Health (Knesset member Yaakov Litzman) and the Ministry's Director-General (Prof. Ronni Gamzu) led the coalition, leading eventually to the government order that launched the reform.

Naturally, however, circumstances and priorities change, and the coalition and the leadership that prompted the change are liable to weaken or even disappear entirely. In the case of the mental health reform, the situation is not yet stabilized, and it may be assumed that those elements that stand to lose from its success will try to weaken it in accordance with their own interests. For example, just as this policy paper was being finalized, it became known that under pressure from professionals opposed to the reform, the psychologists' representative

(the Federation of Academics in the Social Sciences and Humanities) and the social workers' representatives (Social Workers' Union) had petitioned the Tel Aviv Labor Court, which ruled in their favor and ordered the state to enter into negotiations with them in the matter of ensuring the workers' rights (it refused, however, to order a stay of the reform's implementation) (Bior, 2015). Although ensuring the workers' rights is a legitimate and worthy topic, this ruling – as also the hearings conducted by the Knesset's Labor, Welfare and Health Committee in June and July, after the reform entered into effect (Labor, Welfare and Health Committee, 2015), and the declaration of a labor dispute by the professional unions of the government mental health clinic workers – may hinder the implementation of the reform.

In order to support the reform's implementation in accordance with the original goals, it is of utmost importance that the social and political groups interested in the success of the reform organize, and an effort be made to form a social and political lobby.

Additionally, the system charged with executing the reform must allocate the administrative and financial resources to sustain and advance it. In the Ministry of Health a special administrative body needs to be established with authority over the reform's implementation, and the existing regulatory bodies established for this purpose need to be strengthened to deal properly with issues that arise in the course of implementation. It is also necessary to encourage independent research to examine both the reform in action and its outcomes and achievements, so that it will be possible to conduct ongoing assessment of the implementation process and to modify whatever needs fixing in its course.

It is important that financial resources be designated specifically for research and evaluation of the reform so that these activities will not have to compete with other budget demands, and the administrative apparatus established must have enforcement authority. If these two steps in combination are not taken, and if the heads of the Ministry of Health do not lend their full political and administrative support to it, it is doubtful that the reform in mental health can fully realize its goals.

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