Promises and Pitfalls on the Road to a Mental Health Reform in Israel*

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ABSTRACT

This study assessed efforts to reform the mental health (MH) service system in Israel, moving the locus of treatment and care from a mental hospital system to the community. It focuses on changes which occurred in MH policy and services especially during the last decade, evaluating trends and issues regarding legislation, clients, budgets and personnel of the system. Findings indicate a drastic decline in the number of psychiatric beds, length of stays in inpatient services, a reduction in the number of MH personnel, and a dramatic increase in rehabilitation services in the community. However, no government hospital was closed and budgets for hospitals actually increased, while MH community clinics' budget was reduced. The efforts to transfer responsibility for MH services to the health care provider organizations have not been successful yet and the reform has not been completed, endangering the progress achieved so far. Promises and perils on the road towards a successful reform are discussed. It seems that the stigma and the social exclusion of persons suffering from mental disorders, as well as the salience of the issue of MH in relation to other problems the Israeli society has to deal with, have contributed to the failure of efforts to reform the MH service system.

* I would like to thank many who assisted me in obtaining the data for this study and who commented on my assessment, particularly from the Ministry of Health. Though I greatly appreciate the input of all the people who helped me along the way, I take full responsibility for the content of this article. Also it doesn't necessarily represent the formal positions of the organization I am employed by.

INTRODUCTION

On July 18, 2007, the Knesset (Israel's legislature) approved a bill to reform the mental health (MH) service system (1) and moved it to committee for debate and consideration of amendments toward the final vote. However, toward the end of 2008, as new elections approached, it became apparent that the bill would not reach the stage of final approval. Thus, another attempt to reform the MH service system in Israel failed. The proponents of the reform still hope that the newly-elected Knesset will resume the process and approve the long-awaited MH reform. For almost 40 years, Israel has been trying to reform its MH service system. The objective of the planned reform has been to transfer the locus of treatment and care from a mental hospital system to the community. During these years, four major efforts to achieve a radical reform failed (2-4).

In spite of the fact that persons who suffer from a mental disability represent a large population group, the treatment, rehabilitation and care for this group has not received proper public attention within Israeli society. It seems that the social marginality of this group, the stigma from which its members suffer, their exclusion from mainstream society, and the salience of this issue in relation to other problems Israeli society has to deal with explains the low level of public attention to the matter, and has contributed to the failure of efforts to reform the service system for them (2).

The last two efforts to enact a MH reform law were related to the National Health Insurance Act (1994) (5). The original intent of the legislature to transfer the responsibility for MH services to the health care provider organizations and integrate MH services with general health care services has been postponed for about 13 years since its due date for implementation set by the legislature (2, 6, 7).

In spite of the failure of a radical reform, some incre-

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mental changes in the MH service system, especially during the last decade, have occurred. These might have created facilitating conditions for a reform. However, there are many pitfalls along the road toward reforming the system.

This paper assesses these changes in the MH service system, and discusses their meaning in relation to the policy objectives to transfer the focal point to the community. Following background information on the scope of the problem of mental disabilities in Israel and a short review of the previous efforts at reform, the changes in the MH service system over the last decade are assessed.

Analysis of the data is based on examination of the critical elements of the MH service system, namely, clients, financial resources and personnel, and the principles governing their allocation and movement within the system. In addition, legislation related to the treatment and care of persons suffering from a mental disability during this period is assessed.

The discussion of the changes is focused on the target population, budget allocations, services rendered, personnel training and availability, and research and evaluation. Although the target population of MH services encompasses a wide range of suffering from a variety of conditions at various levels of disability, this paper focuses mainly on persons with severe and persistent mental illnesses. While this group seems to be the most disabled and of high priority for MH services, it does not mean that those with less severe problems do not need services or that the attempted reform excludes them or that they could not benefit from it.

Continuing problems and current issues related to factors that hinder the reform and those that might facilitate it are presented. An attempt to understand the problems of reforming the MH service system within the prevailing socio-political environment is made. Considering the environmental conditions and the target population for whom policy changes are attempted, efforts at a radical reform vs. incremental changes are discussed. Finally, tentative conclusions with regard to the critical conditions necessary for implementing these kinds of reforms in MH as well as remarks on the main factors in overall policy changes are made.

MENTAL DISABILITY IN ISRAEL: THE SCOPE OF THE PROBLEM

About one-third of the total number of those receiving disability pensions from the National Insurance Institute (NII) are persons suffering from mental impairments. This is the largest group of all those receiving disability pensions from the NII. In December 2008, their total number was 62,686 (8).

Research in the mid-1990s (9) estimated that 1.2% of the adult population (18-64) suffered from serious mental disorders. Based on the demographic changes since 1996 (10), the number of persons with severe and persistent mental illnesses at the end of 2007 was about 47,000. Due to the changing patterns of MH treatment and care, most of those suffering from severe and persistent mental disorders are in the community (11-13). We found that about 90% of this group was at any point in time during the year in the community, although they could have been hospitalized for sometime during the year in a mental hospital (9).

Since both estimates were based on reported cases only, one can conclude that they are rather conservative. In addition, these figures are for the population group of 18-64. Although it is hard to define the criteria for persistent mental illness for persons less than 18 years of age, there is no doubt that among this group there are some severely mentally ill persons, and among persons 65 years and older there are those with severe mental disorders. In conclusion, based on a most conservative estimate, the number of persons suffering from severe and persistent mental illness in the total population for 2005 reached about 85,000 persons (1.2% of the population) (14).

The scope of mental disorders in society is much larger than the 1.2% of those suffering from severe mental illness. The World Health Organization (WHO) estimated that 10% of the general population suffers at any given time from mental illness and emotional difficulties and that 25%-35% of the population will need MH services sometime during their lifetime (13).

The disability of persons suffering from mental illnesses is associated also with poverty, stigma and social exclusion (13, 15, 16). Mental illnesses were rated by the WHO on the Global Burden of Disease Scale similar to cardiovascular heart diseases and cancers, and they are among the 10 top causes for disability in the world (13, 17). These people use fewer health care services compared to the rest of the population, their morbidity rates are higher than people not suffering from mental disorders and their life expectancy is about 10-15 years shorter than those who are well (15,18,19). Thus, based on health and social measures, this is a large group of people who suffer from severe disability, represent burden to their families, need a lot of health and

social services, and require sizable personal and public resources.

In considering the burden of mental illness, one cannot ignore the emotional, social and economical burden on the family, the community and society in general. Studies conducted abroad inform us not only of the distress to the families who care for a mentally ill member, but also the ramification on their economic condition and even their physical health (20, 21).

Mental illness also has economic consequences. A recent study conducted in the United States reported the tremendous effect on the annual earning loss of persons suffering from serious mental disorders (22). Proportionately to the size of the population in Israel and adjusted to the differences of the GDP, according to a rough estimate, the figure for Israel would be approximately US$2.5 billion in lost annual earnings. In addition to the economic effect due to the loss of earnings of persons suffering from mental disorders and their families, public expenditure for treatment and care for those persons composes a sizable portion of the GDP of this country (2, 23, 24).

How many people are affected directly by the severe and persistent mental disorders of their family members? No study has been done in Israel on this subject. However, if one uses a conservative estimate, taking into account an average nucleus family (parents and children) of 3.7 persons (25), and given the figures of the NII of 60,000 persons, age 18-64, suffering from severe mental disorders in the country, the number of affected family members would be about 225,000, about the same number as the residents of a medium size city, and about 5.5% of the total adult population (18-64) of the country. If we were to add to this figure the number of people suffering from chronic and severe mental illness under age 18 and above 65, this number would increase significantly (14).

PREVIOUS EFFORTS TO REFORM THE MENTAL HEALTH SERVICE SYSTEM

Since the early 1970s, Israel's official policy has been to introduce a fundamental reform of its MH services. The attempts to reform corresponded with the general trends of change in MH services occurring in the western world (11, 12). The ideas behind this attempted policy change were based on advanced principles of mainstreaming psychiatric care by integrating MH services in the general community-based health care systems (26). Community-based MH services, as opposed to a system based on psychiatric hospitals, have been considered clinically better, more humane, as well as more economically viable (27, 28).

Assessment of the MH system in Israel between 1970 and 1990 revealed weak community services, dominance of mental hospitals and strong medicalization approaches towards the treatment and care of persons suffering from mental illness (2, 29). In view of these, as well as the traditional orientation of the Israeli health system toward hospitals and acute care, the objectives of the reforms represented a radical shift in policy.

From the early 1970s to the mid 1990s, there have been three major attempts – mostly initiated by the government – at radical MH reform. The recent fourth attempt has failed as well.

The first attempt at reform began in 1972 with the reorganization plan of MH services (The Tramer Plan) (3, 30). This plan was based on the American model of community MH centers' program anchored in law in the United States nine years earlier (31). The Tramer Plan, which was the flagship of MH services and the Ministry of Health for a decade, brought about substantial financial assistance from a Jewish philanthropic organization based in the United States; however, it did not lead to the expected radical MH reform, and in effect didn't materialize (3, 28, 32).

The second attempt was an agreement between the Ministry of Health and Kupat Holim Clalit (Clalit), the health care organization of the labor union (which provided health services to about 80% of the population at the time), signed in April 1977 (the Menczel-Doron agreement). The purpose was to implement the previously stalled Reorganization Plan of MH services. The Menczel-Doron agreement stated that MH services would be provided to all residents by region, at no cost, and that the government would finance the program (33). However, aside from minor changes in the delivery of MH services in the country, basically, the agreement was not implemented. Furthermore, following the agreement Clalit canceled its insurance coverage and thus its responsibility for the provision of MH services to its insured members, putting it on the government. As it turned out, this step had grave consequences which burden the attempts to improve the MH system to this day (2, 4, 34).

The third attempt was connected to the National Health Insurance Act (NHI) (5) and to the reform plans of MH services which followed. Those who planned the

reform (4, 35) believed that the reform in insurance, meaning moving responsibility of MH services to the health care providers, would assist a structural reform in MH services, reducing the use of inpatient services and would bring about the development of a system of community MH services (2, 4, 36).

In all three attempts mentioned above, the Ministry of Health and the Clalit health care provider were the major stakeholders, and were directly involved in the negotiations. However, analysis reveals that there were other stakeholders, some even were parts of the major ones, which affected the outcome. Among those other stakeholders, the Ministry of Finance was crucial. Indifference or lack of support by the Ministry of Finance was a major factor for the failure of all three attempts (2-4). During the recent attempt, organizations of family members and users as well as psychologists and social workers became especially involved in the process.

Conflicts between the parties revolved around issues of budget, control and professional and organizational autonomy. The proponents of the reforms failed to mobilize a strong coalition, and the leadership of the Ministry of Health lacked a strong commitment to the reforms. Failure to implement the reforms was also partly due to the structure of services, their historical and organizational background, and the traditional orientation that views curative medicine and hospitals as the hub of the system (2, 4).

Since processes and outcomes of previous efforts to reform the MH system have been assessed elsewhere (2), it is only important to point out that the case studies of the previous efforts illuminated the circumstantial and contextual factors that perhaps had not given the reform a chance to begin with. These include: social marginality, social exclusion and the stigma of the population of persons suffering from mental disorders. In addition, the prominence, or rather the lack of it, of the issue, and the minor importance the public has attributed to the issue within the framework of other problems and circumstances with which it has dealt during this time have also contributed to failure of the reform.

Perhaps, the environmental conditions during the period studied were not ripe for a change. Throughout the time the reform was attempted, Israeli society was in a constant situation of existential concern, and did not and perhaps could not pay attention or have the energy or the will to take care of problems regarding weak and excluded populations, such as people with mental illness.

Furthermore, during the periods in which reforms were attempted, major changes and traumatic events occurred. About a year and a half after the Ministry of Health announced the reorganization plan, the Yom Kippur War broke out. The political turnabout of 1977 occurred close to the Menczel-Doron agreement, and the assassination of Prime Minister Rabin occurred during the mid-90's attempt at reform.

Finally, the recent attempt to reform the MH service system during the period of 2006-2009 (37) has been faced with major contextual issues that might explain its failure. These are the political upheaval during the years 2007-2008, the global financial crisis of September-October 2008, and finally the latest Israeli war against the Hamas in Gaza as the year 2008 was ending. Will the Israeli society have the energy and determination to undertake a major social change while it has to cope with major pressing social, economic and political issues?

RECENT CHANGES IN MENTAL HEALTH POLICY AND SERVICES

Following the failure of the third attempt at reforming the MH system in 1996 (4), Israel launched partial (or incremental) reforms that may become important parts of achieving the objective of moving the locus of treatment and care for MH services to the community. Included is the legislation of the Rehabilitation of the Mentally Disabled in the Community Law (RMD) and the establishment of rehabilitation services in the community as well as the plan for reducing the number of psychiatric beds in the country. These changes, later called the Rehabilitation Reform and the Structural Reform, were intentional policy changes, done by the government alone without involvement of the health-care providers. Apparently, they are turning out to be an important part of a comprehensive change of the MH system in the country, yet to be completed (10, 38-41).

Inpatient services. From 1996 to 2006, the number of psychiatric beds in Israel declined by 50%, from 6,599 to 3,453. The rates went down from 1.17 per 1,000 of the general population in 1996 to 0.49 in 2006 (a 60% decline). From 1996 to 2007, the number of hospitalization days in psychiatric hospitals declined by 47%, from 2,289,984 days in 1996 to 1,213,264 in 2007 (Table 2) (39, 42). Net bed occupancy steadily declined from 93% in 1997 to 72% in 2005 (and rose to 84% in 2006 and 2007). Persons discharged from inpatient services spent longer periods in the community before readmission. Also, the

proportions of long stay patients (one year or longer) among the total inpatient population show a constant decline during the decade starting in 1996 (68% to 44%) (37, 40). Between the years 1995 and 2005 the average length of stay of persons discharged from inpatient care declined by one half and the average length of stay for all inpatients declined by 60% (Table 2).

Data on readmissions reveal a different trend. Whereas the rates of first admissions have not changed during the decade from 1996 to 2006 (the increase of 23% in the numbers reflects the growth in the population), the numbers and rates of readmissions increased (43% and 16% respectively) (39, 42).

During this period, four out of eight private mental hospitals were closed (39); however, none of the government hospitals were closed. Several former private psychiatric hospitals actually changed their function and title, becoming community residences (similar to nursing homes). These residences are designated for severely mentally disabled persons who are considered a separate category and have not become part of the clientele of the rehabilitation services. As seen in Table 1, reduction of psychiatric beds was in all types of mental institutions. However, proportionately, private mental hospitals show the greatest decline in beds.

Table 1. *Psychiatric Beds by Ownership*

Ownership	1996	%	2006	%	Percentage of Change 1996-2006
Private	2419	36.7	228	6.6	-91%
Governmental	3660	55.5	2804	81.2	-23%
Clalit Healthcare Provider	369	2.3	306	8.9	-17%
Public	151	2.3	115	3.3	-24%
Total	6599	100	3453	100	-48%

Source: Ministry of Health, Mental, Health Services, Dept. of Information and Evaluation (39, 42)

Rehabilitation services in the community. During the same period there has been a substantial improvement in rehabilitation services for people with mental disabilities (41, 43). Based on the RMD 2000 law, the newly-established rehabilitation system includes protected and supported housing, sheltered and supported employment, completion of education, social clubs and more (40, 41, 43). By the end of 2007, it provided services for about 14,000 persons with mental disabilities, in comparison with 4,350 in 1998 (39, 44). The number

Table 2. *Inpatient Days in Psychiatric Hospitals and Psychiatric Departments in General Hospitals, 1995-2007* [1]

Total average length of stay (inpatient care)	Average length of stay of persons discharged (inpatient care)	Number of days[2]	Year
260	216	2,255,591	1995
151	107	2,289,948	1996
339	300	2,211,756	1997
180	148	2,101,190	1998
181	155	2,011,289	1999
280	260	1,842,867	2000
130	117	1,722,537	2001
124	108	1,642,462	2002
120	110	1,578,505	2003
116	106	1,489,716	2004
100	90	1,407,847	2005
182	176.	1,315,975	2006
90	84.	1,213,264	2007

[1] Source: Ministry of Health, Mental Health Services, Department of information and Evaluation (39, 42)
[2] Total net days from admission to discharge, not including days the patient did not sleep in the hospital

of people with mental disabilities living in supported living in the community was more than doubled during a period of five years after the enactment of the Law. It increased from about 2,150 in the end of the year 2000 to 7284 at the end of 2007 (42, Y. Shershevsky, personal communication, April 1, 2007; August 5, 2008).

Legal changes. Although it would be hard to measure the exact effect of legislation and court rulings on the changes that have been taking place, it would be safe to conclude they had an impact. In addition to the RMD (40), other legal changes include: the revisions of the MH law (45), the Law for Equal Rights for People with Disability (46), Basic Law: Human Dignity and Liberty (47), and numerous court rulings regarding people with mental illnesses. These laws have been affecting the flow of persons in and out of inpatient facilities; their treatment and care; as well as their quality of life in the community.

Changes in budgetary allocations. The changes in the MH service system are also reflected in the budget allocations during the last decade (Table 3). While in 1999, the year an experimental program in community rehabilitation began, the percentage of rehabilitation in the government MH budget was a tiny 3.8%, in 2007 it had reached about one-quarter of the total budget. Based on constant prices (adjusted to the 2007 health price index), the budget for inpatients constitutes about

20% less of the general MH budget than it did in 1999 (though the total amount [in constant prices] slightly increased). In contrast, the budget for rehabilitation services increased eightfold. In the budget year of 2008 the allocation for rehabilitation services was NIS386 million, an increase of about 20% from the one for the 2006 budget (48)

In spite of the substantial decline in the number of psychiatric beds, in constant values, the budget for inpatient services remained approximately the same during the decade (48). Also, the increased number of previously long-term hospital patients who are now in the community was not reflected in an increased budget for community ambulatory services. As shown in Table 4, during the 12 years that followed the implementation of the NHI (5) there has been a 40% decline (in constant prices) in the budget for these services. This decline was attributed to the government's expectation the reform would be completed, thus the responsibility for MH services would be transferred to the health care providing organizations. The Ministry of Finance did budget NIS50 million for developing ambulatory services during this transition period, while a reform is still being attempted. However, so far only 20% of the money has been used due to conditions imposed by the Ministry of Finance (D. Fast & Y. Polakevits, personal communication, January 1, 2009).

A court gave a ruling (49) for an additional budget for MH community clinics to be provided by the health care providers; though the sum is debated between the government (NIS120 million) and the health care providers (NIS40 million) (D. Fast & Y. Polakevits, personal communication, January 1, 2009).

In addition to the special allocation for rehabilitation services in the MH Services budget the Ministry of Housing has been providing housing subsidies for protected living arrangements for persons with a mental disability who meet the criteria for this type of subsidy. Since there is no available data on the total amount of housing subsidies for persons in the protected housing program of the rehabilitation services of the Ministry of Health, one can only make an estimate. At the end of 2007, about 6,300 persons were receiving a housing subsidy of NIS650 per month, bringing the total amount of subsidies from the Ministry of Housing for persons in housing rehabilitation programs close to NIS50 million.

Changes in the workforce. The changes during this decade are reflected also in the number of positions in MH services within the Ministry of Health. From 3,702 positions in 1999, to a peak of 3,724 in 2003, the number declined to 3,348 in 2008 (Table 5) (23, 39). Ministry of Health officials claimed that during this period a few positions (financed by government) were added by NGOs for the provision of community MH services (Y. Polakevits, personal communication, January 1, 2009).

Table 3. *Inpatient and Rehabilitation Budgets,[1] Government Mental Health Services, 1999-2007 (In thousands of NIS)*

In Current Prices				
	1999	2001	2002	2007
Inpatients	794,750	942,508	950,654	949,081
Rehabilitation	39,739	95,815	213,547	375,754
Other expenses[2]	185,031	235,839	197,497	291,784
Total[3]	1,043,129	1,274,162	1,361,698	1,616,619

In constant prices based on prices of the health price index of 2007				
	1999	%	2007	%
Inpatients	921,472	78.4	949,081	58.7
Rehabilitation	44,746	3.8	375,754	23.2
Other expenses	208,345	17.7	291,784	18.0
Total	1,174,563	100	1,616,619	100

[1] All budgets in this paper are based on the data of the final budget. The budget actually used may differ from the budget originally allotted.
[2] Other expenses include: drug-rehabilitation centers, clinics in the community and autism care (and in 2007 also acquisitions of hospitalization substitutes).
[3] It is important to note that this analysis is based only on the budget given by the Ministry of Health for MH services. There are additional funds for services in the community, such as from NGOs, welfare services and health care providing organizations, mostly the Clalit healthcare provider. However, most of the budget for MH services comes from the Ministry of Health.
Source: Israel State Budget, 1999-2007 (48)

Table 4. *Government Mental Health Ambulatory Clinics, 1995-2007 [1]*

	1995	2002	2007	% of change 1995 between 2007
Clinics affiliated with hospitals	84,776	88,570	41,535	-51%
Clinics in the community	67,979	47,049	49,557	-27%
Total [2]	152,755	135,619	91,092	-40%

[1] In thousands of NIS,constant prices based on prices of the health index of 2007.
[2] In addition, there are external providers of ambulatory services such as the Association for Public Health Serices and Clalit Healthcare Provider.
Source: State Budget years 1995, 2002, 2007 (46).

This decline is even more alarming when one examines the changes in the number of positions in the Ministry of Health and compares them to the changes in the number of positions in MH services. While the total number of positions in the Ministry of Health increased during the decade from 1995 to 2005 by about 15% (from 21,795 to 26,867), MH services lost 345 positions, or 10% of its workforce, in a period of eight years (39, 48). Since so far, according to the National Health Insurance Act (5), the government has continued to be responsible for the delivery of MH services, one might wonder how to explain this decline in the number of MH government positions. Perhaps it would be safe to conclude that the reason for this change was a result of the structural and rehabilitation reforms or the expected insurance reform.

DISCUSSION

No doubt, a significant change has occurred during the last decade in the MH service system of the country. It seems that policy decisions reflected in the structural reform and rehabilitation have affected this change. However, since the insurance reform has been stumbling for the last 13 years, the other achievements are endangered, and the MH service system may experience a setback. Research has shown that a lack of adequate community MH services may result in an increase of hospitalizations (50). No one knows whether the new government and the newly-elected Knesset of 2009 will follow up on the last government decision to reform the MH system, transferring responsibility for MH services to the health care providers.

The following will discuss the hindrances and the promises of these changes and suggest what may facilitate the long-awaited objective to create strong and responsive community MH services. Some lessons which could be learned from the Israeli experience will be illuminated.

The two major changes that have been underway during the last decade, namely the substantial reduction in psychiatric beds and the establishment of a community rehabilitation system, may serve as important facilitating factors for the 13-year-long attempted MH insurance reform.

Although most indicators, such as the decline in the number and rates of inpatient services, length of stay, number of hospitalization days, longer community stays between hospitalizations, and reduction in the proportion of long-stay patients among mental hospitals' population, show that inpatient services move in the direction of government policy, i.e., becoming mainly a service for acute patients, there are still some disturbing factors. According to the latest published statistics, in 2007, long-stay patients in mental hospitals were more than one quarter of the total population in the hospitals (27%) (39). In an acute care system, this proportion of long-term patients seems too high.

Furthermore, in spite of substantial reduction in the number of psychiatric beds, no government hospital has been closed during this period. Admittedly, during the last decade, the government was able to close several private mental hospitals. However, its effort to close a major government mental hospital in the central region failed (51, 52). Countries which reformed their MH service system reduced the number of their MH institutions substantially, allowing money saved on inpatient services to "follow the patients into the community" (11, 53, 54). For example, in England and Wales, from 130 mental hospitals which existed in 1975, only 15 remained in the year 2000 (55). Furthermore, in a system emphasizing community care, one would have expected an increase in the services of day hospitals. Data do not show this (39). Also, it seems that if community MH clinics and rehabilitation services would have sufficiently increased and would function better, the rates of readmissions could be reduced. Thus, in spite of the progress towards reforming the system, there is still much to be desired.

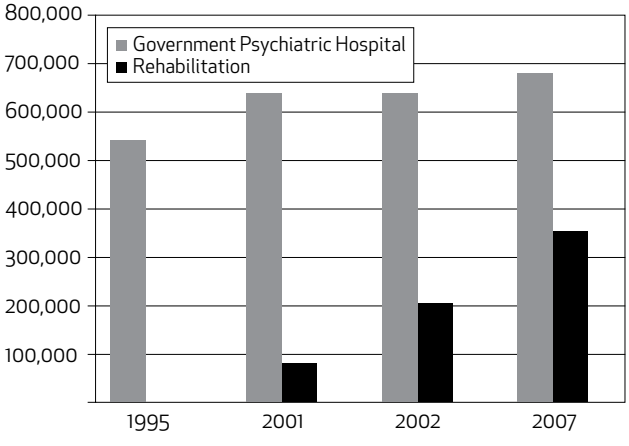
While around 90-95% of people with chronic mental illness are in the community at any given point in time (9, 39), only about 30% of the government MH service budget is directed towards community services, including ambulatory and rehabilitation services (39, 48). This distribution is different than the one in general health services, in which about half of the systems' expenses is directed towards community services (23, 24).

Also, in spite of the substantial decline in the number and rates of inpatients (Table 1), in constant prices, there was no decline (and even a slight increase) in the budget for inpatient services during the same period (Table 3). In addition, the budget for government hospitals actually increased during the years 1997-2006 (Figure 1), while during the same period there was an actual decline in ambulatory service budgeting (Table 4).

Although the decline in the number of psychiatric beds in government mental hospitals was much smaller than in private ones (23% and 91% respec-

tively) (Table 1), in no way was it insignificant. Thus, the increase of about 25% in the budget allocations for government mental hospitals (Figure 1) is noticeable and perhaps even puzzling. The explanation provided by the Ministry of Health was that government hospitals had been under-budgeted and needed additional funds in order to stabilize their budget (Department of Budgeting, Ministry of Health, personal communication, March 28, 2007). However, the timing of this increase, which happen to be during the time period the government was trying to achieve the MH reform and transfer responsibility for MH services to the health care provider organizations, makes one wonder whether this was not aimed, at least in part, at neutralizing the opposition of the strong lobby of the government psychiatric hospitals and of the Israel Medical Association to the planned reform (4).

Fig 1. *Government Mental Hospitals' and Rahabilitation Services' Budgets, 1995-2007*



*In thousands of NIS,constant prices based on the 2007 health index
Source: State Budget 1995-2007 (37)

Another somewhat disturbing fact revealed in the assessment of the data was the noticeable decline in the budget for ambulatory services (Table 4) and the neglect of developing community infrastructure for MH services (Table 5). These are contrary to trends in other countries, emphasizing the humane and economic costs of depressions and anxiety reactions and as a result investing in community MH services for what has been termed as "soft psychiatry." Recently, the U.K. government allotted £180 million in order to enhance such services (56, 57).

The neglect of maintaining at least the status quo in the level of budget allocations for MH community clinics, and the prolonged period of postponed legislation of the reform and delayed implementation of it, have had an adverse effect on MH services in the community. Furthermore, the uncertainty of whether the planned reform will be implemented at all has caused labor unrest in the clinics and affected the ambulatory services even further.

A major concern in the debate regarding the pros and cons of the planned reform was the lack of adequate community infrastructure of clinics and other community MH services necessary for a successful implementation of the MH reform. One would have expected that during the long period the reform has been debated, government would have invested in developing and strengthening community facilities. However, assessing the distribution of development budgets during the last decade or so shows almost no funds allotted for community service development. As shown in Table 5, almost all budgets went to government mental hospitals. Furthermore, it seems that it would be difficult to decide to close newly-renovated institutions, even if the MH reform calls for it.

Table 5. *Government Development Budgets for Mental Health Services, 1995-2008**

Hospitals	223,250	97%
Clinics in the community	6,750	3%
Total	6,750	100%

* In thousands of NIS, in current prices. Does not include foundations such as roads, sewage etc., only building.
Source: Department of Development and Building, Ministry of Health

While in other Western countries about 10% of the health budget is allotted for MH services (51), in Israel only 5% is. Although there is no study on this matter, it would be safe to conclude that this situation causes many people with mental disabilities to pay for services privately, or to give up on them because of a lack of resources.

Whereas the budget allocation for general health services has been adjusted for increase based on demographic changes and has an annual addition for new technologies, MH services, which according to the National Health Insurance Law remained in government responsibility, do not have such arrangements. Several years ago, the then Minister of Health, N. Dahan, transferred about NIS20 million from the new technology adjustments item for new interventions in rehabilitation services. Such additions have been a matter for continu-

ous negotiation between the MH Services, the Ministry of Health and the Ministry of Finance, and under a threat of budget cutbacks during the year.

There is no doubt that the enactment of the RMD law of 2000 was a great achievement. This law entitles persons who meet the criteria of mental impairments of 40% (as defined by the NII), to a "basket" (package) of rehabilitation services, determined by professional experts (40). However, this law and the rehabilitation system that has been established are being threatened. The government proposal for a MH reform includes items to fundamentally change the Rehabilitation Law (1, Sec. 12). It is being proposed that rehabilitation services would be contingent on budgetary allotment and administrative decision (1). Legally, the entitlement principle would not be changed. However, not providing services when needed would create a waiting list, impose burden on persons, families and communities, and may in fact cause many mentally disabled persons to be neglected and cause their condition to deteriorate. Thus, in fact, this proposed change eliminates the entitlement for the service. Comparably, it is like denying an Old Age NII's pension (to an elderly person who is entitled to it by law), arguing that no money was left in the budget for this purpose.

Establishment and early development of the rehabilitation services was based on a five year plan for gradual growth of the service. However, increase to meet the growing needs of the population not yet included in the program has not been assured, nor is the continuation of the present budget certain. Whereas, during the first five years (2001-2005) there was a budget agreement between the Ministry of Finance and the Ministry of Health for an annual increase of the budget for the rehabilitation services (38, 58), in recent years, budget allocation is a matter for negotiation. This does not allow proper multi-year planning, an essential requirement for a developing system.

In the recent MH reform plans, debated in the Knesset during 2007-2008, a planned increase of 1,200 persons each year for the next seven years was mentioned contingent to the reform being approved (59). The ground for this number of assumed increase of services has been unclear. The only possible explanation for the origin of this figure is that it was based on the average annual increase in past years and on what the bureaucrats had decided when the program was launched. One knows that the number of recipients is not determined only by demand. It can be controlled by other factors such as availability of the service or of the workforce responsible for implementing the program.

No research was done estimating the potential annual increase of persons in need of and who qualify for rehabilitation services. Nor do we know on what basis the government determined that the steady state of the rehabilitation services would be reached in seven years with an addition of 8,400 persons to the current figure of 14,000 receiving rehabilitation services in the community (58). Since the estimate of those who are entitled to the service is about 50,000-60,000 persons, it could very well be that the figure mentioned by the government is well below the actual need.

In planning adequate services for the future, one must take into account demographic changes. Based on the CBS's estimates of 1.4% annual growth of the general population, the population in Israel in the year 2020 would be 8.6 million persons (an increase of 20% from 2007) (60). Assuming the same rate of persons suffering from severe and persistent mental disabilities, the estimated number of those eligible for rehabilitation services would be 63,000-75,000 persons. One might wonder whether there have been any plans for this estimated additional demand for rehabilitation services. It is just a decade away.

The past experience of an annual increase of recipients may be a reflection of several factors such as the insufficient number of personnel administering the service. This could account for the high proportion (25%) of those who were approved to receive a package of rehabilitation services but did not in the end use the service (39; Y. Shershevsky & L. Botzer, personal communication, August 5, 2008). Regardless of what causes this situation, the fact is that the current number of annual additions for rehabilitation services is several hundreds below the actual number of persons approved for the service.

There has been insufficient monitoring and evaluation by the Ministry of Health of the different rehabilitation services, examining whether these privatized organizations observe the standards set by the Regulator and their contracts. A lack of appropriate regulation may create a situation by which instead of deinstitutionalization and community rehabilitation, trans-institutionalization may take place, resulting in creation of sub-standard "mini-hospitals" in the community (61, 62).

Furthermore, no outcome studies on MH services have been conducted, nor have criteria for such studies

been developed. The system lacks comprehensive data that would allow it to follow up on such matters as fidelity of programs, quality of life of users of the system and their mobility within the system and progress in their conditions. Admittedly, parts of the system are emergent, but it is about time these issues were addressed and acted upon (63).

There has been another serious issue in relation to budgets and services for the target population of persons with a mental disability. Once the special laws and policies are established for treatment, care and rehabilitation in the community, services previously provided by different central and local governments and civil authorities were cut, and budgets were moved by the agencies for other pressing needs, assuming the special laws must cover the needs of its target population. An example of such a trend is the decision of the Ministry of Labor and Social Affairs, announcing that persons with psychiatric disabilities are outside of its jurisdiction (64). In order to prevent any misunderstanding, the Ministry announced that it would not take on any duties within the framework of the (then planned) MH reform (65).

In view of the current effort to legislate and implement the MH reform, we must be aware and concerned that resources might be cut or removed for other purposes. As already mentioned, the proposal calls for a drastic amendment of the rehabilitation law that, no doubt, will result in reduction of services. Since the three major components of the MH service system are interdependent, this amendment would affect the inpatient and ambulatory services. Similarly, once the MH reform passes and services are transferred to the health care providers, they will compete for resources with other branches of medicine. In such competition between psychiatry and other medical specialties, such as cardiology, oncology and gynecology, it is clear who has the upper hand. Furthermore, considering the low social status of the severely mentally ill, and their social marginality, the health care provider organization might be inclined to save money, providing services at the lowest possible level. If this happens, it would have adverse ramifications for all components of MH services and quality of services would be negatively affected. I assume the Ministry of Health is aware of these problems, but is the Regulator strong enough to perform its duty vis-à-vis the health care providing agencies?

Analysis of previous efforts at MH reforms indicated that one of the major factors for failure of these efforts was the non-involvement of the Ministry of Finance (2, 4). In the recent effort, the Ministry has supported the reform. However, it seems that although improving the services might be one of the objectives, decreasing government expenditures and reducing the number of government positions in the work force in MH services might have been the Ministry of Finance's main objective. Policy studies show that saving the government money remains a prime driving force in such reforms throughout the world (12, 66, 67). Indeed, the Ministry of Finance conditioned its support and budgeting of the rehabilitation services on a substantial reduction in the number of psychiatric beds, decline in the average length of stay in mental hospitals and reduction of number of employees in mental institutions (41, 58).

Based on an average cost of hospitalization per day, using 2007 constant prices, the saving for the government during the years 1995-2007 could have amounted to somewhere around 900 million NIS. For the sake of illustration, the current average annual budget per person in rehabilitation services is about NIS27,000. This means the budget saved from hospitalizations could have given solutions for about another 33,000 people in rehabilitation services. Admittedly, not all the potential savings were realized or could have been realized due to the fact that no government mental hospitals were actually closed during this period, but it definitely looks as if substantial savings were made.

The above might be a reflection of an attitude of policy makers and, in fact, a practice that endangers the whole MH reform. Transferring the locus of MH services from a hospital-based system to a community-centered one is not just a matter of reducing the number of psychiatric beds, or shortening the length of stay of patients in mental hospitals or of saving money for the government. As important as these matters are, the reform means much more. It is a fundamental change in the culture and practice of the MH service delivery system, as well as a fundamental change in the health and welfare systems and the attitudes of the society at large toward persons who suffer from mental disabilities. Integrating MH services into the general health care services entails a major change in medical practice altogether. It requires retraining the family doctor and changing the ways in which medical service organizations operate. Furthermore, caring for people who suffer from a mental disability in the community is much more than transferring mentally ill persons from hospitals to protected living arrangements in the community. It is very easy for a system to slide

into a process of moving people from the back-wards of hospitals to the back-alleys of the community (61, 68). In the business world, in order to develop a new product, one needs first to invest; hoping to reap the fruits of the investment later. In other countries, as governments were attempting to reform MH services, they did indeed invest, providing the system with extra funds ("a hump," using an Australian expression) in order to facilitate the change (54, 55). As impressive as some of the trends in Israel during the last decade are, analysis shows reluctance on the part of government to invest in the system what is really needed in order to give the reform a good chance of succeeding.

Related to the lack of sufficient support on the part of policy makers and the subsequent shortage in funds, two additional issues loom clearly. There is a shortage of trained personnel for the new tasks in the reformed system, a need for training programs for professionals, caretakers and users, and a pressing need for research of process and outcome of new services such as CBT, family supports, case management, different components of rehabilitation services, as well as new medications and therapies in inpatient services. Although there have been some efforts in these directions, they are far from what is needed.

CONCLUDING REMARKS

Israel stands now at a crossroad. Soon we will know whether the new government will pick up where the outgoing government left off, and resume the efforts to reform the MH system. The Ministry of Finance, a key stakeholder, has been threatening that it will withdraw the proposal or block its implementation if some of the items in the proposed reform, such as the clause changing the rehabilitation law, are amended. Furthermore, even if the reform is legislated there are quite a few hindrances on the road to its implementation.

Analysis of past efforts at reform showed that circumstances, outside the MH system, might have been one of the major reasons for failure of these efforts (2, 4). The global economic crisis of 2008-2009, as well as the internal political change, may cause hesitation on the part of government to launch a structural change in the social-medical arena, committing itself to investing several hundred millions NIS during the next few years. Although there seems to be wide support for the reform, the coalition is not strongly determined to implement the reform and there has also been a strong opposition to it.

The dilemma for reform supporters is whether and how they can bring the matter to the forefront of the public agenda or whether they are completely dependent on social-environmental circumstances which are beyond their control. Evidence suggests that unless an issue is on the public agenda it is hard to recruit the political and public support needed for achieving a change (69). Given the fact that currently there is no dramatic crisis in the MH service system drawing public attention and in view of the marginality of the population for which the reform is intended, and also considering the current economic crisis, one should not be surprised if efforts to reform the MH system will be stalled.

Furthermore, as we have seen here and elsewhere, at times other issues confronting society serve also as a convenient excuse to avoid the social, professional and ethical minefield of the treatment and care for persons suffering from mental disorders (2). This leads to refraining from radical reforms and preferring a conservative approach, bringing about incremental changes (67).

Hopefully, the group that has been involved for the last 13 years in attempting to pass the reform and which may have created some commitment to the matter, as found in other similar cases of reforms (70), gives a chance to the present planned effort to reform the system. However, enacting the MH reform law will only be the first step. It will require a lot of effort, commitment and political and public support in order to overcome the perils along the way toward reforming the MH services system and improving the treatment and care for persons suffering from a mental disability, as well as enhancing their quality of life.

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COMMENTARY 1

Howard H. Goldman

Of the substance of "Promises and pitfalls on the road to a mental health reform in Israel" by Uri Aviram (1), I know nothing – or at least I previously knew nothing of mental health reform in Israel. I have no basis upon which to agree or disagree with the analysis. I have no professional experience with the mental health system of Israel. I have not studied mental health policies emanating from Jerusalem. Apart from a fellowship in 1972 while a medical student, I have not been in Israel at all. But I have a keen interest in mental health policy and mental health services throughout the world, so it is from that perspective that I comment on the thoughtful and impassioned paper by Uri Aviram.

By way of disclosure I have known and admired Professor Aviram and his work for three decades. In 2008 he wrote a favorable review of a book I wrote with the historian Gerald Grob (2) on federal mental health policy in the United States. In his paper Aviram also referenced this work and its central focus on progress due to sequential, incremental reform in the U.S., when fundamental transformation was not feasible or likely. He draws a contrast between our emphasis on incrementalism and the wish and expectation for fundamental reform of the mental health system in Israel.

It is not that I do not favor sweeping fundamental change. Often anything less than transformation seems inadequate to alter major problems in delivering mental health services. It is just so difficult to implement such radical change. Uri Aviram illustrates this point dramatically in his detailed analysis of (failed) mental health reform in Israel.

Why is fundamental change so illusive?

There is a lack of commitment and political will. What comes through the analysis of reform in Israel is Aviram's sense of frustration that little of what was expected gets implemented. He portrays a mismatch of need and accomplishment, reform repeatedly falling short. As a naïve reader, I found myself asking, "What is it exactly that needs changing? Who is concerned about the problems? Most importantly, what is the level of commitment to reform?" The analysis is not clear on these questions. The political and societal opportunities perceived by those who pressed for reform are not revealed. The paper does not really answer the critical question, "What is the basis for expecting that the reforms will be implemented?" Without the answer it is hard to evaluate the consequences of the failed reform – for the mental health system, for the service users and their families, and for the broader society.

For the uninitiated reader, the paper does not outline the vision for the reform. What are the services and the

treatment technology that will make the reform produce the intended outcomes of improved mental health for Israeli society? What will be the division of labor in the health and social service sectors to implement any reform? And who in the society cares or has a stake in the outcome? Were there divisions of opinion or strategy among the advocates and the politicians? Were there conflicts within the service provider or service user communities? Where is the political will for fundamental reform or even small incremental changes? Answering these questions may help to understand the sources of frustration of mental health advocates, reflected in Aviram's story of failed reform.

The focus has been stronger on the organization and financing of care than on the content of care. From the 1970s until the end of the century in the United States advocates and planners of mental health services, particularly for those adult service users with the most functional impairment, focused on the organization and financing of services (2). This focus tended to neglect the content and quality of care and treatment. The emphasis on organization and financing also is seen in the description of mental health reform in Israel as presented by Aviram. Most of the attention is directed on how to organize services; where to provide them, and how to pay for them. Integration and coordination become ends in themselves, as if the quality of services were already high, needing only to be connected together for service users and their families.

In the U.S. a series of demonstration programs was launched to promote integration of services within systems of care for adults with severe impairments (3, 4). The evaluations of these demonstrations concluded that it was possible to integrate services without improving measurably the outcomes for service users. The quality of clinical services is limited; there has been a substantial gap between what we know is effective and what is delivered in routine care (5). Similar demonstrations to integrate mental health services for children produced the same results (6). In the wake of these lessons, mental health services have shifted attention to the content and quality of services. This movement toward implementing evidence-based services is somewhat more pronounced in services for adults. Service reforms for children still emphasize integrated systems of care and wrap-around services, while they also work to develop evidence-based services.

Aviram's analysis briefly breaks away from the almost exclusive focus on organizing and financing care in the paragraphs just before his concluding remarks. After discussing the shortage of resources he argues that two issues "loom" for the future: The lack of a professional workforce capable of delivering high quality services in a reformed system of care and the continued need for more research to provide the evidence-based treatments and services for the future. These are points in common between Israel and the U.S. – and perhaps the whole world of mental health service delivery. I think that this is the most favorable area for policy intervention, and the most important for improving the outcomes of treatment.

There is a lack of appreciation of the potential impact of a well-orchestrated sequence of incremental changes. The 13-year history reviewed by Aviram parallels a similar period in the U.S., where there was a more successful outcome but with a more limited objective. During this period advocates worked for passage of so-called "parity" legislation to improve health insurance coverage of treatment for mental illness, covering services for mental disorders on the same basis as other medical conditions. In 1996 a federal parity law was passed that focused only on annual and lifetime limits on payment for treatment of mental illness. Dissatisfied with this partial success, advocates pressed for comprehensive parity on a wide array for fronts – in State insurance regulations, in private coverage for federal employees, and back in the U.S. Congress. They succeeded in 2008 with the passage of comprehensive parity in Medicare and in private insurance. The 1996 law had followed a series of incremental changes in Medicare and in the various States starting in the 1980s, and the incremental reforms of the more recent interval culminated in the comprehensive reforms of 2008. These successes demonstrated that reformers persevered, having learned the lessons of "inching forward" in a sequence of incremental steps (2).

Every political context is different. What worked for parity legislation in the U.S. may not work in other countries, such as Israel. Fundamental reform may be possible elsewhere, but Aviram's analysis reflects the frustration of failed comprehensive reform in Israel. It also reflects the author's profound commitment to improving mental health services.

Where are we headed in the United States, and are there lessons for Israel?

The passage of mental health insurance parity legislation in 2008 provides a foundation for considering mental health benefits in the newly passed health insurance reform of 2010. Mental health policy in the U.S. has

made progress in conservative times by having a vision of a model mental health service system and working toward that vision in piecemeal fashion. The results have not always been ideal or even as intended, but slowly the mental health service system has changed. In their book, *Better but not Well,* Richard Frank and Sherry Glied demonstrate that in general the mental health of the American people is better now than it was in 1950, although those with the greatest impairment remain at risk of a poor quality of life and limited access to services and benefits (7).

A presidential mental health commission during the Bush administration produced a report with a set of nonpartisan recommendations. Together with the parity legislation of 2008 these recommendations serve as a blueprint for change in the next decade. The past decade in Israel has also witnessed efforts at mental health reform, but without a successful outcome. I think the lesson from the U.S. is the importance of a blueprint with wide support and an impressive imprimatur. When political opportunities arise, a blueprint can guide reform toward a consensus vision of a better future.

In both Israel and the U.S. there are new government administrations, facing extraordinary challenges. Uri Aviram suggests that the current global fiscal crisis may make leaders in Israel hesitant about social change. In the U.S. the crisis seems to have created a political opportunity for substantial reform. Whatever the political climate, any significant reform legislation will require a commitment to implement changes in mental health policy. Let us hope that the commitment will match the promise of better services. We are more likely to get there with the prodding of thoughtful policy analysts like Uri Aviram.

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COMMENTARY 2

Julian Leff

Uri Aviram identifies four failed attempts in the past four decades to reform the Israeli mental health system. In discussing this problem Aviram focuses mainly on people with severe and persistent mental illness. The official policy in Israel has been the integration of mental health services into the general community based healthcare systems. Aviram identifies the first attempt to achieve this as the Tramer Plan initiated in 1972 and based on the U.S. program of community mental health centers (CMHCs) backed by President Kennedy. It is unfortunate that this American policy was chosen as the model for Israel, since it was doomed for failure in the U.S. The CMHCs were staffed by enthusiastic young people brought up in the 1960s and with an agenda to radically change society. These idealists found themselves faced with the opposition of powerful vested interests, which they lacked the experience to challenge successfully. Furthermore the U.S. healthcare system was, and still is, largely provided by private insurance companies which anticipate no profit from chronic mental illnesses so exclude them from coverage. Eventually the CMHC movement was fatally undermined by the misappropriation of a large part of its funds by President Nixon. It would have been more appropriate for the Israeli government to formulate its plan on the U.K. system, since both countries have the advantage of a national health service, although organized differently.

In fact this was the next attempt to achieve reform: the Israeli Ministry of Health forged an agreement in 1977 with Kupat Holim Clalit, which provides health cover to 80 percent of the population. The agreement was that Kupat Holim, an arm of the labor union, would provide free mental health care and be reimbursed by the government. However, Kupat Holim opted out of this agreement, passing back to the government responsibility for the provision of mental health care. A third effort to affect a shift in focus to community based

services hinged on reform of the insurance system, but this too failed. Aviram places the responsibility for these failures on lack of cooperation by the Ministry of Finance. He cites the stigma of mental illness and its low priority for the public as contributory factors to the lack of will in the Government to ensure solid backing for the attempted reforms.

The success of the deinstitutionalization policy in the U.K. was largely due to consistent advocacy by successive governments, both of the right and the left. This unusual, perhaps unique, consensus was due to quite different thinking. The right believed, incorrectly, that money could be saved by closing the psychiatric hospitals. In fact the cost of a good standard of community care is equivalent to the cost of long-stay care in a psychiatric hospital (1). Only a poor level of community care saves money. The policy of the left was inspired by consideration for the civil rights of people with a mental illness. Yet last year the Labour Government implemented an Act allowing medication to be given compulsorily to people in the community, despite vigorous opposition by the Royal College of Psychiatrists. There is a parallel here with Israel in that threats of violence against the population, missiles in Israel, terrorist bombing in the U.K., by creating an atmosphere of fear can adversely affect policy relating to mental illness.

There does appear to be some optimism that the Israeli Government is now intent on facilitating the shift to community based services through its own measures instead of relying on reluctant partners. The figures given by Aviram for inpatient beds, length of stay, and the closure of private hospitals chart a move away from the reliance on psychiatric hospital care. On the other hand, the increasing readmission rate suggests that there is a problem with what came to be called the "revolving door patient" in the U.K. and U.S. systems of care. This resulted from a policy of brief admissions without adequate support services in the community. During frequent visits to Israel over many years I learned that rehabilitation services were poorly developed and very unevenly distributed. This unsatisfactory situation has been improving recently as a result of the RMD2000 Law. However, establishing all the components of a community based mental health service and ensuring that they work together smoothly and efficiently is a massive task which takes considerable time and the investment of substantial funds. In England and Wales, where this policy has been implemented over more than fifty years, with the closure of almost all the 130 psychiatric hospitals, "work rehabilitation programmes are poorly developed and unevenly distributed, and many specialized rehabilitation professionals, such as occupational therapists, are now working as generic mental healthcare workers" (2).

Aviram notes that in 2003 almost half the population in Israeli mental hospitals were long-stay patients. In the U.K. program it became evident that the least disabled patients were discharged first, leaving a residual population of those who require the most support services in the community. These "difficult to place" patients include a substantial proportion of the "new long-stay" who have been admitted to acute wards fairly recently. It must be recognized that such patients continue to arise in the community after the closure of psychiatric hospitals and that they occupy acute beds on admission wards for long periods of time. An additional demand on admission services stems from the fact that even when previously long-stay patients are settled in sheltered accommodation in the community, crises arise requiring admission to hospital. We found that for every 100 long-stay patients discharged to the community ten were in an admission ward at any one time (3). These two factors have produced a serious problem in the U.K. since they were not anticipated in the planning process, and indeed admission beds were reduced for no reason other than to save money. For some years throughout the U.K. many admission wards have been running at 120% occupancy, necessitating the admission of acute patients to private hospitals at a cost to the National Health Service. There are possible remedies for this problem: a number of innovative alternatives to hospital admission have been tried and found to work, for example the acute day hospital, crisis houses, crisis homes, and 24-hour home treatment teams (4). Difficult to place patients can be moved out of hospital after a period in a specialized rehabilitation facility, which ideally should be placed in the communities from which the patients were admitted (5).

As Aviram states, opposition to deinstitutionalization can arise among professionals who have a vested interest in maintaining their hospital beds, which are seen as a source of status. In the reprovision program in north London the psychiatric specialists in one of the psychiatric hospitals scheduled for closure went on strike and refused to allow any outside agency to assess their patients for suitability for discharge. The strike collapsed after six months and the hospital was eventually closed, demonstrating that managers in

the National Health Service have more power than the psychiatric specialists, one result of the Thatcher revolution. The other major source of opposition stems from the public, many of whom associate mental illness with violence. It is crucial to alter these stigmatizing attitudes, not only to ease the inclusion of discharged patients in the community, but also because public opinion can influence government policy in a democratic country such as Israel. It has been shown that small scale educational programs targeted at specific groups are much more cost-effective than national campaigns (6, 7).

While every country has a unique health system and set of governmental priorities, there are sufficient similarities between Israel and the U.K. for the former to learn from the mistakes the latter made in implementing one of the most comprehensive deinstitutionalization programs in the world.

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COMMENTARY 3

Mordechai Shani

Until the end of the 1990s mental health services in Israel was a neglected field.

Contrary to the opinion of Prof. Aviram, no serious efforts to reform the mental health services in Israel were made prior to 1995. The director of the mental health services in the Ministry of Health (MOH), Dr. Tramer, who desired to make changes (The Tramer Plan) did not receive any support from the Ministry of Health leaders. An agreement signed five years later by the Director General of the MOH and the director of the Kupat Holim Clalit – the Menczel-Doron Agreement – was void of any meaning other than being a declaration. The treasurer of the MOH did not sign this agreement and practically no budget was allocated for the idea's implementation.

The Netanyahu Commission, which investigated the health services in Israel, devoted a full chapter to the issue of the neglected field of mental health services. However, even when enacted, the National Health Insurance Act postponed the transfer of mental health services to the Kupot Holim.

During 1995 there was tremendous pressure to transfer the insurance of mental health services to the Sick Funds. However, I am delighted that my colleagues and I failed in this endeavor. Since there were thousands of patients who had been hospitalized for years, the Kupot Holim refused to become responsible for their insurance. Therefore, a solution was devised that would keep these patients under the auspices of the Ministry of Health. Such a ridiculous solution would prevent the enactment of the Rehabilitation of the Mentally Disabled in the Community Law (RMD).

During 1996 it was becoming clear that nobody in Israel could give a clear assessment of just what was wrong at the root of mental health services. A committee comprised of the Ministry of Health and Ministry of Welfare failed to define how many psychiatric patients in the community needed rehabilitation.

A demonstration project, therefore, was established by the MOH and the Ministry of Finance. Sixty million shekels were allocated to the rehabilitation of mentally ill patients provided they fulfill two criteria:

1. They have at least a 40 percent disability pension due to mental health problems.
2. Their disability pension was not recognized by the National Insurance Institute (NII) prior to January 1, 1997.

This draconic limitation was implemented since the leaders of the project were fearful, due to the limited budget at their disposition, of an influx of thousands of patients who were recognized before January 1, 1997.

The lessons learned from this demonstration project had a strong impact on the proposal for the Rehabilitation

Law of the Mentally Disabled Act, led by Member of Knesset Tamar Gozhansky.

Consequently the RMD abolished the draconic limitation of January1,1997, but kept the 40 percent disability pension as the lower limit of eligibility.

The implementation of the RMD was linked by the Ministry of Finance to a proposed reform of psychiatric hospitals. This linkage enabled two important reforms of the Israel Mental Health System between 2001 and 2006.

Here, the targets were as follows:

- To gradually allocate funds for the RMD, reaching 300 million shekels in 2005.
- To transfer all patients not suffering active psychiatric disease from hospitals to protected shelters.
- To gradually reduce patient's length of stay in psychiatric hospitals.
- To reduce the frequency of readmissions.

The implementation of the RMD proved successful, placing 7,800 patients in protected shelters, and a budget of 400 million shekels in 2009.

At the same time there was a substantial increase in the number of places in protected shelters, there was a parallel decrease in the number of beds in psychiatric hospitals.

As Prof. Aviram described, there is a gradual decrease in the number of beds in mental health institutions. This pace has increased from 2000; thus, from a peak of 2.38 beds per 1,000 in 1970, we have reached a ratio of 0.47 per 1,000 in 2008.

Currently, only patients with active disease are hospitalized. While in 2000 there were more than 2,300 patients who were hospitalized longer than a year, in 2008 their number was 950. This seems to be the stable level of acute patients who have an active disease longer than one year.

Furthermore, the average hospitalization of adults hospitalized under a year decreased from 38 days to less than 33 days.

There was, however, a failure in decreasing the revolving doors. The aim was to reduce the revolving door within 30 days after discharge from 18 to 12 percent, and within 31 to 180 days from 43 to 36 percent. Most of the high readmission rate occurs within 30 days from hospital discharge.

There was practically no improvement in the 30 day readmission rate. The dominant factors in this are the hospitals, whether in regards to the preparation of patients for discharge, or the integration with community services.

An additional achievement of the structural reform was the closure of private psychiatric hospitals. The only private psychiatric hospitals currently functioning are for the mentally retarded with severe personality disorders.

As Prof. Aviram elaborated, the transfer of the insurance responsibility from the government to the HMO has not been completed. The early dismissal of the previous Knesset prevented proceeding with the issue of getting a bill for reforming mental health passed in the Knesset.

Prof. Aviram believes that the failure of the transfer of insurance responsibility of mental health services to the HMO is due to the circumstantial and contextual factor. Recently the annual conference of the health system at the Dead Sea devoted itself to discussing the failure of the health system's various reforms. The general notion was that it is very difficult to introduce reform in Israel's public service, and that, in general, it is very difficult to introduce reforms in health care systems across the western world.

One must also recall that two reforms – that of the RMD and that of psychiatric hospitals – were successful.

The global financial crisis does not have an impact on the failure, since, even now, the Ministry of Finance remains committed to this change and has allocated the necessary funds.

It was interesting to hear former Member of Knesset Ran Cohen speak at the Dead Sea Conference. Ran Cohen headed the subcommittee of the Welfare and Health Committee of the Knesset, which considered the amendments. During his speech Cohen said he was originally antagonistic to the reform, since he viewed it as privatization that would cause damage to the patients and problems to the RMD. However, after learning all of the details and the various amendments to the proposed law, he became an ardent believer in the law.

It is too early to predict whether the government will continue with the legislation to transfer the insurance to the HMO.

It should be recalled that also in the Netherlands, reorganization of the mental health services insurance was enacted only in 2008 (1).

However, even if the insurance should not be transferred to the HMO, I do not see any possible damage to the two successful reforms. There is constant supervision of data and, in spite of the data presented by Prof. Aviram, until June 2009 there was no negative effect of the RMD or on increasing the burden of hospitalization. The hospital admission rate, occupancy and average length of stay are stable.

Even if the legislation should pass in the near future,

the actual process of integrating mental health services into primary care is a long one.

In Spain, the 1986 General Health Care Act reorganized the country's health insurance, and the completion of the Health Care Decentralization to the 17 autonomous communities was completed in 2002. However, the absence of psychological and social services being integrated with primary care remains the norm rather than the exception (2).

There is, therefore, a strong committee in the Ministry of Health which will supervise the outcome of the reform and no funds will be allocated to other purposes from psychiatry.

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COMMENTARY 4

Gaby Shefler

Why did the Insurance Reform in Mental Health in Israel fail?

The paper by Aviram is a retrospective survey that follows-up 15 years of prolonged failure of the Ministry of Health to implement the National Health Insurance Act (NHIA) on Mental Health. Two major reforms were planned: (a) dramatic decrease in the total number of psychiatric beds (known as the *constructional reform*) and (b) transfer of the responsibility for all mental health services from the government to the medical insurance companies (the *insurance reform*). These changes were planned to catch up with international policies where the main avenue for mental health care is in the Community Mental Health Centers (CMHCs) and primary medical care.

In the 1990s, mental health services in Israel, both psychiatric hospitals and community facilities, were highly developed, with national and international recognition of their achievements (1-5). Many clinician-researchers achieved recognition in international professional organizations, psychobiological researchers such as Belmaker, Zohar, Kaplan De-Nour, Lerer, Klein and Shalev, and psychotherapists and psychoanalysts such as Moses, Klein, Noy, Winnik, Zellermayer, Ilan and Gumbel.

The Netanyahu Commission Report (6) had two major criticisms of CMHCs: (a) the weight of professional mental health services in Israel was provided by hospitals and not by CMHC, (b) a lack of CMHC services in the peripheral areas. Lack of services in the peripheries is characteristic not only in regard to CMHCs but also general medicine, education and culture. Although the resolution of this inequality could have been carried out by the Ministry, it was this detail that was held up as a trigger for these two major reforms. Neither the Netanyahu Report nor any of the articles written by supporters of the insurance reform (7, 8) criticized the professional level of the CMHCs.

The Ministry of Health and its mental health services division were very enthusiastic to implement the NHIA. In addition, they sought to transform the mental health services division from active responsibility for the hospitals and CMHCs into a ministerial unit that plans national policies regarding mental health, and supervises their implementation (as recommended by the Netanyahu Report).

The constructional reform was successfully implemented. Table 1 in Aviram's article shows that within 10 years the number of beds decreased by 48%. A more detailed look, however, shows that 91% of the private beds were closed while only 23% of government and 24% of public psychiatric beds were closed. These numbers create bias in the costing of the change: One would have expected that a 50% reduction in the number of beds would result in an equivalent reduction in the in-patient budget, which did not happen. The closed beds were in institutions that ran at very low standards and very low cost. It was the Ministry of Health that had, in the first place, created these two levels of poor and rich psychiatric hospitals, and by selective closure of low cost private psychiatric beds, the hospital budgets were unchanged. The constructional reform succeeded because it was professionally justified, and because it was directed by the "experts" – the directors of psychiatric hospitals. This did not lead to a shift of budget to CMHC, Table 5 shows that in the same period 97% of the total budget was allocated to hospitals and 3% to community care. Not one psychiatric government hospital was closed. Of interest,

despite the bed reduction, the total number of patients did not change, implying that the hospitalizations became much shorter. The closure of beds must have resulted in more patients attending CMHCs, and yet the budget for CMHC not only did not grow but was reduced by 40% over 10 years (Table 4).

The insurance reform is a form of privatization of a government service, but with a strange basis: the government will pay the insurance company *en bloc* for the expected treatments for the whole year, and the insurance companies will be responsible to supply all mental health services according to an agreed services basket, most of which they will purchase from professionals organized in various forms. Instead of improving the efficacy or the transparency of decisions taken in CMHCs, the ministry planned to shut down all the government CMHCs. This drastic move, later canceled, could only be understood as a declaration that the standards of CMHCs over the decades were inadequate and their replacement would be an improvement.

CMHC providers were concerned about the services basket – what is included and what is excluded, and who are the professionals who deliver those services. It was clear that the insurance companies sought a minimum basket of services, and started planning and compiling lists of independent professionals to supply cheaper services for various forms of psychotherapy.

The process of implementing the insurance reform was run mainly by psychiatrists, most of them past and present directors of psychiatric hospitals, while most of the professionals within the community services were excluded from the discussions and decision-making procedures and I see it as one of the major reasons why it did not work. The insurance reform is a political rather than professional act, directed with power and arrogance, but with little professional expertise. There are many additional reasons for the failure of the insurance reform: the refusal of the Finance Ministry to provide the additional budget required, the resistance of the CMHC directors, interest groups such as patients and their families, and professionals worried for the future of patients and professionals. The professional standards achieved in community psychiatry were threatened, with the possibility of staff losing their jobs, and CMHCs shutting down.

CMHC workers were convinced that when the medical insurance companies would become the paymasters for community mental health, due to budget considerations they would do everything possible to limit and minimize their obligations toward the patients. Diagnostic groups were excluded from treatment: situational crises and adjustment disorders (i.e., people suffering after aggression or sexual abuse, unemployment, patients suffering responses to physical illness, stress due to social factors, etc.). Psychotherapy in various forms and particularly long term dynamic psychotherapy were threatened from several quarters: (a) The health insurance companies started encouraging GPs to perform crisis intervention based on medication and basic skills of therapeutic relations. From personal communications with GPs, and statements made in the Committee of Labor, Health and Welfare at the Knesset, it is clear that primary care physicians have neither the time nor the training for such interventions. Goldfracht et al. (9) surveyed 99 primary care physicians and found 37% had little interest in treating mental health problems, 47.7% thought these issues best treated in CMHCs, and 43.3% declared they have experienced personal difficulties in treating psychiatric and mental health patients, while 85% identified time constraint as a major barrier in the care of mental health issues in primary care. (b) A major decrease in training and supervision hours will restrict the level of psychotherapy and (c) parts of the new services basket were based on very general assumptions of the usefulness of short term treatments. These considerations were superficially calculated and were settled by a fixed limit of the number of therapeutic sessions each person is entitled to (usually 24). These decisions were not taken with regard to research findings in Israel (10, 11) that showed that time limited psychotherapy is suitable for only about 20-30% of the patients in an average CMHC assigned to dynamic psychotherapy.

The years have passed, governments and health ministers and directors of the services have come and gone – and the insurance reform has not proceeded, despite the effort invested by administrators and professionals in the ministry and the Reform Advisory Board.

Roe et al. (12) state that no empirical evaluation of psychiatric rehabilitation was performed in Israel since the implementation of the Rehabilitation Law. During such a long period one would similarly expect that the ministry would initiate studies in order to know empirically about outcomes and efficacy of various modalities of treatments, the proportion of the population referred to CMHCs, etc. The only study we are aware of (13) found that 46% of a representative sample of Israel residents prefer to consult on mental health issues with experts in CMHCs, while only 35% prefer a primary care clinic.

From those of the sample who had received treatment in a CMHC, 78% were satisfied with the service.

One of three blocked health reforms that were analyzed in a 2009 conference was the insurance reform in mental health services. The presenters stated that: "Many factors contributed to the blocking of the insurance reform, and the main factors are: (a) complaints of many of the participants in this reform of 'lack of transparency,' (b) lack of reliable and available data to all the participants, and (c) lack of research base" (14, p.34).

High levels of stigmatization and stereotyped thinking typify Israeli society (15, 16). Despite these findings, the increase in numbers of referrals to CMHC indicates that patients are not stopped by stigma in referring to CMHCs. A growth in the number of patients in government CMHCs between the years 1999 (46,961 patients) to 2005 (66,762 patients) reflects an increase of 42%, and a decrease of 5-8% in these numbers towards 2007, a decrease explained by technical reasons of computers systems (17). This growth suggests stigma does not deter referrals to the present system.

The Ministry of Health in an attempted unilateral action submitted the insurance reform as a bill of parliament and in 2005 the Knesset approved its first vote. The committee for labor, social and health affairs wisely decided to transfer the proposal to a sub-committee headed by MK Ran Cohen for further discussions. The discussions of this subcommittee took over six months and every detail was debated. This process revealed the intentions of administrators versus CMHC professionals, consumer organizations and the complex motives of the reform planners, government and medical insurance companies.

Important issues remain unresolved in regard to the insurance reform: confidentiality in that the identity of patients in CMHC care were not known to the insurance companies, out-reach in response to calls from the community and the management of uncooperative patients.

From an economic viewpoint, the insurance reform is bound by needs versus budgets. As in politics, conditions are viewed in a narrow lens and may create irreversible problems. If the insurance reform is carried out, due to the very limited resources allocated for professional staff training we may find ourselves with no continuing professional education, and in the future a massive dearth of professionals. In the short term, there will be a decrease of students and interns applying to the helping professions. The medical insurance companies claim (rightfully from their perspective) that they are responsible only for mental health service delivery and not for training and research, goals usually taken care of on a national scale by the state and the government.

The insurance reform has not been implemented, although some improvement in controls, reporting and organizing systems were adopted during the preparations for the reform. On the other hand the government strangled the CMHCs both in manpower and in morale, and, although no CMHC has been closed as planned, in many CMHCs there is a severe shortage of manpower and decrease in staff morale. Thus far, there has been little benefit from the reform process but a lot of harm. This prolonged process in which the staff of CMHCs was reduced (as a preparation for handing over responsibility to the medical insurance companies), retiring or resigning staff were not replaced. In addition to the demoralization among the staff and functional decomposition of the CMHCs, this created prolonged waiting lists for psychotherapy, and refusals of treatment due to lack of personnel.

By allocating the budgets that were allocated to the insurance reform, and by engaging the professional skills and motivation of CMHC staff, the deficiencies of CMHCs could be repaired. Mental health, and especially community mental health, are not profitable, and should not be privatized. It should remain under the auspices of the government.

The Ministry of Health should open new CMHCs in the periphery. Training programs for mental health practitioners in all professions should remain the responsibility of the ministry. Leaving the training in one hand and the supply of services in private economics-driven agencies will lead to a decrease in the availability of these services to the public, and will set us years back.

The insurance reform was not planned as a benign professional reform, rather an oppositional antagonistic act against what was taken to be an ineffective service.

I think that the Ministry of Health cannot discharge itself from the responsibility of this non-profitable crucial service, and it has to continue to administer CMHC services with improvements, incorporating new intervention methods, and with cooperation of the CMHC professionals in order to regain its previous professional level and pride. Any other option is less desired, as proved by the endless unsuccessful efforts with no result to implement the insurance reform.

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AUTHOR'S RESPONSE

Uri Aviram

Unfortunately, since this article was accepted in September 2009, the saga of attempting a mental health reform has continued. Recently, however, after a year and a half of hesitation and indecision, the government has decided to pursue its attempt to reform the mental health system, and has asked the Legislature to renew the legislative process leading to the planned reform (1, 2). We have yet to witness the completion of the process, the enactment of the reform, and, of course, its implementation However, there seems to be some hope ahead.

There is no doubt that when planning a reform, the social and political conditions and circumstances of the country need to be examined. Leadership, commitment and ongoing political support are a necessary condition for the success of any attempt to bring about substantial change in mental health services.

As can be inferred from the commentators, we can learn about the field of mental health services from the experience of the United States and of Britain, as well as other countries such as Holland. Unlike Israel, Britain succeeded in closing down most of its mental health hospitals.

Similarly to what occurred in the United States (3), the initiators and planners of the reform in Israel believed that the organizational and financial changes would lead to a change in the nature and quality of the services. However, as Howard Goldman stated, other countries' experience shows that organizational and financial changes do not guarantee the quality of care in mental health services. These lessons must be remembered once the planned reform in Israel moves to the implementation stage.

Furthermore, it seems that some of the supporters of the reform are also interested in a financial saving for the government's treasury. It is appropriate that decision makers in the field of mental health in Israel take into account Leff's comment regarding the cost of appropriate community mental health services.

Of the two Israeli commentators, Mordechai Shani supports the reform, and was one of its designers, and Gaby Shefler opposes it. Although I disagree with the latter's negative stance regarding the importance of the insurance reform, and consider the integration of

mental health services with general health services, and transferring the responsibility to the healthcare providers as a crucial part of changes needed, I do agree with some of his comments regarding the quality of care, the need of a clear definition of the range of problems to be taken care of in the mental health system, and the standards of manpower and its training.

Gaby Shefler positively notes the structural reform, but ignores the rehabilitation reform, which was a necessary, though not the only, condition for the success of the structural reform. In addition, the picture Shefler presents regarding the quality of ambulatory services in mental health may be misleading. Though there may be a high level of treatment knowledge, his evaluation of the level of the system's functioning and its organizational efficiency is surprising. The supply and extent of services is far from satisfactory and the budget for community clinics decreased in the last decade. Previously also, the supply of services was far from satisfactory. The waiting time for receiving treatment has become longer, and the fact that many people who had the financial resources were forced to turn to the private market, while others who didn't have the resources to do so remained without treatment, implies that the community system is lacking.

Gaby Shefler wishes to broaden the diagnostic categories included in the legitimate subjects for treatment in the suggested reform, and to enable long-term psycho-dynamic therapeutic technologies for use in services rendered. The range of legitimate problems for treatment in the framework of community treatment services is an important subject worthy of a serious discussion. However, it is hard to believe that in the existing financial reality, with the manpower employed, the priorities needed and reliable and valid knowledge in the field, adopting long-term psychodynamic treatment methods is possible or even worthy.

I am doubtful if the main or only motive of government mental health clinics' psychologists' objection to the insurance reform in mental health is due to their concern for the level and quality of services or the needy population; and not also driven by an interest to keep their autonomy and professional monopoly along with a financial interest of preserving the private mental health market. However, they are justified in their concern over the conditions of their future employment, and the government must be sensitive to these concerns.

I do agree with Gaby Shefler's comment on the ongoing harm for ambulatory services and its effect on the level of mental health services which is offered. The mental health system – hospitalization, community clinics, and community rehabilitation – is an integrative system. Inadequate functioning in one of the components harms the others. It may be that the phenomenon of the "revolving door" and the fact that the structural reform hasn't stood up to part of the expectations regarding recurrent hospitalizations and living in the community as Mordechai Shani states, can be explained by a failure of the ambulatory and rehabilitative systems.

It may be true as Shani says that since the 1990s there is more interest in mental health, partially due to the Netanyahu Committee (4) and the National Health Insurance Law (5). However, I disagree with his opinion that prior to this period there was no interest in the mental health system in and no attempts to change it.

Although it is true that during the 1990s there was a turn-around in the stance of the Ministry of Finance, and its involvement is crucial for implementing changes in the system; during the 1970s, there were also significant attempts at a reform. There is empirical evidence that Dr. Tramer, the head of mental health services in the beginning of the 1970s, had support and backup from at least part of the leadership of the mental health services as well as from the heads of the Ministry of Health (6). Direct funding from the State's budget isn't necessarily a condition or an exclusive catalyst for a reform. In the case of Tramer's reorganizational plan, one of the factors assisting support in the plan was the fact that it enabled raising philanthropic contributions for developing the plan, which in turn, assisted in financing the regular mental health services as well as in developing new community service plans in mental health (6).

Contrary to Mordechai Shani's claim, the agreement signed in 1977 between Menczel (Director General of the Ministry of Health) and Doron (Head of Kupat Holim Clalit), also had the support of the Ministry of Health. In the beginning it was also funded by the budget, however later, because of a technical problem of a missing document, and/or a change of stance of the Ministries of Health and Finance, it wasn't financially honored. I have no reason to doubt these facts, as Shani was the Director General of the Ministry of Health after Jacob Menczel served his tenure, and he was probably involved or even responsible for Ministry of Health's change of stance on the matter. This being said, when the agreement was signed, the heads of the Ministry of Health, including the Minister serving at the time, backed up the agreement and supported it. In addition

to their desire to improve mental health services, which were in bad shape at the time, and their desire to implement the Tramer plan, they saw in the plan a preliminary attempt to implement a national insurance plan, which Victor Shem-Tov, the Minister of Health at the time was trying to advance. Because of Clalit's objection to legislate a national health insurance law at the time, and because of its dominance in the country's healthcare system, the Ministry of Health thought that the regional organization of mental health services, included in the plan, could be a step towards the desired change in the overall health system. In the eyes of the mental health services, the plan had an influence on regional distribution of the services. This influence expressed itself mainly in geographical regions with excess numbers of inpatient beds, and where arrangements between service suppliers needed to be negotiated.

Formally, the Ministry of Health decided not to respect the agreement, however Clalit healthcare services didn't agree to the interpretation and the decision of the Ministry of Health. In years to come, during the budget discussions between Clalit and the Ministries of Health and Finance regarding the coverage of the yearly deficit of Clalit, the latter turned in the bill for psychiatric services as included in the general deficit calculation. Thus, during many years, the psychiatric services and their budget were taken into account while calculating the State's support for Clalit. Only after twenty-five years, following rulings of the district and supreme courts (7, 8) the fields of responsibility of the healthcare providers and of the State regarding supplying and funding mental health services were determined clearly, and the disagreement regarding the interpretation of the Menczel-Doron agreement came to an end.

As these lines are being written, the fate of the mental health reform is still not clear. Sixteen years have passed since the country's legislature decided within the National Health Insurance Law that during a period of three years, mental health services will be transferred to the responsibility of the healthcare providers. As shown, a number of government decisions, and a first reading decision of the Knesset (9), didn't bring an end to the process. It isn't the place in this document to analyze the reasons for the situation and its meaning for mental health services or for policymaking in general in Israel. However, it is important to emphasize that continuation of this situation of a lack of decision, which brings about damage and demoralization among the mental health workers and in the system in general, also risks the reforms achieved so far, and gravely harms the people in need of the mental health system.

It may be, as is the opinion of Howard Goldman, that the chance for a radical reform in mental health is slight. It may be that incremental reform of the system is the realistic and optimal alternative. Howard Goldman justly states that there is a need for a comprehensive plan which will clearly elaborate a vision and goals, and with time – when there is a political opportunity for implementing the plan or parts of it – it will be presented and implemented. In order for this to happen, in addition to a detailed contingency plan, there needs to be a professional bureaucratic and civil lobby, which will be ready to organize and take advantage of a political and social opportunity in order to promote the change in mental health services, and improve the treatment and care for people who suffer from psychiatric illnesses and mental health problems in general.

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