

Mr Chairman, Ladies and Gentlemen,

We have been examining for several days now at this conference, why it is that reforms are so difficult to put into practice and have asked whether the era of reforms is over. My research on mental health reform here in Israel sheds interesting light on the stakeholder role in this question.

The story begins with the enactment of the Israeli National Health Insurance Law in December 1994 (nineteen ninety four). The law came into force on January first, 1995 (nineteen ninety five). It provides a basket of health services to which each citizen is entitled by registering with one of four healthcare insurance providers.

The law, as enacted, contained a second schedule itemizing the basket of services to be provided by the healthcare providers and a third schedule listing those services that would remain the

responsibility of the State. These were the psychiatric, geriatric, public health and rehabilitation equipments services. When the then Minister of Health, Dr. Ephraim Sneh presented the law on December twentieth 1994 (nineteen ninety four) this separation between the treatment of physical and mental healthcare met with strong objections by an influential body of Knesset members. It was very effectively argued that the situation where healthcare insurance providers would look after physical health while mental care would remain the responsibility of the Ministry of Health, that is of the State, was not viable. The result was that Dr. Sneh promised the Knesset that psychiatric treatment would be transferred to the healthcare insurance providers' basket of services with, quote, "a slight delay". These were his precise words. The upshot was that the law's provision of a three year period of grace for healthcare insurances to bring their basket up to standard was understood to apply to the transfer of the State's responsibility for mental health services as well.

I stand before you here today, 12 (twelve) long years after the Law was enacted and it will probably come as no surprise that up to this very day the separation between physical and mental treatment remains – the healthcare insurance providers are responsible for the body and the State continues to be responsible for the mind. During this whole period, since the first of January 1995 (nineteen ninety five) and until today there have been no less than twelve 12 target dates for the transfer to be carried out. It simply hasn't happened. But I have some good news: the good news is that the 13th (thirteenth) target date is almost upon us. It is now only two weeks away on January 1st, (first) 2007 (two thousand and seven). The bad news is that right now, as I stand here, it is not certain that it will really happen in two weeks time.

The situation is in fact much graver than it sounds. Mental health is in any case a neglected and problematical field. The fact that it has been on the verge of being transferred from the Ministry's responsibility to that of the healthcare providers for endless years

has meant that neither party was willing to invest time, energy and resources until the transfer materialized. Meanwhile, as long as psychiatric treatment remains the responsibility of the State it undergoes both overall budgetary cutbacks mandated by the Ministry of Finance and minimal incremental budgetary supplements. On the other hand healthcare providers budgets are increased in accordance with predetermined indexes incorporated in the National Health Insurance Law. In addition healthcare providers must comply with the law's stipulations for accessibility and availability and can be sued in court for non-compliance. The State has no such constraints. Its services are limited by budgetary requirements rather than objective and legally binding criteria.

The purpose of my research on Mental Health Reform in Israel and the Attempts at its Implementation was to find out the reason why the reform was not implemented despite the widespread agreement on its importance. The first recommendation out of the ten proposed by the WHO (world health organization) in its report on

mental health of 2001 (two thousand and one) is the integration of physical and mental health services. My research looks for an answer why even 12 (twelve) years after the law's enactment physical and mental healthcare services have not been integrated. The research asks questions with regard to the reform's planning processes, distinguishes the impeding and encouraging factors and focuses heavily on stakeholder influence. It uses case study and stakeholder analysis and includes about fifty in depth interviews held in the years 2001 (two thousand and one) to 2004 (two thousand and four) as well as a variety of documents from multiple sources.

The findings point to the fact that the main impediment to the legislature's requirements was stakeholder resistance. There were three main stakeholder bodies influencing the process of reform – the Ministry of Health, the Ministry of Finance and the healthcare insurance providers. Of these, the Ministry of Health contained several ambivalent vested interest groups so that while its official

stance was pro-reform, resistance arose from the fact that the transfer of responsibility for mental health to the healthcare insurances would further reduce the sum total of Ministry resources and power after these had already been greatly diminished when parts of the Ministry's budgets were transferred to the healthcare providers as a result of the passage of the National Health Insurance Law.

The Ministry of Finance had its own reservations about the mental health reform and was unwilling to make budgetary provisions for elements that until then had been partially funded by the patients themselves.

The health insurance providers had concerns over the high number of hospital beds required and the expense involved. Another problem was their lack of experience in rehabilitation. A third problem was that the health insurance providers feared that once in their care, the stigma of mental disability would be reduced, thus

flooding them with an enlarged patient population and increased expenditure.

Psychiatric hospital directors formed another group of influential stakeholders and were concerned over reductions in health insurance providers' use of their services and thus a reduction in the resources at their disposal. Meanwhile, psychiatrists and psychologists were worried that the enhanced public services would reduce their private practices. At the same time other mental healthcare professionals such as social workers and nurses feared redundancies or salary reductions caused by the transfer of mental healthcare services from the hospitals to the community. Similarly the staff of Ministry of Health clinics feared closure because healthcare providers would make arrangements with private mental health practitioners. Finally, the complex of cross currents and issues at work can be seen from the changes in position taken by the mentally disabled family member groups. Initially family groups of very severe cases opposed the reform for fear that

hospital budgets would be channeled to community care. Once the initiative was taken to unite all the family member groups and fears were assuaged, the groups joined the ranks of reform supporters. However, lately these groups have once more voiced their reservations due to Ministry of Finance attempts at budget reductions for rehabilitation within the community and the intended closure of government clinics.

The net result was that on the one hand the reform met diffuse but widespread opposition, while on the other there was no consolidation of a support coalition. This, as well as inadequate planning, the lack of political and public lobbies, lack of leadership and political commitment because of frequent changes of Ministers and Ministry directors general, all militated against the reform.

These findings are in line with other research pointing out the difficulties inherent in reform such as Kingdon 1995 (nineteen

ninety five) who emphasizes the necessity of policy change to be in the public eye.

By not including precise provisions for mental health reform, the National Health Insurance Law of 1994 (nineteen ninety four) missed a window of opportunity for such reform. January first 2007 (two thousand and seven) and possibly the whole of 2007 (two thousand and seven) are another window of opportunity since the past few years have seen a major planning effort with transparency of data and stakeholder participation that had not been undertaken previously. At the same time some problems that disturbed stakeholders have been smoothed over by the passage of the Rehabilitation of the Mentally Disabled in the Community Act in the year 2000 (two thousand) and a corresponding fifty percent reduction in hospital bed requirements. The contribution of my research towards this has been in a broad case study description of the activity and conduct of stakeholders involved in the mental health insurance reform over several years. The research helped

decision makers understand the forces obstructing and promoting reform and the instruments of planning and control that had to be improved. The research pointed out the covert means used by stakeholders. As Knesset Member Yossi Katz, a former head of the Knesset Labour and Social Affairs Committee told me: “There’s the committee meeting room and there’s the chairman’s office. In the first you speak for the minutes, in the other you say what you don’t want to go into those minutes”. The research cast light on the immense importance of understanding all the facets and outcomes of organizational politics as pertaining to impeding reforms. It was also one further means of drawing public attention to the subject. Only time will tell whether 2007 (two thousand and seven) will finally see the implementation of the reform.

Further details on my research will appear in a coming issue of the International Journal of Law and Psychiatry, Montreal University.

Thank you.