The Israeli Reform of Psychiatric Hospitalizations

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In the last few decades there has been a tendency towards re-institutionalization, which has generated extensive reforms in the allocation of psychiatric beds in many western countries [1–4]. The number of psychiatric beds in Israel reached its peak in 1970 – namely 2.38 per thousand. Gradually, by the year 2000, that number declined to 0.88 per thousand, a decline that was not related to any change in policy of the Ministry of Health. Only in 2000, based on the recommendation of a National Committee, did the Ministry of Health adopt a policy of actively reducing the number of psychiatric beds during the 5 year period 2001–2005. The basic concept was that only patients with active psychiatric symptoms would be hospitalized.

In this issue of *IMAJ* the article by Baruch et al. [5] describes the situation one year prior to the "reform" and 3 years during the reform's implementation. The period 2001–2005 was the time during which the Rehabilitation Mental Health Bill of 2000 was implemented.

This bill enabled the Ministry of Health to transfer all chronic patients without an active disease, but who have functional limitations, to protected shelters. In March 2005 there were 5100 patients in protected shelters, parallel to the decline in the number of psychiatric beds in the hospitals. When one counts the number of psychiatric beds in January 2005 together with the number in protected shelters, it exceeds the number of psychiatric beds in 2000. This is also typical in several European countries [6]. At the end of 2005 there will be, in Israel, 3200 psychiatric beds – a rate of 0.45 beds/1000. Of these 3200 beds, 2250 are for acute care (less than one year hospitalization) and 300 for children and adolescents.

There are also 950 beds for patients whose acute symptoms continue for more than one year of hospitalization. Data gathered by Dr. Lerner from the Falk Institute (a research facility in Jerusalem) show that practically speaking there are two populations – older patients who have been hospitalized for 10 years or more and newly admitted patients with an active disease of more than one year. Most of the latter are new patients who are discharged from hospitals during the subsequent 3 years of hospitalization. After 4 years of hospitalization only 0.5% of those admitted to hospitals are still hospitalized.

The trend of a decrease in the length of hospitalization continued also in the first half of 2005, when only two hospitals – "K" (44.2 days of average hospitalization) and "V" (52 days of average hospitalization) – had an average stay of more than 40 days for adults hospitalized for less than a year. The national average was 34.1 days.

The policy of the Ministry of Health towards 2006 is that the health maintenance organizations only reimburse for 33 days for adults, 45 days for adolescents and 70 days for children. This attitude will force the hospitals' management to be more adamant in directing department heads to reduce the average length of stay. In the past, there were department directors who tried to justify longer length of stay as a tool to reduce re-admissions within one month of discharge. Although this parameter is a manifestation of the hospital's treatment, there is no linkage between longer length of stay and shorter re-admissions within one month.

The current re-admission rate within one month – 16.8% – is higher than the target of 12 days as proposed by the Ministry of Health. The Ministry of Health's role is to investigate the reasons for this rate and to decide whether the proposed target is unrealistic. Preliminary data show correlations between a high rate of re-admission and age below 65, a history of previous re-admissions, hospitalization under 7 days, and a diagnosis of schizophrenia. However, there is a clear difference in the rate of re-admission among the various hospitals. On the other hand, the goal of 24% re-admission within 30–180 days has been achieved. The rate of 23.1% was achieved in 2003 although there is still a significant deficiency in community mental health services.

Another target for the reform in Israel is an admission rate for hospitalization not exceeding 3.2 patients per thousand. In reality, the rate of admissions today is 3.0/1000. With regard to involuntary admissions, the finding of 25.3% demonstrates a trend of increased involuntary admissions and is an international phenomenon. Those who try to explain the relatively longer length of stay in their institutions based on the rate of involuntary admissions cannot justify it by the high number of such admissions.

Looking ahead to the end of this decade it seems that Israel will have approximately 0.4 beds/1000, with an average occupancy of 95%, and an average length of stay of 32 days for adults, 40 days for adolescents and 65 days for children. Of the 0.4 beds/1000, approximately 70% will be for patients who will be admitted for less than one year.

The challenge is to strengthen the community services and to transfer the responsibility of caring for mental health pa-

tients to the health funds. It must be stressed that without the insurance reform the benefits of de-institutionalization might be lost. There is currently an oral agreement between the Ministry of Health and the Ministry of Finance that this reform will be implemented in January 2007. The understanding is that by the end of 2005 a written agreement will be executed between these ministries so that 2006 will be dedicated to the preparation of this reform. However, given that until now fifteen such dates for the proposed reform have come and gone, one can only wonder.

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