THE ISRAELI HEALTHCARE SYSTEM

A brief overview
Prepared by the Israeli Medical Association
# Table of contents

The State of Israel - general background 8

The development of Israel’s healthcare services up to the establishment of the state 9

The Ministry of Health 11

The Israeli Medical Association 12

Characteristics of the health system 15

The health system in numbers - an international comparison 18

The debate over the update of the health care package 26

Public-private mix 28

The Medical Profession 29

Workforce shortage 31

Recent reforms in healthcare 34

Quality improvement in the Israeli healthcare system 36

Recent ethical issues in the Israeli health care system 37
Figures

**Figure 1:** The national health expenditure in OECD countries as a percentage of the GDP, 2018

**Figure 2:** Health expenditure per capita in OECD countries, US$ PPP 2018

**Figure 3:** Public expenditure as a percentage of total health expenditure in the OECD and Israel, 1995-2018

**Figure 4:** Number of practicing physicians per 1,000 population in OECD countries, 2000 and 2017

**Figure 5:** The number of practicing nurses per 1,000 population in OECD countries, 2000 and 2017

**Figure 6:** The number of acute care beds per 1,000 population in Israel and the OECD 2000-2017

**Figure 7:** The number of CT scanners and MRI units OECD countries per one million population, 2017

**Figure 8:** NHI sources of financing 2018 (%)

**Figure 9:** Annual update rate of the healthcare services package for added medication and medical technologies

**Figure 10:** Number of licensed physicians up to age 67 per 1,000 population, 1970-2018

**Figure 11:** Number of licensed physicians up to age 65 per 1,000 population in different districts – before and after the collective agreement
Abbreviations

Central Bureau of Statistics
{CBS}

European Forum of Medical Associations
{EFMA - WHO}

European Union of Medical Specialists
{UEMS}

Israeli Medical Association
{IMA}

Ministry of Health
{MoH}

Ministry of Finance
{MoF}

National Health Insurance
{NHI}

National Health Insurance Law
{NHIL}

National Insurance Institute
{NII}

Organisation for Economic Cooperation and Development
{OECD}

Standing Committee of European Doctors
{CPME}

World Medical Association
{WMA}
The Israeli Health System

The State of Israel - General Background

Israel is a small country located on the eastern shores of the Mediterranean Sea. Its territory stretches over 22,072 sqm, with a population of approximately 9 million residents – 74% Jews, 21% Arabs, with the rest consisting of various minorities such as Druze. Hebrew and Arabic are Israel's official languages; English and Russian are its most common foreign languages.

Israel was established in 1948. It is a democracy with a multi-party parliamentary government system. Every citizen over the age of 18 can vote. The head of state is the president, yet his authorities are mostly ceremonial. The Legislative Branch is called the Knesset, and it consists of 120 Knesset members. Elections to the Knesset take place every four years in national-proportional elections. The Prime Minister heads the Executive Branch (the government), and s/he is usually the leader of the largest party amongst the coalition parties forming the government.

Israel is mostly comprised of urban population. Less than 10% of its population resides in rural settlements. In comparison to other developed countries, Israel’s population is relatively young. The rate of residents under the age of 15 is 28.3%, the highest percentage among the member states of the Organisation for Economic Cooperation and Development (OECD). Israel’s fertility rate among women aged 15-49 is the highest among member states in the organization, with 3.1 children per woman, compared to a mean of 1.7 in other OECD states. The percentage of elderly in Israel (65 years and older) is 11.6% compared to the mean of 17.2% in OECD member states.

Israel is a developed country, industrialized and technologically advanced. The local currency is the New Israeli Shekel (NIS). In 2015, Israel’s GDP per capita was approximately 37,800 dollars (in Purchasing Power Parity) – lower than the OECD average of about 43,000 dollars. Israel’s economic inequality is high among the OECD member states, rivaled only by eight members countries where inequality is higher.

According to the OECD’s better life index, Israel is highly ranked in different aspects of quality of life. Israel is ranked fifth in its residents’ satisfaction with their lives and seventh in the
Common health indexes show that Israeli residents enjoy a high level of health, even in comparison with the most developed countries. Israel's life expectancy is steadily rising and currently stands at 82.6 years, above the OECD average. Much like many other countries, the life expectancy of women is higher than that of men. Concurrently, the infant mortality rate is gradually decreasing and now stands at 3.1 deaths to one thousand births (lower than the OECD average).

The development of Israel's healthcare services up to the establishment of the State

Before Israel was occupied by Britain in 1917, Israel's healthcare was mostly the responsibility of charitable and religious institutions, which provided healthcare services as part of their missionary activity in the Holy Land. The contribution of the Ottoman regime to the field of healthcare was minor.

Various European countries and Christian healthcare organizations at the time established institutions in Israel to care for the sick, provide for the needs of the pilgrims, care for its non-Jewish population, and gain political foothold in Israel. This led, for example, to the establishment of the French, German, Italian and Scottish hospitals. Israel's first Jewish hospital was established in 1854 in the old city of Jerusalem, as part of the Rothschild family's financial aid to the Jewish settlement. Later, other hospitals were established in Jerusalem, including Bikur Holim, Misgav LaDach and Shaare Zedek. The aid operation also covered medical aid to the farmers of the agricultural settlements, and included another Rothschild funded hospital in Zichron Yaakov for famers and laborers, which treated Arabs and Jews alike.

Clalit Healthcare Services was founded in 1911 to guarantee provision of medical services to the workers of the Second Aliyah. Later on, additional health funds were established, including Leumit and Maccabi.

In the early 20th century, the Jewish settlement amounted to about 50 thousand people, while the number of Jewish physicians in 1912 was only 32. In January 1912, Dr. Moshe Sherman initiated a gathering at which it was decided to establish the "Hebrew Medicinal Society in Jaffa", whose members would be certified physicians, veterinarians and pharmacists. Similar physicians' societies were founded in additional settlements and, after the First World War, converged into one association – The Hebrew Medical Association, which changed its name after the state was established to the Israeli Medical Association (IMA) and limited membership to licensed physicians. It should be noted that even early on the physicians' organization did not consider itself to be just a trade union designed to provide professional protection to its members, but also a professional organization with scientific goals, aspiring to affect the level and quality of medical services provided.

Later on, the Hadassah Medical Organization in the United States made a crucial donation for the development of Israel's healthcare services. The organization established hospitals and aided public healthcare, preventive medicine and the eradication of infectious diseases while maintaining professional standards free of political and ideological tendencies.

The large influx of immigrants from central Europe in the early to mid 20th century brought with it many physicians. Upon their arrival, the practice of independent physicians started to develop. Concurrently, hospitals were established all across Israel, and a health services network was established by local authorities.

The contribution of the British Mandatory health department to the formation of Israel's healthcare services was relatively small. The health department of the Israeli government handled sanitation and other infectious diseases during the years of the Mandate, and did not invest in medical infrastructure. The health department served, de facto, as Israel's Ministry of Health (MoH).

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2 The Second Aliyah refers to the massive influx of immigrants during the years 1904-1914, when approximately 35 thousand Jews arrived, mainly from Russia and Poland.
Once the British Mandate ended and the State of Israel was established, the MoH was formed, inheriting the Mandatory health department.

The Ministry of Health

The MoH was founded in 1948, upon the establishment of the State of Israel. The function of the office is to see to the formulation and execution of government policy on health issues, and to fulfill the ministerial functions that fall on every government office – supervision and control, legislation, planning etc. The MoH carries the overall national responsibility to ensure the health of the residents of the State.

One of the inheritances left by the British Mandate's health department to the State of Israel at its inception was a network of military hospitals and institutions designed to provide healthcare services to the public. The MoH temporarily took upon itself to provide those services, as well as the responsibility for other medical services that were provided by the Hadassah organization, with the intention that these services would later be assigned to local authorities. In practice, this temporary situation turned into a permanent situation accompanying the Israeli healthcare system to this very day.

Essentially, the MoH possesses three key roles:

1. Regulator—including policy, supervision, control, planning, and legislation.
2. Service provider – the MoH maintains over a quarter of the hospitalization beds, and half of the preventative medicine services via Family Healthcare Centers (Tipot Halav).
3. Insurer – according to the National Health Insurance Law (NHIL), 1994 (the third addendum to the law), the Ministry is in charge of providing and financing long term nursing care services, preventive medicine services, rehabilitation and mobility equipment to invalids, as well as being responsible for a designated portion of the mental health services\(^3\).

\(^3\) It should be noted that following the mental health reform, most responsibility over these service was assigned to the healthcare clinics, as part of the second addendum to the law.
The multiplicity of sometimes competing roles can impair the Ministry’s ability to fulfill both its ministerial function and its function as a service provider and is liable to create conflicts of interest. For instance, as a regulator, the MoH sets standards that are meant also to apply to institutes under its ownership. As a financer of services, the Ministry often acquires services from private service providers that it itself supervises. These suppliers compete over the provision of services with the Ministry itself (through the institutes it owns).

Additionally, the Ministry's involvement in three functions simultaneously does not always allow it to efficiently fulfill its ministerial role. The MoH is busy dealing with the daily operation of the health services to the individual, and these daily needs can push aside long-term ministerial functions. Some claim that the fact the ministry also owns many of the hospitals results in higher prices for the services it provides.

Almost each committee that dealt with the healthcare system during the past thirty years recommended the need to separate the Ministry's ministerial functions from its operations as provider and financer of health services. Attempts to separate the government hospitals from the direct operation of the Ministry were unsuccessful. Even the establishment of a statutory authority of government medical centers subject directly to the Minister of Health was recently revoked — an authority that was originally established following the recommendation of a consulting committee. Furthermore, there have been several attempts to assign both the financing and insuring of services, currently subject to the Ministry, to the health funds, yet these attempts encountered many difficulties. Nonetheless, recently, most mental health services were assigned to the health funds as part of a complex and controversial reform.

**Israeli Medical Association**

The IMA is the representative organization and trade union of Israeli physicians, operating as a professional, independent and nonpartisan organization dedicated to promoting Israeli physicians and medicine. The IMA's principal goals are to advance the professional, scientific, and economic objectives of its members, maintain the proper professional and ethical level of the medical profession and attend to the status of the physician and the medical profession in Israel.

The IMA grew from an association of seven members, those physicians who established the Hebrew Medicinal Society for Jaffa and the Jaffa District on 11 January 1912. At its inception, the IMA was called the Hebrew Medical Society (HMS), but upon Israel's establishment, the organization opened its gates to all physicians, irrespective of religion.
and nationality. The IMA accepts as members all physicians lawfully licensed to practice medicine in Israel.

As of 2020, the IMA has over 25,900 members physicians, comprising most of the physicians in Israel. The IMA is comprised of 52 scientific associations, each representing a medical branch that is a recognized specialty field in Israel, as well as workgroups and scientific societies whose members deal with interdisciplinary fields and/or various medical fields that are not official specialty fields. In total, there are currently 224 associations, workgroups, and societies in the IMA.

Organizationally, there are seven professional organizations that are members in the IMA: Physicians’ Organization of Clalit Health Services, State Physicians’ Organization, Hadassah Physicians’ Organization, Tel Aviv Municipality Physicians’ Organization, Physicians’ Organization of Meuhedet Health Fund, Physicians’ Organization of Maccabi Healthcare Services, and Physicians’ Organization of Leumit.

The IMA is judicially recognized as the sole representative organization of Israeli physicians. This status was gained through efforts on the part of the IMA, beginning with the establishment of the State, to oppose both requests of the state physicians to hold independent negotiations with the employers and the Histadrut Labor Union, which intended to include within its ranks all salaried physicians, and leave the IMA only with the areas of medical ethics and scientific development.

4 Including dentists, interns and medical students there are currently over 28,500 IMA members.
IMA Regulations specify the structure of the organization, its goals and the scope of its activity, subject to change from time to time based on the decisions of the organization institutes. Following are the main IMA institutes:

- **The General Assembly** - convenes once every four years. The Assembly discusses and decides upon all of the IMA’s issues and is entitled to revoke the decisions of the rest of its institutes. Additionally, it chooses the Central Committee, chairperson of the Committee (who is also the chairperson of the IMA), the Scientific Council, and various committees. The assembly is compiled of delegates, who are selected by the professional organizations in accordance with the index representing the relative influence of each IMA organization.

- **The Central Committee** - This body manages, coordinates and guides the IMA, and acts to implement its goals. The committee supervises IMA institutes, chooses the IMA secretariat and supervises its activity and the work of the organizations, is entrusted with responsibility for collective bargaining, coordinates the fee collection, etc.

- **The IMA Chairperson** - is the chairperson of the Central Committee, who acts as leader of the organization and as its representative vis a vis the public and outside organizations. The General Assembly selects the chairperson for a four-year term of office.

- **IMA Secretariat** - a body elected by the Central Committee, which acts as the IMA’s executive arm. The secretariat holds its meetings at least once a month, and its functions include: implementation of the policy and decisions of the Central Committee; proposals of new policies and/or amendments to the IMA regulations; supervision over IMA committees and institutes; decisions on policy, economic and organizational topics, etc.; approval of collective agreements; declaring national and local strikes; approving the IMA’s budgets etc.

- **IMA Tribunal** - has 24 members plus a chairperson. The IMA Tribunal adjudicates conflicts between an IMA institute and a member, or between different IMA institutes. The Tribunal also deliberates upon conflicts or allegations of a personal nature of an IMA member against his colleague, which are connected to the medical profession, as well as conflicts between members of the IMA and institutes or people outside it, which are connected to the medical profession.
The Ethics Committee - investigates complaints of an ethical nature against physicians, and formulates ethical rules that guide the work of the physicians. The decisions of the committee are reflected in its Ethical Code and in position papers that are published among the physicians. Committee members include senior physicians from diverse specialty fields.

The Scientific Council - an independent scientific body designated by law to oversee the training and specialization of physicians in Israel. As part of its activity, the Scientific Council monitors the residency training of over 5,000 medical residents, holds residency exams, and approves the completion of residency in the various medical fields. The Scientific Council also conducts accreditation of residency departments, approves new fields of specialization and fellowships and is involved with continuing medical education.

The IMA is instrumental in shaping medical and health policy, whether such policy affects physicians, patient rights, public health or the practice of medicine.

The IMA is also an active member of various international organizations such as the World Medical Association (WMA), the Standing Committee of European Doctors (CPME), the European Union of Medical Specialists (UEMS) and the European Forum of Medical Associations (EFMA-WHO).

Characteristics of the Israeli Healthcare System

Israel's healthcare system, much like other healthcare systems, is comprised of a mix of public and private services provision and finance. The Israeli healthcare system is mainly public. As of 2018, about 64% of the national healthcare expenditure came from public finance and designated taxing, with the rest coming from private expenses, both direct payment from households for healthcare services and private health insurances (both complementary insurance purchased through the health funds and commercial insurance marketed by insurance companies). The national expenditure on healthcare in Israel is 101 billion NIS, and it constitutes about 7.5% of the GDP – a rate considered low compared with other developed countries. About 85% of Israeli citizens currently have some kind of private insurance – a relatively high rate, considering the fact that the state provides a basic services package to all its citizens.5

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The NHIL (1994) sets a healthcare package that is uniform, equal and universal to all of Israel’s citizens.\(^6\) Pursuant to the law, citizens are insured with mandatory insurance in one of the four health funds that act as non-profit organizations: Clalit Healthcare Services, which is the largest healthcare clinic, Maccabi Healthcare Services, Meuhedet Healthcare Services and Leumit Healthcare Services. The healthcare services budget is distributed among the funds by the National Insurance Institute (NII), in accordance with the number of insured in each fund and considering other elements such as members’ age, sex, and place of residence (outlying areas verses central district). The health funds’ package includes services such as medications, doctors’ visits, hospitalization services, and paramedical treatments. Concurrently, the state funds a separate services package supplied by the MoH, which includes mental health services, geriatrics, preventive medicine, and rehabilitation equipment. In recent years, the healthcare system has constructed a reform that would assign the mental health services to the healthcare clinics. A different reform covers dental health services for children as part of the health funds' basic package.\(^7\)

Israel has 45 general hospitals, 11 of which are government operated, 8 belong to Clalit Healthcare Services, 11 are private and the rest are public institutes affiliated with the Hadassah organization, the Mission, and other organizations. Only 2.9% of the general admission beds are in private hospitals – the rest are in government or public hospitals and healthcare services institutes. The rate of general admission beds in Israel has been regularly decreasing since the 80’s, and now stands at about 1.8 beds per 1000 people. This rate is low compared to accepted rates in other developed countries (although, as we shall demonstrate later on, one should take into consideration Israel’s young population as compared to “older” countries).\(^8\)

The non-profit organizations of the third sector also fulfill important roles in Israel’s healthcare system. Among them, we find Magen David Adom, which serves as Israel’s emergency and rescue service, the Yad-Sarah organization that assists people with disabilities and provides home based medical equipment, and the Ezer Mizion organization, which is the largest organization in Israel in the field of medical and rehabilitation aid to patients and their families.

\(^6\) National Health Insurance Law, 1994.  
The IDF’s medical corps is also a central component in the provision of medical services in Israel. Other organizations of paramount importance in the health system are the representative organizations of the different healthcare employees – physicians, nurses, pharmacists etc.9

Common healthcare indexes such as life expectancy and infant mortality indicate that the health of Israel’s residents is similar to that of residents in other developed countries. The life expectancy is constantly increasing, and is higher than the average life expectancy of residents in OECD states. Infant mortality is steadily decreasing, and its rate is similar to the OECD’s average rate.10 However, there are gaps in these health indexes among the different population groups, and they favor Jews as compared to Arabs and residents of the central district as compared to those of the outlying areas.

Thus for example, according to the MoH and the Central Bureau of Statistics (CBS), the gap in life expectancy between the residents of Ra’anana in the upscale, centrally located Sharon region and the residents of Rahat in the South is about eight years. The inequality is also apparent in the health infrastructure data – the number of physicians and beds in relation to the size of the population in the Southern and Northern districts is lower as compared to the central district, Tel Aviv and Jerusalem.11

**The Challenge of Coronavirus**

The novel Coronavirus disease (COVID-19) emerged from Wuhan, China in late December 2019, and quickly spread all around the world. In Israel, the first cases were identified in February 2020. The World Health Organization declared the outbreak a “public health emergency of international concern” in January 2020, and a pandemic at the beginning of March. Israel, like other countries, began to take measures to mitigate the spread of the pandemic, such as physical distancing and contact tracing, cancellation of events and quarantine, as well as limiting flights coming in to Israel, and isolation of all arriving passengers for 14 days in designated facilities or at home.

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According to data published by the Ministry of Health in June 2020, more than 17,000 confirmed cases were identified in Israel, and almost 600,000 tests for coronavirus were performed. 291 patients died; however, most of them had underlying medical conditions. The highest rate of cases in Israel was identified among the age group of 20-29, and the second highest among those aged 40-49. As of June 2020, most patients in Israel have had mild forms of the disease, and more than 14,000 have recovered.

The Health System in Numbers – International Comparison

The national expenditure on health in Israel is one of the lowest in the OECD, and constitutes only two thirds of the mean expenditure in the organization.

Figure 1: The national health expenditure in OECD countries as a percentage of the GDP, 2018

Source: OECD Health Statistics 2019
From the above diagram, it appears that the percentage of the GDP in Israel spent on national health is one of the lowest among developed countries and indicates the relatively low place the investment in health has in the priorities of the economy.

The public expenditure per person in Israel is also low compared to OECD states and constitutes only about 60% of the average among the organization’s member states. The level of public expenditure per person in Israel is similar to that in South Korea and Eastern European countries such as the Slovak Republic and Estonia. This fact corresponds to the continuing decrease in the public share of the health expenditure since the NHIL was enacted, and concurrently, to the increase in the rate of private expenditure.12

Figure 2: Health expenditure per capita in OECD countries, US$ PPP 2018

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Figure 3: Public expenditure as a percentage of total health expenditure in the OECD and Israel, 1995-2018

Source: OECD Health Statistics 2019

This diagram indicates that the percentage of public expenditure in Israel (of the total health expenditure) is lower than the accepted percentage in other developed countries, and this gap tends to increase over time, although there has been a slight increase in the Israeli expenditure over the past three years.

A similar picture appears regarding health system workforce and infrastructures, which are a direct outcome of the State’s investment in health. For instance, the rate of practicing physicians in Israel today is lower than the average rate in OECD states. Moreover, as can be seen in the following diagram, Israel is the only OECD country where the number of physicians per 1,000 has decreased between 2000-2017.13

The percentage of nurses in Israel, compared to developed countries, is even lower, as is indicated in the following diagram. As a result, the MoH is working to expand training frameworks for nurses.
The number of acute hospital beds per population is also one of the lowest among developed countries, and despite this, it continues to decrease.

Source: OECD Health Statistics 2019

14 Including psychiatric beds, according to OECD definitions.
Israel is also characterized by an especially low rate of MRIs, as indicated in the following diagram.\textsuperscript{15}

**Figure 7:** The number of CT scanners and MRI units in OECD countries per one million population, 2017

It should be noted that as opposed to other infrastructure measurements, the rate of MRI units in Israel has increased in recent years, yet it is still one of the lowest among developed countries. A similar picture arises when comparing Israel's number of CT scanners per one million people to that in other countries.

**National health insurance law**

In June 1994, the Knesset approved the NHIL, which took effect in January 1995. The law, which states that "National insurance shall be founded on principles of justice, equality and mutual assistance", is the formative law of the Israeli healthcare system. According to this law, all residents are mandated to have health insurance, and each resident is entitled to a defined service package. The law embraces the insured's freedom to choose his healthcare fund, defines collection apparatuses and allocation of public resources, and determines the state's duty to finance the service package to which residents are entitled.

Before the law's enactment, health insurance arrangements were voluntary, and although most of the population chose to be insured (95%), there were still about 250,000 residents (5% of the population) who remained without health insurance.

Once the law went into effect, health insurance became mandatory for all residents of the State with no relation to financial means or other conditions. The law also replaced the unofficial and non transparent mechanisms used to define the service package and eligibility thereto with a publicly regulated, transparent and controlled system. A determination was added that the health services in the package shall be "of reasonable quality, provided within a reasonable time, and within a reasonable distance," although this definition is subject to broad interpretation.

Beyond the package of services under the responsibility of the health funds, the law also includes a package under the responsibility of the MoH, which covers psychiatry services, long term care hospitalization, preventive medicine, and rehabilitation devices. Nonetheless, the health fund package constitutes the lion's share of all health services and in 2018, the cost of this package was approximately 51 billion NIS.

The services are funded through three main sources (see figure below):

1. Health insurance fee – a designated tax collected by the NII.

2. State budget – completion of the package cost from the general government budget.\(^{16}\)

3. Co-payments – payments by the insured for partial finance of the health services

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\(^{16}\) Until 1997, Israel had a "parallel tax" which was collected from employers to finance healthcare services. After it was revoked, the government increased its participation in supplementing the package cost.
The resources comprising the health care service package are divided among the four health funds using a designated distribution mechanism known as "capitation", introduced when the law went into effect in 1995. In accordance with the social justice perspective depicted in the NHIL, the capitation mechanism was designed to provide insured members, without respect to their health status, equal opportunities to receive health services, by justly dividing resources among the health funds. The division formula at the core of the capitation mechanism was designed to calculate the portion of the budget required for each fund in accordance with the needs of its members, as much as these can be measured and quantified. This formula creates, in fact, a form of "affirmative action" among the health funds, so that "compensation" is given to a fund whose insured require more healthcare services, such as a fund with a higher rate of elderly members. Proper allocation is meant to make the fund indifferent to the health risk of the insured, thus barring incentives for unjust allocation of healthcare services or selecting members based on their health condition, age, gender, socio-economic status, or any other relevant factor. However, despite the update of the capitation mechanism over the years, there is still a need to continue to examine and update relevant health, demographic and social-financial criteria on a regular basis, in order to adapt the mechanism to the principles of equality and justice of the NHIL.
The debate over the proper update of the health package

In 1992, the Ministry of Finance (MoF) gave its consent to promote the national health insurance bill under two conditions:

1. The proposed legislation would not expand the eligibilities in the health service package beyond the ones existing at the time.

2. The proposed legislation would not increase the burden of payments for health tax.

In exchange for passing the law, its supporters had to relinquish the idea of regularly updating the services in the package. Thus, the services provided within the NHIL were in fact the services the Clalit Health Fund was providing at the time of the legislation (it should be noted that the law allows the clinics to provide additional healthcare services beyond the basic package). It was further decided that an automatic adaptation to price changes would be done pursuant to the law, in accordance with the health cost index, while the demographic and technological update would be determined by the government, according to its discretion and subject to the priorities it sets from time to time.

In practice, between 1995-1997, no designated funds were allocated to the addition of services to the package. In 1998, following heavy public and media pressure, the healthcare services package was updated with a sum of 150 million NIS, designed to include 17 technologies, most from the field of oncology. Only in 1999, was an organized and methodical process for introducing new technologies to the basic services package initiated. The updating process is conducted by a professional committee, which includes public representatives among its members. In reaching its decisions, committee members take into account cost-benefit considerations, as well as values and social considerations. However, many practitioners agree that there is a large gap between the allocated budget for the update of the package, and the budget required to include in it vital medications and medical technologies.

Implementing the NHIL without introducing appropriate update mechanisms is in fact the main cause for the ongoing disagreement around the package budget. In addition, the updating mechanism itself needs to be addressed, specifically the three existing update coefficients: the cost of health coefficient; the demographic coefficient (due to population growth and aging); and the technological coefficient (for medications and new medical technologies).
Cost of health coefficient
The price coefficients according to which the cost of the package is updated each year are specified in the fifth addition to the law. There are those who claim that the components of the prices in the health cost index do not accurately reflect the cost increase of the health funds' input. The main conflict, concerning the price of a day of hospitalization, is not included in this index, despite the fact that about 45% of the health funds' expenses are spent on hospitalization services, whose rate of price increase was higher than the health cost index.

The demographic coefficient
This index is meant to reflect the increased cost in providing services as a result of the population both increasing and aging. The conflict regarding the demographic update coefficient concerns the lack of compensation to the health funds for the demographic increase of Israel's population and its aging factor, exhausting the practical value of package cost per person.

The technological coefficient
This index is meant to express the changes to the package cost as a result of technological improvements in diagnosis and medical care. The increasing tension between the global scientific advancements in the field of medicine and the government's budget limit allocated to closing the technological gap has resulted in an incisive public and professional discussion about updating the package, with the participation of Knesset Members, the Ministries of Finance and Health, health funds, the medical community and patients' organizations. The media and public interest in the topic reached its peak in 2006 during the demonstrations and hunger strikes held by cancer patients and their families in front of the Knesset and the MoF, demanding to include new oncologic medicines in the healthcare package. At the same time, there were increased calls to legislate an automatic update to the budget covering technological advances, which would guarantee the expansion of the services package by a certain amount each year, without being dependent on a government decision. In practice, the average update of the services package by the government is only 1% per year. The position of the IMA is that the healthcare package must be regularly budgeted by law at an increase rate of 2% of the package cost; this is also the position of patient organizations.
The IMA has, for many years, been warning of the continuous erosion of the healthcare package. Senior economists support this claim, estimating that in 2014 the healthcare package suffered from a cumulative shortage of about 4 billion NIS, for the update of new medications and technologies alone. Taking into account the demographic component and the health cost coefficient, the cumulative erosion of the package reaches a sum of about 13 billion NIS.

**Public-Private Mix**

As mentioned above, the NHIL aims to assure uniform, equal and universal healthcare services to all of Israel's citizens. Nevertheless, alongside the public system, a prospering private healthcare market has been steadily growing for many years. Thus the Israeli healthcare system can be described as a public-private mix.

Section 10 of the NHIL allows the health funds to offer their members complementary insurance, which covers services not included in the basic package. Each member has the right to join the plan his or her health fund offers and the membership fees of the complementary plans are uniform to all age groups.
The complementary insurance plans of the health funds include the following key services: reimbursement for life saving transplants and surgeries abroad and other vital treatments, second medical opinions, alternative medicine, periodic checkups, medical equipment and a limited number of medications not found in the basic package. Additionally, the plans allow choosing a physician, but the choice is limited to private hospitals or the public hospitals in Jerusalem where there are private medical services arrangements.

Another component of the health insurance sector is commercial health insurance, offered by commercial insurance companies that operate for profit. These insurance plans are divided into individual insurance (single insured) and group insurance (through the workplace or for members of different organizations). Unlike complementary insurance, joining the insurance requires underwriting, and the insurance premium is not uniform. In addition, commercial insurance companies, as opposed to the health funds, are not obligated to insure everyone who asks to be insured. About 80% of Israel's residents have complementary insurance. Approximately 40% of them have double health insurance — complementary and commercial. The rate of residents with some type of private healthcare insurance in Israel is one of the highest among developed countries. This indicates the public's lack of trust in the capability of the public health insurance system to provide the proper response when needed, in light of the aforementioned budget crunch.

The Medical Profession

Education and training:

In order to become a physician in Israel, one must undergo 6 years of undergraduate education. There are currently 5 medical schools in Israel—at Hebrew University in Jerusalem, Tel Aviv University in the center of the country, Ben Gurion University in the South (Beersheva) and the Technion (Haifa) and Bar Ilan University (Safed) in the North.

Acceptance to medical school in Israel is extremely competitive, and as a result many Israelis choose to study abroad, mostly in European countries such as Italy, Hungary, Lithuania and Romania.

Following 6 years of study, of which three are pre-clinical and three are clinical, the student performs a year of internship in a designated hospital. The 12 month internship covers 9 months of mandatory rotations in internal medicine, surgery, pediatrics, emergency medicine and intensive care, 2 months of elective rotations and one month vacation. There is also an option to undergo "straight internship" in internal medicine, surgery or pediatrics, 6 months
of which are then counted towards subsequent residency training in the chosen field.

At the end of the internship, physicians educated in Israel will receive a license to practice medicine. Foreign educated physicians will be required to undergo a licensing exam, unless they come from a country that is exempt from such exam.

**Residency training:**

Although legally eligible to practice medicine with just a basic license, the vast majority of Israeli physicians continue on to 4-6 additional years of postgraduate training in one or more of 32 basic specialties, and often another 2-3 years in one of 27 subspecialties. These are performed in any one of 1,932 IMA Scientific Council accredited departments in Israeli hospitals and clinics.

Approximately midway through residency, the physician will take the Stage 1 residency exam, which is a multiple choice, fact based test of his or her theoretical medical knowledge. Towards the end of residency, the resident will take the Stage 2 oral exam, which tests him or her on the practical application of such knowledge.

Upon completion of the residency period, successful completion of the Stage 1 and Stage 2 exams and a letter of recommendation from the department head, the resident may apply to the Scientific Council of the IMA to be granted specialty certification. After reviewing his or her file, the relevant professional committee of the Scientific Council will inform the applicant if anything is missing, or recommend to the MoH that he or she be granted specialty certification. The actual certification is granted by the Ministry.

**Continuing Medical Education (CME):**

CME in Israel is not mandatory. Nonetheless, each physician is encouraged to continue his or her medical education beyond the years of formal education and to remain current in new medical developments. The IMA issues certificates to physicians who complete a set amount of CME.
Workforce shortage

In recent decades, developed countries have been forced to deal with increasing demand for healthcare services due to far-reaching demographic, social and economic trends. Most countries have difficulty keeping up with this demand increase for several reasons, including the inadequate rate of physician training, reduction of work hours in the field, particularly among young physicians, and an increase in retirement rates.

The ideal percentage of physicians within the Israeli population has been debated over the past decade. In addition to the systematic factors delineated above, there are local circumstances heightening the strain on the Israel healthcare system. The increase in the number of retiring physicians, the sharp decline in the number of doctors immigrating to Israel, and the failure to expand the scope of physician training frameworks in medical schools have all given rise to very real concerns regarding an anticipated physician shortage in Israel, and have generated a reexamining of the scope of medical manpower required by the healthcare system. This state of affairs has led to the establishment of various committees that recommended the expansion of physician training institutions. The establishment of the medical school in Safed is expected to elevate the number of physicians in the future, but meanwhile the number of physicians per population has continued to decrease since the late 1990s.

Figure 10: Number of licensed physicians up to age 67 per 1,000 population, 1970-2018


The 1970’s saw a continuous increase in the number of physicians per 1,000 persons, while in the 1980’s, the number of physicians remained static due to the decline in immigration to Israel during these years. In the early 1990’s there was an accelerated increase in the
percentage of physicians as a result of renewed surges of immigration, but the late 90’s saw the
beginning of a downward trend in the percentage of physicians, again due to decreased immigration. In 2018, the rate of medical license holders under 67 was 3.3 physicians per 1,000 persons, with a total of 29,580 physicians.

In addition to the overall decrease in physician manpower, Israel contends with a disparity between the scope of healthcare services available in the periphery as compared to that in central Israel. This disparity is part of the general inequity and imparity that exists between central Israel and the periphery with respect to other areas of life, including employment, education, welfare and transportation. One of the most complex problems with health services in the periphery is the difficulty in attracting medical and nursing manpower from central Israel. Central Israel offers physicians — both young and more senior — economic, social, cultural and educational opportunities unavailable in the periphery. As a result, many doctors prefer to concentrate their practices in the center of the country.

In order to narrow the gap between periphery and center, as well as between the less attractive medical specialties such as anesthesiology and pathology and the more attractive ones, the physicians’ collective agreement signed in August 2011 included financial incentives for medical residents who choose to work in the periphery and in specialties in distress as specified in the agreement. Immediate impact was achieved in the first years after the agreement as medical centers in the south and north of the country experienced an influx of residents. Hospital departments once closed reopened due to the arrival of new medical manpower.
Figure 11: Number of licensed physicians up to age 65 per 1,000 population in different districts – before and after the collective agreement

![Bar chart showing the number of physicians per 1,000 population in different districts for the years 2008-2010 and 2012-2014.](image)

Source: Ministry of Health, Inequality in Health 2015, December 2015

Although inequality remains, we see that in 2012-2014 the northern and southern districts experienced an increase in the number of physicians per population as opposed to a decrease in the central districts, thus narrowing the geographical gap during the three years following the agreement. The long term impact of the agreement remains to be seen, as it is unclear to what extent the government will be able and willing to continue providing financial incentives to medical residents as a solution to healthcare disparities.

The MoH expects a continuing decrease in the rate of physician in the coming decade. The MoH forecast is 3 physicians per 1,000 in 2025, slightly above the target of 2.9 set by a former professional MoH committee.17 Considering the current heavy workload experienced by physicians, lack of sufficient access by patients to medical services, an ageing population, and growing demand for healthcare, it is not clear why the MoH set the bar so low, while most OECD countries have been experiencing a gradual increase in their rate of physicians. Therefore, once again, the IMA is compelled to warn of a looming crisis in the healthcare

system, especially in light of the extraordinary share of Israeli physicians aged 55 and above (close to retirement age) — almost half of all physicians and the highest share in the OECD after Italy.18

**Prominent recent reforms in health care**

Efforts to implement various reforms in the Israeli health care system have notably intensified in recent years. Some of these reforms have been, or are in the process of, being implemented. Others have not been realized yet. Three recent and prominent reforms are reviewed hereinafter.19

**Mental health reform**

Israel’s NHIL, adopted in 1994, stipulated that the legal responsibility for the provision of mental health care should be transferred from the government to the health funds within three years. Shortly after that, the planned transfer was officially put on hold. Subsequently, several attempts were made to pass the legislation needed to effect the transfer, but these were all unsuccessful. Accordingly, Israel’s mental health system continued to function separately from its physical health system in terms of financing, planning, organization and practice setting. The government was responsible for the provision of mental health care, while the health funds were responsible for physical health care.

In April 2012, the Israeli cabinet decided to move ahead with the transfer of responsibilities, stipulating that implementation would be gradually spread over a three-year period. The transfer of responsibility is often referred to as the “mental health insurance” reform, conceived in the context of broader mental health reforms that included efforts to reduce the number of inpatient beds and to develop community-based rehabilitation services. In July 2015, mental health services were added to the set of services that the health funds must provide to their members within the framework of the National Health Insurance (NHI). As such, mental health care became a legally guaranteed right of all Israeli citizens, rather than a service where availability is highly dependent on available budgets. The government specified the set of mental health services that must be provided and substantially increased

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19 This review is based on the following publication (with minor adjustments): B. Rosen, R. Waitzberg and S. Merkur, “Israel: health system review”, Health Systems in Transition 17, no.6 (2015): 1–212.
the level of funding to cover the costs expected to be incurred by the health funds in light of this new responsibility.

Nonetheless, there is some controversy over this reform. Concerns were raised that the quality of services delivered by the health funds would be compromised as a result of budgetary considerations. Furthermore, no mechanism was set to ensure that the resources allocated for mental health services would be used for this specific purpose only and not diverted to other services, particularly in light of the tight financial constraints under which the funds operate.

**Long-Term Care reform**

Israel’s Long-Term Care (LTC) system is seriously fragmented. MoH planners and many independent analysts took the view that this fragmentation was resulting in service gaps, duplication, inefficient incentives and inadequate investment in prevention and rehabilitation. In 2011, the MoH put forward a detailed plan for a major, three-phase reform of the LTC system. The reform sought to situate overall responsibility for LTC with the health funds within the framework of NHI. In the first phase, the NII was expected to increase the benefit levels for community-based LTC services and the health funds were expected to assume professional oversight of those services. In the second phase, the legislature was expected to add institutional LTC to the set of benefits for which the health funds are responsible under the law. In the third phase, the health funds were expected to assume financial responsibility for community-based services as well. The reform also sought to increase the level of government financing for LTC — both in institutional and community settings.

The reform plan had several objectives, one of which was to increase efficiency by having a single government agency (MoH) and a single set of insurer/providers (the health funds) responsible for all the aspects of LTC. The proposed integration would have provided incentives for health providers to place those in need of LTC in the most cost-effective setting. In addition, the reform sought to reduce the financial and care burden on the families of people needing LTC.

By mid-2015, the reform plan had not been adopted and implemented. The MoF raised concerns about the Israeli government’s capacity to absorb the additional budgetary obligations. The NII and the Ministry of Social Welfare (whose roles in LTC would have been reduced by the proposed reform) voiced concerns about the potential for over-medicalization of LTC. As a result of resistance from these and other groups, the reform effort has been on hold since 2013.
Dental care reform

When Israel adopted NHI in 1995, dental care was not included in the benefits package, other than maxillofacial surgery for trauma and oncology, and dental care for oncology patients. The 1990 Netanyahu Commission had recommended that services provided under NHI include maintenance and preventive dental care for children aged 5–18 years, and maintenance and rehabilitative dental care for elderly people, but these were not included in the NHI Law. This changed in 2010, when the NHI benefits package was extended to include preventive and preservative dental care for children up to age 8. The age limit was later extended to 12. Care is provided by the four health funds, with preventive services free and preservative services provided with small co-payments. A survey conducted in 2013 found that 45% of children aged 2–12 years used the publicly funded services.

Although access to dental care for children up to age 12 has been secured, serious concerns remain regarding utilization in this age group, particularly for vulnerable populations. Dental treatment for specific groups of patients with congenital syndromes competes with other new medical technologies to be added to the NHI. Because of budget limitations, only a few of these groups receive publicly funded services. Recently, two additional measures were introduced: the extension of dental coverage for children up to age 18 and to the elderly (75 and above), in order to ensure access to dental care for those who need it most and can afford it least.

Quality improvement in the Israeli healthcare system

In recent decades, many countries have devoted considerable efforts in an attempt to improve the performance of their health care systems. These efforts can be seen in a range of scientific, organizational, administrative and financial activities grouped under the heading of “quality assurance” or “quality improvement”. Policy makers, health authorities, health providers, insurers, associations of physicians and other health workers, as well as private and public bodies, are involved in continued and complex processes whose purpose is to ensure the quality of clinical treatment in particular, and the function of the health system as a whole.

Quality improvement can take many forms. For instance, the production of clinical guidelines has become an increasingly common part of clinical practice. Clinical guidelines are systematically developed statements designed to assist practitioner and patient decisions about appropriate treatment in specific clinical circumstances.

In Israel, as in many other countries, the responsibility for preparing clinical guidelines rests with professional scientific societies. The IMA’s Institute for Quality in Medicine reviews the
guidelines and assists with their preparation, publication and distribution to physicians in Israel. In addition, the Israeli MoH prepares clinical guidelines, in the form of circulars, through its advisory National Councils. The health funds also formulate their own internal guidelines.

Another example of quality improvement activity is Continuing Medical Education (CME). As opposed to many other healthcare systems where CME is a mandatory requirement from practitioners, linked to re-licensure or re-accreditation, in Israel, as noted earlier, CME is undertaken on a voluntary basis. The health funds, hospitals, and scientific associations run professional refresher courses and workshops, and the IMA is responsible for granting credits for recognized activities. However, only a small minority of physicians routinely engage in formal CME activities.

Quality measurement is another example of the development of quality improvement mechanisms in Israel. There is an ever-growing demand from the public, healthcare providers, regulatory agencies and the government, for evidence based quality measurement. Quality improvement has become part of the everyday routine of many healthcare professionals. The MoH runs a national quality measurement program in the community with the cooperation of the four health funds. In addition, the Ministry has begun a project to measure the outcomes of hospital care. This program is managed by a review committee appointed by the Director General of the MoH. The IMA and its scientific societies serve as advisory bodies in these quality measurement initiatives.

**Recent ethical issues in the Israeli healthcare system**

Like all health systems worldwide, the Israeli system is faced with an array of ethical issues, some of which are more indigenous to the region in which the country is located.

One recent issue that captured national and international attention is the forced feeding of hunger strikers. In 2014, the Israeli Ministry of Justice proposed a bill that would allow the forced feeding of such hunger strikers. While cognizant of the security issues Israel faces, the IMA felt they could not support such a bill, which they viewed as unrealistic, unnecessary (as no detainee or prisoner in Israel has ever died during the course of a hunger strike) and potentially exacerbating, rather than helping to solve the problem. In addition, the fundamental change underlying the proposal is in contradiction with and contrary to accepted medical ethics in Israel and throughout the world, including the IMA’s ethical Code and the WMA’s Declaration of Tokyo and Declaration of Malta, which recognize it as a form of inhuman and degrading treatment. In order to help the doctors navigate their ethical
obligations, the IMA set up a hotline for physicians to call with any questions they may have, and released a handbook of professional and ethical guidelines20.

Despite their objections, the bill was passed into law in July 2015, following which the IMA petitioned the High Court of Justice (HCJ) against it. In September 2016, the HCJ denied the petition, asserting that the law was constitutional, although the decision notes that it should be used only as a last resort measure. Regardless, the vocal IMA opposition brought the issue of forced feeding to the forefront of public consciousness (The Israeli Medical Association Website, 2015; Siegel-Itzkovich, 2015) and the IMA continues to remind physicians of their ethical duty, notwithstanding the law.

Medical tourism is another issue with far reaching medical and ethical implications. The IMA Ethics Bureau, in conjunction with the leading medical tourism companies operating in Israel, produced a joint ethical treaty (similar to the treaty it signed several years earlier with the pharmaceutical industry) to establish guidelines for the proper treatment of medical tourist before, during and after their treatment in Israel. The guidelines focus on the regulation of ethical and professional treatment of the medical tourist, on preventing harm to the local patient and strengthening local healthcare by ensuring that income from medical tourism is funneled back into the local healthcare system.

A third issue recently dealt with by the Ethics Bureau is that of a physician’s freedom of expression versus his or her responsibility to uphold the dignity of the profession. Specifically, to what extent can a physician freely express his or her personal views on topics such as politics, abortion or sexual preferences? The Bureau felt that while freedom of expression is the fundamental right of a physician as it is of every citizen of Israel, a physician should carefully weigh his words especially as these appear in the media. In any event, a physician may not abuse his or her position by presenting views as if they are based on medical knowledge.

These and many other position papers from the IMA Ethics Bureau can be found on the IMA website-https://www.ima.org.il/ENG/ViewContent.aspx?CategoryId=10996

The entire ethical code can be found at https://www.ima.org.il/userfiles/image/EthicalCode2018.pdf

20 See http://www.ima.org.il/ima/FormStorage/Type8/IMAHungerEN.pdf