Can people afford to pay for health care?

New evidence on financial protection in Israel

Ruth Waitzberg
Sharvit Fialco

Abstract

This review is part of a series of country-based studies generating new evidence on financial protection – affordable access to health care – in health systems in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance. Catastrophic health spending is lower in Israel than in many European Union countries but higher than in countries with similar or heavier reliance on out-of-pocket payments. It is heavily concentrated in households with low incomes and mainly driven by out-of-pocket payments for outpatient medicines and dental care. This is likely to reflect limited coverage of dental care and weaknesses in the design of user charges (co-payments) for other types of health care. Although take-up of voluntary health insurance (VHI) is high, VHI does not address these gaps in coverage; it also presents significant challenges for equity and efficiency. Efforts to improve financial protection should focus on re-designing coverage policy to make it more protective for people with lower incomes; supporting these changes to coverage policy by sustaining and further increasing public spending on health, so that it is in line with Israel's level of economic development; and finding ways to curb the growth of VHI.

Keywords

ISRAEL
HEALTH CARE FINANCING
HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
POVERTY
UNIVERSAL COVERAGE

Suggested citation

Waitzberg R, Fialco S (2024). Can people afford to pay for health care? New evidence on financial protection in Israel. Copenhagen: WHO Regional Office for Europe.

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in *unmet need*, and lead to *financial hardship* for people using health services. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health-care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (*unmet need*) and the share of households experiencing financial hardship caused by out-of-pocket payments (*impoverishing* and *catastrophic health spending*). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO headquarters and the WHO Regional Office for Europe. The country consultation includes regional and global financial protection indicators. See UHC watch[1] for more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe? Financial protection is a Sustainable Development Goal, part of the European Pillar of Social Rights and at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial

[1] WHO Regional Office for Europe (2024). UHC watch [online database]. Copenhagen: WHO Regional Office for Europe (https://apps.who.int/dhis2/uhcwatch, accessed 1 August 2024).

hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

Contents

Figures, tables and boxes

Figures

Tables

Boxes

Acknowledgements

Authors
Ruth Waitzberg
Sharvit Fialco

Editors
Jorge Alejandro García-Ramírez
Sarah Thomson

Series editors
Sarah Thomson
Jonathan Cylus
Tamás Evetovits

This series of financial protection reviews is produced by the WHO Barcelona Office for Health Systems Strengthening, which is part of the Division of Country Health Policies and Systems in the WHO Regional Office for Europe. The series editors are Sarah Thomson, Jonathan Cylus and Tamás Evetovits.

The review of financial protection in Israel was written by Ruth Waitzberg (Myers-JDC-Brookdale Institute and Technische Universität Berlin) and Sharvit Fialco (Myers-JDC-Brookdale Institute). It was edited by Jorge Alejandro García-Ramírez and Sarah Thomson (WHO Barcelona Office).

The WHO Barcelona Office and the authors are grateful to Michal Laron and Bruce Rosen (Myers-JDC-Brookdale Institute), Harel Goren (Ministry of Welfare of Israel), and Michal Goldberg and Rachel Brener Shalem (Ministry of Health of Israel) for their feedback on an earlier draft of the review.

Thanks are also extended to the Central Bureau of Statistics of Israel for providing the authors with microdata from Israel's household budget survey. Data on financial protection were shared with the Central Bureau of Statistics as part of a WHO consultation on universal health coverage indicators held in 2023.

WHO gratefully acknowledges funding from the Government of the Autonomous Community of Catalonia, Spain.

This publication has been produced with the financial assistance of the Ministry of Welfare and Ministry of Health of Israel and the Myers-JDC-Brookdale Institute. Its contents are the sole responsibility of WHO and can in no way be taken to reflect the views of the funders.

Abbreviations

COVID-19	coronavirus disease
EU	European Union
GDP	gross domestic product
GP	general practitioner
NHI	national health insurance
NIS	new Israeli shekels
OECD	Organisation for Economic Co-operation and Development
SHI	Social health insurance
VHI	voluntary health insurance

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
NET	Netherlands (Kingdom of the)
POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia

SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in Israel experience financial hardship when they use health care or financial barriers that prevent them from accessing health care. It covers the period from 2005 to 2024 using data from household budget surveys from 2005 to 2022 (the latest available year), data on unmet need for health care up to 2021 (the latest available year) and information on health coverage policy (population coverage, service coverage and user charges) up to April 2024.

The review's main findings are as follows.

- In 2022 2% of households were impoverished or further impoverished after out-of-pocket payments and 5% of households experienced catastrophic health spending.

- Catastrophic health spending is heavily concentrated in households with low incomes. The incidence of catastrophic health spending is higher than the national average in households in the poorest consumption quintile (15%) and households headed by ultra-orthodox Jews (10%), older adults (9%) or Arabs (7%).

- In the two poorest quintiles catastrophic health spending is mainly driven by outpatient medicines and dental care. In the richer quintiles it is mainly driven by dental care, followed by outpatient medicines.

- In 2021 11% of adults reported unmet need for health care due to cost, rising to 19% in the poorest quintile. In the same year unmet need for outpatient medicines due to cost was also higher than the national average (6%) in the poorest quintile (13%).

Coverage policy in Israel has some strengths.

Entitlement to national health insurance (NHI) benefits is based on permanent residence and does not depend on payment of earmarked contributions (the "health tax"), so all permanent residents are covered.

The NHI scheme covers a wide range of health care, including good coverage of outpatient prescribed medicines, and there is an explicit process in place to update the benefits package and its budget every year.

User charges (co-payments) for primary care visits (visits to general practitioners, internal medicine specialists, gynaecologists and paediatricians) were abolished in 2015 and there are no co-payments for inpatient care, diagnostic tests (laboratory tests) and the treatment of a few communicable and chronic conditions. Some co-payments are capped.

The children of non-permanent residents whose parents pay a monthly contribution are entitled to health care financed by the Ministry of Health. Since 2018 the benefits package for these children has matched NHI benefits.

However, there are gaps in all three dimensions of coverage.

- The NHI benefits package does not cover dental care for adults unless they are aged 72 or older. Coverage of medical products for eye care (glasses) is limited. Waiting times are

an issue for specialist outpatient care, imaging diagnostic tests, surgical procedures, rehabilitation and outpatient child development services (e.g. physiotherapists and psychologists). Distance is a barrier for people living in peripheral areas.

- Co-payments are applied to outpatient specialist care and medicines and their design is weak in several ways: co-payments for outpatient prescribed medicines are in the form of percentage co-payments; the only income-based exemption is for co-payments for outpatient specialist visits; and there is no cap on all co-payments.

- Asylum seekers and refugees who do not work and undocumented migrants (these groups amount to 1% of the population) only have access to publicly financed emergency care and some primary care and specialist care for a few conditions.

- Although take-up of voluntary health insurance (VHI) is high, VHI does not address these gaps in publicly financed coverage, particularly for people with lower incomes. By skewing health care resources towards richer households, VHI also presents significant challenges for equity and efficiency.

Increases in public spending on health and spending through VHI have not reduced the incidence of catastrophic health spending. This may be because catastrophic health spending is heavily driven by out-of-pocket payments for services that are not covered by the NHI scheme (e.g. dental care); increased public spending on health has been allocated in ways that do not reduce out-of-pocket payments (e.g. raising physician salaries but not reducing co-payments for people); coverage expansions have failed to focus on reducing unmet need and financial hardship for households with low incomes; and the additional spending has not been large enough to increase public spending on health as a share of gross domestic product (GDP) – by this measure Israel lags behind countries with similar or lower levels of GDP per person.

Improving financial protection will only be possible if the Government continues to invest in health, despite the economic challenges created by the war, and if public spending on health rises to match Israel's level of economic development.

Additional public funds for health should be used to address gaps in coverage for people with low incomes. This could be achieved in the following ways:

- Expand coverage of publicly financed dental care (especially for children and adults with low incomes), and of medical products, particularly those related to rehabilitation and disabilities, for which there has been a surge in demand since the escalation of the war.

- Avoid introducing any new co-payments for publicly financed health care. Replace percentage copayments for outpatient prescribed medicines with low, fixed (flat-rate) co-payments (like those used for visits to outpatient specialist care). Reduce co-payments (discounts) for people receiving welfare support from the National Insurance Institute, as a first step towards exempting people with low incomes from all co-payments. Unify existing co-payment caps, extend a unified cap to all co-payments and link it to income, so that it is more protective for people with lower incomes.

- Improve access to coverage for the children of refugees, asylum seekers and undocumented migrants by breaking the link between their entitlement to publicly

financed health care and payment of a monthly fee by their parents, and extend coverage for non-permanent resident adults who are not employed.

The Government should also find ways to curb the growth of VHI providing faster access to care and to continue to limit dual coverage (having VHI from a health plan and a commercial insurer). Israel's experience, echoed by international experience, shows that this type of VHI undermines equity and efficiency when it is allowed to play a significant role in the health system. Part of the solution lies in bringing down waiting times for publicly financed health care to more acceptable levels, finding ways to prevent doctors from shifting users from public to private practice and improving access to health care in peripheral areas.

1. Introduction

This review assesses the extent to which people in Israel experience financial hardship when they use health care or financial barriers that prevent them from accessing health care. It covers the period from 2005 to 2024 using data from household budget surveys from 2005 to 2022 (the latest available year), data on unmet need for health services up to 2021 (the latest available year) and information on health coverage policy (population coverage, service coverage and user charges) up to April 2024.

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019; WHO Regional Office for Europe, 2023). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however; policy choices are also important.

Israel is a high-income country with a generally strong and stable economy. However, economic growth has been affected since the war (OECD, 2024a) and, even before the war, levels of income inequality and child poverty were persistently high. In 2020 the Gini coefficient was 0.39 in Israel, compared to a European Union (EU) average of 0.31, and 29% of children were living in relative poverty (Central Bureau of Statistics, 2020), compared to an EU average of 20% (Bank of Israel, 2023; Gal, Madhala & Oberman, 2023; Eurostat, 2024a; Eurostat, 2024b; OECD, 2024b).

The out-of-pocket payment share of current spending on health is similar in Israel to the EU average (20% and 19%, respectively, in 2021) (WHO, 2024). This is partly because Israel relies much more heavily on voluntary health insurance (VHI) to finance health care than most countries in Europe and globally; in 2021 VHI accounted for 10% of current spending on health in Israel (up from 6% in 2005), which is more than double the EU average of 4% (WHO, 2024).

The out-of-pocket payment share of current spending on health fell from a peak of 30% in 2005 to 20% in 2021 (WHO, 2024), which reflects the doubling of public spending on health per person in real terms over the last 20 years. In spite of the increase in public spending on health, however, it remains low as a share of GDP: 5.4% in Israel in 2021, compared to an EU average of 7.2% (WHO, 2024). This is lower than expected given Israel's level of GDP per person and on a par with countries with much lower levels of GDP per person (e.g. Bulgaria, Greece and Hungary) (WHO, 2024).

This review is the first in-depth analysis of financial protection in Israel. Earlier studies have used different methods than those used in this study or data was limited to people aged over 60 (Baird, 2016a; Baird, 2016b; Yerramilli et al., 2018).

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy. Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5 (covering both financial hardship and unmet need). Section 6 provides a discussion of the results of the financial

protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the Methods page of UHC watch (WHO Regional Office for Europe, 2024).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

	Impoverishing health spending
Definition	The share of households *impoverished* or *further impoverished* after *out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and *utilities* (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household *consumption* distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, *basic needs* for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors where relevant
Data source	Microdata from national *household budget surveys*
	Catastrophic health spending
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care. This includes all households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they have no capacity to pay before or after out-of-pocket payments).
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Note: see the Glossary provided by UHC watch for definitions of words in italics (WHO Regional Office for Europe, 2024).
Source: WHO Regional Office for Europe (2019).

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the household budget surveys conducted by

the Central Bureau of Statistics between 2005 and 2022 (the latest available year). Data are usually collected between January of the year of the study and the January of the following year. The survey typically covers 6000–9000 households and the response rate has ranged from 65% in 2019 to 43% in 2022 (Central Bureau of Statistics, 2023a).

All currency units in the study are presented in new Israeli shekels (NIS), with notes on inflation-adjusted spending where relevant. In 2022 NIS 10 had the equivalent purchasing power of €1.74 in the average EU country.

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using survey data (Box 1). In Israel data on unmet need for health care and dental care are collected using a bi-annual survey carried out by the Myers-JDC-Brookdale Institute (Population Survey on the Level of Services and Health System Performance; Myers-JDC-Brookdale Institute, 2024). These data can be disaggregated by age, gender, educational level, income and other factors. Adults aged over 22 are surveyed every two years for health care and at longer intervals for dental care.

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health services but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupain-Guillot & Guillot, 2014), which suggests that unmet need can be a useful indicator of affordable access to health care.

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health services they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Source: WHO Regional Office for Europe (2019, 2023).

3. Coverage policy

This section briefly describes the governance and dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) – and reviews the role played by VHI.

3.1 Population coverage

The basis for entitlement to publicly financed health care is permanent residence as defined by the 1995 National Health Insurance (NHI) Law. Residents must enrol in one of the four competing non-profit health plans in the NHI scheme (Clalit, Leumit, Maccabi and Meuhedet). They can choose their health plan and switch health plan twice every 12 months on one of six dates set by the National Insurance Institute (National Insurance Institute, 2024a).

Enrolment in a health plan does not depend on the payment of contributions – known as the "health tax" – to the NHI scheme (see Box 2) (Government of Israel, 1994; Waitzberg & Rosen, 2020).

Military personnel and prisoners are covered by parallel public schemes. The military scheme provides benefits that are similar to the NHI scheme. Since 2019 the scheme for prisoners has not been obliged to match NHI benefits (Prison services, 2019).

Children (up to 18 years old) without a visa or whose parents are refugees, asylum seekers or undocumented migrants are covered by the Ministry of Health if their parents pay a monthly fee of NIS 120 per child. The fee entitles these children to the same benefits as children covered by the NHI scheme and is capped at two children per household, so there is no need to pay for additional children. However, children lose coverage if their parents fail to pay the fee for more than six months. Regardless of coverage status, children with a visa or whose parents are undocumented migrants can attend school and receive school health services free at the point of use (Ministry of Health, 2016).

In 2021 2% of the population was not covered by the NHI scheme: 1% were documented non-permanent resident workers, who are required to purchase private health insurance, and 1% were adult undocumented migrants, asylum seekers and refugees, who are only entitled to publicly financed emergency care and some some primary care and specialist care for selected conditions (Population and Immigration Authority, 2021).

Non-permanent legal resident workers (typically temporary residents working in agriculture, construction and long-term care but also employed refugees, asylum seekers and undocumented migrants) are not covered by the NHI scheme and must be covered through mandatory private health insurance purchased from commercial insurance companies by their employer and funded jointly by employers (who must pay at least two thirds of the premium cost) and employees (Kolzchut, 2024). This is difficult to enforce for undocumented migrants. Commercial insurance companies contract one of the four health plans (Clalit) to provide health care for non-permanent resident workers, who account for around 1% of the population (Population and Immigration Authority of Israel, 2021). This type of private health insurance is regulated to ensure open enrolment, premiums set at a flat rate (NIS 6 a

day in 2023) and coverage of a wide range of primary and specialist health care, but there is no obligation to cover pre-existing medical conditions, childbirth or psychological services.

Adult refugees, asylum seekers and undocumented migrants who do not work (around 1% of the population) are not covered by the NHI scheme and are entitled to publicly financed emergency care and some some primary care and specialist care for selected conditions only, funded directly by the Ministry of Health (maternal and infant care, infant immunizations, tuberculosis, diagnosis of HIV/AIDS and abortion for women under 18 or who have been raped; in Tel Aviv municipality they can also access diagnostic tests and specialist care for some chronic conditions through selected hospitals and walk-in clinics) (Government of Israel, 1995; Knesset, 2013).

There are special arrangements in place for Ukrainian citizens. Those with at least one Jewish grandparent are eligible for Israeli citizenship, permanent residence and covered by the NHI scheme (Government of Israel, 2023). Those without have refugee status. From July 2024 Ukrainian refugees can be covered by the NHI scheme if they pay a monthly contribution of NIS 140 for a child and NIS 320 for an adult aged over 60. Adults under 60 cannot be covered by the NHI scheme but can buy private health insurance and, if they work, their employer will finance two-thirds of the VHI premium (Government of Israel, 2024). Between 2022 and 2024 Ukrainian refugees under 60 were only entitled to publicly financed emergency care but those over 60 were covered by a commercial insurance company, with premiums financed by the Ministry of Health; the insurer contracted a health plan to provide this group of people with the same benefits as the NHI scheme (Government of Israel, 2023).

Box 2. Entitlement to the NHI scheme is based on residence rather than payment of contributions

Although the NHI scheme is financed through earmarked contributions (the "health tax"), as well as general revenues from the government budget, entitlement to NHI benefits is based on permanent residence and enrolment with one of the four health plans rather than payment of contributions.

With the exception of married women not working outside the home, all resident adults pay the health tax, which is levied on wages and on other sources of income in two "steps": the first step is a 3.1% deduction a month on income up to NIS 7522 (which is 60% of the average monthly income as of January 2024); the second is a 5% deduction on income above this level capped at NIS 49 030 (as of January 2024). Adults without an income pay a flat monthly rate of NIS 116 which is about €20 (as of January 2024) (National Insurance Institute, 2024b). An amendment to the 2024 general budget includes an increase in the health tax to 3.3% for the first step and 5.2% for the second step. Both changes will be implemented in 2025 (Maoz-Breuer & Waitzberg, 2024).

Health plans are obliged to accept all applicants in return for a risk-adjusted capitation payment from the National Insurance Institute. They do not have access to any information about whether enrollees have paid the health tax or not. Responsibility for the non-payment of the health tax rests with the National Insurance Institute.

The complete separation of payment of contributions from entitlement to benefits was deliberately enshrined in the 1995 NHI Law for two reasons: first, to ensure that health plans would not be able to impose sanctions on anyone who fell behind on payment, and thus to

ensure that entitlement would not depend on ability to pay the health tax; and second, to prevent health plans from knowing the income level of their enrollees, which might undermine equity in the provision of health care and lead to "negative selection" of enrollees.

A Government bill put forward while the NHI Law was under discussion explains that the proposed separation stemmed from the recognition that "the health service is a basic service that the state must provide to its residents by virtue of being resident" (Government Bill No. 2189 of June 30, 1993).

Source: authors, based on Rosen, Waitzberg & Merkur (2015) and personal communication with Tuvia Horev (Ben Gurion University of the Neguev, Israel), October 2023.

Key changes to coverage policy in the last 30 years are summarized in Table 2.

Table 2. Changes to coverage policy, 1995–2024

Year	Month	Policy change	Health services targeted	People targeted
1995	January	Introduction of the mandatory NHI scheme.	All health services	Covered people
2001	July	The Ministry of Health signs an agreement with one of the four health plans (Meuhedet) mandating the provision of health care to children under 18 years old not covered by the NHI scheme.	All health services	Non-covered people
2010	January	Abolition of co-payments for visits to well-baby clinics (outpatient care) under the NHI scheme.	Outpatient care	Covered people
2010	July	Free preventive and preservative dental care treatment to be provided to children under 8 years old covered by the NHI scheme.	Dental care	Covered people
2011	July	Free preventive and preservative dental care treatment to be provided to children under 10 years old covered by the NHI scheme.	Dental care	Covered people
2012	July	Free preventive and preservative dental care treatment to be provided to children under 12 years old covered by the NHI scheme.	Dental care	Covered people
2015	January	Abolition of co-payments for primary care visits to primary care (general practitioners (GPs), paediatricians, gynaecologists) under the NHI scheme.	Outpatient care	Covered people
2015	April	Expansion of the agreement between the Ministry of Health and one of the four health plans (Meuhedet) to provide health care to children under 18 years old not covered by the NHI scheme.	All health services	Non-covered people
2015	May	Introduction of a standard policy in VHI, with uniform coverage and uniform premiums by age group for specialist consultations and surgical procedures.	All health services	People with VHI
2015	May	VHI is no longer allowed to cover user charges for NHI scheme benefits.	All health services	People with VHI

2015	July	Coverage of mental health care is moved from the Ministry of Health to the NHI scheme.	Mental health care	Covered people
2015	September	VHI is required to cover a minimum list of severe illnesses, including chronic renal failure, HIV/AIDS, cancer and Parkinson's disease.	All health services	People with VHI
2015	September	VHI is no longer allowed to cover services provided by doctors that are not contracted by insurers.	All health services	People with VHI
2015	September	All VHI policies now need to include a document giving details of covered services and entitlements.	All health services	People with VHI
2016	January	Free preventive and preservative dental care treatment for children under 14 years old added to the NHI benefits package.	Dental care	All children
2016	February	Changes in VHI coverage and premiums are now only allowed to take place once every two years.	All health services	People with VHI
2016	February	Commercial VHI policies for different services must be marketed separately and not as a bundle, and insurers must provide people with transparent information on the cost of each type of policy (by establishing an online platform to allow people to compare coverage options).	All health services	People with VHI
2016	February	Commercial VHI must offer a uniform policy for surgical procedures.	All health services	People with VHI
2017	January	Free preventive and preservative dental care treatment for children under 15 years old added to the NHI scheme benefits package.	Dental care	Covered people
2018	June	Free preventive and preservative dental care treatment for children under 16 years old added to the NHI scheme benefits package.	Dental care	All children
2018	December	Elimination of eligibility waiting periods for VHI for people switching from one health plan to another for mandatory health insurance coverage.	All health services	People with VHI
2019	January	Free preventive and preservative dental care treatment for children under 18 years old added to the NHI scheme benefits package.	Dental care	All children
2019	February	All pharmacies must accept digital prescriptions for outpatient medicines from all health plans.	Medicines	Covered people
2020	December	Coronavirus disease (COVID-19) tests and vaccines added to the benefits package throughout the COVID-19 pandemic.	Diagnostic tests and outpatient medicines	Covered people
2020	December	Establishment of a COVID-19 testing and vaccination centre.	Outpatient medicines and diagnostic tests	Covered people

2022	July	Dental care for adults above 72 years old expanded to include free preventive and preservative dental care treatment, including root end fillings, the installation of up to four implants for the purpose of supporting a complete lower prosthesis and consultation with a specialist dentist.	Dental care	Covered people
2022	September	Dental care to be provided through mobile clinics for covered people in nursing homes or long-term care centres with at least 150 older people.	Dental care	Covered people
2023	July	Glasses for children under 8 years old added to the benefits package up to a maximum of one pair a year and maximum waiting times introduced for visits to optometrists and ophthalmologists (30 days) and receiving new glasses (14 days) introduced for these children.	Medical products	Covered people
2024	February	Introduction of reforms to limit dual coverage. Commercial insurers will need to pay the cost of surgery in a private hospital for policyholders with dual coverage (i.e. those who hold commercial and health plan VHI policies). In addition, commercial insurers are no longer permitted to sell people who are already covered by health plan VHI a similar commercial policy for surgery; they can only sell them a commercial policy for surgery that covers any difference in the actual cost of surgery and the what the health plan VHI policy covers.	Inpatient care	Covered people
2024	March	Increase (from 2025) in the health tax to 3.3% for the first step (up from 3.1%) and 5.2% for the second step (up from 5%).	All health services	Covered people

Note: these changes do not include annual expansions of the NHI benefits package, which are determined by the "benefits basket committee" (see section 3.2 for details).
Source: UHC watch (WHO Regional Office for Europe, 2024).

3.2 Service coverage

The NHI scheme benefits package is explicitly defined using a positive list. New services and medical technologies (including medicines) are added to the NHI benefits package on a yearly basis, following revision and approval by the Minister of Health. No technologies or services are removed. The addition of services and technologies is based on recommendations from a public interdisciplinary committee (the "benefits basket committee") consisting of representatives from the health system, the Ministry of Finance, clinicians, patients, religious groups, and ethical and economic experts. The committee's recommendations reflect health technology assessments, including a cost-effectiveness analysis and other considerations (e.g. budget impact, the amount of people benefiting and overall cost to the health system, as well as ethical and equity considerations). The committee also assesses the additional budget required to meet the cost of new additions.

The list of NHI-covered medicines is comprehensive and includes a wide range of prescribed and over-the-counter medicines and medical products. It is also updated annually.

NHI coverage of dental care is extremely limited, except for preventive and preservative treatment for people aged under 18 and over 72 years old. NHI dental care benefits were introduced in 2012 and slowly expanded between 2012 and 2018. Glasses are only covered for children under the age of 8. The coverage of mental health care (psychotherapy) and long-term care at home is also limited.

Public health, preventive care, infant immunization and long-term care are funded directly by the Ministry of Health and are not part of the NHI benefits package.

All health plans operate nation-wide and are obliged to offer a standard national benefits package, but they can also offer additional services to attract members (Rosen, Waitzberg & Merkur, 2015). The military scheme provides benefits that are similar to the NHI scheme. Since 2019 the scheme for prisoners has not been obliged to match NHI benefits (Prison services, 2019).

People covered by the NHI scheme can choose from a network of public and private providers who have an agreement with the health plans. They must generally present a health plan membership card when accessing health care, but it is possible to access some services without the card (e.g. through a health plan's mobile application, website or call centre).

Access to GPs, primary care and community-based "common" specialists (i.e. within ear, nose and throat, gynaecology, ophthalmology, dermatology, orthopaedics and breast surgery specialisms) does not require a referral. Visits to other (less common) outpatient specialists, hospital-based specialists, diagnostic tests, rehabilitation, development services (provided by allied health professions) and inpatient care require a referral from a doctor. Inpatient care also requires approval from the health plan. Users can access emergency care without referral and are entitled to full exemption from co-payments if the visit is for a life-threatening emergency or requires hospitalization. Prescription medicines require a prescription from a doctor. Pharmacists have recently been allowed to renew and change the doses of prescribed medicines. There are no caps on service volumes.

Waiting times are an issue for specialized outpatient care, imaging diagnostic tests, surgical procedures, rehabilitation and outpatient child development services (speech therapist, physiotherapists, dieticians, psychologists and occupational therapists). The following policies have aimed to reduce waiting times.

- In 2018 the Minister of Health set maximum waiting times of between 20–30 days for a list of elective surgical procedures for complex or life-threatening situations. This policy was abolished, however, and currently there are no maximum waiting times.

- Targets for specialized outpatient care and child development services were introduced in 2010 but abolished in 2016 because they failed to reduce waiting times for public providers and fuelled private provision funded by the health plans, which also did not manage to meet the targets, leading to adverse effects for public providers.

- Between 2013 and 2014 the Ministry of Health accelerated the adoption of activity-based payments to hospitals, which reduced the average length of stay for some surgical procedures, freeing resources to treat other patients, which may have reduced waiting times (Waitzberg et al., 2022).

- In 2016 the Ministry of Health and Ministry of Finance launched a programme to increase the supply of publicly financed elective surgical procedures.

- In 2020 the Ministry of Health launched a reform to improve access to publicly financed child development services by increasing funding and the availability of providers.

- Since 2019 the Ministry of Health has monitored waiting times for visits to specialists in five of the most common specialties (within gynaecology, ophthalmology, dermatology, orthopaedics and otorhinolaryngology). Data by city and health plan are publicly available (Ministry of Health, 2024).

Box 3 describes the impact of the COVID-19 pandemic on population coverage, service coverage and access to health care in the country.

Box 3. Impact of the COVID-19 pandemic on access to health care

The COVID-19 pandemic and Government responses to the pandemic have exacerbated existing challenges in access to health care in Israel.

COVID-19 services were added to the benefits package without user charges (including diagnostic tests in some phases of the pandemic). Population coverage was extended to give undocumented immigrants temporary access to COVID-19 services (Waitzberg et al., 2020; 2021a; 2022).

Increased public spending on health was also used to pay for new health workers or extra hours of work among existing staff; greater hospital capacity, mainly intensive care unit beds and dedicated COVID-19 wards; expanded primary care, e-health, phone consultations and telemedicine; and compliance with stricter hygiene and isolation regulations.

Lockdowns led to a small reduction in the use of preventive health services (e.g. annual haemoglobin A1c tests among people with diabetes and breast cancer services) and a large increase in respiratory-related visits to emergency rooms among infants and children (Haklai et al., 2022; Rose et al., 2022; Shinan-Altman, Levkovih & Tavori, 2020).

Health plan deficits increased significantly in 2020 (Ministry of Health, 2023a) but out-of-pocket payments for user charges in the NHI scheme fell by 12% due to reduced use of health care (Ministry of Health, 2021).

Source: authors.

3.3 User charges (co-payments)

The Ministry of Health regulates user charges. Health plans can define the level of user charges based on a range determined by the Ministry of Health, so user charges vary slightly

by health plan. User charge levels are updated annually based on the price index and structural changes in health plan revenue (Waitzberg & Rosen, 2020).

Primary care visits, visits to some specialists (within paediatrics, gynaecology and internal medicine) and inpatient care are free at the point of use but user charges are applied to all other outpatient care and the design of these co-payments is complex (Table 3).

Most user charges are in the form of fixed co-payments, but percentage co-payments (co-insurance) are applied to outpatient prescribed medicines; although there is a cap on these co-payments for people with chronic conditions, there are no exemptions for people with low incomes (Table 3).

All households benefit from a separate cap on co-payments for outpatient specialist visits and diagnostic tests, but there is no overall cap on all user charges (Table 3). Neither of the caps is linked to income.

People requiring dialysis or being treated for cancer, HIV/AIDS, Gaucher disease, cystic fibrosis, thalassemia, haemophilia and tuberculosis are exempt from user charges for visits, medicines and medical products relating to those conditions. Other groups of people are also exempt from co-payments, but income-based exemptions are usually only available for people over 65 years old (Table 3).

Mechanisms to protect people from user charges (reduced rates, exemptions and caps) are applied automatically at the point of use through digital tools. The National Insurance Institute sends the health plans information about people eligible for exemptions and health plans update their systems automatically. However, some people may face administrative barriers to being officially recognized as part of a group that is eligible for protection (e.g. if they have to undergo need or income tests).

Table 3. User charges for other health care covered by the NHI scheme

Type of health care	Type of user charge	Reduced user charges	Exemptions from user charges	Cap on user charges
Primary care visits	NA	NA	NA	NA
Inpatient care	NA	NA	NA	NA
Inpatient medicines	NA	NA	NA	NA
Outpatient specialist visits	None for visits to paediatricians, gynaecologists and internal medicine specialists, who are considered primary care physicians Fixed co-payments for: • first visit in a calendar quarter to a specialist by specialty: NIS 22 to NIS 35 depending on the health plan • visit to allied health professionals and rehabilitation: NIS 28.60 per visit • physiotherapy: NIS 36 per quarter, regardless of the number of visits • visit to clinics for attention deficit hyperactivity disorder: NIS 33 per visit • visit to self-employed psychologists: NIS 61 for the first visit and NIS 148 for subsequent visits • visit for group psychotherapy after the first visit: NIS 68 per visit	NA	**All outpatient specialist visits** • people over the retirement age (62 for women and 67 for men) who receive income support allowances or who have been recognized as prisoners for Zionist activities • adults receiving disability (physical and mental) or old-age benefits and their dependents • children under 18 years old receiving disability (physical and mental) benefits • visits for dialysis, cancer, HIV/AIDS, Gaucher disease, cystic fibrosis, thalassemia, haemophilia and tuberculosis **Visits to allied health professionals and rehabilitation** • children in households receiving income support allowances • victims of traffic or work accidents and organ donors **Child development services** • children in households receiving income support allowances • children under 3 years old • children with somatic developmental disorders	Quarterly cap per household (including children under 18 years old) on all user charges for all outpatient specialist visits and diagnostic tests: • NIS 218–273 depending on the health plan • reduced by 50% for documented immigrants in the first year after arrival • reduced by 50% if at least one household member is over the retirement age (62 for women and 67 for men)
Diagnostic tests	None for most diagnostic tests Fixed co-payments: • nuchal translucency screening: NIS 47.44 • cervical examination for women under 35 years old: NIS 105 • visit to diagnostic imaging institutes (non-general hospitals): NIS 36 per quarter	NA	• victims of traffic or work accidents and organ donors • tests for dialysis, cancer, HIV/AIDS, Gaucher disease, cystic fibrosis, thalassemia, haemophilia and tuberculosis	No
Outpatient emergency visits	**Community-based visits** Fixed co-payment for visits without a referral: NIS 94.19 per visit **Hospital-based visits** Fixed co-payments for visits without a referral: • people arriving between 01:00 and 06:00: NIS 217	NA	• community-based visits: victims of traffic or work accidents and organ donors • hospital-based visits: visits that lead to an inpatient stay, urgent visits (e.g. for physical or mental trauma) or visits relating to traffic or work injuries, domestic violence or sexual assault	No

Type of health care	Type of user charge	Reduced user charges	Exemptions from user charges	Cap on user charges
	• people arriving between 06:00 and 01:00: NIS 911			
Outpatient prescribed medicines	Percentage co-payments (co-insurance): • 10% of the maximum consumer price per generic item, with a minimum payment of NIS 18 • 15% of the maximum consumer price set by the Ministry of Health per branded item, with a minimum payment of NIS 18	Reduced by 10% for people over 72 years old and people over the retirement age (62 for women and 67 for men) receiving income support allowances Reduced by 50% for all documented immigrants in the first year after arrival	• victims of traffic or work accidents and organ donors • World War II veterans or Holocaust survivors • medicines for dialysis, cancer, HIV/AIDS, Gaucher disease, cystic fibrosis, thalassemia, haemophilia and tuberculosis	Monthly cap on all co-payments for outpatient prescribed medicines for people with chronic conditions: NIS 298–315 depending on the health plan, reduced to NIS 146–157.50 for people over retirement age (62 for women and 67 for men)
Medical products	None for covered medical products Percentage co-payments (co-insurance): 10% of the price of glasses for children under 8 years old capped at up to NIS 100 per pair, depending on the degree of vision impairment Balance billing: hearing aids and glasses	NA	NA	NA
Dental care visits	None for covered services for eligible groups of people: children under 18 years old and people over 72 years old are entitled to a free annual check up Adults aged 19–71 pay the full cost of dental care visits	NA	NA	NA
Dental care treatment	Fixed co-payments for covered services for eligible groups of people Children under 18 years old • preservative and preventive care: NIS 25.75 per treatment up to a maximum of NIS 51.53 per visit • emergency dental care: NIS 25.76 per treatment People over 72 years old • preservative and preventive care: NIS 35 to NIS 212 per treatment • emergency dental care: NIS 70.88 per treatment Adults aged 19–71 pay the full cost of dental care treatment	NA	Victims of traffic or work accidents and organ donors	No

Notes: NA: not applicable. In 2022 NIS 10 had the equivalent purchasing power of €1.74 in the average EU country. Source: UHC watch (WHO Regional Office for Europe, 2024).

3.4 The role of VHI

VHI plays a significant role in the health system, covering over 89% of the population in 2022 (Fig. 1**)** and accounting for 10% of current spending on health and 32% of private spending on health in 2021 (WHO, 2024).

It is sold by the four health plans (who can only sell VHI to people they cover) and by commercial insurance companies and plays a complementary (services) role covering services excluded from or not fully covered by the NHI scheme (e.g. dental care, child development services and occupational therapy) and a supplementary role providing people with faster access to treatment and treatment in private facilities (Sagan & Thomson, 2016; Thomson, Sagan & Mossialos, 2020).

Dual coverage – that is, having VHI from a health plan and a commercial insurer – is permitted. Data from the household budget survey indicate that VHI coverage has grown from around 79% of households in 2007 to around 89% in 2022 (Fig. 1). In 2022 50% of households had health plan VHI only and 38% had both health plan and commercial VHI (up from 21% in 2007); a further 1% had commercial VHI only.

VHI sold by health plans is regulated by the Ministry of Health and must offer open enrolment, lifetime coverage and premiums that can only vary by age. Commercial VHI is regulated more loosely by the Ministry of Finance; commercial insurers must offer uniform policies for surgical procedures by age and gender but they can reject applications, vary premiums for other policies by risk and terminate contracts.

Since 2015 health plans and commercial insurance companies have not been allowed to offer VHI covering user charges for NHI benefits. Commercial VHI can cover services that go beyond health plan VHI, such as medical treatment abroad and medicines not covered by the NHI scheme. In the past commercial VHI could cover benefits that are already covered by health plan VHI, but this was abolished for new commercial VHI policies in 2016. A new regulation introduced in 2024 requires commercial insurers to shift people who also have health plan VHI to a new policy that only covers any difference between the actual cost of surgery and the cost covered by health plan VHI; it also requires commercial insurers to pay the cost of surgery in a private hospital for policyholders with dual coverage (Waitzberg & Maoz-Breuer, 2024) (see Table 2).

Survey data indicate that most people buy VHI sold by the health plans for faster access to a wider range of services or better care, and that more than half of those with commercial VHI do not know what services their VHI policy covers (Brammli-Greenberg, Yaari & Avni, 2020).

In addition to a culture of risk aversion and people's lack of awareness of the overlap between health plan and commercial VHI, dual coverage is also likely to reflect aggressive marketing by insurers. It has been a policy concern for many years, because:

- it increases the financial burden of VHI premiums on households;

- it wastes household resources – some people pay premiums for two policies with the same cover (estimated to be about NIS 760 million in 2018) but only one policy can be used in the event of a claim (Ministry of Health, 2023b); and

- as it is fuelled by increased take-up of commercial VHI, which pays private providers higher tariffs than health plan VHI, it pushes up private provider tariffs; this draws health workers away from public facilities, exacerbates workforce shortages in the publicly financed part of the health system (Ministry of Health, 2023c), increases waiting times for publicly financed health care, pushes more people to seek privately financed treatment and widens inequalities in access to health care among those with and without VHI.

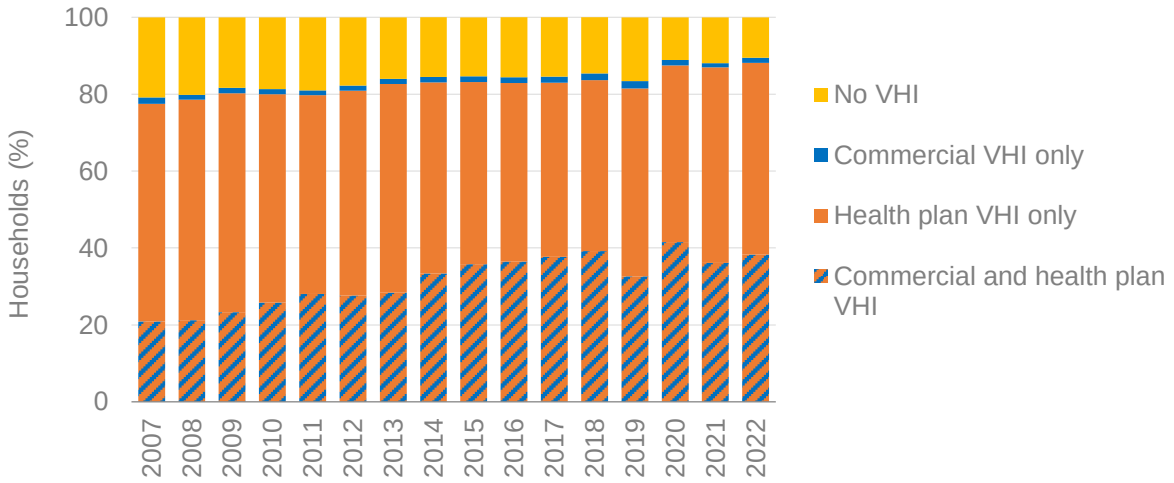
Many reforms have tried to reduce dual coverage and the inefficiencies associated with it (see Table 2), but with limited success.

Take-up of VHI varies widely across consumption quintiles (Fig. 2). In 2022 20% of households in the poorest quintile did not have any form of VHI, compared to just 5% in the richest quintile. Poorer households are also much less likely to have both health plan and commercial VHI (16% in the poorest quintile) than richer households (57% in the richest quintile).

The characteristics of people with VHI varies by type of VHI. Enrolment in health plan VHI is higher among older adults, Jews (compared to Arabs) and people with chronic conditions, while enrolment in commercial VHI is higher among younger adults, Jews (compared to Arabs) and healthy people (Laron, Maoz-Breuer & Fialco, 2022). Health plan VHI is generally cheaper than commercial VHI.

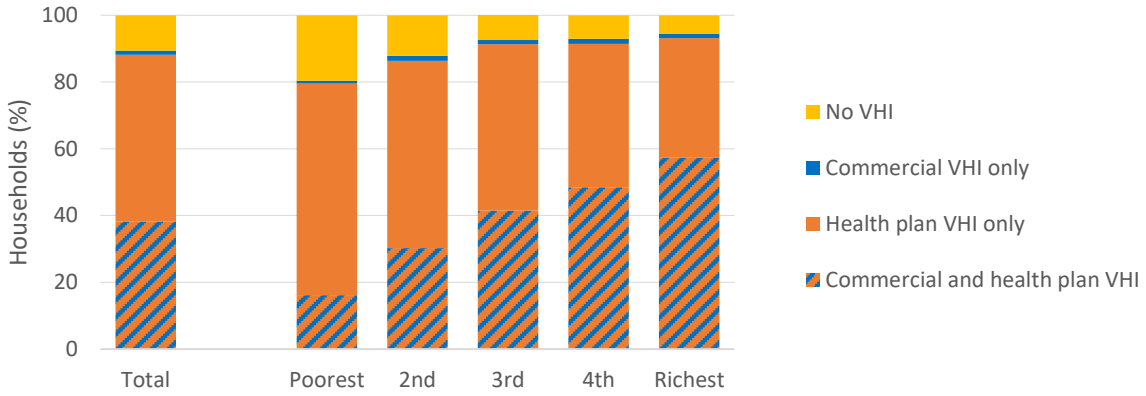
User charges for health care financed by health plan and commercial VHI are likely to be a barrier to using VHI for people with lower incomes. In 2021, for example, only 6% of people in the poorest quintile with health plan VHI used it to finance health care, compared to 26% of people in richer quintiles; health plan VHI-holders in the poorest quintile were also less likely to use VHI to finance specialist visits than those in the richest quintile (Laron, Maoz-Breuer & Fialco, 2022; Waitzberg, Maoz Breuer, and Katz, 2023). As a result, lower-income households with VHI are subsidising the costs of VHI-financed health care for higher-income households.

Fig. 1. Share of households with VHI by type of VHI



Note: data for 2005 and 2006 are not shown because household budget survey codes for VHI in those years were not disaggregated by commercial and health plan VHI.
Source: authors, based on household budget survey data.

Fig. 2. Share of households with VHI by type of VHI and consumption quintile, 2022



Source: authors, based on household budget survey data.

Table 4 highlights the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 4. Main gaps in coverage

	Main gaps in publicly financed coverage	**Is VHI able to cover these gaps?**
Population coverage	Undocumented migrants and most non-working refugees and asylum seekers have very limited access to publicly financed health care: emergency care and some primary care and specialist care for selected conditions only. If refugees or asylum seekers are employed, they are required to be covered by mandatory private health insurance purchased by employers and jointly funded by employers (who must pay at least two thirds of the flat-rate premium cost) and employees. However, insurers offering this form of coverage are not required to cover pre-existing conditions or childbirth and it is difficult to enforce mandatory private health insurance for undocumented migrants.	To a limited extent. Mandatory private health insurance covers documented non-permanent resident workers, including employed refugees and asylum seekers, but insurers offering this form of coverage are not required to cover pre-existing conditions or childbirth.
Service coverage	The NHI scheme offers only limited coverage of dental care for adults aged between 19 and 72, glasses (only covered for children under 8 years old), psychotherapy and long-term care at home. Waiting times are an issue for publicly financed elective surgical procedures, specialist outpatient care, imaging diagnostic tests, rehabilitation and child development services.	To some extent. Over 80% of the population has VHI sold by the health plans and nearly 50% has commercial VHI. However, take-up of VHI is less common among residents with lower incomes.
User charges	Primary care visits, visits to some specialists (within paediatrics, gynaecology and internal medicine) and inpatient care are free at the point of use but user charges are applied to all other outpatient health care and the design of these co-payments is complex. Percentage co-payments are applied to outpatient prescribed medicines and although there is a cap on these co-payments for people with chronic conditions, there are no exemptions for people with low incomes. All households benefit from a separate cap on co-payments for outpatient specialist visits and diagnostic tests, but there is no overall cap on all user charges. Neither of the caps is linked to income and income-based exemptions are usually only available for people over 65 years old.	No. VHI does not cover user charges. Since 2015 VHI sold by the health plans and commercial insurance companies have not been allowed to cover user charges for NHI scheme benefits.

Source: UHC watch (WHO Regional Office for Europe, 2024).

3.5 Summary

All permanent residents (98% of the population) are covered by the NHI scheme because entitlement to NHI benefits is based on permanent residence, not on payment of earmarked contributions (the health tax). The children of refugees, asylum seekers and undocumented migrants are entitled to the same benefits as children covered by the NHI scheme if their parents pay the Ministry of Health a monthly fee of NIS 120.

The 2% of the population that is not covered by the NHI scheme includes documented non-permanent resident workers (1%), who are covered by mandatory private health insurance, and adult refugees, asylum seekers and undocumented migrants who do not work (1%), who are only entitled to publicly financed emergency care and a few other services for selected conditions. There are special arrangements in place for Ukrainian refugees.

Health plans operate nationally and are obliged to offer the same minimum benefits package, which is relatively comprehensive. However, coverage of dental care is limited to children under 18 and people aged over 72, coverage of glasses is limited to children under 8 and coverage of psychotherapy and long-term care at home is also limited.

Waiting times are an issue for elective surgical procedures, specialist outpatient care, imaging diagnostic tests, rehabilitation and child development services.

Although primary care visits and inpatient care are free at the point of use, a complex system of user charges is applied to most other types of health care. Older people with low incomes are exempt from some co-payments, but not from percentage co-payments for outpatient prescribed medicines. People with some chronic conditions are exempt from all co-payments for health care related to those conditions. There are two separate caps on co-payments but neither of them is linked to income and they do not cover all co-payments.

VHI sold by the health plans covers almost 90% of the population and 38% also have VHI sold by commercial insurance companies (dual coverage). Take-up varies widely by socioeconomic status, however, with only 5% of households in the richest quintile not having any form of VHI, compared to 20% in the poorest quintile.

Both types of VHI play a complementary role, covering services excluded from or not fully covered by the NHI scheme, and a supplementary role, offering faster access to health care and greater choice of provider or enhanced amenities in health facilities.

The very high take-up of supplementary VHI and the high prevalence of dual coverage undermine equity and efficiency in the health system, skewing health care resources in favour of richer households and resulting in households with lower incomes subsidising access for richer households. Many reforms have attempted to reduce dual coverage, with limited success.

4. Household spending on health

The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second and third parts use household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system) and household spending on VHI. The fourth part considers the role of informal payments.

4.1 Public and private spending on health

Health accounts data show that out-of-pocket payments accounted for 20% of current spending on health in 2021, just above the EU average of 19% (Fig. 3). The out-of-pocket payment share has fallen substantially in Israel, from a peak of 30% in 2005, narrowing the gap with the EU.

Israel relies more heavily on VHI to finance health care than most countries in Europe and globally. In 2021 VHI accounted for 10% of current spending on health in Israel – more than double the EU average of 4% (Fig. 3), on a par with Ireland (10%) and surpassed only by Slovenia (14%) (WHO, 2024). The VHI share nearly tripled in Israel between 2000 and 2021, but the EU average did not change much during this time.

The large decrease in reliance on out-of-pocket payment in Israel reflects sustained increases in public spending on health per person, which nearly doubled between 2003 and 2021 (Fig. 4). During this time out-of-pocket payments per person did not grow much, while VHI spending per person tripled (Fig. 4).

The decrease in the out-of-pocket payment and VHI shares in Israel and the EU since 2020 reflect increased public spending on heath in response to the COVID-19 pandemic and the lower use of health care in 2020 (Waitzberg et al., 2021b).

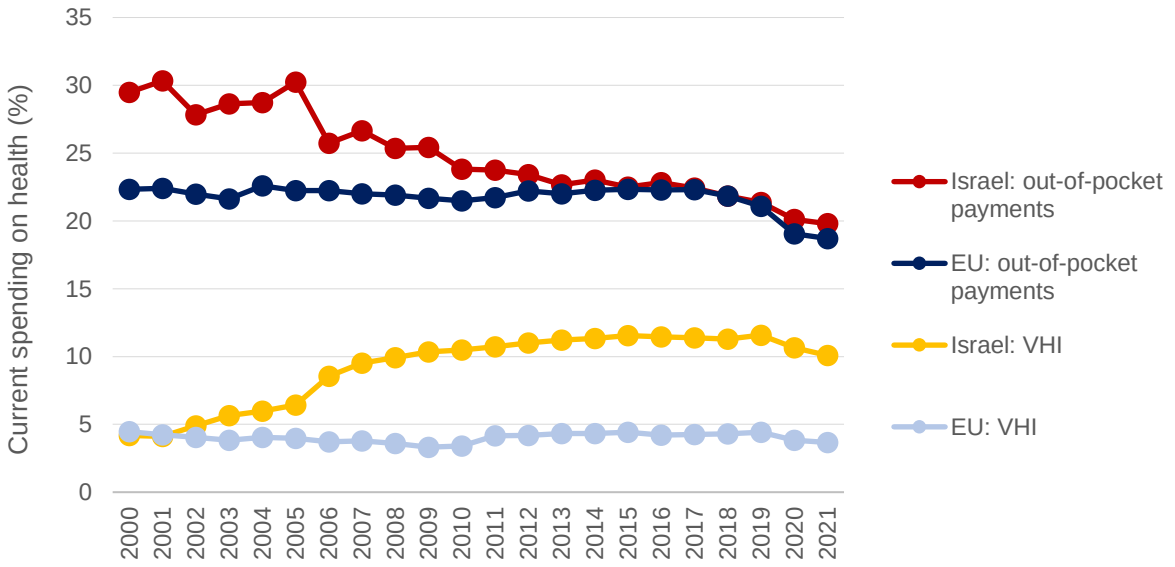
Although public spending on health in Israel has grown steadily over time in real terms, it accounted for only 5.4% of GDP in 2021, much lower than would be expected given Israel's level of GDP per person (Fig. 5). In 2021 the level of spending was well below the EU average of 7.2% (WHO, 2024) and on a par with countries with much lower levels of GDP per person (e.g. Bulgaria, Greece and Hungary) (Fig. 5).

Israel's very low ratio of public spending on health to GDP reflects the low priority given to health in allocating the government budget, as well as the small size of total government spending in relation to GDP. In 2021 public spending on health accounted for only 13% of total government spending, below the EU average of 15% (Fig. 6). "Priority to health" grew from a low of 9% in 2002 to reach a pre-COVID-19 peak of 12% in 2019, but it has always remained below the EU average (data not shown) (WHO, 2024). At 41% in 2021, total government spending as a share of GDP in Israel was far below the EU average of 47% and lower than in most EU countries (WHO, 2024).

Broken down by type of care, the public share of current spending on health in Israel is higher than the EU average for inpatient care (98% in Israel versus 80% in the EU), slightly higher than the EU average for medicines and medical products (48% versus 46%), but much lower than the EU average for outpatient care (67% versus 84%) and dental care (less than

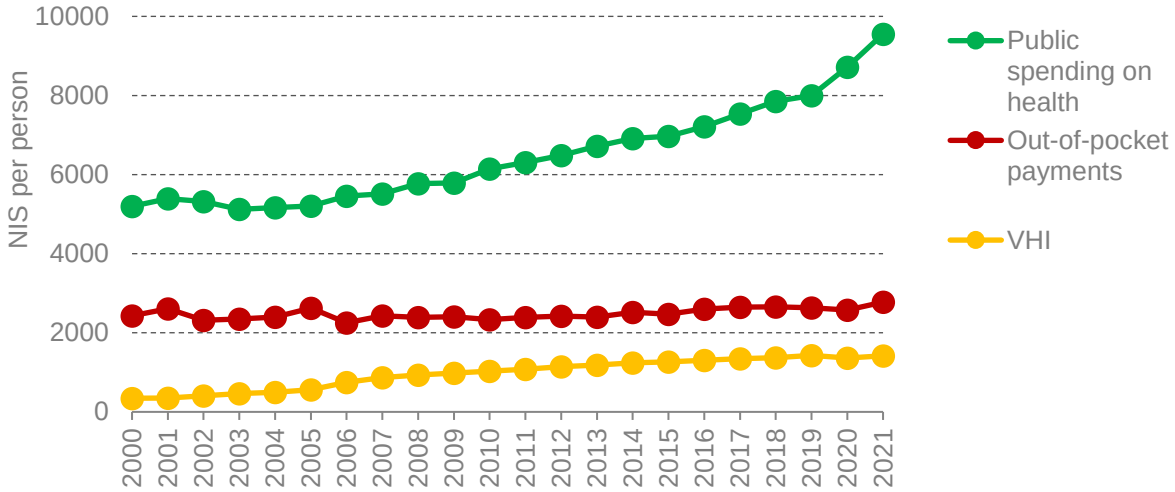
2% versus 33%) (Fig. 7). VHI mainly finances outpatient care and some dental care but does not finance medicines.

Fig. 3. Out-of-pocket payments and VHI as a share of current spending on health, Israel and the EU



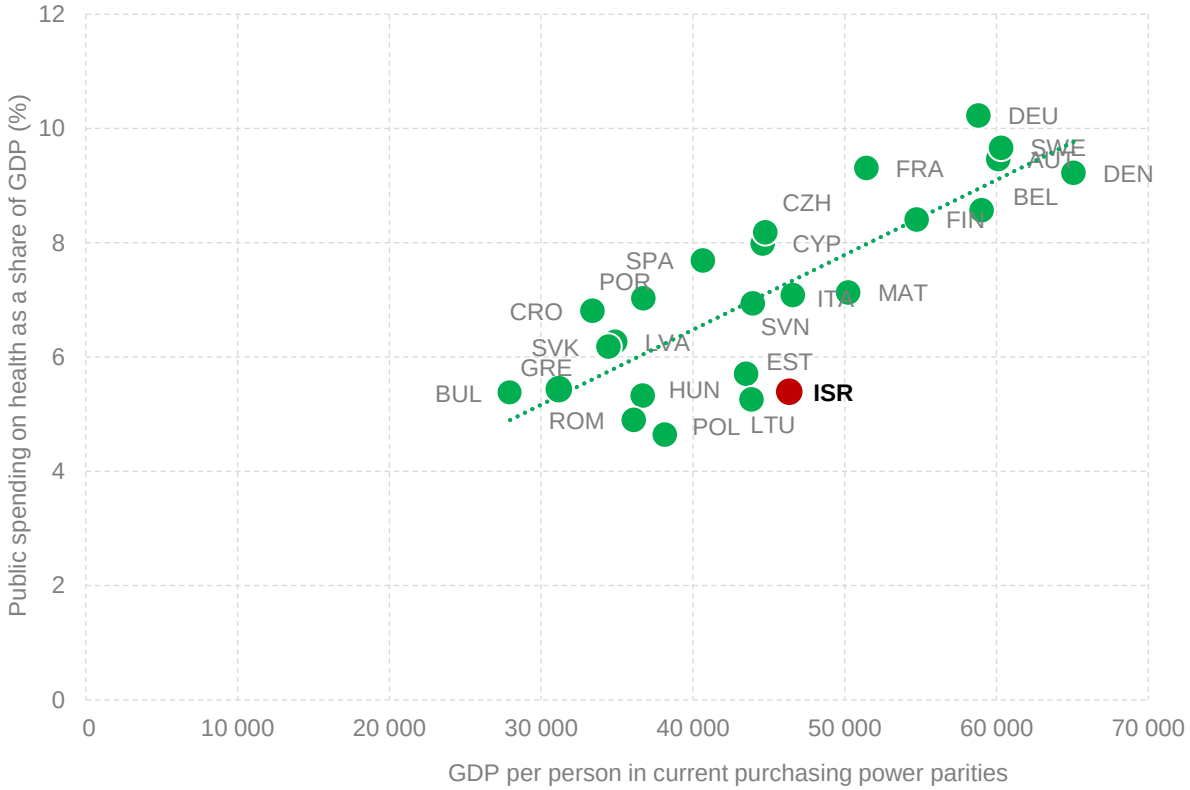
Note: VHI is defined here as a coverage scheme provided on a voluntary basis by enterprises or purchased by individuals.
Source: data from health accounts (WHO, 2024).

Fig. 4. Health spending per person by financing scheme



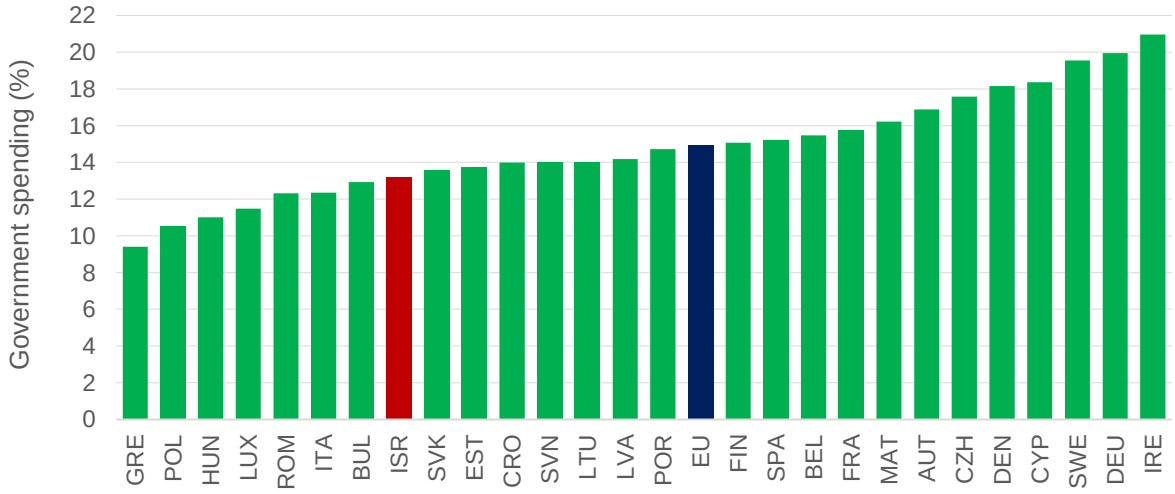
Notes: amounts are shown in 2021 constant prices. Public spending on health is defined here as revenue from the government budget and social health insurance (SHI) contributions. VHI is defined here as a coverage scheme provided on a voluntary basis by enterprises or purchased by individuals.
Source: data from health accounts (WHO, 2024).

Fig. 5. Public spending on health and GDP per person in Israel and EU countries, 2021



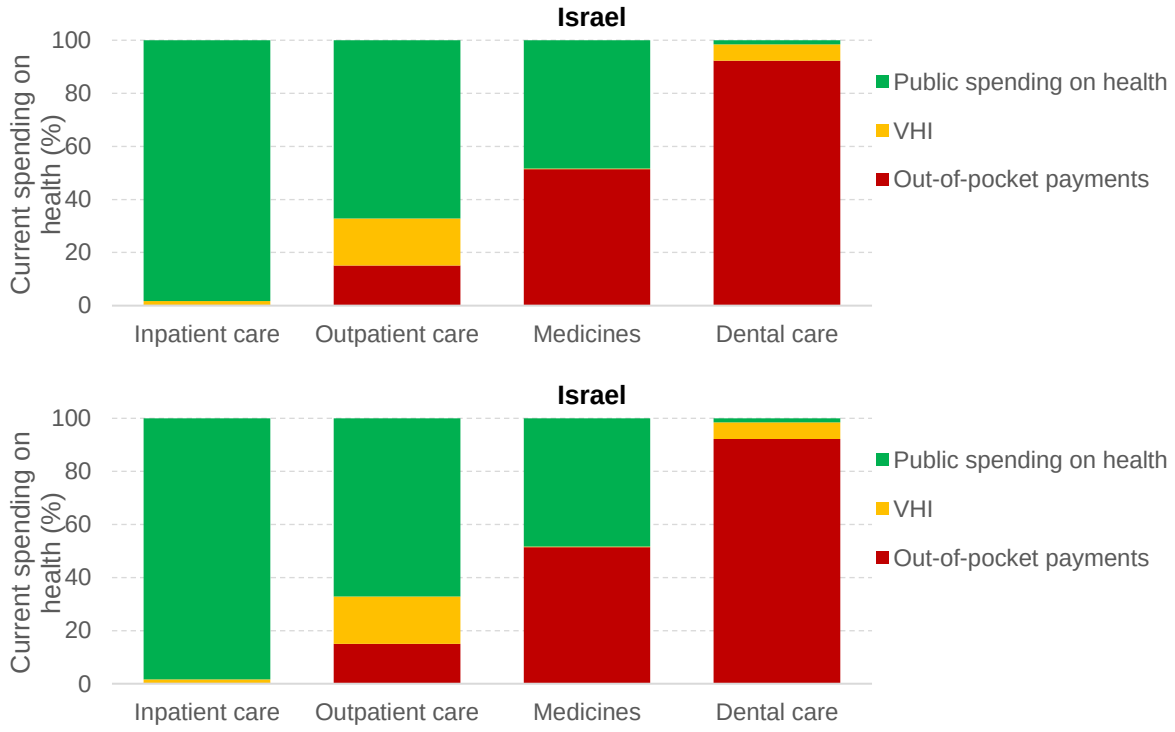
Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. Israel is shown in red. The figure excludes Ireland and Luxembourg (because they are outliers in terms of GDP per person) and the Netherlands (Kingdom of the) (because Dutch data on public spending on health are not internationally comparable). The list of country codes used here can be found in the Abbreviations.
Source: data from health accounts (WHO, 2024).

Fig. 6. Public spending on health as a share of total government spending in Israel and EU countries, 2021



Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. The figure excludes the Netherlands (Kingdom of the) because Dutch data on public spending on health are not internationally comparable. The list of country codes used here can be found in the Abbreviations.
Source: data from health accounts (WHO, 2024).

Fig. 7. Breakdown of current spending on health by type of care and financing scheme in Israel and the EU, 2019



Notes: 2019 is the latest year of data available for Israel. Data for diagnostic tests are not available for Israel. Medicines includes outpatient medicines and medical products. Outpatient care includes general and specialized care. Data for the EU includes the United Kingdom.
Source: data from national health accounts (OECD, 2024c).

4.2 Out-of-pocket payments

Household budget survey data show that in 2022 72% of households reported out-of-pocket-payments, down from 80% in 2015 (Fig. 8). Households in the poorest consumption quintile are consistently much less likely to report out-of-pocket payments (57% in 2022) than households in the richest quintile (79%). In 2020 there was a sharp drop in all quintiles due to the COVID-19 pandemic (Fig. 8); in this year there was a temporary decline in use of non-COVID-19 related health care and most of the care provided was covered by public funds.

The annual average amount spent out of pocket per person was NIS 2375 in 2022, up from NIS 1632 in 2005 (Fig. 9). It has increased consistently over time, except in 2020 due to the COVID-19 pandemic. The increase over time was mainly driven by growth in out-of-pocket spending in the richest quintile. The richest households consistently spend around ten times as much as the poorest households.

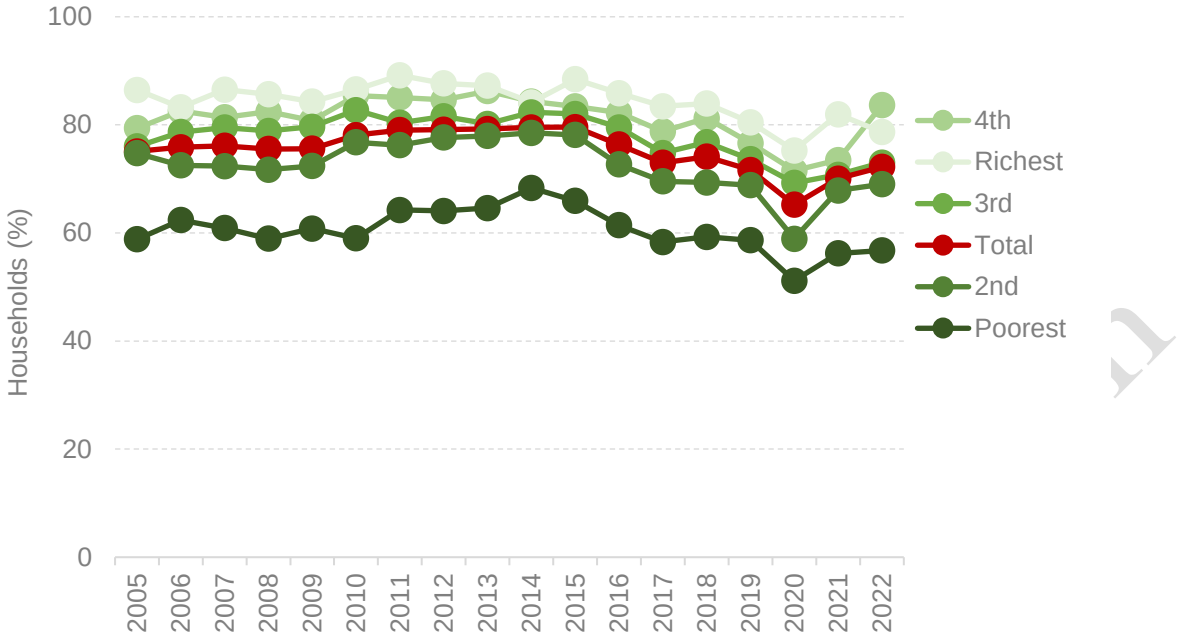
In 2022 out-of-pocket payments accounted for 4.6% of total household spending (the household budget) on average and ranged from around 3% in the poorest quintile to 5% in the richest, indicating a progressive distribution across quintiles (Fig. 10). On average the out-of-pocket payment share has increased since the beginning of the COVID-19 pandemic.

Out-of-pocket payments in 2022 were mainly driven by dental care (38%), followed by outpatient medicines (23%), medical products (18%) and outpatient care (19%) (Fig. 11). Spending on inpatient care and diagnostic tests accounted for about 3%. Over time the inpatient care share fell and the outpatient care share increased but the other shares did not notably change.

There is large variation in the drivers of out-of-pocket payments across quintiles in all years. In 2022 the share spent on outpatient medicines and medical products was higher in poorer households, while the share spent on outpatient care was higher in richer households (Fig. 12). Between 2005 and 2022 the outpatient medicines share of out-of-pocket payments fell in the poorer quintiles, dropping particularly sharply (from 48% in 2005 to 25% in 2022) in the poorest quintile (data not shown).

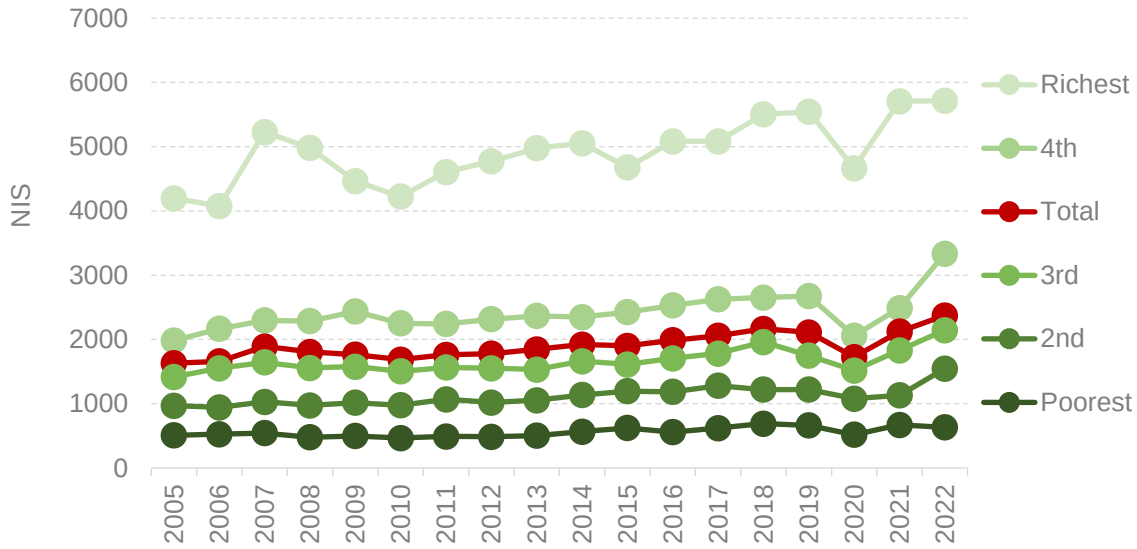
Per person spending on outpatient care and dental care has increased particularly sharply over time (Fig. 13), mainly driven by higher spending in the richest quintiles (data not shown). Spending on outpatient medicines and medical products has also increased but at a slower rate and – again – mainly driven by higher spending in the richest quintiles (data not shown). Per person spending on all types of care fell sharply in 2020 (particularly for dental care and medicines), probably related to a reduction in the use of health care that year due to the COVID-19 pandemic (Fig.13).

Fig. 8. Share of households with out-of-pocket payments by consumption quintile



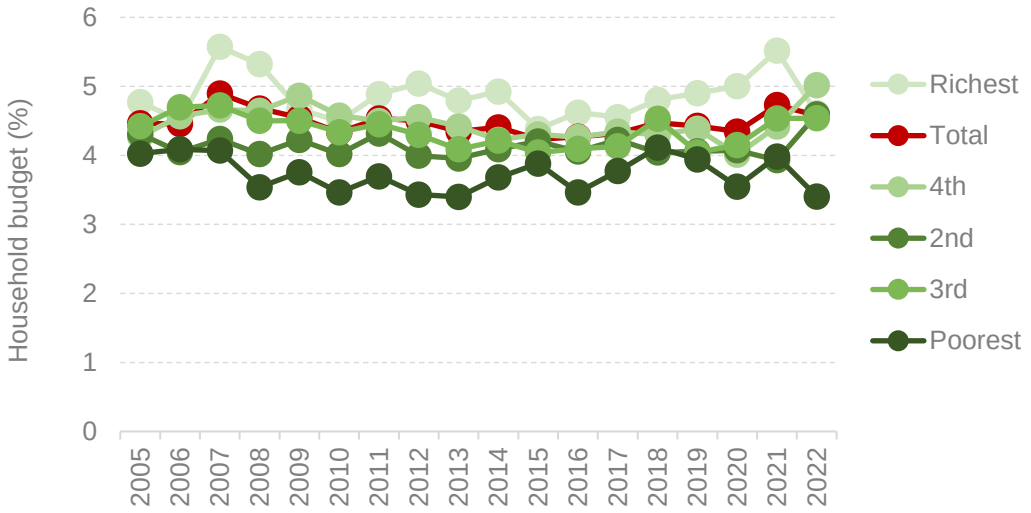
Source: authors, based on household budget survey data.

Fig. 9. Annual out-of-pocket spending on health care per person by consumption quintile



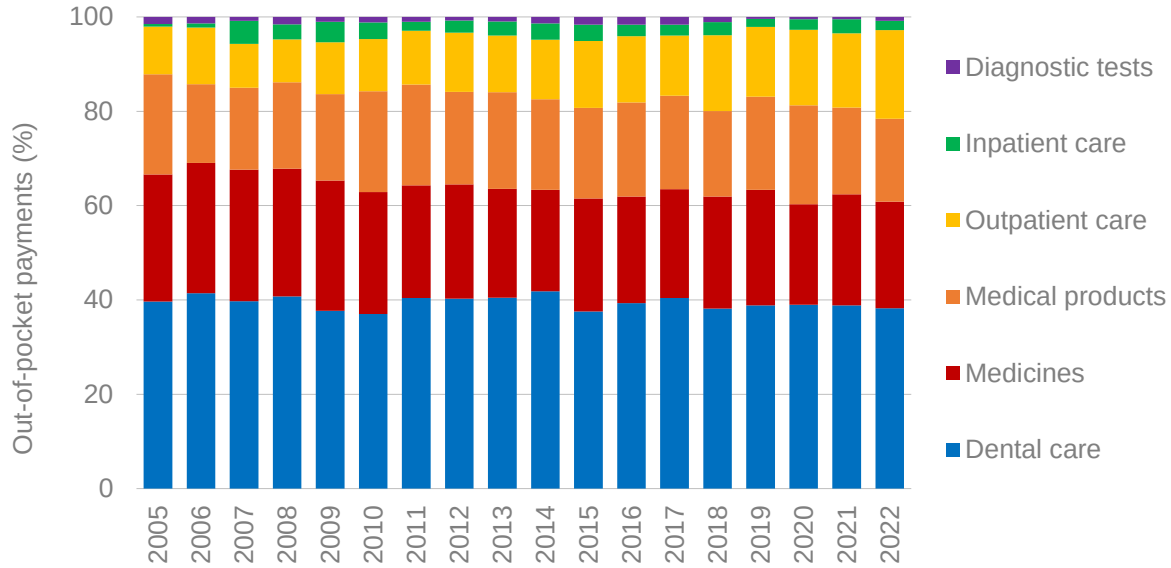
Note: amounts are shown in real terms (base year 2020).
Source: authors, based on household budget survey data.

Fig. 10. Out-of-pocket payments for health care as a share of household consumption by consumption quintile



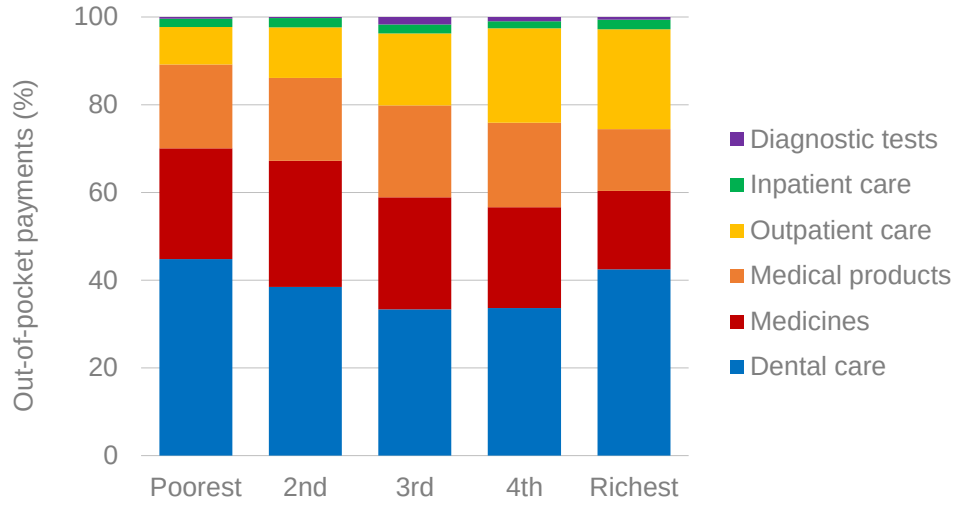
Source: authors, based on household budget survey data.

Fig. 11. Breakdown of out-of-pocket spending by type of health care



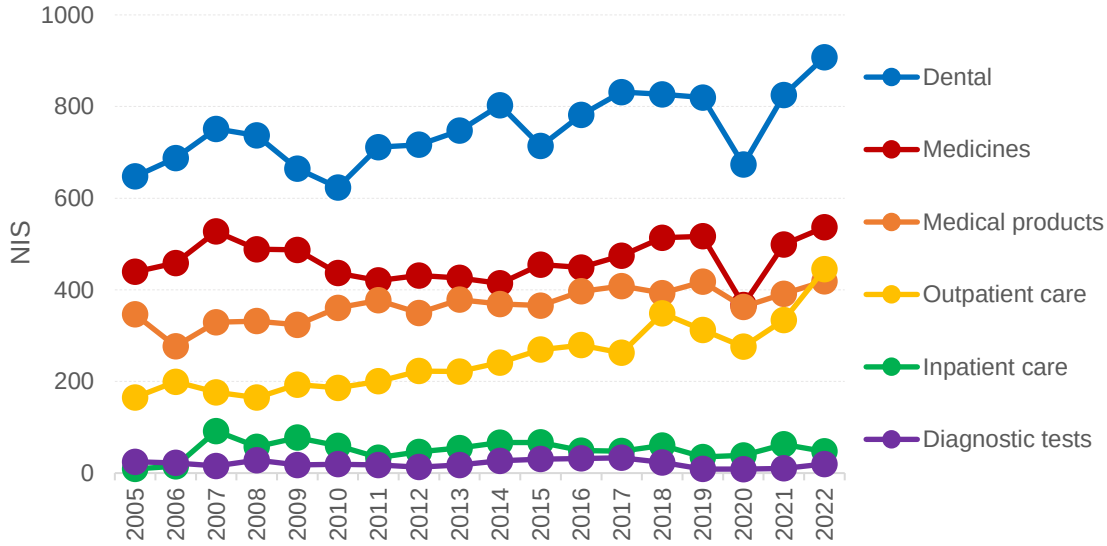
Note: medical products include things like glasses, contraceptives, vaccines and non-medicine products and equipment.
Source: authors, based on household budget survey data.

Fig. 12. Breakdown of out-of-pocket spending by type of health care and consumption quintile, 2022



Note: medical products include things like glasses, contraceptives, vaccines and non-medicine products and equipment.
Source: authors, based on household budget survey data.

Fig. 13. Annual out-of-pocket spending on health care per person by type of health care



Notes: amounts are shown in real terms (base year 2020). Medical products include things like glasses, contraceptives, vaccines and non-medicine products and equipment.
Source: authors, based on household budget survey data.

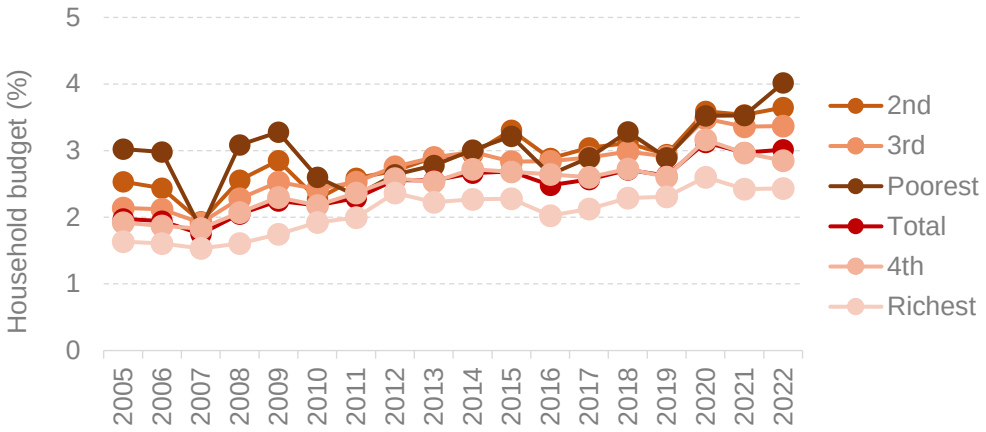
4.3 VHI premiums

Data from the household budget survey show that in 2022 VHI premiums accounted for 3% of total household spending (the household budget) on average (Fig. 14). When this is added to the 4.6% households spend out of pocket on average, it is evident that the financial burden of private spending on health is substantial (7.6% in 2022) (Fig. 15).

On average the share of household budgets spent out of pocket on health care has fallen over time (see Fig. 10) and out-of-pocket payments are less of a financial burden for poorer

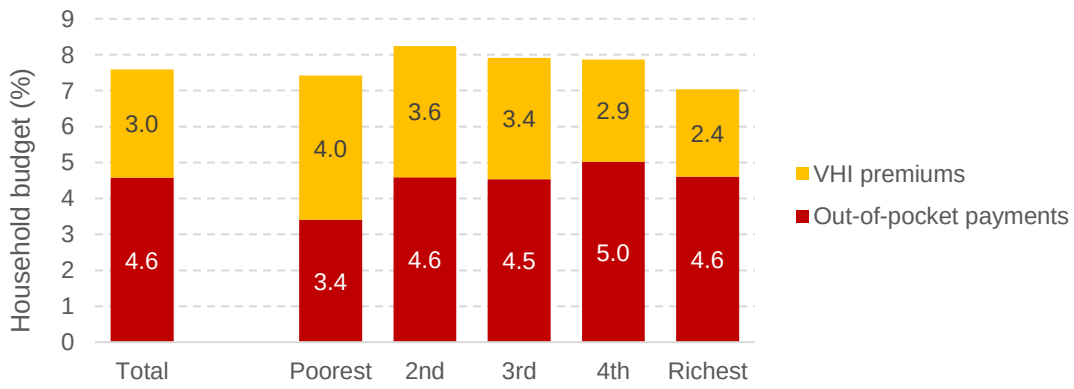
households (3% of total household spending in 2022) than richer households (5%) (Fig. 15). In contrast, the share of household budgets spent on VHI premiums has increased sharply over time (Fig. 14) and the distribution of VHI premiums across quintiles is consistently regressive – higher in the poorest quintile (4% in 2022) than in the richest quintile (2% in 2022) (Fig. 15).

Fig. 14. Spending on VHI premiums as a share of household consumption by consumption quintile



Source: authors, based on household budget survey data.

Fig. 15. Spending on out-of-pocket payments and VHI premiums as a share of household consumption by consumption quintile, 2022



Source: authors, based on household budget survey data.

4.4 Informal payments

Data from two surveys suggest that informal payments have been an issue in the past. A 2013 survey found that 12% of adults aged over 30 reported paying informally for health care (Cohen & Filc, 2017). A different survey carried out in 2016 found that 6% of adults aged over 22 had paid informally for health care in the past five years; those who underwent surgery were twice as likely to pay informally than people using other types of health care (Brammli-Greenberg et al., 2014). More recent data (beyond 2016) are not available.

4.5 Summary

Health accounts data show that out-of-pocket payments accounted for 20% of current spending on health in 2021, just above the EU average of 19%. The out-of-pocket payment share has fallen substantially in Israel over time, reflecting sustained increases in public spending on health per person.

Although public spending on health in Israel has grown steadily over time in real terms, it accounted for only 5.4% of GDP in 2021, well below the EU average of 7.2% and much lower than would be expected given Israel's level of GDP per person – Israel is on a par with countries with much lower levels of GDP per person (e.g. Bulgaria, Greece and Hungary). Israel's very low ratio of public spending on health to GDP reflects low "priority to health" in allocating the government budget, as well as the small size of total government spending in relation to GDP.

Broken down by type of care, the public share of current spending on health in Israel is highest for inpatient care (98%) and outpatient care (67%), and lowest for medicines and medical products (48%) and dental care (less than 2%). The public share of current spending on health is substantially lower in Israel than the EU average for outpatient care (84%) and dental care (33%).

Israel relies more heavily on VHI to finance health care than most other countries in Europe and globally. In 2021 VHI accounted for 10% of current spending on health in Israel – more than double the EU average of 4%. The VHI share nearly tripled in Israel between 2002 and 2015, in contrast to the EU average, which did not greatly change. VHI mainly finances outpatient care and some dental care but not outpatient medicines.

Household budget survey data show that richer households are more likely to incur out-of-pocket payments than poorer households. The richest households consistently spend around ten times as much out of pocket as the poorest households.

Out-of-pocket payments are mainly driven by dental care (38%) on average, followed by outpatient medicines (23%), medical products (18%) and outpatient care (19%). However, the share spent on outpatient medicines and medical products is consistently higher in poorer households, while the share spent on outpatient care is consistently higher in richer households. Over time the outpatient medicines share fell quite sharply in the poorest quintile.

Household budget survey data show that in 2022 VHI premiums accounted for 3% of total household spending (the household budget) on average. When this is added to the 4.6% households spend out of pocket on average, it is clear that the financial burden of private spending on health is substantial (7.6% in 2022).

The share of household budgets spent out of pocket on health care has fallen on average. In 2022 out-of-pocket payments were less of a financial burden for poorer households (3% of total household spending) than richer households (5%). In contrast, the share of household budgets spent on VHI premiums has increased sharply over time and VHI premiums are

consistently regressive, accounting for a much higher share in the poorest quintile (4% in 2022) than in the richest quintile (2% in 2022).

Survey data suggest informal payments have been an issue in the past, but recent data (beyond 2016) are not available.

5. Financial protection

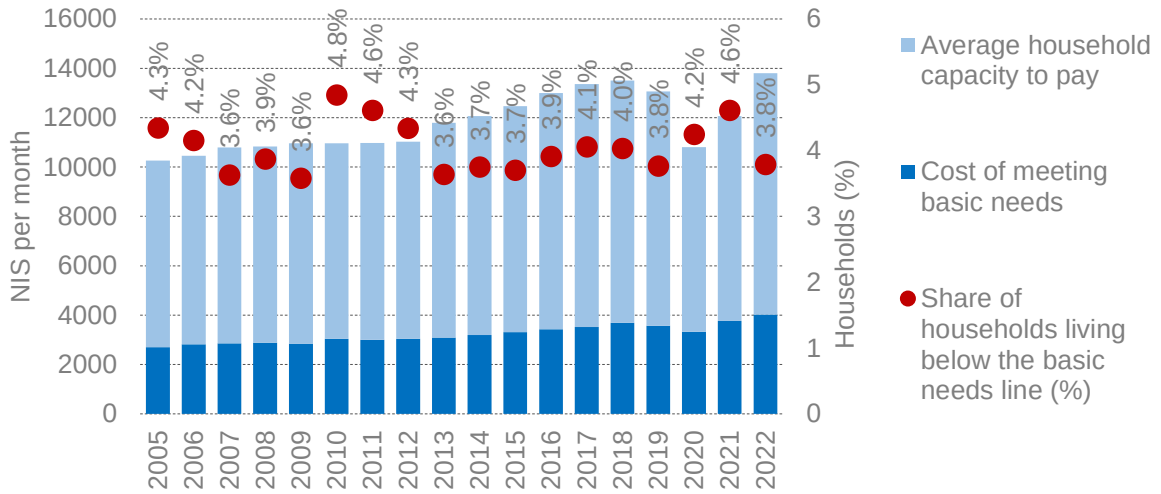
This section uses data from the Israeli household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households that use health services. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health services.

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household's budget after spending on basic needs. In this study basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and fuel) among a relatively poor part of the Israeli population (households between the 25th to 35th percentiles of the consumption distribution), adjusted for household size and composition. In 2022 the monthly cost of meeting these basic needs (the basic needs line) was NIS 4031, which was above the monthly national poverty line per person (50% of median income) of NIS 3076 (National Insurance Institute, 2023).

On average the cost of meeting basic needs and household capacity to pay for health care increased between 2005 and 2022 (Fig. 16), with a sharp decrease during the peak of the COVID-19 pandemic (2020 and 2021). The share of households living below the basic needs line was 4% in 2022 (Fig. 16), following an increase in 2020 and 2021 and a peak of 5% in 2010 after GDP fell in response to the global financial crisis (Bank of Israel, 2010).

Fig. 16. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic needs line



Note: amounts shown in real terms (base year 2020). Capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities.
Source: authors, based on household budget survey data.

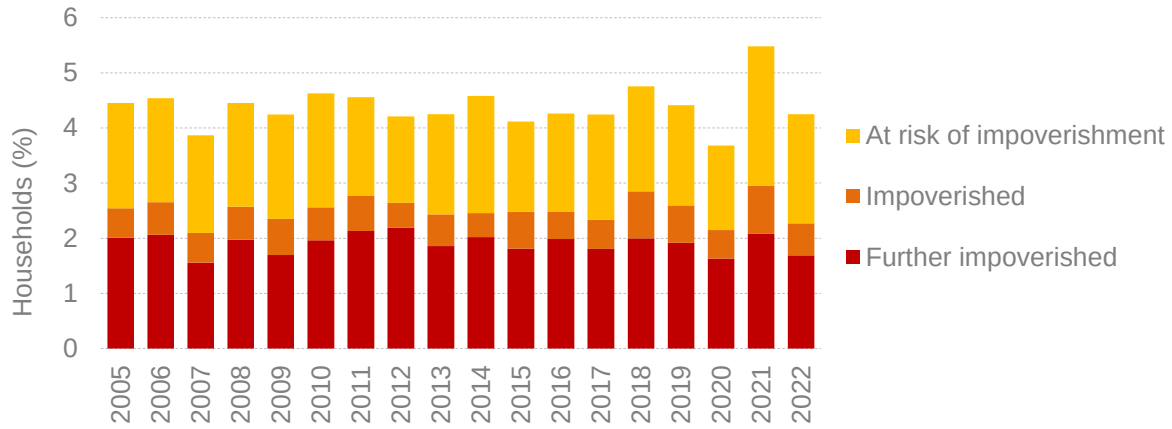
5.2 Financial hardship

How many households experience financial hardship?

Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. In 2022 2% of households were impoverished or further impoverished after out-of-pocket payments; this share has not greatly changed over time except for a decrease in 2020 (reflecting a drop in the use of health care in the first year of the COVID-19 pandemic) and a sharp increase in 2021 as people compensated for health care postponed in 2020 (Fig. 17).

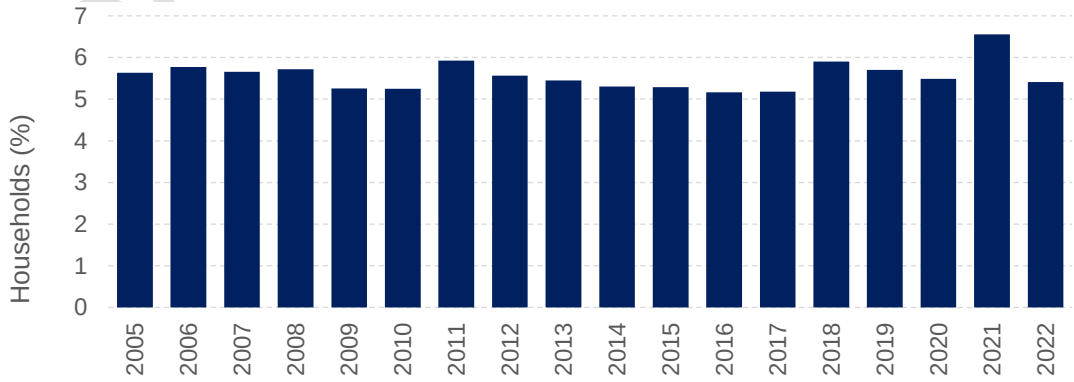
Households with catastrophic health spending are defined in this study as those who spend more than 40% of their capacity to pay for health care. In 2022 5% of households experienced catastrophic health spending – a share that has not greatly changed over time but had its highest level in 2021 (Fig. 18).

Fig. 17. Share of households at risk of impoverishment after out-of-pocket payments



Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments; further impoverished if its total spending is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line.
Source: authors, based on household budget survey data.

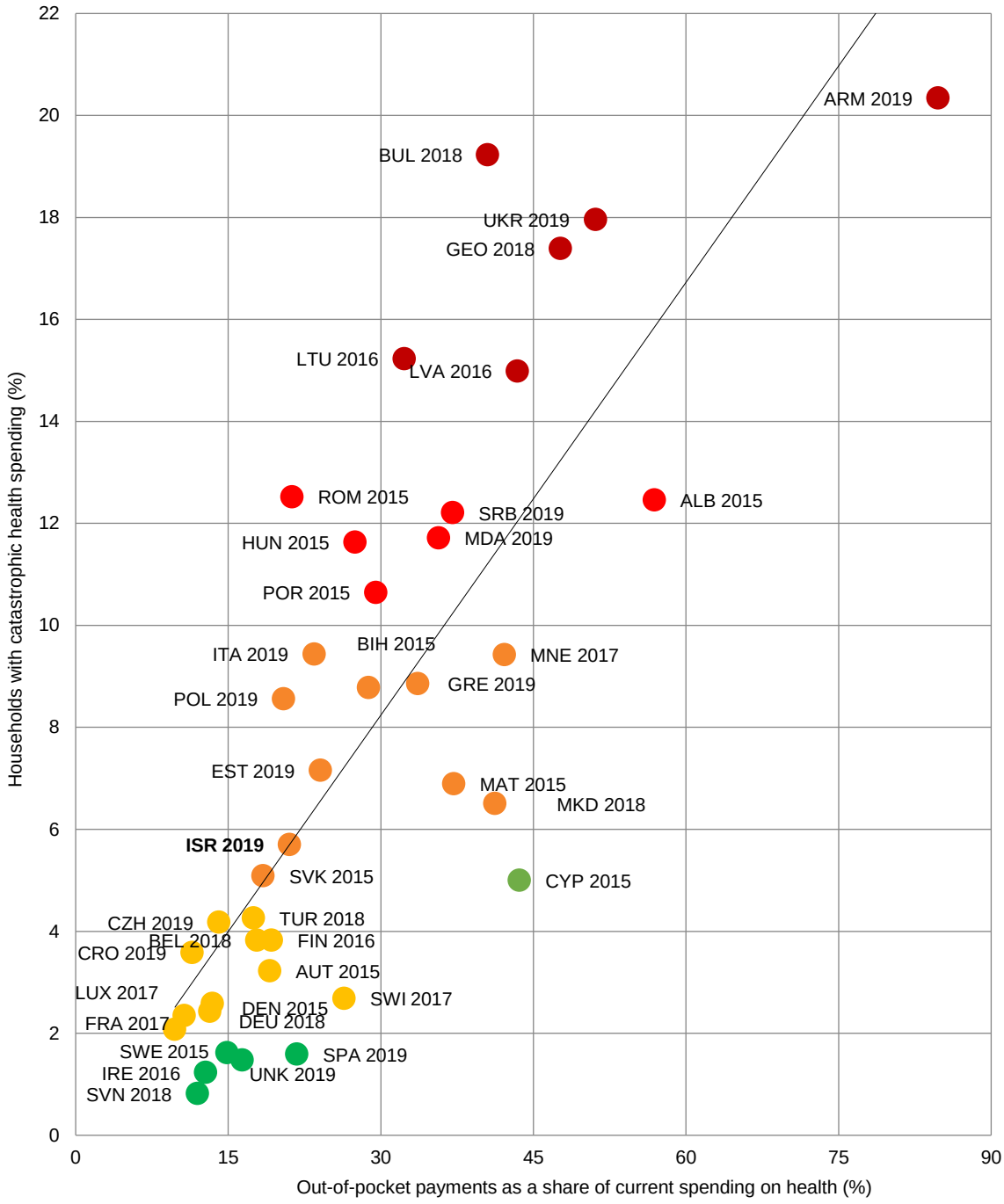
Fig. 18. Share of households with catastrophic health spending



Source: authors, based on household budget survey data.

The incidence of catastrophic health spending in Israel is lower than in many EU countries but higher than in countries with similar or heavier reliance on out-of-pocket payments – for example, Austria, Belgium, Finland, Spain and Switzerland (Fig. 19).

Fig. 19. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, 2019 or latest available year before COVID-19



Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. Dots are coloured by the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red > 15%. The list of country codes used here can be found in the Abbreviations.
Source: UHC watch (WHO Regional Office for Europe, 2024).

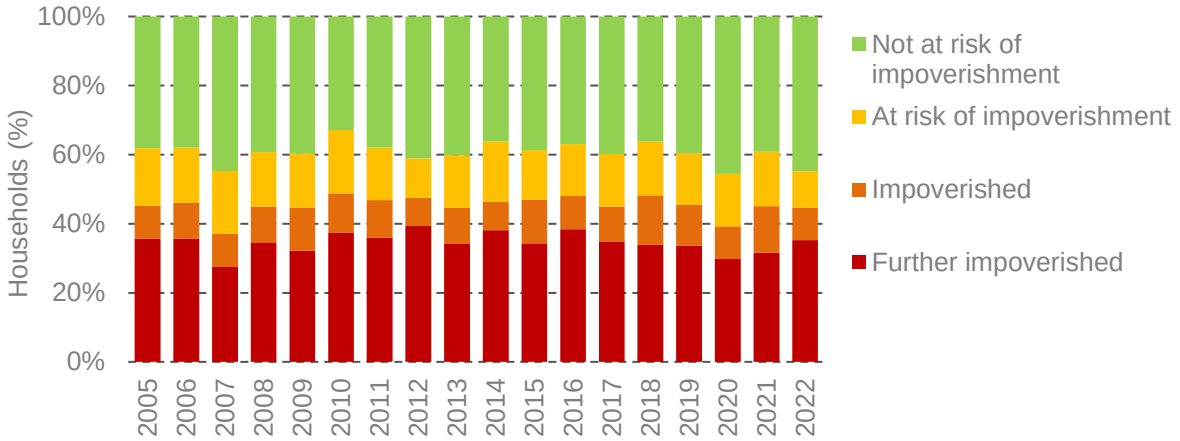
Who experiences financial hardship?

Just over half of all households with catastrophic health spending are further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 20).

Households with catastrophic health spending are heavily concentrated in the poorest consumption quintile (Fig. 21). In 2022 15% of households in the poorest quintile experienced catastrophic health spending, compared to 2% in the richest and 5% on average.

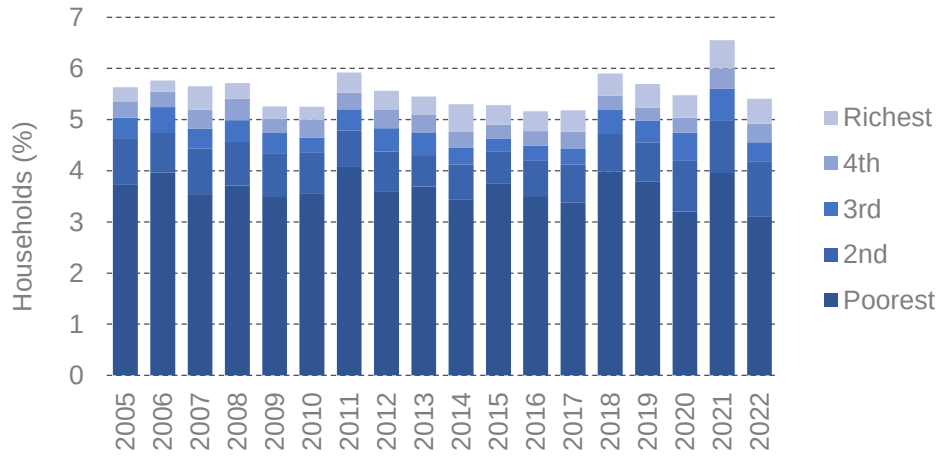
The incidence of catastrophic health spending is also much higher than average in households headed by ultra-orthodox Jews (10%), older adults (9%) or Arabs (7%) (Fig. 22). These findings reflect higher rates of poverty among ethnic and cultural minority groups (Waitzberg et al., 2020).

Fig. 20. Breakdown of households with catastrophic health spending by risk of impoverishment



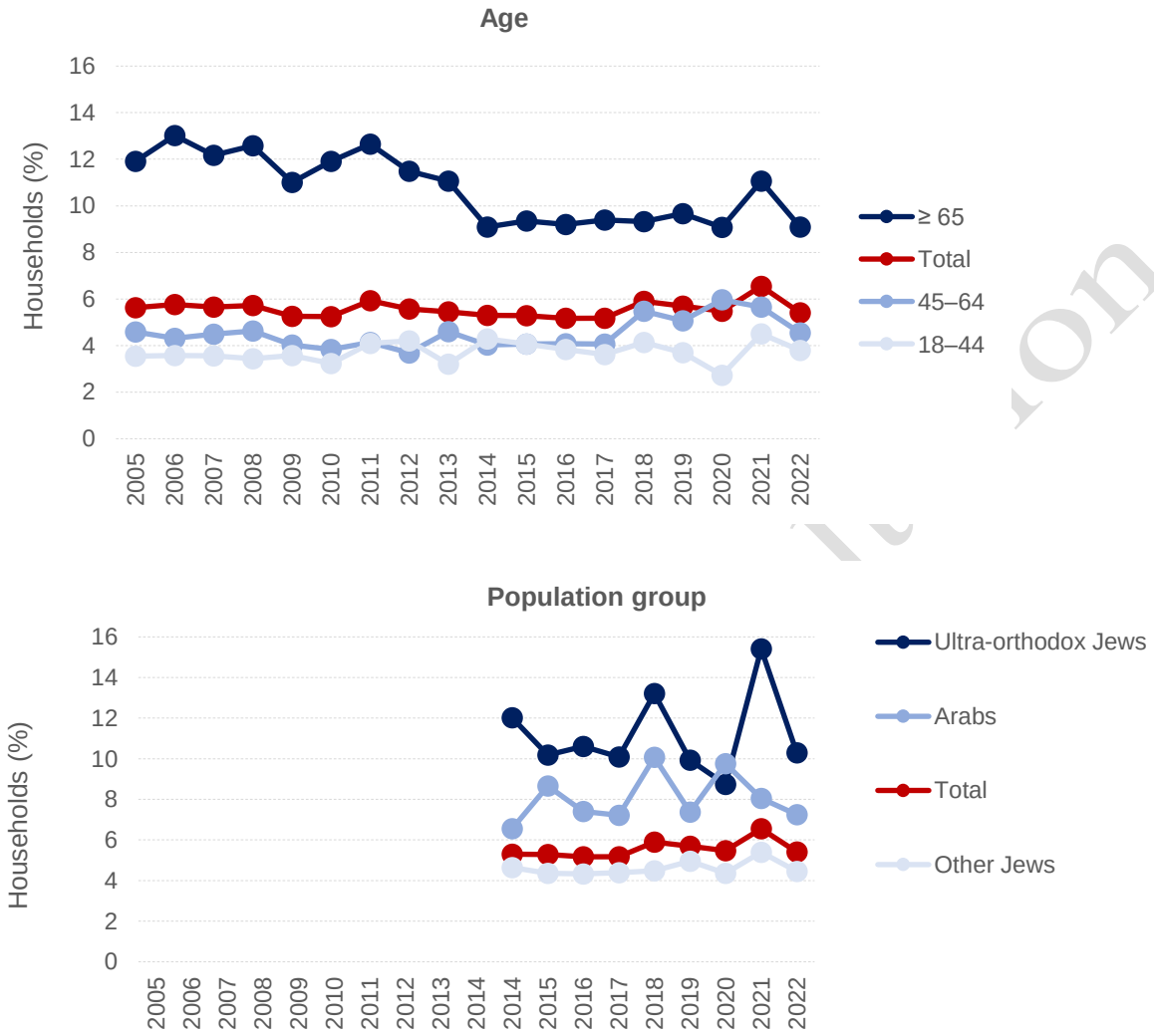
Note: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments; further impoverished if its total spending is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line.
Source: authors, based on household budget survey data.

Fig. 21. Share of households with catastrophic health spending by consumption quintile



Note: quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales.
Source: authors, based on household budget survey data.

Fig. 22. Share of households with catastrophic health spending by age and population group



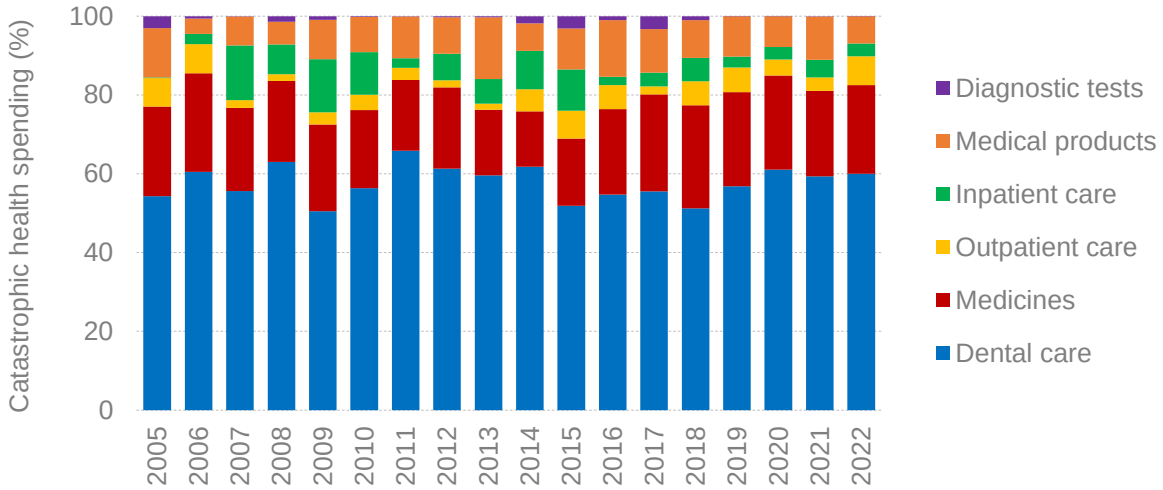
Notes: age and population group refer to the head of the household. The household budget survey did not consistently disaggregate data for population groups before 2014.
Source: authors, based on household budget survey data.

Which health services are responsible for financial hardship?

In 2022 catastrophic health spending was mainly driven by dental care (60%), followed by outpatient medicines (22%) and outpatient care (7%) (Fig. 23). These shares have fluctuated over time but the main drivers have not changed (Fig. 23).

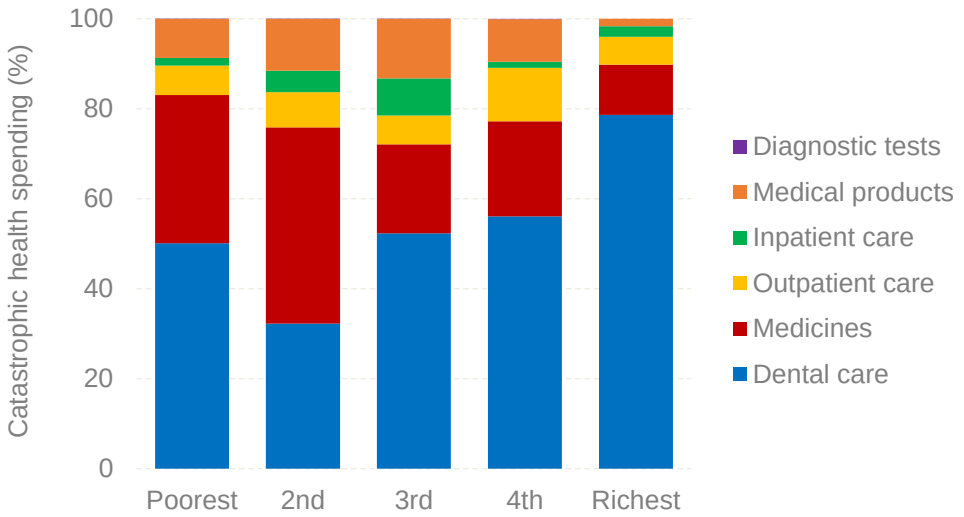
The drivers of financial hardship vary substantially by consumption quintile. In 2022 catastrophic health spending in the two poorest quintiles was mainly driven by medicines (33% for the poorest and 44% for the second quintile) and dental care (Fig. 24). In the richer quintiles it was mainly driven by dental care, followed by outpatient medicines (Fig. 24).

Fig. 23. Breakdown of catastrophic health spending by type of health care



Note: medical products include things like glasses, contraceptives, vaccines and non-medicine products and equipment.
Source: authors, based on household budget survey data.

Fig. 24. Breakdown of catastrophic health spending by type of health care and consumption quintile, 2022



Note: medical products include things like glasses, contraceptives, vaccines and non-medicine products and equipment.
Source: authors, based on household budget survey data.

5.3 Unmet need for health care

Data on unmet need for health care (see Box 1) due to cost, distance or waiting time show that in 2021 42% of adults reported unmet need for publicly financed health care (medicines, diagnostic tests or outpatient care), mainly due to waiting time (Fig. 25). Unmet need for publicly financed health care has grown since 2014, driven largely by an increase in unmet need due to waiting time. It does not vary substantially by VHI status but is higher than average among ultra-orthodox Jews and richer people (Fig. 26). Higher than average unmet need among richer people might be a consequence of this group seeking VHI-financed health care to avoid waiting times. In 2021 residents in the peripheral areas reported higher levels of

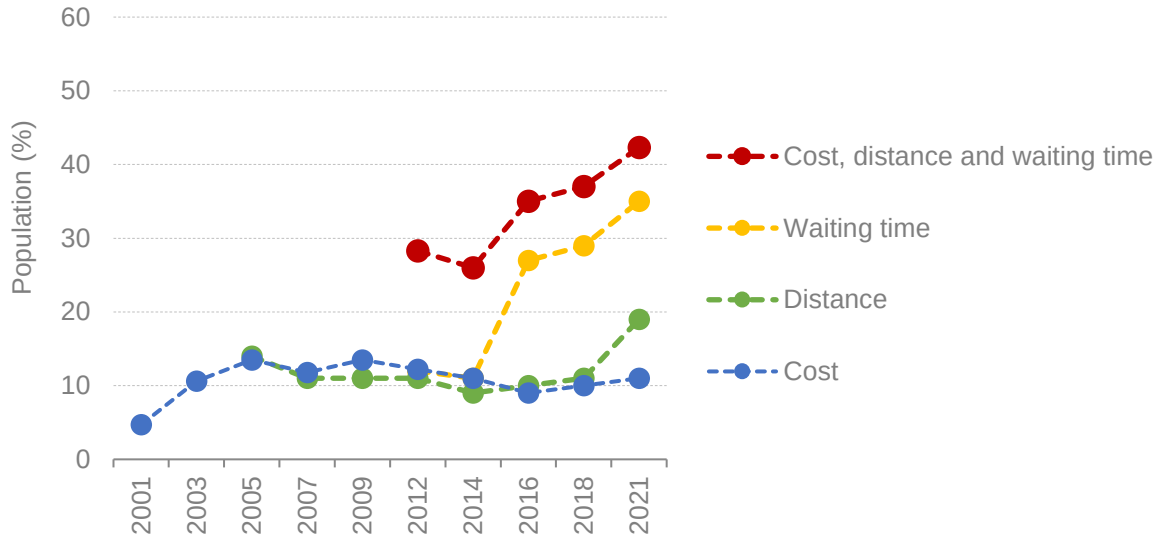
unmet need due to distance than residents in central areas (24% and 18% respectively, data not shown; Laron, Maoz-Breuer & Fialco, 2022). Half of those reporting unmet need due to distance or waiting time sought and received privately financed health care, particularly people with VHI and those with higher incomes.

Focusing on unmet need for health care due to cost alone shows that in 2021 this type of unmet need varied substantially by income, with 19% of adults in the poorest income quintile reporting unmet need compared to 11% on average and only 7% in the richest quintile (Fig. 27). Unmet need for health care due to cost also varies by ethnic and cultural group, with higher shares among ultra-orthodox Jews (23%) than Arabs or other Jews. Older adults report lower shares (8%), while people with chronic conditions report average rates, which may indicate that the design of coverage policy is relatively protective for these two groups of people.

Unmet need for outpatient medicines due to cost is also much higher than the national average in the poorest income quintile (13% in 2021 compared to 6% on average in the same year; data not shown), although it is lower than unmet need for health care due to cost (19% in the poorest quintile).

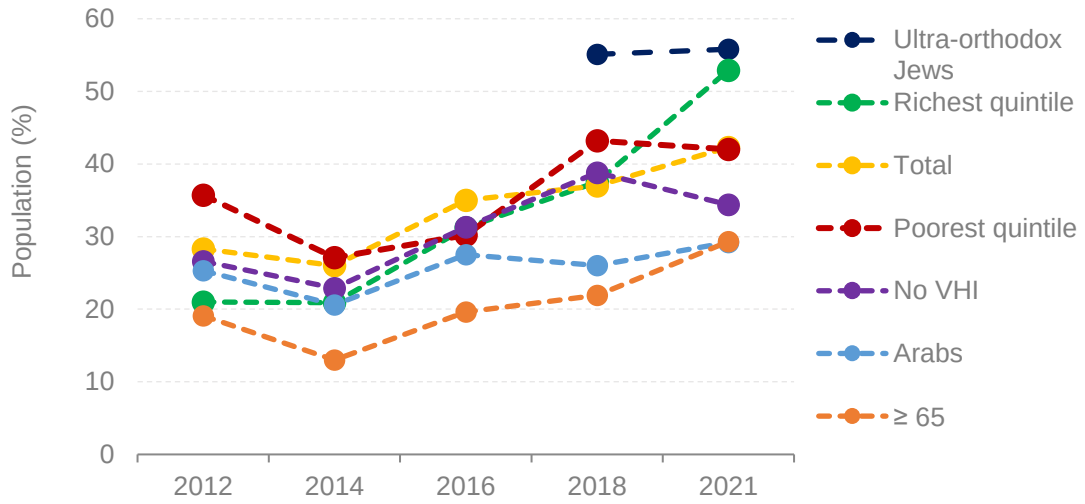
Unmet need for dental care due to cost (18% in 2016, the latest available year; Fig.28) is much higher than unmet need for publicly financed health care due to cost (4% in 2016; data not shown) and is marked by substantial and persistent income inequality; in 2016 (the latest available year) it was reported by 31% of adults in the poorest quintile and only 9% in the richest quintile (Fig. 28).

Fig. 25. Self-reported unmet need for publicly financed health care due to cost, distance and waiting time



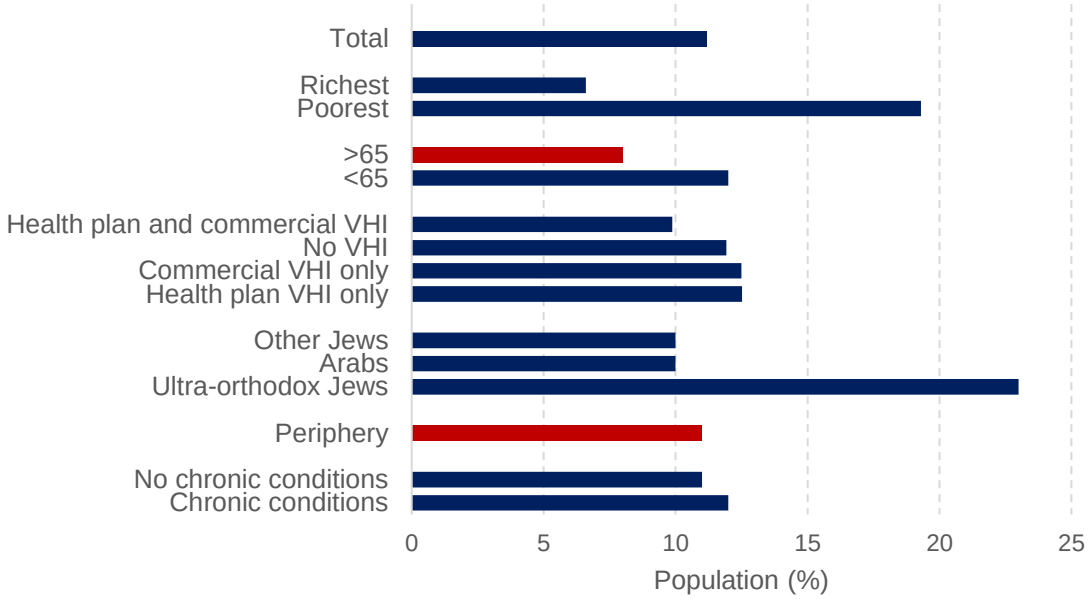
Notes: population refers to adults over 22 years old. Data are reported for the past 12 months for health care financed by the NHI scheme. Data on cost are for outpatient medicines, diagnostic tests and (from 2016) outpatient care. Data on distance (only available from 2005) and waiting time (only available from 2012) are for any type of health care.
Source: authors, based on data from the Myers-JDC-Brookdale Institute (2024).

Fig. 26. Inequality in self-reported unmet need for publicly financed health care due to cost, distance and waiting time



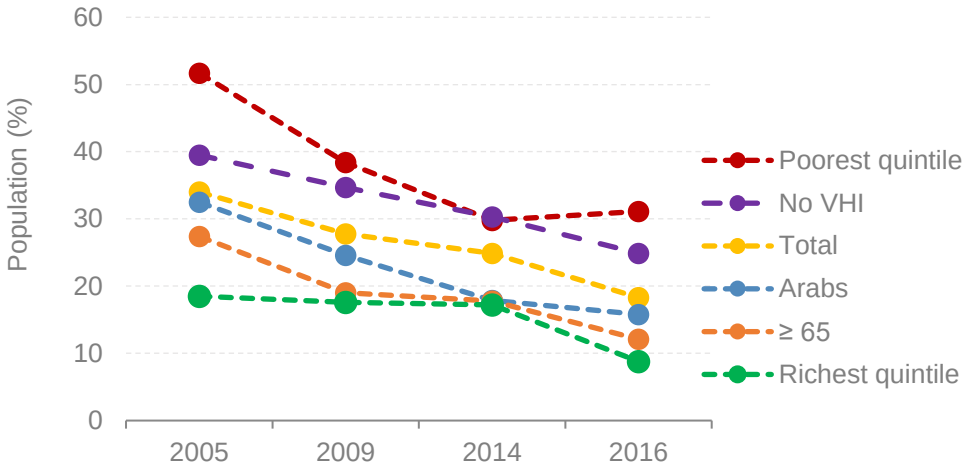
Notes: population refers to adults over 22 years old. Health care is defined here as outpatient medicines, outpatient care and diagnostic tests. Data on unmet need for health care are only available in selected years. Disaggregated data for ultra-orthodox Jews are only available from 2018.
Source: authors, based on data from the Myers-JDC-Brookdale Institute (2024).

Fig. 27. Inequality in self-reported unmet need for publicly financed health care due to cost, 2021



Note: population refers to adults over 22 years old. Health care is defined here as outpatient medicines, outpatient care and diagnostic tests. "Periphery" refers to households in areas with lower access to educational, economic and social activities. Bars in red indicate statistically significant results (p = 0.01).
Source: authors, based on data from the Myers-JDC-Brookdale Institute (2024).

Fig. 28. Inequality in self-reported unmet need for dental care due to cost



Note: population refers to adults over 22 years old. Data on unmet need for dental care are only available in selected years. Disaggregated data for ultra-orthodox Jews are not available.
Source: authors, based on data from the Myers-JDC-Brookdale Institute (2024).

5.4 Summary

The incidence of catastrophic health spending in Israel is lower than in many EU countries, but higher than in countries with similar or heavier reliance on out-of-pocket payments – for example, Austria, Belgium, Finland, Spain and Switzerland.

In 2022 2% of households were impoverished or further impoverished after out-of-pocket payments and 5% of households experienced catastrophic health spending. Both indicators have remained stable over time.

Catastrophic health spending is heavily concentrated in households with low incomes. In 2022 the incidence of catastrophic health spending was highest among households in the poorest quintile (15%) and those headed by ultra-orthodox Jews (10%), older adults (9%) and Arabs (7%).

In the two poorest quintiles catastrophic health spending is mainly driven by outpatient medicines and dental care. In the richer quintiles it is mainly driven by dental care, followed by outpatient medicines. The fact that dental care is a smaller than average driver of catastrophic health spending in poorer households reflects high levels of unmet need for dental care in these households.

In 2021 11% of adults reported unmet need for health care due to cost, rising to 19% in the poorest income quintile. In the same year unmet need for outpatient medicines due to cost was also higher than the national average in the poorest quintile (13% compared to 6%). Unmet need for dental care due to cost is much higher than unmet need for health care and marked by substantial income inequality – 31% of adults in the poorest quintile reported unmet need for dental care in 2016 compared to only 9% in the richest quintile.

6. Factors that strengthen and undermine financial protection

This section considers factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Israel and which may explain the trend over time.

6.1 Coverage policy

Coverage policy in Israel has some strengths. The following aspects offer examples of good practice to other countries:

- Unusually for a SHI scheme, entitlement to NHI benefits is based on permanent residence and does not depend on payment of earmarked contributions (the "health tax"), so all permanent residents are covered.

- The NHI covers a wide range of health care, including good coverage of outpatient prescribed medicines, and there is an explicit process in place to review and update the benefits package and its budget every year.

- User charges (co-payments) for primary care visits (including visits to GPs, internal medicines specialists, gynaecologists and paediatricians) were abolished in 2015 and there are no co-payments for inpatient care, diagnostic tests (laboratory tests) and the treatment of a few communicable and chronic conditions (dialysis, cancer, HIV/AIDS, Gaucher disease, cystic fibrosis, thalassemia, haemophilia and tuberculosis). Some co-payments are capped including co-payments for outpatient specialist visits and diagnostic imaging and, for people with chronic conditions, co-payments for outpatient prescribed medicines.

- The children of refugees, asylum seekers and undocumented migrants are entitled to the same benefits as resident children if their parents pay a fee of NIS 120.

Gaps in all three dimensions of coverage policy persist, however.

Population coverage: adult refugees, asylum seekers and undocumented migrants who do not work (around 1% of the population) only have access to publicly financed emergency care and some primary and specialist care for a few selected conditions. If refugees and asylum seekers are employed, they are required to be covered by mandatory private health insurance purchased by employers and jointly funded by employers (who must pay at least two thirds of the flat-rate premium cost) and employees. However, insurers offering this form of coverage are not required to cover pre-existing conditions or childbirth and it is difficult to enforce mandatory private health insurance for refugees and asylum seekers.

Service coverage: although the NHI benefits package is broad, it does not cover dental care for adults unless they are aged 72 or older; coverage of medical products for eye care (glasses) is limited – it is only covered for children under the age of 8; waiting times are an issue for elective surgical procedures, specialized outpatient care, imaging diagnostic tests, outpatient child development services (such as physiotherapists and psychologists); and distance is a barrier for people living in peripheral areas.

Although the NHI scheme gradually introduced dental care for children and older adults between 2012 and 2019, publicly financed dental treatment is subject to user charges and many people continue to pay out of pocket for privately provided treatment due to long waiting times for publicly financed dental care and lack of awareness of public entitlements (Ashkenazi et al., 2016; Berg-Warman et al., 2021; Shahrabani et al., 2015). Two recent committees have recommended expanding coverage of dental care and improving the regulation of publicly and privately provided care (Ministry of Health, 2023b; 2023c).

User charges are applied to most outpatient specialist visits, emergency care without referral, outpatient imaging diagnostic tests, prescribed medicines and medical products. The design of user charges policy is complex and marked by the following weaknesses:

- **Percentage co-payments are applied to outpatient prescribed medicines**; although there is a cap on these co-payments for people with chronic conditions, which is more protective for older people, there are no exemptions for people with low incomes. This is likely to be one reason why this type of health care is the main driver of catastrophic health spending for people in the poorest income quintile, and unmet need for health care and medicines due to cost is much higher than average in the poorest income quintile.

- **The only income-based exemption is for co-payments for outpatient specialist visits;** older people receiving income support allowances are exempt from these co-payments, as well as children needing development services or rehabilitation and living in households receiving support allowances.

- Although all households benefit from a cap on co-payments for outpatient specialist visits and diagnostic tests (which is separate from the cap on co-payments for outpatient prescribed medicines for people with chronic conditions), **there is no overall cap on all user charges and neither of the caps is linked to income**.

6.2 VHI

VHI accounts for an unusually high share of current spending on health (10% in Israel in 2021, compared to an EU average of 4%) and covers a very high share of the population (around 90% in 2022). In spite of the large number of policy holders, VHI does not address important gaps in publicly financed coverage, particularly for people with lower incomes. It does not fill gaps in population coverage or gaps caused by user charges and it plays a very minor role in addressing gaps in dental care coverage – 92% of all spending on dental care came from out-of-pocket payments in 2021 (see Fig. 7) and dental care accounted for 38% of out-of-pocket payments in 2022 (see Fig. 11).

Very high take-up of supplementary VHI (providing faster access to treatment) and the high prevalence of dual coverage (people who hold both health plan and commercial VHI) come at a cost, reducing equity and efficiency by skewing health care resources towards richer households in the following ways:

- Take-up of VHI is much higher in richer than poorer households. In 2022 only 80% of households in the poorest quintile had VHI compared to 95% in the richest (see Fig. 2).

- VHI premiums represent a significant financial burden on households. In 2022 households spent 3% of their budget on VHI premiums on average, in addition to spending 4.6% of their budget through out-of-pocket payments (see Fig. 10 and Fig. 14).

- Dual coverage adds to the financial burden on households and wastes resources because many people pay twice for the same sort of VHI policy.

- VHI widens inequities in access to care, with VHI owners enjoying shorter waiting times and wider choice and availability of providers.

- User charges for VHI-financed health care are a financial barrier to access for VHI-covered households with lower incomes. As a result, richer households make more use of VHI-financed health care than (covered) poorer households (Waitzberg, Maoz-Breuer & Katz, 2023). This means people with low incomes are subsidizing VHI-financed access to health care for richer people.

- The growth of commercial VHI affects the quality and availability of publicly financed health care by pushing up health care prices, drawing health care professionals away from publicly financed providers and exacerbating workforce shortages and waiting times in the publicly financed part of the health system. This pushes more people to seek privately financed treatment and widens inequality in access to health care among those with and without VHI (Ministry of Health, 2023c).

6.3 Public spending on health

Sustained increases in public spending on health and spending through VHI (see Fig. 4) have not reduced the incidence of catastrophic health spending over time. There are several possible reasons for this:

- Catastrophic health spending is mainly driven by out-of-pocket payments for services that are not actually covered by the NHI (e.g. dental care and medical products). Dental care accounted for 38% of out-of-pocket payments and 60% of catastrophic health spending in 2022 (see Fig. 11 and Fig. 23), but in 2019 public spending only accounted for 1.6% of all spending on dental care, the latest year of data available (see Fig. 7).

- Increased public spending on health has been allocated in ways that do not reduce out-of-pocket payments (e.g. raising physician salaries but not reducing user charges). The average income of hospital-based specialists grew by 76% between 2007 and 2018 (Belinsky, Ben Naim & Hecht, 2018) and the average income of GPs employed by health plans and self-employed GPs grew by 74% and 66% respectively in in real terms between 2010 and 2018 (Ben Naim & Hershko, 2018) – in all instances at a much higher rate than average prices (Central Bureau of Statistics**,** 2023b).

- Coverage expansions have not focused enough on reducing unmet need and financial hardship for households with low incomes.

- The additional spending has not been large enough to increase public spending on health as a share of GDP so that it is in line with Israel's level of economic development. At 5.4% in 2021, public spending as a share of GDP in Israel is well below the EU average

of 7.1%. It is much lower than in countries with similar or lower levels of GDP per person (e.g. Croatia, Czechia, Portugal, Slovenia and Spain) and on a par with countries with much lower levels of GDP per person (e.g. Bulgaria, Greece and Hungary). This means there is scope to increase this ratio in Israel.

6.4 Summary

Coverage policy in Israel has notable strengths: all permanent residents are entitled to NHI benefits, regardless of payment of earmarked contributions; the NHI schemes covers a wide range of health care, including outpatient prescribed medicines; there are no user charges for primary care visits, inpatient care and some diagnostic tests; and the children of asylum seekers, refugees and undocumented migrants are entitled to the same benefits as children covered by the NHI scheme if their parents pay a monthly fee.

Gaps in coverage persist, however: the NHI benefits package excludes dental care for many adults and offers very limited coverage of eye care; waiting times are a concern for various types of health care; the design of co-payments for outpatient specialist care and outpatient prescribed medicines is weak; and adult asylum seekers, refugees and undocumented migrants (1% of the population) only have access to publicly financed emergency care and some care for a handful of conditions.

Although VHI covers a very high share of the population and accounts for an unusually large share of current spending on health, it does not address important gaps in publicly financed coverage, particularly for people with lower incomes. Very high take-up of supplementary VHI and the high prevalence of dual coverage reduce equity and efficiency by skewing health care resources towards richer households.

Sustained increases in public spending on health have not reduced the incidence of catastrophic health spending over time because they have not been large enough to increase public spending on health as a share of GDP and additional funds have not been allocated in ways that reduce out-of-pocket payments, particularly for people with low incomes.

7. Implications for policy

Financial hardship caused by out-of-pocket payments is lower in Israel than in many EU countries (5% of households experienced catastrophic health spending in 2022, the latest year of data available), but it is higher than in countries with similar or heavier reliance on out-of-pocket payments, such as Austria, Belgium, Finland, Spain and Switzerland (see Fig. 19).

Catastrophic health spending is heavily concentrated in households with low incomes and those headed by ultra-orthodox Jews, older adults and Arabs. Over half of all households with catastrophic health spending are in the poorest consumption quintile, with an incidence (15% in 2022) that is three times higher than the national average.

In the two poorest quintiles catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines and dental care. In the richer quintiles it is mainly driven by out-of-pocket payments for dental care, followed by outpatient medicines**.**

Unmet need for publicly funded health care due to cost, distance and waiting time has grown over time, is very high and is mainly driven by waiting time (affecting 42% of adults in 2021, the latest year of data available). It does not vary much by income or VHI status, but in 2021 half of those reporting unmet need due to distance or waiting time used privately financed health care and these rates were higher among people with VHI and those with higher incomes. Levels of unmet need for health care, dental care and outpatient medicines due to cost are much higher than average in the poorest income quintile, clearly indicating that financial barriers to access are more common in poorer households.

These findings reflect notable strengths in the design of coverage policy. All permanent residents in Israel are entitled to NHI benefits, regardless of payment of earmarked contributions. The NHI covers a wide range of health care, including good coverage outpatient prescribed medicines; there are no user charges for primary care visits, inpatient care and some diagnostic tests; and the children of refugees, asylum seekers and undocumented migrants are entitled to the same benefits as resident children if their parents pay a monthly fee of NIS 120.

However, substantial income inequality in financial hardship and unmet need indicate key gaps in coverage. The NHI benefits package excludes dental care for many adults and provides very limited coverage of medical products; the design of co-payments for some outpatient specialist care and outpatient prescribed medicines is weak; and adult refugees, asylum seekers and undocumented migrants who do not work (around 1% of the population) only have access to publicly financed emergency care and some primary and specialist care for a handful of conditions.

VHI is an inefficient way of financing health care and exacerbates inequalities in access. In spite of the large number of policy holders, VHI does not address important gaps in publicly financed coverage, particularly for people with low incomes, and the very high take-up of supplementary VHI and the high prevalence of dual coverage reduce equity and efficiency by skewing health care resources towards richer households.

Public spending on health has not been effective enough at protecting households with low incomes from out-of-pocket payments. This is because additional funds have not been

large enough to increase public spending on health as a share of GDP or allocated in ways that reduce out-of-pocket payments.

Improving financial protection will only be possible if the Government continues to invest in health, despite the economic challenges created by the war, and if public spending on health rises to match Israel's level of economic development.

Additional public funds should be used to address gaps in coverage for people with low incomes. This could be achieved in the following ways:

- Expand coverage of publicly financed dental care (especially for children and adults with low incomes), and of medical products, particularly those related to rehabilitation and disabilities, for which there has been a surge in demand since the escalation of the war.

- Avoid introducing any new co-payments for publicly financed health care. Replace percentage copayments for outpatient prescribed medicines with low, fixed (flat-rate) co-payments (like those used for visits to outpatient specialist care). Reduce co-payments (discounts) for people receiving welfare support from the National Insurance Institute, as a first step towards exempting people with low incomes from all co-payments. Unify existing co-payment caps, extend a unified cap to all co-payments and link it to income, so that it is more protective for people with lower incomes.

- Improve access to coverage for the children of refugees, asylum seekers and undocumented migrants by breaking the link between their entitlement to publicly financed health care and payment of a monthly fee by their parents, and extend coverage for non-permanent resident adults who are not employed.

The Government should also find ways to curb the growth of VHI providing faster access to care and to continue to limit dual coverage (having VHI from a health plan and a commercial insurer). Israel's experience, echoed by international experience, shows that this type of VHI undermines equity and efficiency when it is allowed to play a significant role in the health system. Part of the solution lies in bringing down waiting times for publicly financed health care to more acceptable levels, finding ways to prevent doctors from shifting users from public to private practice and improving access to health care in peripheral areas.

References

Ashkenazi Y, Yankellevich A, Zusman S, Natapov L (2016). Patterns of Utilization and Experiences of Children in Dental Care Following the Reform of Dental Care in Israel. RR-710–16. Jerusalem: Myers-JDC-Brookdale Institute (https://brookdale.jdc.org.il/en/publication/patterns-utilization-experiences-children-dental-care-following-reform-dental-care-israel/).[2]

Baird K (2016a). High Out-of-pocket Medical Spending among the Poor and Elderly in Nine Developed Countries. Health Serv Res. 51(4):1467–1488. (https://doi.org/10.1111/1475-6773.12444).

Baird K (2016b). The incidence of high medical expenses by health status in seven developed countries. Health Policy. 120 (1):26–34 (https://doi.org/10.1016/j.healthpol.2015.10.004).

Bank of Israel (2010). Annual report 2009. Jerusalem: Bank of Israel (https://www.boi.org.il/en/communication-and-publications/regular-publications/bank-of-israel-annual-report/bank-of-israel-annual-report-2009/).

Bank of Israel (2023). Annual report 2022. Jerusalem: Bank of Israel (https://www.boi.org.il/en/communication-and-publications/regular-publications/bank-of-israel-annual-report/bank-of-israel-annual-report-2022/).

Belinsky A, Ben Naim G, Hecht Y (2018). שכר רופאי בתי החולים הממשלתיים מרפואה ציבורית ופרטית – ממצאים ומגמות [Salary of government hospital doctors from public and private medicine – findings and trends]. Jerusalem: Ministry of Finance of Israel (https://www.gov.il/he/departments/publications/reports/article_29012018) (in Hebrew).

Ministry of Finance (2022). עצמאים לעומת שכירים – שכר רופאי המשפחה בקופות החולים, 2018-2010 [Analysis of the salary of family doctors according to the form of employment and other characteristics 2010–2018]. Jerusalem: Ministry of Finance of Israel (https://www.gov.il/BlobFolder/dynamiccollectorresultitem/periodic-review-07092022/he/weekly_economic_review_periodic-review-07092022.pdf) (in Hebrew).

Berg-Warman A, Schiffman IK, Zusman SP, Natapov (2021). Oral health of the 65+ age group in Israel-2020. Isr J Health Policy Res. 10: 58 (https://doi.org/10.1186/s13584-021-00494-6).

Brammli-Greenberg S, Waitzberg R, Medina-Artom T, Adijes-Toren A (2014). Low-budget policy tool to empower Israeli insureds to demand their rights in the healthcare system. Health Policy. 118(3) (https://doi.org/10.1016/j.healthpol.2014.11.005).

Brammli-Greenberg, Yaari I, Avni A (2020). Public Opinion on the Level of Service and Performance of the Healthcare System 2016. Jerusalem: Myers-JDC-Brookdale Institute. (https://brookdale.jdc.org.il/en/publication/public-opinion-on-the-level-of-services-and-performance-of-the-healthcare-system-in-2016/).

Central Bureau of Statistics (2020). ממדי העוני והאי-שוויון בהכנסות –2020 לפי נתונים מנהליים

[2] All online references were accessed on 4 July 2024.

[The dimensions of poverty and income inequality - 2020 According to administrative data]. Jerusalem: Central Bureau of Statistics (https://www.btl.gov.il/Publications/oni_report/Documents/oni2020.pdf) (in Hebrew).

Central Bureau of Statistics (2023a). Household expenditure survey. Jerusalem: Central Bureau of Statistics (in Hebrew).

Central Bureau of Statistics (2023b). Average monthly wages per employee job at current prices. Jerusalem: Central Bureau of Statistics (https://www.cbs.gov.il/he/publications/doclib/2023/y_labor0523/e4_02.pdf).

Chaupain-Guillot S, Guillot O (2014). Health system characteristics and unmet care needs in Europe: an analysis based on EU-SILC data. Eur J Health Econ. 16:781–96. (https://doi.org/10.1007/s10198-014-0629-x).

Cohen N, Filc D (2017). An alternative way of understanding exit, voice and loyalty: the case of informal payments for health care in Israel. Int J Health Plan and Manag. 32(1):72–90 (https://doi.org/10.1002/hpm.2309).

Cylus J, Thomson S, Evetovits T (2018). Catastrophic health spending in Europe: equity and policy implications of different calculation methods. Bull World Health Organ. 96(9):599–609 (https://doi.org/10.2471/BLT.18.209031).

Eurostat (2024a). Persons at risk of poverty or social exclusion by age and sex. In: Eurostat [online database]. Brussels: European Commission (https://ec.europa.eu/eurostat/databrowser/view/ilc_peps01n/default/table?lang=en&category=livcon.ilc.ilc_pe.ilc_peps).

Eurostat (2024b). Gini coefficient of equivalised disposable income. In: Eurostat [online database]. Brussels: European Commission (https://ec.europa.eu/eurostat/databrowser/view/ilc_di12/default/table?lang=en&category=livcon.ilc.ilc_ie.ilc_iei).

Gal J, Madhala S, Oberman O (2023). Israel's Social Welfare System After the COVID-19 Crisis: An Overview. Jerusalem: Taub center (https://www.taubcenter.org.il/en/research/israels-social-welfare-system-after-the-covid-19-crisis-an-overview-2022/).

Gibson G, Grignon M, Hurley J, Wang L (2019). Here comes the SUN: Self-assessed unmet need, worsening health outcomes, and health care inequity. Health Econ. 28(6):727–735. (https://doi.org/10.1002/hec.3877).

Government of Israel (1994). חוק ביטוח בריאות ממלכתי [National Health Insurance Law]. Jerusalem: Government of Israel (in Hebrew).

Government of Israel (1995). חוק זכויות החולה [Patient Rights Law]. Jerusalem: Government of Israel (https://www.nevo.co.il/law_html/law00/71833.htm) (in Hebrew)

Government of Israel (2023). המשך מתן סיוע הומניטרי לאזרחי אוקראינה שנמלטו מהמלחמה בארצם ואינם זכאי שבות [Government decision number 1212 from the 31.12.2023. Continuing to provide

humanitarian aid to citizens of Ukraine who fled the war in their country and are not entitled to return]. Jerusalem: Government of Israel (https://www.gov.il/he/pages/dec1212-2023) (in Hebrew).

Government of Israel (2024). הרפואי לסיוע בנוגע עדכון [Update regarding medical assistance]. Jerusalem: Government of Israel (https://govextra.gov.il/molsa/tzav-hashaa/home/internal-page-medical-assistance) (in Hebrew).

Haklai Z, Applbaum Y, Myers V, Saban M, Gordon E, Luxenburg O, et al (2022). The effect of the COVID-19 pandemic on non-COVID respiratory ED visits in Israel. Am J Emerg Med. 53:215–221 (https://doi.org/10.1016/j.ajem.2022.01.005).

Knesset (2013). שירותי בריאות לעובדים זרים ולחסרי מעמד אזרחי
[Health services for foreign workers and those without civil status]. Jerusalem: Knesset (https://m.knesset.gov.il/activity/info/mmm/pages/document.aspx?ver=1%26docid=90be8d55-f7f7-e411-80c8-00155d010977) (in Hebrew).

Kolzchut (2024).ביטוח בריאות לעובדים זרים [Health insurance for foreign workers]. Tel Aviv: Ministry of Law (https://www.kolzchut.org.il/he/%D7%91%D7%99%D7%98%D7%95%D7%97_%D7%91%D7%A8%D7%99%D7%90%D7%95%D7%AA_%D7%9C%D7%A2%D7%95%D7%91%D7%93%D7%99%D7%9D_%D7%96%D7%A8%D7%99%D7%9D) (in Hebrew).

Laron M, Maoz-Breuer R, Fialco S (2022). Population Survey on the Level of Service and Health Care System Performance in 2021–2022. Jerusalem: Myers-JDC-Brookdale Institute (https://brookdale.jdc.org.il/en/publication/population-survey-on-the-level-of-service-and-health-care-system-performance-in-2021-2022/).

Maoz-Breuer R, Waitzberg R (2024). Progressive Rise in NHI earmarked contributions ('The Health Tax'). Health Systems and Policy Monitor. Brussels: European Observatory on Health Systems and Policies (https://eurohealthobservatory.who.int/monitors/health-systems-monitor/updates/hspm/israel-2015/progressive-rise-in-nhi-earmarked-contributions-(-the-health-tax-)).

Ministry of Health (2016). חוזר המנהל הכללי מס' 5/2016: אספקת שירותי בריאות לקטינים הנמצאים בישראל ואינם מבוטחים על פי חוק ביטוח בריאות ממלכתי [Circular of the Deputy Director for Provision of health care services to minors in Israel which are not covered by the national health insurance law, publication number 05/2016]. Jerusalem: Government of Israel (https://www.health.gov.il/hozer/mk05_2016.pdf) (in Hebrew).

Ministry of Health (2021a). דוח מסכם על פעילות קופות החולים לשנת 2020 [Annual report on the activities of the health plans for 2020]. Jerusalem: Government of Israel (https://www.health.gov.il/PublicationsFiles/dochHashvaatui2020.pdf) (In Hebrew).

Ministry of Health (2023a). דוח מסכם על פעילות קופות החולים לשנת 2022 [Annual report on the activities of the health plans for 2022]. Jerusalem: Government of Israel (https://www.gov.il/BlobFolder/reports/dochhashvaatui2022/he/files_publications_units_shaban_dochhashvaatui2022.pdf) (in Hebrew).

Ministry of Health (2023b). המלצות הביניים של וועדת העשור לצמצום אי השוויון

2021 בבריאות ואת דוח אי שוויון בבריאות וההתמודדות עמו לשנת [Main points of the interim recommendations of The Committee for Determining the Strategy for Reducing Health Gaps in the Coming Decade- Interim Report: Recommendations for 2021]. Jerusalem: Government of Israel (https://www.gov.il/BlobFolder/news/14112022-02/he/NEWS_misc_files_inequality-2021-t.pdf) (in Hebrew).

Ministry of Health (2023c). הוועדה להעצמת שירותי הבריאות בישראל, ואסדרת מערכת הבריאות הציבורית והפרטית"(ועדת אש)"דו"ח [The Committee for the Empowerment of Health Services in Israel, and regulation of the public and private health system ("Ash Committee")]. Jerusalem: Government of Israel (https://www.gov.il/BlobFolder/unit/health-services-regulation/he/files_committees_independent-committee-health-services-regulation-private-health-system_ash_committee_final_report.pdf) (in Hebrew).

Ministry of Health (2024). זמני המתנה לרפואה יועצת בקהילה [Waiting times for consulting medicine in the community]. Jerusalem: Government of Israel (https://storymaps.arcgis.com/stories/a40387a8100b48d4923f52120922d704) (in Hebrew).

Myers-JDC-Brookdale Institute (2024). Trends in public opinion about the level of service in the health system and its functioning, according to background characteristics – an interactive report. Jerusalem: Myers-JDC-Brookdale Institute (https://brookdale.jdc.org.il/en/publication/trends-in-public-opinion-about-the-level-of-service-in-the-health-system-interactive-report/).

National Insurance Institute (2023) דוח ממדי העוני והאי-שוויון בהכנסות – 2022 [Report on the dimensions of poverty and income inequality in 2022]. Jerusalem: National Insurance Institute (https://www.btl.gov.il/Publications/oni_report/Documents/oni2022.pdf) (in Hebrew).

National Insurance Institute (2024a). Switching from one HMO to another and transfer cancellation. In: National Insurance Institute [website]. Jerusalem: National Insurance Institute (https://www.btl.gov.il/English%20Homepage/Insurance/Health%20Insurance/Registration/Pages/Transferring.aspx).

National Insurance Institute (2024b). Health insurance rates. In: National Insurance Institute [website]. Jerusalem: National Insurance Institute (https://www.btl.gov.il/English%20Homepage/Insurance/Health%20Insurance/Pages/Healthinsurancerates.aspx).

OECD (2024a). Israel. In: OECD Economic Outlook. Volume 2024 Issue 1: An unfolding recovery. Paris: OECD Publishing (https://doi.org/10.1787/55442006-en).

OECD (2024b). Income distribution. In: OECD Social and Welfare Statistics [online database] Paris: OECD (https://doi.org/10.1787/data-00654-en).

OECD (2024c). Health Statistics. Paris: OECD (https://www.oecd.org/en/data/datasets/oecd-health-statistics.html).

Prison services (2019). הטיפול הרפואי באסיר [Medical treatment of prisoners]. Jerusalem: Government of Israel (https://www.gov.il/he/pages/ips_nohl) (in Hebrew).

Population and Immigration Authority (2021). מוגש על ידי רשות האוכלוסין וההגירה - אגף תכנון נתוני זרים בישראל מדיניות ואסטרטגיה [Data on the Foreign Population in Israel, Population and Immigration Authority - Policy and Strategy Planning Division. Edition No. 2021/3. October 2021]. Jerusalem: Government of Israel (https://www.gov.il/BlobFolder/generalpage/foreign_workers_stats/he/zarim_2021.pdf) (in Hebrew).

Rose AJ, Ein mor E, Krieger M, Ben-yehuda A, Cohen AD, Matz E, et al (2022). Israeli COVID lockdowns mildly reduced overall use of preventive health services, but exacerbated some disparities. Int J Qual Health C. 34(3):mzac071 (https://doi.org/10.1093/intqhc/mzac071).

Rosen B, Waitzberg R, Merkur S (2015). Israel: health system review. Health Systems in Transition, 2015; 17(6):1–212 (https://iris.who.int/handle/10665/330248).

Sagan A, Thomson S (2016). Voluntary health insurance in Europe: role and regulation. Copenhagen: WHO Regional Office for Europe and European Observatory on Health Systems and Policies (https://iris.who.int/handle/10665/326316).

Shahrabani S, Benzion U, Machnes Y, Gal A (2015). The use of dental services for children: implications of the 2010 dental reform in Israel. Health Policy. 119(2):117–26. (https://doi.org/10.1016/j.healthpol.2014.11.007).

Shinan-Altman S, Levkovich I, Tavori G (2020). Healthcare utilization among breast cancer patients during the COVID-19 outbreak. Palliat Support Care. 18(4):385–391 (https://doi.org/10.1017/S1478951520000516).

Thomson S, Sagan A, Mossialos E, editors (2020). Private Health Insurance: History, Politics and Performance. Cambridge: Cambridge University Press. (https://doi.org/10.1017/9781139026468).

Waitzberg R, Davidovitch N, Leibner G, Penn N, Brammli-Greenberg S (2020). Israel's response to the COVID-19 pandemic: Tailoring measures for vulnerable cultural minority populations. Int J Equity Health. 19 (1):71 (https://doi.org/10.1186/s12939-020-01191-7).

Waitzberg R, Rosen B (2020). The Israeli Health Care System. In: Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton G, editors. International profiles of health care systems. New York: The Commonwealth Fund (https://www.commonwealthfund.org/sites/default/files/2020-12/International_Profiles_of_Health_Care_Systems_Dec2020.pdf).

Waitzberg R, Sophie G, Dimova A, Bryndová L, Vrangbæk K, Jervelund SS, et al (2021a). Balancing financial incentives during COVID-19: A comparison of provider payment adjustments across 20 countries. Health Policy. 126(5):398–407 (https://doi.org/10.1016/j.healthpol.2021.09.015)

Waitzberg R, Quentin W, Webb E, Glied S (2021b). The Structure and Financing of Health Care Systems Affected How Providers Coped With COVID-19. Milbank Q. 99(2), 542–564. (https://doi.org/10.1111/1468-0009.12530).

Waitzberg R, Siegel M, Quentin W, Busse R, Greenberg D (2022a). It probably worked: a Bayesian approach to evaluating the introduction of activity-based hospital payment in Israel. Isr J Health Pol Res. 11(1): 8 (https://doi.org/10.1186/s13584-022-00515-y).

Waitzberg R, Hernández-Quevedo C, Bernal-Delgado E, Estupiñán-Romero F, Angulo-Pueyo E, Theodorou M, et al (2022b). Early health system responses to the COVID-19 pandemic in Mediterranean countries: A tale of successes and challenges. Health Policy. 126(5):465–475. (https://doi.org/10.1016/j.healthpol.2021.10.007).

Waitzberg R, Maoz-Breuer R, Katz E (2023). Disparities between Population Groups in Israel in the Use of the Health Plans' Voluntary Health Insurance Programs (HP-VHI). Jerusalem: Myers-JDC-Brookdale Institute (RR-969-23; https://brookdale.jdc.org.il/en/publication/disparities-between-population-groups-in-israel-in-the-use-of-the-health-plans-voluntary-health-insurance-programs/).

Waitzberg R, Maoz-Breuer R (2024). Reform to reduce dual VHI coverage for surgery. Health Systems and Policy Monitor. Brussels: European Observatory on Health Systems and Policies (https://eurohealthobservatory.who.int/monitors/health-systems-monitor/analyses/hspm/israel-2015/reform-to-reduce-dual-vhi-coverage-for-surgery).

Wagstaff A, van Doorslaer E (2003). Catastrophe and impoverishment in paying in health care: with applications to Vietnam 1993–98. Health Econ. 2(11):921–34. (https://doi.org/10.1002/hec.776).

WHO (2010). The world health report: health systems financing: the path to universal health coverage. Geneva: World Health Organization (https://iris.who.int/handle/10665/44371).

WHO (2024). Global Health Expenditure Database [online database]. Geneva: World Health Organization (http://apps.who.int/nha/database/Select/Indicators/en).

WHO Regional Office for Europe (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/311654). License: CC BY-NC-SA 3.0 IGO.

WHO Regional Office for Europe (2023). Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/374504). License: CC BY-NC-SA 3.0 IGO.

WHO Regional Office for Europe (2024). UHC Watch [online database]. Copenhagen: WHO Regional Office for Europe (https://apps.who.int/dhis2/uhcwatch).

Xu K, Evans D, Kawabata K, Zeramdini R, Klavus J, Murray C (2003). Household catastrophic health expenditure: a multicountry analysis. Lancet 362:111–7. (https://doi.org/10.1016/S0140-6736(03)13861-5).

Xu K, Evans D, Carrin G, Aguilar-Rivera A, Musgrove P, Evans T (2007). Protecting households from catastrophic health spending. Health Aff. 26(4):972–83. (https://doi.org/10.1377/hlthaff.26.4.972).

Yerramilli P, Fernández Ó, Thomson S (2018). Financial protection in Europe: a systematic review of the literature and mapping of data availability. Health Policy 122(5):493–508 (https://doi.org/10.1016/j.healthpol.2018.02.006).