Journal Homepage: - www.journalijar.com

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)

Article DOI: 10.21474/IJAR01/23180
DOI URL: http://dx.doi.org/10.21474/IJAR01/23180

ISSN (O): 2320-5407
ISSN (P): 3107-4928

*RESEARCH ARTICLE*

# THIRTY YEARS AFTER ISRAEL'S NATIONAL HEALTH INSURANCE LAW: FINANCING TRENDS, POLICY CHALLENGES, AND FUTURE DIRECTIONS, 2005–2024

**Dvir Levin**

## Manuscript Info

*Manuscript History*
Received: 4 February 2026
Final Accepted: 8 March 2026
Published: April 2026

*Key words:-*
Israel; National Health Insurance; health financing; public–private mix; health policy; universal coverage; healthcare capacity

## Abstract

**Background:** Israel's National Health Insurance (NHI) law created durable universal coverage, but the long-term adequacy of financing remains contested. Thirty years after enactment, the key policy question is no longer whether legal entitlement exists, but whether the public core has kept pace with demographic growth, technology costs, and service-capacity needs.

**Methods:** This study used a secondary policy-analysis design based on official macro-level data. The quantitative backbone consisted of the Central Bureau of Statistics (CBS) national expenditure on health series for 2005–2022, supplemented by CBS media releases for 2023 and 2024 and by OECD Health at a Glance 2025 indicators for comparative context. The revised version adds clearer discussion of trend interpretation,terminology,the temporary pandemic effect, supplementa ry insurance, and regional equity.

**Results:** National expenditure on health increased from NIS 47.4 billion in 2005 to NIS 146.0 billion in 2024, a nominal increase of 208.3% and an approximate compound annual growth rate (CAGR) of 6.1%. Yet health expenditure as a share of GDP remained broadly stable before the pandemic, averaging 7.27% in 2005–2019, before rising to 8.3% in 2020 and then returning to 7.6% in 2022, 7.2% in 2023, and 7.3% in 2024. Private financing averaged 36.6% of total expenditure in 2005–2019 and still accounted for 33.6% in 2024. OECD 2025 comparative indicators show that Israel continues to combine full population coverage with below-OECD-average spending per capita, nurse density, and hospital-bed supply.

**Conclusion:** The evidence supports a balanced but critical interpretation. Israel's NHI system remains a major social-policy achievement, yet the financing trajectory points to persistent structural tightness rather than a fully resolved universal model. Future policy should tie budget updates more explicitly to demographic and technological pressure, strengthen workforce and infrastructure planning, and protect the public core from cumulative segmentation.



**Corresponding Author:-** Dvir Levin

## Introduction:-

Israel's National Health Insurance Law, enacted in 1994 and implemented in 1995, established universal entitlement to a defined basket of health services delivered mainly through four non-profit health funds. In institutional terms, the reform created a durable public framework based on mandatory coverage, regulated competition among the funds, and a financing model that combines a dedicated health tax with government-budget transfers.Three decades later, the central analytical issue is not whether the law succeeded in creating formal universality. The more difficult question is whether the public core has been financed and maintained at a level that matches rapid population growth, technological expansion, service expectations, and the need for workforce and infrastructure development.That question matters because a health system can remain universal in law while becoming tighter in practice. Waiting times, staffing constraints, infrastructure bottlenecks, and the growing practical importance of supplementary and private channels may all develop without formal retrenchment of legal rights. For that reason, the long-term evaluation of NHI must focus not only on entitlement, but also on financing adequacy, the public–private balance, and system capacity.

### Background and Analytical Focus:-

The financing logic of NHI is straightforward in principle. Residents are covered for a statutory basket of services; the National Insurance Institute collects a dedicated health tax; and the state supplements funding through budget transfers. This design was intended to align solidarity, predictability, and managed competition.In practice, financing adequacy has always been sensitive to three interacting pressures: demography, medical technology, and institutional segmentation. Rapid population growth requires recurrent expansion in staffing, facilities, equipment, and service volume. New diagnostics, drugs, and procedures raise the cost of maintaining an up-to-date public basket. Supplementary and private financing can widen the gap between formal entitlement and effective access.The present analysis therefore treats expenditure growth, GDP-share stability, financing composition, and comparative resource indicators as connected dimensions of one policy problem. A rise in total spending is important, but it is not sufficient evidence of adequacy if the macroeconomic effort remains flat, the private share remains substantial, or system resources lag behind comparator countries.Two additional contextual refinements were emphasized by peer review. First, the pandemic spike should be distinguished from a permanent structural shift in the financing baseline. Second, national financing trends should be read alongside the long-standing center–periphery gap in service capacity, because tighter financing is unlikely to affect all regions equally.

## Materials and Methods:-

This study used a descriptive secondary policy-analysis design based entirely on public aggregate data. The main national data source was the CBS national expenditure on health series, with annual current-price expenditure and financing-share tables for 2005–2022. These were updated with CBS media releases on national expenditure on health in 2023 and in 2024. OECD Health at a Glance 2025: Israel was used for the most recent comparative indicators on spending, workforce, and hospital resources.Four dimensions were examined: total national expenditure on health at current prices; national expenditure on health as a share of GDP; financing composition, including health tax, government-budget financing, private financing, and direct out-of-pocket payments; and selected comparative indicators that help interpret whether expenditure levels translated into broad system capacity.

The study is intentionally descriptive rather than econometric. Its aim is not to estimate causal effects, but to determine whether the most recent official data are consistent with an interpretation of sustained structural pressure within a formally universal system.A full inflation-adjusted real-per-capita series would strengthen the analysis. Because the official backbone of this article is the CBS current-price macro series and recent media releases, the revised manuscript treats this as an important extension for future work rather than as a fully reconstructed parallel series.

## Results:-

**Table 1 summarises the benchmark values used in the article. Figures 1–6 then visualise the main trends and the most recent comparative context.**

| Year | Total expenditure (NIS bn) | Health exp. (% GDP) | Health tax (%) | Government budget (%) | Private financing (%) |
|---|---|---|---|---|---|
| 2005 | 47.4 | 7.2 | 25.0 | 35.7 | 37.2 |
| 2010 | 64.3 | 7.2 | 25.3 | 35.8 | 36.9 |
| 2015 | 86.3 | 7.3 | 24.1 | 37.9 | 36.1 |
| 2020 | 118.2 | 8.3 | 21.4 | 47.5 | 30.0 |
| 2022 | 132.6 | 7.6 | 22.5 | 42.3 | 33.9 |
| 2023 | 136.3 | 7.2 | 23.2 | 40.6 | — |
| 2024* | 146.0 | 7.3 | 23.0 | 42.0 | 33.6 |

**Table 1. Benchmark financing indicators for selected years. *2024 figures are preliminary.**

**Expenditure growth and macroeconomic effort:-**

Total national expenditure on health increased steadily over the period. At current prices it rose from NIS 47.4 billion in 2005 to NIS 146.0 billion in 2024. This is a large nominal expansion and reflects cumulative system growth, inflation, population change, and technological expansion.However, the macroeconomic interpretation is more restrained than the nominal trend alone suggests. Health expenditure as a share of GDP averaged only 7.27% in 2005–2019. The main break appears in 2020, when the ratio increased to 8.3% under pandemic conditions. In the following years the ratio moved back downward, reaching 7.6% in 2022, 7.2% in 2023, and 7.3% in 2024.This pattern suggests that the Israeli health system did grow, but that the broad share of national output devoted to health remained relatively constrained for most of the period. Long-term financing pressure therefore cannot be assessed from nominal growth alone; it must be read together with the relative stability of the GDP share.The pandemic spike should be interpreted primarily as temporary emergency expansion rather than as a permanent structural shift in the financing baseline. The return toward 7.2%–7.3% of GDP by 2023–2024 suggests that the exceptional increase of 2020 was not consolidated into a permanently higher expenditure effort.

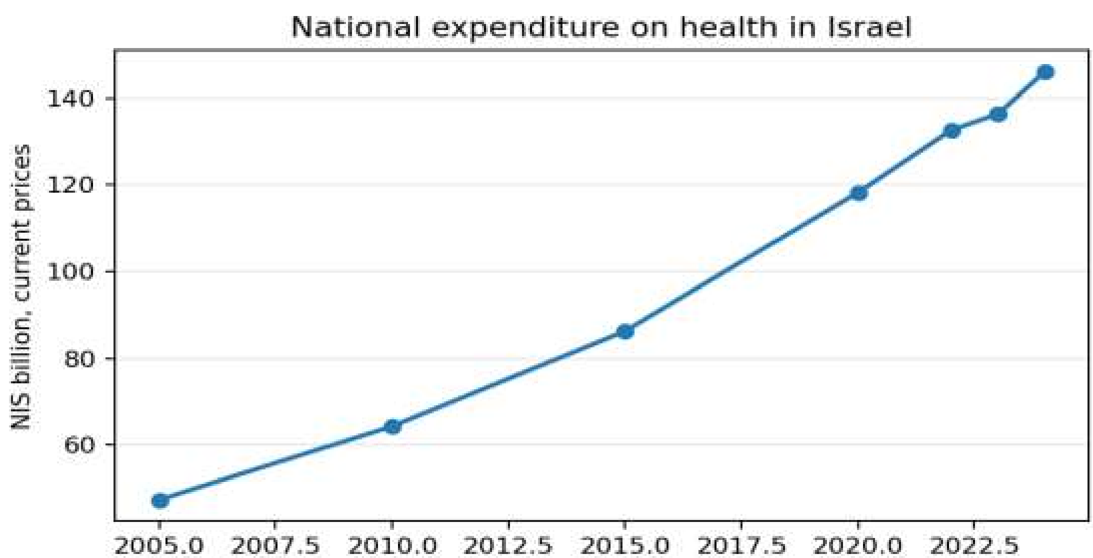


**Figure 1. National expenditure on health in Israel, 2005–2024.**

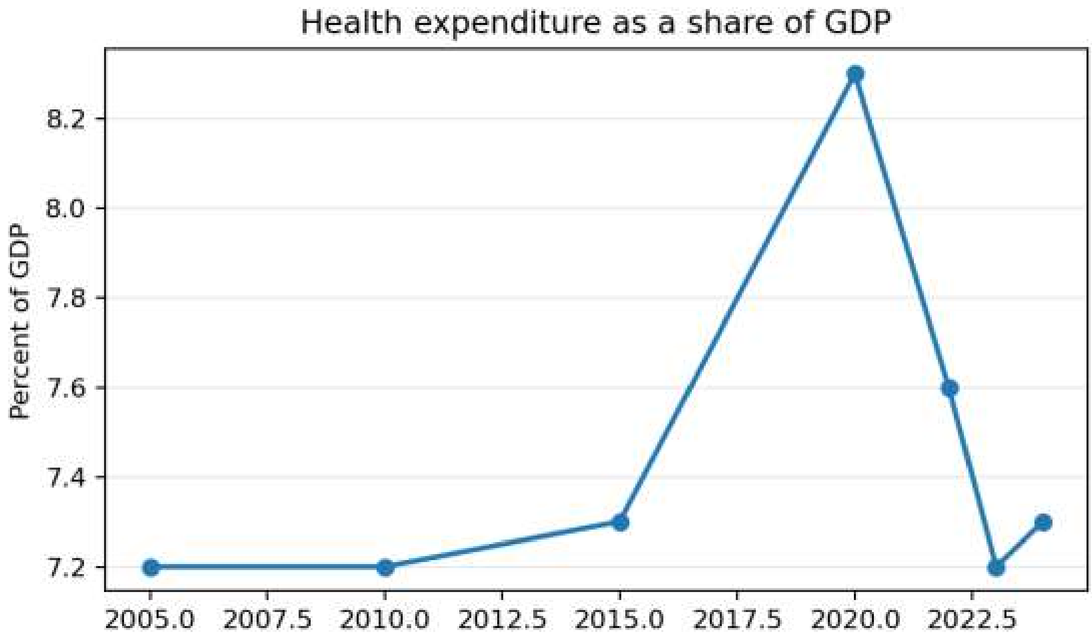


**Figure 2. Health expenditure as a share of GDP, 2005–2024.**

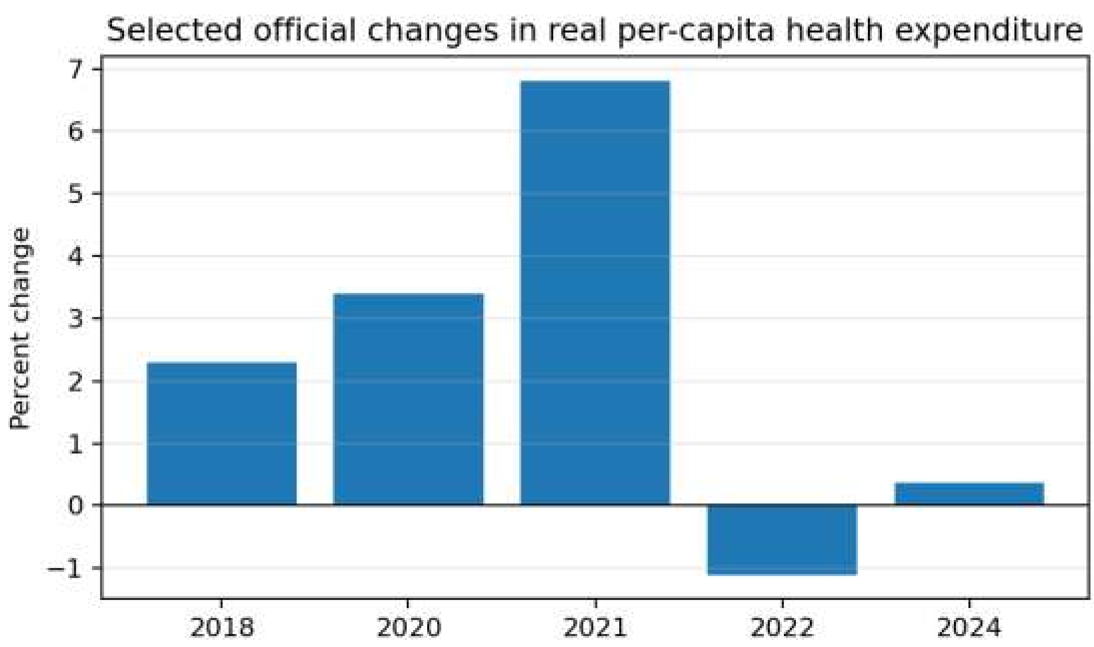


**Figure 3. Selected official changes in real per-capita health expenditure at constant prices (CBS-reported annual changes). Values shown: 2018 +2.3%, 2020 +3.4%, 2021 +6.8%, 2022 -1.1%, 2024 +0.37%.**

These official constant-price per-capita signals do not replace a full long-run real series, but they do reinforce the reviewer's point that nominal growth should be interpreted cautiously. They show that real per-person expansion was uneven across recent years, including a decline in 2022 despite continued nominal expenditure growth.

**Financing composition, household burden, and supplementary coverage:-**

The financing mix adds a second layer to the analysis. Private financing averaged 36.6% of total national expenditure in 2005–2019, indicating that the public system coexisted for many years with a substantial private burden. Although the pandemic period was associated with a temporary increase in government-budget financing, private financing did not disappear as a structural feature.In 2005, private financing accounted for 37.2% of expenditure. By 2015 the private share remained 36.1%. In 2020, under emergency public expansion, the private share dropped to 30.0%, but by 2022 it had returned to 33.9%. According to the 2024 CBS release, private financing still accounted for 33.6% of national expenditure.The composition of public financing also shifted over time. The health-tax share fell from 25.0% in 2005 to 22.5% in 2022, while the government-budget share rose from 35.7% to 42.3% over the same interval. In 2024, the health tax financed about 23.0% of national expenditure and the government budget about 42.0%. This confirms that the public system remains heavily dependent on state-budget supplementation rather than on a fully self-adjusting earmarked mechanism.Supplementary insurance has become widespread in Israel over the last two decades, covering roughly four-fifths of the population in the 2010s–2020s. This strengthens the concern that the practical boundary between public entitlement and private supplementation has become increasingly important for everyday access.

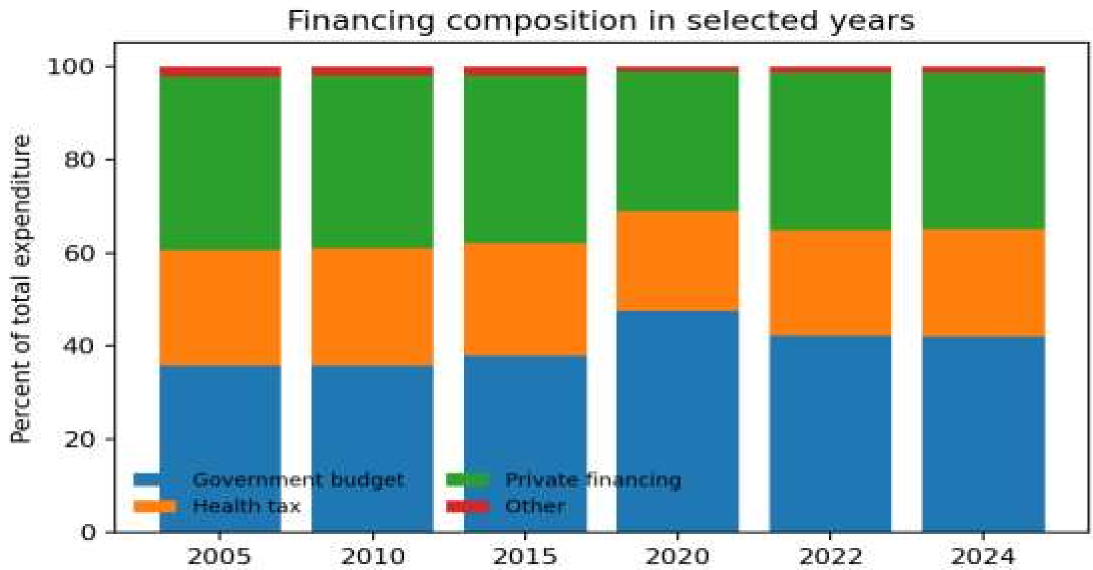


**Figure 4. Financing composition in selected years.**

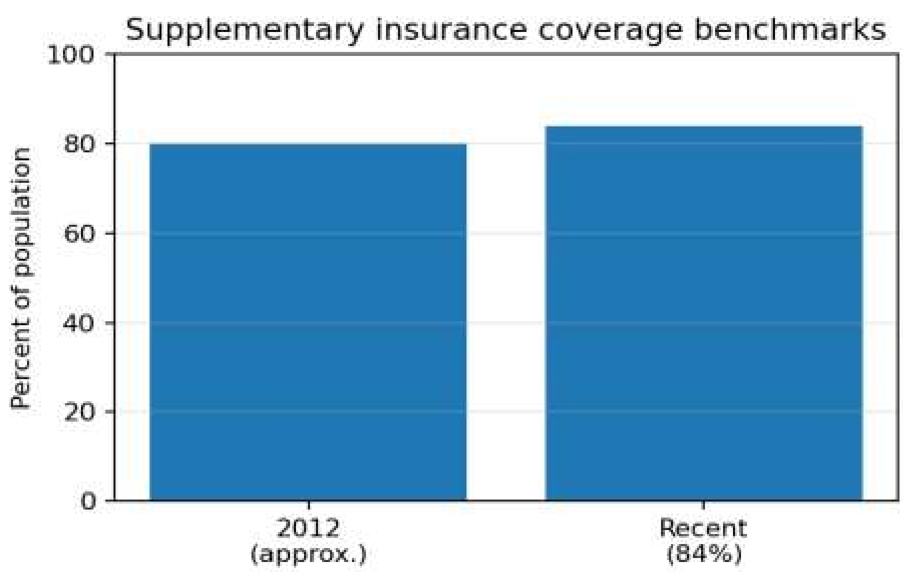


**Figure 5. Supplementary insurance coverage benchmarks in Israel. The 2012 point reflects evidence that nearly four in five Israelis held supplementary insurance; the recent benchmark reflects sources describing coverage at about 84% / over 80% of the population.**

**Comparative system capacity and current pressures:-**

The financing story is reinforced by the most recent OECD comparative indicators. OECD Health at a Glance 2025 reports that Israel continues to cover all residents for a core set of services, but only 62% of health spending is covered by mandatory prepayment compared with an OECD average of 75%. Health expenditure amounted to 7.6% of GDP in the OECD framework, below the OECD average of 9.3%, and spending per capita reached USD PPP 4,352 compared with an OECD average of 5,967.The resource indicators are similarly mixed. Israel had 3.5 practising doctors per 1,000 population compared with an OECD average of 3.9, but only 5.6 practising nurses compared with 9.2 and only 3.0 hospital beds per 1,000 population compared with 4.2. These figures do not mean that the system is failing; rather, they indicate that universal coverage is being maintained with relatively tight resource ratios in key domains.Demographic pressure intensifies this interpretation. On the eve of Israel's 77th Independence Day in 2025, the CBS estimated the country's population at 10.094 million. A system serving a rapidly expanding population can preserve formal universality while still experiencing cumulative operational strain if workforce growth, bed supply, and infrastructure investment do not expand at a comparable pace.

| Indicator | Israel | OECD average |
|---|---|---|
| Population covered for a core set of services | 100% | 98% |
| Mandatory prepayment share of health spending | 62% | 75% |
| Health spending (% GDP) | 7.6 | 9.3 |
| Health spending per capita (USD PPP) | 4,352 | 5,967 |
| Practising doctors per 1,000 population | 3.5 | 3.9 |
| Practising nurses per 1,000 population | 5.6 | 9.2 |
| Hospital beds per 1,000 population | 3.0 | 4.2 |

**Table 2. Selected comparative indicators from OECD Health at a Glance 2025.**

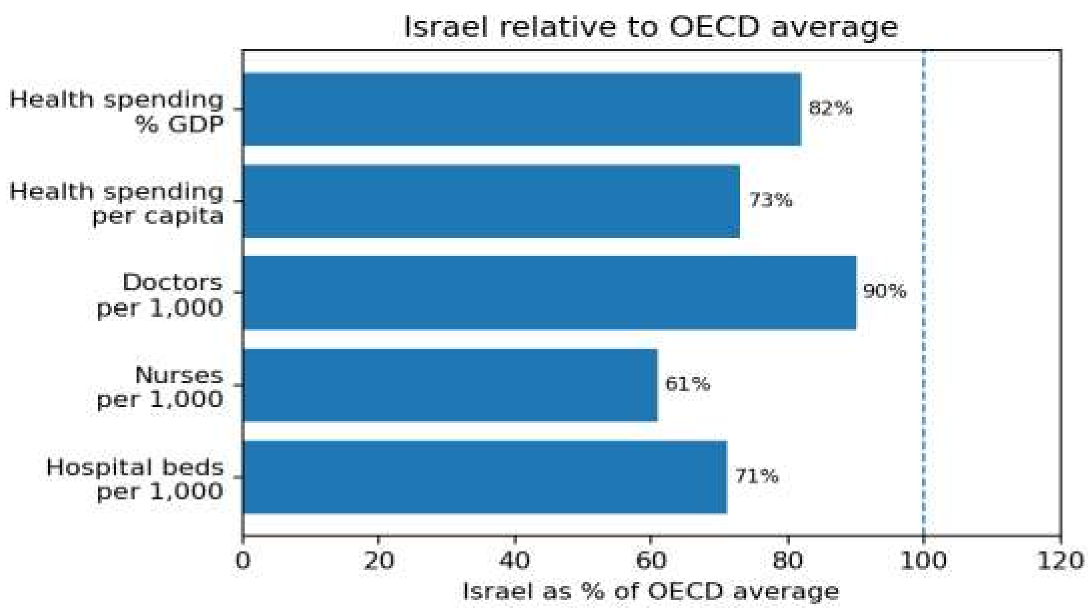


**Figure 6. Israel relative to the OECD average on selected indicators (OECD average = 100).**

## Discussion:-

The revised evidence supports a balanced conclusion. Israel's NHI system remains one of the country's most important social-policy achievements. At the same time, the financing pattern is more compatible with structural tightness than with a decisively well-resourced universal model.The key point is not that spending failed to rise. It did rise substantially. The stronger point is that expenditure growth coexisted with a long period of GDP-share stability, a persistent private financing share, and resource levels that remain below OECD averages in several key categories. This combination helps explain why formal entitlement can coexist with waiting times, staffing shortages, and continued reliance on supplementary and private channels.A further implication concerns regional equity. Even when national entitlement is uniform, tighter financing and capacity constraints are likely to be felt most sharply in peripheral areas where staffing, bed availability, and specialist access are already less robust than in the center. The financing question is therefore also an equity question, not only a macro-fiscal one.

### Policy Directions:-

First, basket and budget updates should be linked more explicitly to demography, ageing, and the diffusion of high-cost technologies. Nominal annual increases are an incomplete guide when the insured population and the clinical content of care are both changing rapidly.Second, policymakers should treat the public–private balance as a core system outcome. A universal system can remain equitable only if private financing complements rather than compensates for under-funded public capacity.Third, workforce and capital planning require stronger long-horizon protection. The OECD comparison suggests that nurse density and hospital-bed availability remain particularly tight. Sustained investment in training capacity, retention, and physical infrastructure is therefore part of financing adequacy itself.Fourth, data governance should be improved. Transparent, timely, and policy-linked expenditure reporting is essential for credible public decision making about the health basket, waiting times, staffing, and infrastructure gaps.

## Limitations:-

This study is descriptive and does not estimate causal effects. The article combines national-accounts expenditure data with OECD comparative indicators that are not identical in methodology, although they are appropriate for complementary interpretation. In addition, the 2024 CBS figures are preliminary.The revised paper also notes that a full inflation-adjusted real-per-capita series would enrich the analysis. The current article should therefore be read as a policy-analysis update rather than as a full deflator-based national accounts reconstruction.

## Conclusion:-

Thirty years after the enactment of NHI, Israel still presents a compelling example of durable universal coverage. Yet the updated data suggest that the system's central challenge has shifted from legal inclusion to financing adequacy and capacity maintenance. National expenditure has grown strongly in nominal terms, but the long-run GDP share remained relatively flat for most of the period, the private share of financing remains substantial, and comparative resource indicators point to continued workforce and infrastructure tightness.The practical implication is straightforward. The next phase of NHI reform should focus less on the existence of universal entitlement and more on the conditions that make universality function well: predictable public financing, stronger workforce and capital investment, improved transparency in basket updating, and explicit protection of the public core from cumulative segmentation.

## Declarations:-

## Acknowledgments:-

None.

### Funding:-

No external funding was reported for this manuscript.

### Conflict of interest:-

The author declares no conflict of interest.

### Ethical statement:-

This manuscript used only aggregate public data and published institutional reports. No ethical approval was required.

**Data availability:-**
All data used in this article were drawn from publicly available publications of the Central Bureau of Statistics and the OECD.

**Reader note on CAGR:-**
Compound annual growth rate summarizes the average annual pace at which a quantity would have grown if it had increased at a constant compounded rate over the whole period. It differs from a simple average of annual percentage changes.

## References:-


1. Central Bureau of Statistics. (2019). National expenditure on health, 2018. Media release. Government of Israel.
2. Central Bureau of Statistics. (2021). National expenditure on health, 2020. Media release. Government of Israel.
3. Central Bureau of Statistics. (2023). National expenditure on health, 1962–2021. Government of Israel.
4. Central Bureau of Statistics. (2024a). National expenditure on health, 1962–2022. Government of Israel.
5. Central Bureau of Statistics. (2024b). National expenditure on health in 2023. Media release. Government of Israel.
6. Central Bureau of Statistics. (2025a). National expenditure on health in 2024. Media release. Government of Israel.
7. Central Bureau of Statistics. (2025b). Israel’s Independence Day 2025. Media release. Government of Israel.
8. Bowers, L., & Waitzberg, R. (2016). Your place in line: Waiting times in Israel’s public hospitals. Taub Center policy brief.
9. Chernichovsky, D. (2019). The healthcare system: An overview. In State of the Nation Report: Society, Economy and Policy 2019. Taub Center for Social Policy Studies in Israel.
10. Green, M. S., Hayek, S., Tarabeia, J., Yehia, M., & HaGani, N. (2017). A national survey of ethnic differences in knowledge and understanding of supplementary health insurance. Israel Journal of Health Policy Research, 6, Article 12.
11. National Health Insurance Law, 5754–1994, State of Israel.
12. OECD. (2025). Health at a Glance 2025: Israel. OECD Publishing.
13. Rosen, B., Waitzberg, R., & Merkur, S. (2015). Israel: Health system review. Health Systems in Transition, 17(6), 1–212.
14. Shmueli, A. (2018). Supplementary health insurance in Israel: Developments and implications. Israel Journal of Health Policy Research, 7, 58.