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RESEARCH ARTICLE

UNIVERSAL ENTITLEMENT UNDER STRAIN: THE LONG-TERM IMPACT OF ISRAEL'S NATIONAL HEALTH INSURANCE REFORM ON HEALTH SYSTEM MANAGEMENT AND ORGANIZATION

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Abstract

Background: Israel's National Health Insurance (NHI) reform of 1994–1995 established a universal statutory entitlement to a defined basket of health services and reorganized the health system around a regulated pluralist framework. This article re-examines the reform not as a one-time legislative achievement, but as a long-run problem of health-system management and organizational stewardship.

Methods: The study uses a structured secondary policy-analysis design. To improve methodological transparency, the analysis is organized through an explicit analytical framework that links five dimensions—universal entitlement, financing architecture, basket governance, institu tional role allocation, and the public–private boundary of access—to three forms of long-term strain: fiscal, operational, and normative. The source base combines the statutory framework, foundational reform scholarship, later policy and evaluation studies, and the most recent official comparative indicators published by the OECD and the Europe an Observatory on Health Systems and Policies.

Results: The reform achieved a major institutional breakthrough by universalizing legal entitlement and stabilizing a coherent national framework for service delivery through four non-profit health funds. However, the long-term record shows persistent pressure in financing adequacy, basket updating, overlapping regulator provider roles, workf orce and infrastructure capacity, and the growing practical importance of supplementary and private channels. Current official indicators show that Israel combines full legal coverage with relatively low mandatory prepayment, lower-than-OECD-average expenditure per capita, fewer nurses and hospital beds than the OECD average, and incomplete financial protection for part of the population.

Conclusion: Israel's NHI remains one of the country's most important social-policy achievements, but its continued legitimacy depends on the managerial reproduction of universalism. Universal coverage can remain intact in law while becoming more differentiated in practice if financing, governance clarity, and service capacity are not strengthened. The policy challenge is therefore not to replace the NHI model, but to govern its public core more effectively.

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Introduction:-

Israel's National Health Insurance Law, enacted in 1994 and implemented in 1995, transformed healthcare access from a historically fragmented arrangement into a universal statutory entitlement. In institutional terms, the reform redefined the relationship among the state, the Ministry of Health, the four health funds, hospitals, and households by embedding coverage in law and by reorganizing the financing and governance framework through which care is delivered.The Israeli case remains analytically important because it combines universal legal coverage with organizational pluralism. The health funds compete and innovate within a regulated national framework, while the Ministry of Health continues to play multiple roles in planning, regulation, purchasing, ownership and, in some domains, provision. This mixed structure has produced significant efficiency and innovation, but it has also generated recurring tensions concerning accountability, financing adequacy, and equal practical access.

This article addresses a gap in the literature. Much of the classic scholarship on Israeli NHI has examined the political breakthrough of the 1990s, the reform's initial financing logic, or specific later policy problems. By contrast, the present article reframes the reform as a long-run public-management problem: how a formally universal system preserves its practical credibility over time under demographic, fiscal, organizational, and political pressure. The article's specific contribution is therefore interpretive rather than econometric. It integrates foundational reform scholarship with the most recent official comparative indicators to show how universal entitlement can remain legally stable while becoming more strained operationally and normatively.To add theoretical precision, the article distinguishes among three interrelated forms of strain. Fiscal strain refers to the pressure created when the public financing base does not grow adequately relative to need, technology, and expectations. Operational strain refers to shortages or bottlenecks in workforce, beds, infrastructure, waiting times, and service availability. Normative strain refers to the weakening of public confidence that the state-backed system alone can provide timely, equitable, and practically usable access. This three-part distinction helps move the analysis beyond a generic claim that the system is "under strain" and clarifies the mechanisms through which universalism may erode in lived experience even when it remains intact in law.

A brief comparative perspective is also useful. Israel shares some features with other managed-competition or social insurance systems in which multiple insurers or funds operate under a public regulatory framework. Yet Israel's configuration is distinctive because the Ministry of Health has historically retained a more complex combination of regulator, planner, and provider-related roles. That hybridity makes the Israeli case especially instructive for understanding how governance design affects the long-term durability of universalism.The central research question is therefore not whether the NHI reform mattered—it clearly did—but how its long-term implementation reshaped the management and organization of the Israeli health system, and why significant pressures persisted despite the achievement of formal universality. The argument advanced here is that the reform succeeded at the level of legal entitlement and institutional stabilization, but that its long-term credibility depends on the ongoing managerial reproduction of universalism through financing, basket updating, workforce capacity, infrastructure, and governance discipline.

Materials and Methods:-

This study uses a structured secondary policy-analysis design. Its purpose is not to estimate causal effects econometrically, but to evaluate whether the historical development and current performance profile of the Israeli NHI system are consistent with an interpretation of durable universalism operating under fiscal, operational, and normative strain.To strengthen methodological transparency, the study relies on an explicit analytical framework. The framework begins with the 1994–1995 reform as the foundational legal and institutional intervention. It then evaluates the system through five dimensions: (1) universal entitlement, (2) financing architecture, (3) basket-of-services governance, (4) institutional role allocation, and (5) the public–private boundary of access. These dimensions were selected because together they connect rights, resources, administration, and practical access. In other words, they capture the principal channels through which a universal legal commitment is translated—or fails to be translated—into operational reality.

The source base was selected purposively to cover four layers of evidence: (1) the statutory framework created by the National Health Insurance Law; (2) foundational scholarly analyses of the reform's political origins, financing logic, and early implementation; (3) later policy and evaluation literature addressing institutional development, public–private financing, equity, waiting times, insurance literacy, and system drift; and (4) the most recent official comparative indicators published by the OECD and the European Observatory on Health Systems and Policies.

Priority was given to official publications and peer-reviewed sources with direct relevance to entitlement, financing, governance, equity, and system capacity.The analytical procedure was interpretive but systematic. For each dimension, the analysis asked three linked questions: first, what was the original post-reform design logic; second, what long-term management problem became visible over time; and third, what recent comparative or policy evidence indicates the contemporary state of that problem. This procedure does not generate a reproducible meta-analysis in the formal systematic-review sense, but it does provide an explicit and coherent framework for selection, interpretation, and synthesis.

The analytical time frame spans the enactment of the law in 1994 and its implementation in 1995 through the most recent official country indicators published in 2024–2025. The historical discussion is interpretive and policy-oriented, whereas the current-system snapshot uses the latest comparable official indicators for spending, financial coverage, workforce, and infrastructure. No individual-level data were used, and no human participants were involved; ethics approval was therefore not required.

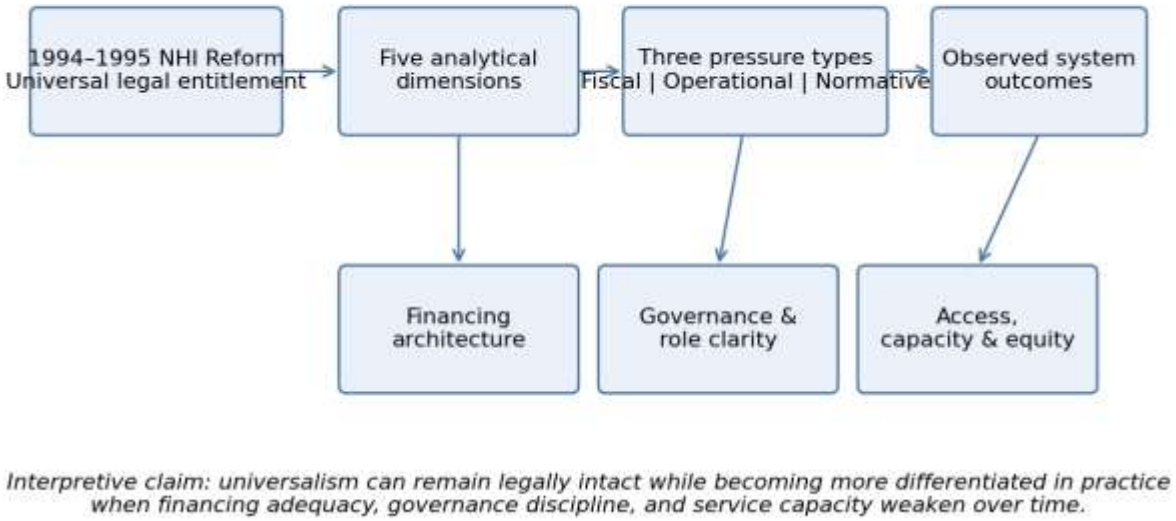

Figure 1. Analytical framework linking reform design, five analytical dimensions, three forms of strain, and long-term system outcomes.

Analytical Dimensions:-

Dimension	Core post-1995 design logic	Long-term management question
Universal entitlement	Universal statutory right to a defined basket of services for all residents.	Did legal universality translate into equal practical access over time?
Financing architecture	Health tax, public transfers, and capitation-based allocation across funds.	Has financing remained adequate and sufficiently public to sustain solidarity?
Basket governance	A defined public basket as the operational core of entitlement.	Has updating kept pace with technology, demography, and demand?
Institutional role allocation	A stronger regulatory and planning role for the Ministry of Health.	Have accountability and regulator–provider boundaries become clearer in practice?

Public–private boundary	Supplementary coverage permitted beyond the public core.	Has growth of private and voluntary channels stratified access or weakened the public core?

Historical and Institutional Background:-

The 1994 law did not emerge in a vacuum. Israeli healthcare developed through health funds, labour-movement institutions, public hospitals, and a patchwork of administrative and financing arrangements that produced important achievements but also left unresolved questions of entitlement, accountability, and equity. The pre-reform system therefore combined service capacity with structural ambiguity: not all residents were covered on equal terms, and institutional responsibility remained diffuse.The political breakthrough of the mid-1990s followed a long history of unsuccessful reform attempts. The Netanyahu Commission helped redefine the debate by highlighting the lack of clarity regarding citizens' rights, the blurred allocation of responsibility among government, sickness funds, and providers, and the need for a more coherent financing and governance structure.Seen from a public-management perspective, the reform was therefore not simply about expanding insurance coverage. It was about codifying social rights, reallocating responsibility, and creating a more governable framework for managing a complex national health system. That historical origin remains important because many of the pressures visible today were already implicit in the design problem the reform sought to solve.

Reform Design and Managerial Logic:-

The NHI reform created universal statutory entitlement to a defined basket of services for all residents and assigned primary service delivery to the four health funds. Financing was reorganized through a combination of health-tax revenue, public transfers, and capitation-based allocation across the funds. In design terms, this represented a shift from fragmented affiliation-based arrangements to a rights-based national framework.From a managerial standpoint, the reform had four central ambitions. First, it sought to align solidarity with predictable financing. Second, it made the basket of services the operational core of entitlement. Third, it aimed to improve transparency and accountability by clarifying who was covered, what was covered, and how resources were distributed. Fourth, it attempted—at least in principle—to strengthen the Ministry of Health as a regulator and planner rather than a direct provider in all domains.However, later scholarship shows that these ambitions were only partially realized. While universal insurance was successfully enacted, other structural reforms progressed unevenly. In particular, the Ministry of Health continued to occupy overlapping positions as regulator, owner, and provider-linked actor, and the public–private boundary of care remained politically and institutionally contested. The Israeli case therefore illustrates how punctuated reform and path dependency can coexist: a major breakthrough at the level of entitlement may occur alongside continuity in institutional structure and incentive problems.

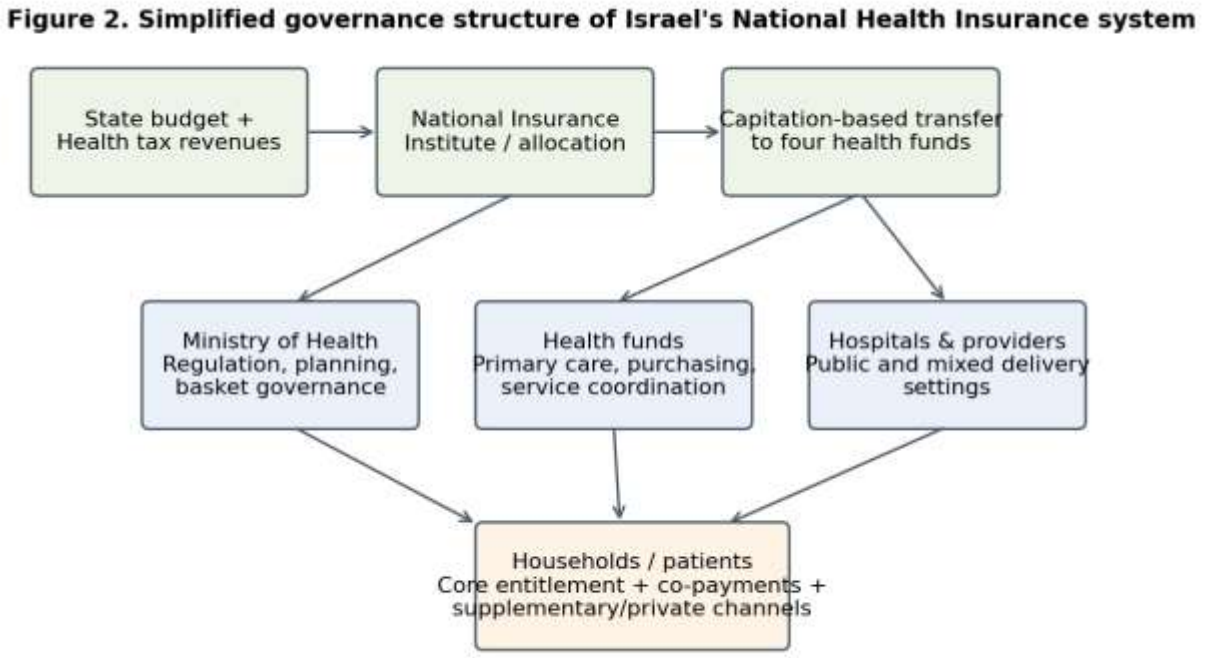

Figure 2. Simplified governance structure of Israel's NHI system, showing the flow of financing, regulation, purchasing, provision, and household interface.

Financing, Benefit Design, and Governance Pressures:-

The financing architecture of NHI lies at the heart of the reform's long-term performance because financing is the point at which solidarity is translated into management. The original design linked entitlement to a public financing framework centred on earmarked health taxation and state participation. Yet later scholarship and official reviews make clear that financing adequacy remained politically contested, particularly as demography, technology, and expectations increased the cost of sustaining the public core. In the analytical terms used here, this is the central site of fiscal strain.The basket of services is equally central. It is not merely a legal inventory of covered services; it is the principal managerial instrument through which the state defines the real content of social rights. Where updating mechanisms become too dependent on annual negotiations, weak utilization data, or fiscal restraint, the practical value of legal entitlement may erode. The question is therefore not only whether a basket exists, but whether it is governed in a sufficiently predictable, evidence-informed, and transparent manner.

A related pressure concerns the public–private boundary. Israeli healthcare remains universal in legal design, yet the expansion of voluntary health insurance, supplementary insurance, co-payments, and private channels can widen the gap between formal entitlement and actual access. This does not amount to formal retrenchment, but it can create functional differentiation by waiting time, geography, capacity bottlenecks, and the ability to bypass public queues. From a management perspective, this boundary is especially important because it affects both the operational resilience and the political legitimacy of the public system.Governance compounds these financing pressures. A system in which the Ministry of Health continues to act in multiple roles may preserve administrative continuity, but it can also blur accountability and complicate long-term planning. Financing, basket governance, and role clarity should therefore not be treated as separate issues. They are interdependent elements of whether universalism is robustly governed or only formally preserved.

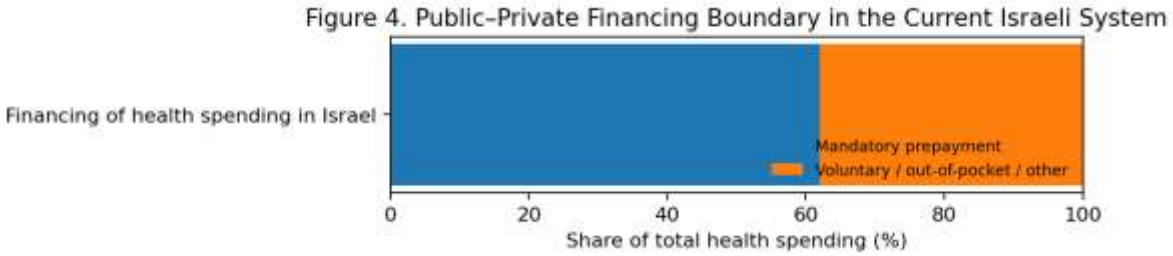

Figure 4. Current public–private financing boundary in the Israeli system, based on the mandatory prepayment share of total health spending reported in recent OECD indicators.

Results:-

The reform produced several durable system-level outcomes. Universal statutory entitlement was established for all residents, the health funds were consolidated within a single national legal framework, and overt exclusion from basic insurance was substantially reduced. The result was a more coherent system architecture centred on four competing non-profit health plans operating under uniform statutory rules.Recent official comparative indicators show that Israel continues to provide 100% population coverage for a core set of services. At the same time, only 62% of total health spending is covered through mandatory prepayment, compared with an OECD average of 75%. Total health expenditure is 7.6% of GDP versus an OECD average of 9.3%, and health expenditure per capita stands at USD PPP 4,352 compared with an OECD average of USD PPP 5,967. Workforce and infrastructure indicators are also lower than the OECD average: Israel reports 3.5 practising doctors per 1,000 population versus 3.9 across the OECD, 5.6 practising nurses per 1,000 versus 9.2, and 3.0 hospital beds per 1,000 versus 4.2.

These indicators matter analytically, not only descriptively. Together they suggest that universal entitlement is being sustained by a relatively lean public financing and capacity base. Lower mandatory prepayment indicates a narrower public share of financing than the OECD norm. Lower spending per capita, fewer nurses, and fewer beds imply tighter operational conditions under which coverage must be implemented. The issue is therefore not that universalism has disappeared, but that its practical realization depends on a thinner margin of public capacity than in many comparator systems.The 2024 Health Systems in Action profile reports additional indicators relevant to financial protection and service access. In 2021, 5.7% of households experienced catastrophic health spending, and 11% of adults reported unmet need due to cost. The same profile also documents regional disparities in service availability, particularly in the south, and describes waiting times and travel distance as factors associated with growing use of private care, often financed through voluntary insurance.Taken together, the current indicator profile supports three connected findings. First, the universal legal framework has endured and continues to structure the system successfully. Second, long-term fiscal and operational pressures remain visible in financing composition, workforce supply, and infrastructure capacity. Third, the existence of supplementary and private channels reduces some pressures for those able to use them, but can intensify normative strain by weakening confidence that the public core alone guarantees timely and equal practical access.

Indicator	Israel	Comparator	Reference year	Interpretive implication
Population covered for a core set of services	100%	OECD average: 98%	2025	Legal universality remains fully intact.
Mandatory prepayment share of health spending	62%	OECD average: 75%	2025	Public financing base is comparatively thinner.
Health expenditure as % of GDP	7.6%	OECD average: 9.3%	2025	Universal coverage operates under lower aggregate spending.

Health expenditure per capita (USD PPP)	$4,352	OECD average: $5,967	2025	Lower spending per person constrains managerial slack.
Practising doctors per 1,000 population	3.5	OECD average: 3.9	2025	Doctor supply is below the OECD average.
Practising nurses per 1,000 population	5.6	OECD average: 9.2	2025	Nursing capacity shows the strongest comparative gap.
Hospital beds per 1,000 population	3.0	OECD average: 4.2	2025	Infrastructure capacity is comparatively lean.
Households facing catastrophic health spending	5.7%	—	2021 (reported 2024)	Financial protection is incomplete for part of the population.
Adults reporting unmet need due to cost	11%	—	2021 (reported 2024)	Formal entitlement does not fully eliminate cost-related barriers.

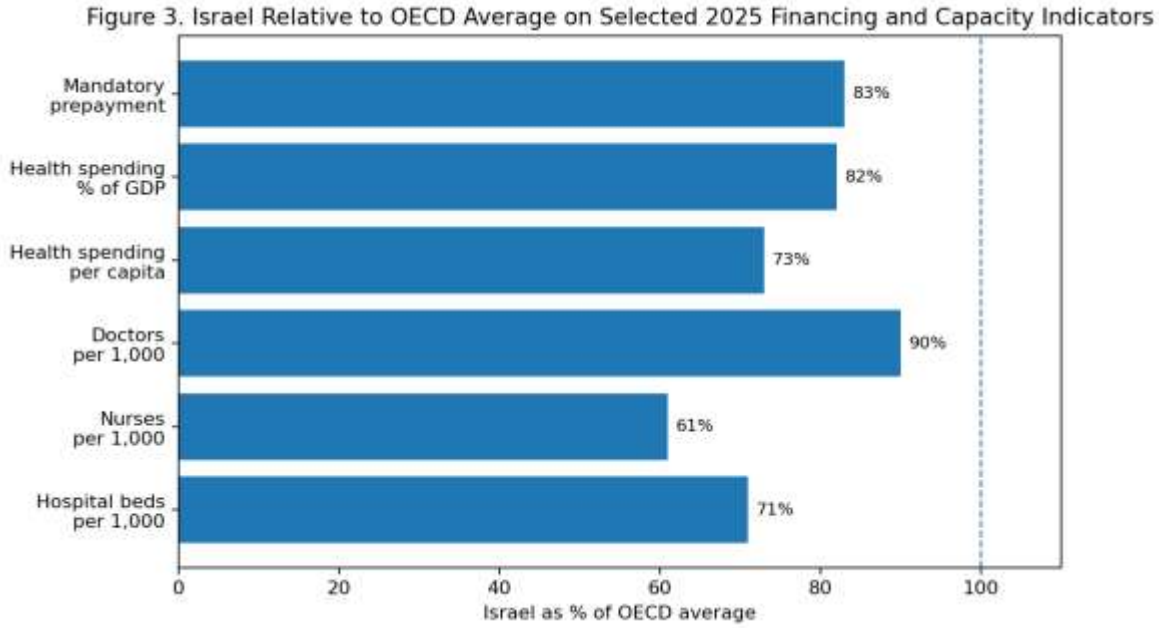

Figure 3. Israel relative to OECD average on selected 2025 financing and capacity indicators.

Discussion:-

The Israeli case offers a broader lesson for the study of health reform: legal universalism is not self-executing. The passage of a major reform can establish rights and stabilize institutional architecture, but the practical value of those rights depends on continuing managerial work—financing, data systems, infrastructure planning, workforce planning, benefit-basket governance, and regulatory discipline. Taken together, the evidence supports an interpretation of the reform as a qualified institutional success operating under sustained structural pressure.

A second lesson concerns pluralism. Israel's model of universal entitlement combined with competing health plans has clear strengths. It can support responsiveness, innovation, and strong primary care. However, pluralism is not neutral. Without sufficiently strong public financing and governance coordination, it can coexist with increasing differentiation in practical access. Where waiting times, geography, insurance supplementation, and private options become more salient, a formally universal system may become progressively less equal in lived experience.

A third lesson concerns the meaning of public management in healthcare. Budget formulas, benefit design, pricing processes, and provider-role boundaries are not merely administrative details. They determine whether social rights remain credible under pressure. Israel's continuing strengths in coverage, quality, and outcomes therefore should not be read as evidence that financing and capacity issues are secondary. Rather, they show that a high-performing system can still drift into segmentation if the managerial reproduction of the public core becomes too weak or too reactive.A brief comparative perspective reinforces this point. Managed competition and regulated pluralism are not uniquely Israeli phenomena; other systems also rely on multiple insurers or funds operating within public rules. Yet Israel's case is particularly instructive because the state's stewardship role remains unusually layered, and because a relatively lean public financing base coexists with strong expectations of universal access. This combination makes the management problem especially visible: the question is not only whether the state guarantees coverage, but whether the public core remains strong enough to make that guarantee meaningfully equal in practice.

Future Policy Directions:-

Several policy directions follow from the analysis. First, basket updating would benefit from a more predictable and transparent mechanism that is less dependent on short-term annual bargaining and better aligned with demographic and technological change.Second, governance would be strengthened by clearer boundaries between the Ministry of Health's regulatory responsibilities and its provider-linked roles. Even where complete institutional separation is not immediately feasible, greater functional transparency and accountability would improve long-term stewardship.

Third, universalism requires more than legal entitlement; it requires operational capacity. Policy therefore should prioritise workforce expansion, nursing supply, regional service availability, and infrastructure investment, especially in areas where reliance on private bypass channels is greatest.Fourth, financial protection should be reinforced so that co-payments, waiting-time pressures, and supplementary insurance dependence do not become routine substitutes for an adequately functioning public core. The long-term sustainability of NHI depends less on rhetorical commitment to solidarity than on whether the public system can still deliver that solidarity credibly in everyday use.

Limitations:-

This article has several limitations. First, it is a secondary policy analysis and therefore depends on the quality, scope, and comparability of existing sources. It does not use individual-level administrative or clinical microdata and does not estimate causal effects.Second, the article combines historical interpretation with current-system indicators. That design is useful for long-run policy analysis, but it means that some sections are more interpretive than statistical. Third, current comparative indicators inevitably compress internal variation by region, sector, and social group. The article therefore should not be read as a substitute for detailed empirical work on waiting times, regional inequality, provider behaviour, or household burden.Finally, because the article prioritises institutionally central sources, it gives greater weight to official publications and high-level policy analyses than to narrower sectoral studies. Future work could strengthen the evidence base by integrating longer financing series, more granular household expenditure data, and regional capacity measures.

Conclusion:-

Israel's National Health Insurance reform remains one of the country's major social-policy achievements. It universalized statutory entitlement, stabilized a coherent national framework, and embedded a public commitment to healthcare access that has endured for three decades.Yet the long-term record also shows that universal entitlement is not equivalent to frictionless equality of access. A universal system must be continually sustained through financing adequacy, predictable basket updating, role clarity, workforce development, and investment in material capacity. Where these supports weaken, universalism can remain intact in law while becoming more differentiated in practice.The policy implication is therefore constructive rather than pessimistic. The historical success of NHI means that the core principles of solidarity and universality are not in question. The more urgent task is to govern those principles more effectively: to reinforce the public core, improve financial protection, reduce capacity

bottlenecks, and ensure that the long-term management of the system matches the strength of its founding social commitment.

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Conflicts of Interest:-
The author declares no conflicts of interest.

Ethics Statement:-
This study relied exclusively on publicly available documents and aggregate indicators. No human participants or identifiable personal data were involved, and ethics approval was not required.

Data Availability:-
All data used in this article are drawn from publicly available sources cited in the reference list, especially the OECD country note for Israel and the European Observatory on Health Systems and Policies.

References:-
1. Aiken, L. H., & McHugh, M. D. (2014). Is nursing shortage in Israel inevitable? Israel Journal of Health Policy Research, 3, Article 10. https://doi.org/10.1186/2045-4015-3-10
2. Bin Nun, G. (2013). Private health insurance policies in Israel: A report on the 2012 Dead Sea Conference. Israel Journal of Health Policy Research, 2, Article 25. https://doi.org/10.1186/2045-4015-2-25
3. Brammli-Greenberg, S. (2015). Inequalities in waiting times by socioeconomic status: A possible causal mechanism. Israel Journal of Health Policy Research, 4, Article 2. https://doi.org/10.1186/2045-4015-4-2
4. Chernichovsky, D. (1995). The political economy of health system reform in Israel. Health Economics, 4(2), 127–137. https://doi.org/10.1002/hec.4730040205
5. Chernichovsky, D. (2013). Reforms are needed to increase public funding and curb demand for private care in Israel's health system. Health Affairs, 32(4), 724–733. https://doi.org/10.1377/hlthaff.2012.0283
6. Chinitz, D. (1995). Israel's health policy breakthrough: The politics of reform and the reform of politics. Journal of Health Politics, Policy and Law, 20(4), 909–932. https://doi.org/10.1215/03616878-20-4-909
7. European Observatory on Health Systems and Policies. (2024). Health systems in action: Israel. World Health Organization Regional Office for Europe.
8. Feder-Bubis, P., & Chinitz, D. (2010). Punctuated equilibrium and path dependency in coexistence: The Israeli health system and theories of change. Journal of Health Politics, Policy and Law, 35(4), 595–614. https://doi.org/10.1215/03616878-2010-018
9. Gannot, R. N., Rosen, B., & Chinitz, D. (2018). What should health insurance cover? A comparison of Israeli and US approaches to benefit design under national health reform. Health Economics, Policy and Law, 13(2), 189–208. https://doi.org/10.1017/S1744133117000287
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. https://doi.org/10.1186/s13584-017-0137-4
11. Gross, R., Rosen, B., & Chinitz, D. (1998). Evaluating the Israeli health care reform: Strategy, challenges and lessons. Health Policy, 45(2), 99–117. https://doi.org/10.1016/S0168-8510(98)00030-X
12. Horev, T., & Avni, S. (2016). Strengthening the capacities of a national health authority in the effort to mitigate health inequity: The Israeli model. Israel Journal of Health Policy Research, 5, Article 19. https://doi.org/10.1186/s13584-016-0077-4
13. Niv-Yagoda, A. (2020). Association between trust in the public healthcare system and selecting a surgeon in public hospitals in Israel: A cross-sectional population study. Israel Journal of Health Policy Research, 9, Article 38. https://doi.org/10.1186/s13584-020-00396-z
14. OECD. (2025). Health at a Glance 2025: OECD Indicators. OECD Publishing. https://doi.org/10.1787/8f9e3f98-en
15. OECD. (2025). Health at a Glance 2025: Israel. OECD Publishing.

16. Rosen, B., Waitzberg, R., & Merkur, S. (2015). Israel: Health system review. Health Systems in Transition, 17(6), 1–212.
17. Shmueli, A. (2014). Income-related inequalities in health and health services use in Israel. Israel Journal of Health Policy Research, 3, Article 37. https://doi.org/10.1186/2045-4015-3-37
18. State of Israel. (1994). National Health Insurance Law, 5754–1994, Sefer HaHukim [Book of Laws], No. 1469, p. 156.
19. Treister-Goltzman, Y., & Peleg, R. (2023). The physician shortage in Israel and a policy proposal for improvement. Israel Journal of Health Policy Research, 12, Article 2. https://doi.org/10.1186/s13584-023-00552-1