

The Healthcare System in Israel: Between the *New Normal* and the *Old Normal*

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The Healthcare System in Israel: Between the *New Normal* and the *Old Normal*

Nadav Davidovitch, Natan Lev, and Baruch Levi

Over the past year, the healthcare system in Israel has undergone far-reaching changes that will affect healthcare in the coming decades. During the writing of this chapter, a war broke out that was unprecedented in every sense of the word, including the number of those killed, wounded, and taken hostage. It has required the healthcare system — in the hospital and in the community — to focus on that crisis. The effects of the October 7 war on the healthcare system are discussed in a separate chapter in this book.

The term *new normal* has been in common use since the outbreak of the COVID-19 pandemic; in practice, it describes a change in reality following a crisis. In May 2023, the WHO announced that COVID-19 is no longer defined as an emergency situation in public health. This does not mean that the virus has been eliminated; indeed, it continues to infect and to develop mutations. However, it no longer threatens the healthcare system and is not likely to bring about its collapse. It is still difficult to estimate the scope of the changes brought about by the COVID pandemic, but it is clear that it constituted a shock to many systems. At the same time, though, the many problems and challenges previously faced by the healthcare system remain with us, including the erosion of budget sources, duplication of insurances, workforce planning issues, and healthcare inequality. The data on national healthcare expenditure show, for example, that Israel returned relatively quickly to the *old normal* that prevailed prior to the pandemic, which was characterized by a low share of public spending devoted to healthcare.

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In this chapter, we will highlight some of the pandemic's effects and lessons learned from it, with the understanding that there is still no comprehensive perspective from which to gain a full understanding of such a dramatic event.

In March 2023, the Ministry of Health's COVID Information Center was officially shut down. This represents an important milestone that was preceded by an evaluation process conducted by the Ministry of Health and the creation of an epidemiological information system by the Division for Public Health within the Ministry. This is but one example of the many structural processes taking place in the healthcare system. It is clear, though, that dealing with the COVID virus also involves other issues related to workforce planning, budgeting of the system, and its management, which need to be discussed.

Among the issues discussed in this chapter is burnout among healthcare workers, which began long before the pandemic, and the narrowness of the perspective taken in response to the pandemic, despite the importance of these issues. This was certainly the case during the initial encounter with the virus, which was characterized by a great deal of uncertainty and high rates of morbidity and mortality. Indeed, the response to the pandemic and the intervention programs had indirect adverse effects on public health as a result of the lockdowns, including weight gain, reduced physical activity, increased rates of smoking, loneliness, depression, and extensive damage from school closures. Similarly, it appears that the pandemic had a greater effect on those from low socioeconomic strata, as has been documented in several reports published by the Taub Center.¹

During the past year, several additional processes of importance have gained momentum. The Planning Authority approved the National Master Plan for Healthcare Institutions for 2048 (TAMA 49) which sets ambitious targets for the development and expansion of the hospitalization system, including home hospitalization. It is clear that without supplementary measures, i.e., the allocation of budget and staffing, this highly important plan will remain only on paper. During the past year, the program to shorten hospital shifts of physicians, and particularly residents, was implemented, initially in the periphery and in specific wards; the ability of insured patients to choose the hospital in which they wish to receive care was expanded; and reforms were

1 For the publications of the Taub Center on the pandemic, see the [Taub Center website](#) and in particular Davidovitch and Levi, 2022.

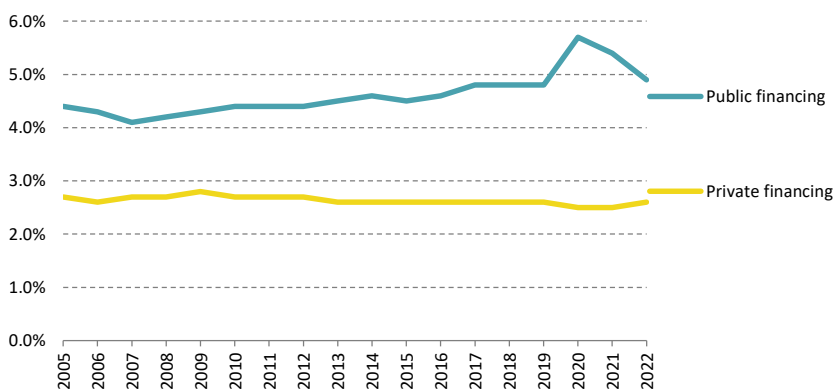
implemented in private health insurance. Also during the past year, Israel experienced a deep social crisis with the continued protests against judicial reform, which had far-reaching effects on all parts of society, including health and the healthcare system.

In this review, the reader is presented with the trends, developments, and up-to-date data on the healthcare system, relative to other high-income countries and to past years. The review is based on information available in databases, research studies, reports, and policy papers of international organizations and national healthcare authorities, including the OECD, the WHO, the Israeli Ministry of Health, and the Central Bureau of Statistics (CBS), as well as State Comptroller reports and publications of stakeholders such as the Ministry of Finance, the health funds, the Israel Medical Association, and other healthcare organizations that are involved in the formation of healthcare policy and regulation in Israel.

Healthcare expenditure

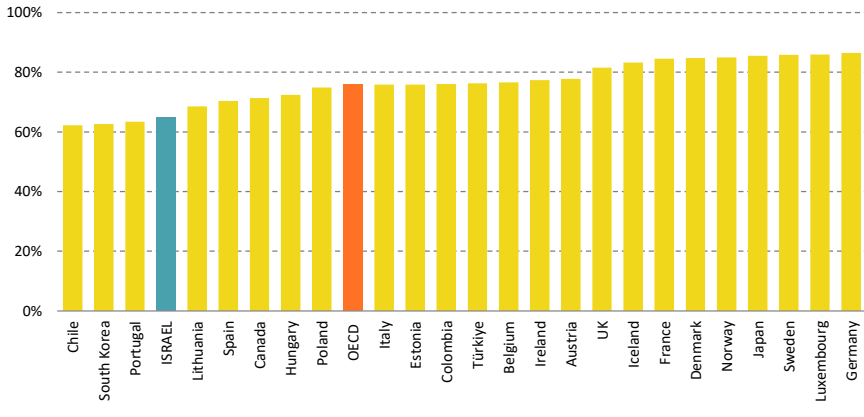
Following the increase in the public financing of healthcare in Israel as a result of the pandemic, as occurred in many other countries as well, the proportion of public expenditure on healthcare returned to pre-pandemic levels, and, in 2022, was 4.9% of GDP (Figure 1). The share of private expenditure was 2.6% of GDP, similar to its level during the past decade.

Figure 1. Public and private financing as a percent of GDP



Source: CBS

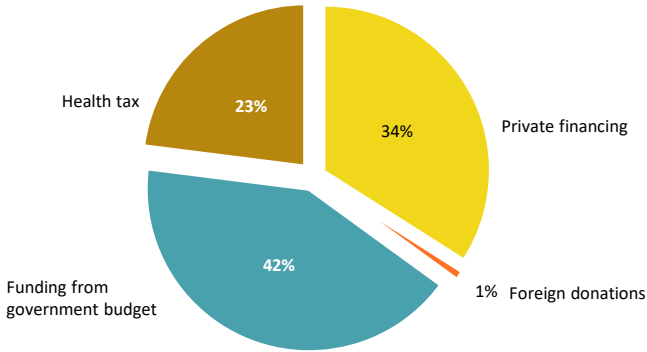
Figure 2. Public expenditure on health as a percent of national expenditure on health, international comparison, 2022



Source: CBS

In 2022, national expenditure on healthcare in nominal prices was NIS 132.6 billion. Although expenditure in fixed prices grew by 0.8% relative to 2021, in per capita terms it fell by 1.1%. In 2022, healthcare expenditure was 7.3% of GDP. This figure puts Israel in the lower third of the OECD countries. The share of public expenditure on healthcare out of total national expenditure puts Israel at an even lower ranking and only Portugal, South Korea, and Chile spend less (Figure 2).

With regard to healthcare financing (Figure 3), in 2022, about 23% of national expenditure on healthcare was financed by the health tax and approximately 42% by the State budget. Total private financing in that same year was about 34% and almost one-quarter of that was direct payments by households for medicines and medical services.

Figure 3. National expenditure on healthcare by financing source, 2022

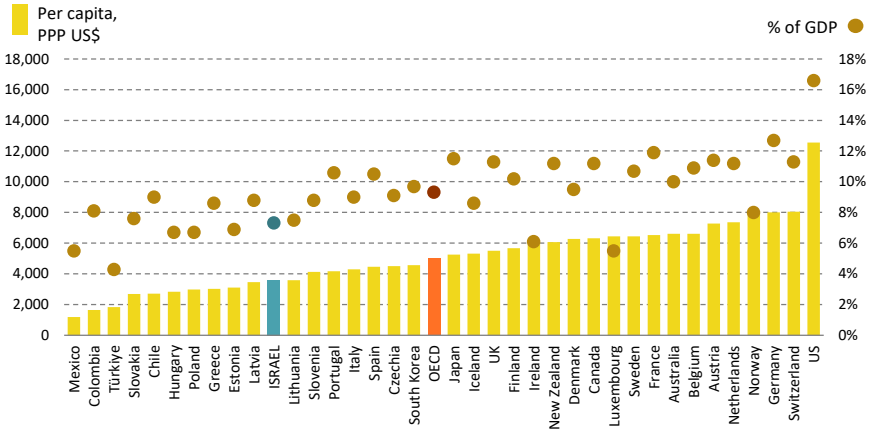
Source: CBS

Current per capita expenditure in Israel in PPP (purchasing power parity) terms was \$3,596, which is lower than in most of the OECD countries. The comparison to other countries does not take into account factors that are likely to affect this expenditure, such as the structure of the health system, the country's employment structure, and the population's age profile. Adjusting for age — which is necessary given Israel's relatively young population — somewhat reduces the disparity between Israel and most of the OECD countries, though it hardly affects its relative ranking in the bottom third (Achdut et al., 2016).

Figure 4 presents the data on current per capita national expenditure and as a percentage of GDP adjusted for age in 2022 for Israel and the OECD countries. The graph shows the US to be an exception and that it continues to lead other countries. The average national expenditure on healthcare as a proportion of GDP in the OECD countries was 9.3%, which is much higher than that of Israel (7.3%). Similarly, while the percentage of national expenditure out of GDP in Israel has remained stable since the passage of the National Health Insurance Law, the average expenditure of the OECD countries has risen, resulting in the current disparity. As we concluded in previous reports, this gap represents the erosion in public expenditure on healthcare in Israel, which is reflected in the growing needs of the healthcare system, from the updating of the healthcare basket to investment in the healthcare workforce and infrastructure, as well as accessibility of healthcare services.

Figure 4. National per capita expenditure as a percent of GDP, age-adjusted, international comparison, 2022

PPP dollars



Source: CBS

Workforce

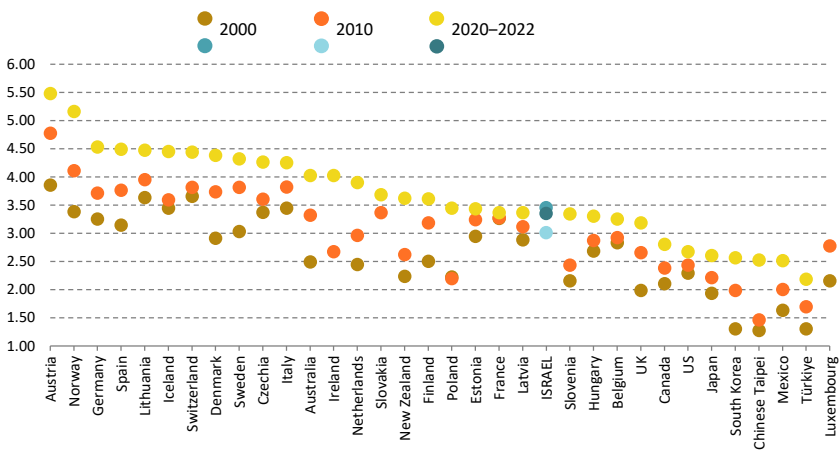
Healthcare workforce planning is of critical importance to the future of the healthcare system. This issue affects the healthcare system's long-term ability to meet the needs of the population and to match the supply of medical professionals to the demand of the population over time. To this end, precise forecasts are needed that account for demographic, economic, social, and other variables. In recent years, the Ministry of Health has invested a great deal of effort in workforce planning as well as in finding solutions to persistent problems, such as low numbers of care providers per capita; the sub-optimal distribution of the workforce leading to scarcities in some of the professions and specializations; an unequal geographical distribution of care providers; and the migration of high-quality workforce to the private health sector.

It is clear that the Ministry of Health cannot carry out all the measures required to achieve real change in the system on its own. Efforts aimed at retaining high-quality healthcare professionals in the periphery, for example, require a partnership with other government ministries and the local authorities. The relationship between the private and public health sectors requires special

attention, since the dominance of the private healthcare market in Israel and the competition over high-quality professionals make it difficult to attract professionals to the public system.²

As can be seen in Figure 5, during the past decade the number of physicians per capita has risen somewhat (from 3 physicians per 1,000 population to 3.3) and is approaching the level in 2000, yet it remains lower than the OECD average.

Figure 5. Number of physicians per 1,000 population, international comparison



Note: Data are for the most current year available.

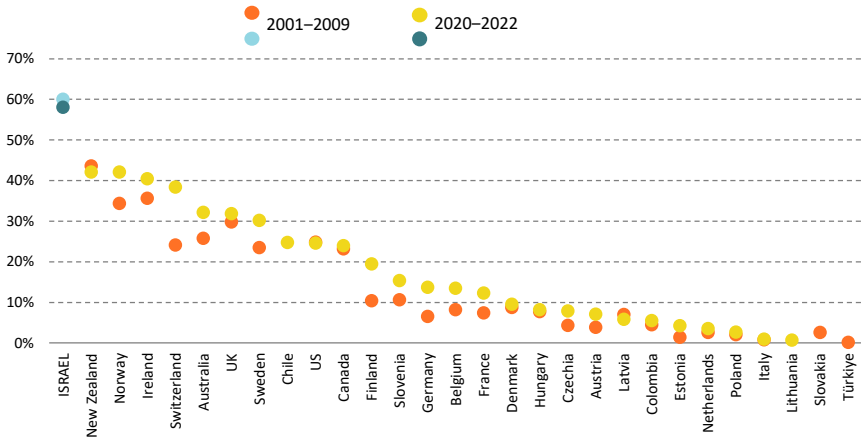
Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: OECD

Another important factor to consider in this context is the healthcare system’s reliance on graduates of foreign medical schools. Their proportion out of the total number of physicians in Israel is close to 60%, which is the highest proportion among the OECD countries (Figure 6). Furthermore, the regional distribution of foreign graduates in Israel is not even, with their share in the periphery at about 80%. However, during the past decade there has been

2 Over the years, this situation has led to several initiatives to limit private healthcare in Israel and to strengthen the public system. Prominent among them is the recent Ash Committee, which submitted its recommendations in November 2022 (Ash Committee Report, 2022).

a decline in their number, primarily as a result of the Yatziv Reform, which reduced the list of foreign medical schools recognized in Israel. Furthermore, the total number of new medical licenses is on an upward trend: in 2021, 2,024 new licenses were issued, which is 2.8 times more than the 727 licenses issued in 2010. Of those, 776 were issued to graduates of medical schools in Israel, which is 2.2 times more than the 349 licenses issued in 2010 (Ministry of Health, 2022c). Despite the Ministry of Health's efforts to deal with this issue — which have led to a welcome increase in the number of new licenses, and particularly of graduates from Israeli medical schools — these numbers are not sufficient in view of the increase in Israel's population and needs, and, therefore, further solutions are required.

Figure 6. The share of physicians trained abroad out of all physicians, international comparison



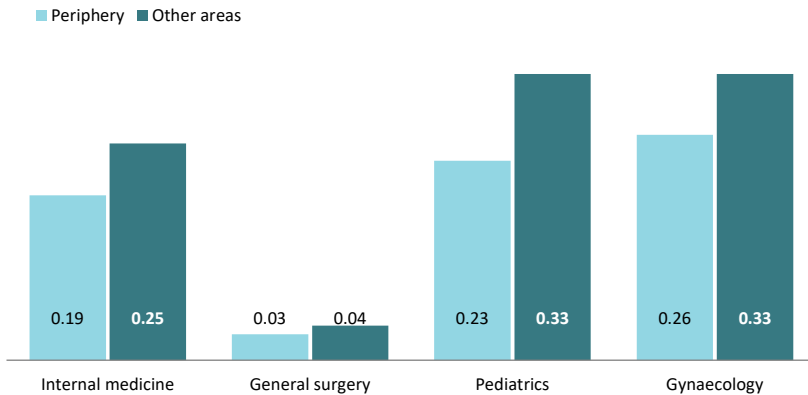
Note: Data are for the most current year available.

Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: OECD

In May 2023, the OECD published a report on medical training in Israel (OECD, 2023b). The report, which was based on discussions with numerous organizations in Israel, including the Taub Center, pointed to an urgent need to train new physicians and to increase the number of physicians per capita.

As noted in previous reports, the number of physicians per capita is lower than the OECD average, and of particular concern is the high proportion of older physicians. According to the Ministry of Health's forecasts, if there is no change in trend, the number of physicians per capita is expected to decline beginning in 2025. This will occur as the result of a combination of trends that are expected to increase the need for physicians and trends that are expected to reduce the number of new physicians entering the system. The expected aging of the population in Israel calls for a higher number of physicians per capita while the aging of physicians means that a greater number will be retiring, and those who continue to work will be reducing their work hours. Thus, the need for physicians is only expected to grow. Moreover, as a result of the Yatziv Reform, which disqualifies those who studied at medical schools that do not meet the standards that have been set, beginning in 2025, the number of students starting their residency training programs will drop by 30% and the available workforce will lessen (OECD, 2023b). These figures will affect the periphery to an even greater extent, where the proportion of graduates from medical schools that are no longer recognized is particularly high. Currently, the number the residents per hospital bed in the periphery is significantly lower than in other regions of the country (Figure 7).

Figure 7. The number of residents per hospital bed in the periphery and other areas of the country, 2022



Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: Ministry of Health

In light of all these factors, the OECD presented several recommendations to improve healthcare workforce planning in Israel:

1. *Improving the mechanism for workforce planning:* The OECD staff concluded that workforce planning in Israel has traditionally been based on a model of crisis management and ad hoc committees have been created to deal with the situation, although the government has not always implemented their recommendations. Other countries are moving toward a more structured work system that allows for the structuring of models and databases to be used for workforce planning, which can strengthen the link between workforce planning and policy formulation. To accomplish this, it was recommended that Israel also establish a designated governmental body for healthcare workforce planning. This body will be responsible for gathering the relevant information to evaluate supply and demand concerning the healthcare workforce, publishing up-to-date forecasts of expected needs, and assessing their implications for training programs in Israel.

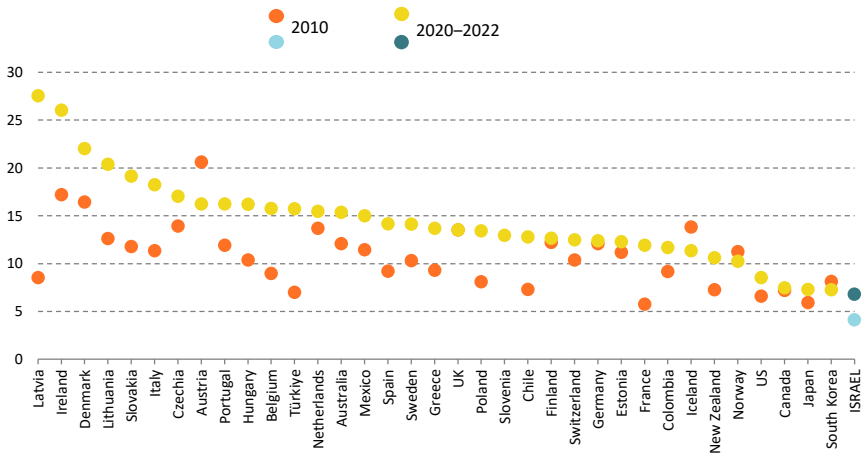
It was also recommended that the adoption of the Dutch model be considered. According to this model, an independent advisory non-governmental body will be established, along the lines of the Dutch Advisory Council on Medical Manpower Planning (ACMMP), in which the main stakeholders in Israel (professional associations, medical schools, health funds, and others) will work together in full and equal partnership. Together, they will develop forecasts for healthcare workforce planning, update the forecasts, and submit recommendations to the government regarding the number of students needed in the medical profession. The adoption of this model requires a cost-benefit analysis, definition of the organization's structure, definition of the roles of the various stakeholders in a way that will create a balance of power, and definition of the relations between this agency and governmental institutions.

2. *Increasing the number of medical students in Israel:* According to data provided by the Ministry of Health, there has been a significant increase in the number of students in medical training in Israel during the past two decades. However, this number was small to begin with, and, consequently, the number of students relative to the population in 2020 was the lowest among the OECD countries (Figure 8). In order to improve the situation, it was recommended that the number of candidates accepted to the six medical schools in Israel be increased; that consideration be given to

opening an additional medical school; and that the number of students required be updated continually, based on workforce forecasts.

A problem that was raised in the report, one that has often been stated by the medical schools, is the shortage of hospital positions for medical students to complete their clinical rotations. This limits the number of students that can be trained each year and contributes to the existing shortage in Israel. Therefore, it was recommended that consideration be given to an expansion of clinical rotations and the opening of new positions in them, by, for example, expanding clinical training to two shifts per day, increasing the number of training shifts per year, increasing the number of students per group, and opening clinical rotations outside the hospitals (for example, in primary medical institutions in the community and in public health institutions). This must also include additional budgets to compensate teaching staff for additional work hours.

Figure 8. Number of medical school graduates in the country per 100,000 population, international comparison



Note: Data are for the most current year available.

Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: OECD

3. *Encouraging students studying abroad to return to work in Israel:* Another recommendation in the report is to provide financial assistance to Israeli students studying in recognized foreign medical schools (which meet the standards set by the Yatziv Committee), while conditioning the assistance on returning to Israel and working in areas of national preference. This type of assistance can serve as a supplementary measure to increasing the number of medical students studying in Israel, despite the constraints on the training system in Israel.
4. *Building a structured plan to allocate candidates among the residency programs:* The report stated that the residency programs in Israel use a free market approach, with each hospital deciding independently on the number of residency positions that are opened each year and on the acceptance of candidates to the various positions. This process is less transparent than similar systems in other countries and hinders the optimal planning of workforce needs. Therefore, it was recommended that a central planning system be created that would be responsible for managing the residency programs, while providing estimates of the number of positions needed, based on workforce forecasts. Another problem noted in the report is that the budget for residents is based on the hospitals' general budget without allocating a designated sum for residency training programs. This results in low wages and difficult working conditions for residents. It is advised that the Ministry of Health create a designated budget to be divided among the residency programs based on the number and composition of resident positions offered in the hospitals and in the community.

An important step in dealing with the shortage in the medical workforce is the reform in healthcare workforce planning initiated by the Financial and Strategic Planning Administration in the Ministry of Health. Within this framework, a number of processes have begun to fill in the missing data needed for optimal workforce planning. In 2021, the Planning Administration published a statistical model that forecasts the future number of physicians in Israel and built a simulator for estimating the effect of policy decisions on the number of medical students in Israel based on data from the six medical schools in Israel (Ministry of Health, 2023d). Towards the end of 2022, new regulations were enacted requiring residents in Israel to register in the Ministry of Health's database beginning in January 2023, a measure that will make a significant

contribution to understanding the status of medical residents and exposing shortages among specialties and across regions in Israel.³

Other steps that are worth noting with respect to the healthcare workforce planning are the creation of an *Atudai Branch*⁴ within the Financial and Strategic Planning Administration in the Ministry of Health⁵ and the implementation of policy encouraging the immigration of physicians to Israel. The Atudai Branch is part of the *Atudai for Israel* program, a national strategy with the goal of promoting high-quality public servants from a variety of populations. In August 2023, the government announced that as part of efforts to strengthen the healthcare system, it will support efforts to bring physicians who are eligible under the Law of Return to Israel. The hope is to add almost 200 physicians to the public health sector. This decision also establishes that hospital staffs will be reinforced by participants in the *Masa Doctors* program, which will be operated as part of the Masa program, and that the project will be allocated up to NIS 1,650,000 from the 2023 budget.⁶

Exchanging training frameworks for foreign medical students to training frameworks for Israeli medical students

Following many years in which it was recommended that training frameworks for foreign medical students in Israel be turned into training frameworks for Israeli medical students, the process will finally begin in the 2023/24 academic year. Previously there were three international programs in Israel (at Tel Aviv University, the Technion, and Ben-Gurion University in the Negev) where foreign students attended a four-year program, following which the vast majority of students returned to their home countries. The goal of the change is to increase the number of Israeli students training in Israel, for whom there is a higher probability of staying in Israel. This facilitates an addition of approximately 130 medical students in Israel (DoctorsOnly, 2022). This measure is expected to have a significant effect on the number of medical licenses granted in Israel beginning in 2025, and it is particularly important given the Yatziv Reform and the disqualification of some foreign medical schools.

3 See the Ministry of Health website, [Medical Interns Reporting to the Ministry of Health](#).

4 An *Atudai* program is an officer academic degree program most similar to ROTC in the US with an emphasis on leadership training.

5 For further details, see the Ministry of Health website, [Reservists for the Healthcare System](#).

6 Government Decision 881 from August 20, 2023, [Continued Strengthening of Israel's Healthcare System Through Bringing Physicians Under the Law of Return](#).

The healthcare professions

In recent years, the number of healthcare providers per capita in many healthcare professions has been on a downward trend. The number of nurses per capita has grown, following a persistent downward trend since the late 1990s. At the end of 2021, 90% of nurses were registered nurses, as opposed to 72% at the end of 2005. The number of dentists per capita is also on an upward trend following a downward trend during the previous decade. There is also a rising trend in other healthcare professions, including pharmacists, psychologists, physiotherapists, occupational therapists, speech therapists, nutritionists, dental assistants, optometrists, dental technicians, and clinical geneticists (Ministry of Health, 2022c).

In the field of nursing care, 3,572 new licenses were granted in 2021, which represents an almost threefold increase since 2010. Of those, 44% are from the Arab and Druze sectors. With respect to age, 41% of registered nurses were under the age of 45 in 2021 (a situation that has remained stable since 2016), as opposed to 54% in 2000. In 2021, 20% of them were aged 67 and older, as compared to 14% in 2010 (Ministry of Health, 2022c). These numbers are evidence of, among other things, aging in the nursing profession.

In contrast, the number of practical and aesthetic dental technicians, medical laboratory workers, and assistant pharmacists continue to decline.

SPOTLIGHT

The Establishment of the Physician Assistant Role in Israel

A physician assistant (PA) is a medical professional who can practice medicine under the supervision of a physician. A PA focuses on prevention, diagnosis, and medical care using a wide variety of health services that traditionally are provided by a physician. This is a relatively new role in healthcare. It began in the US in the 1960s, and since then it has spread to many countries around the world, including Israel (Cohen Aharonov, 2022; Levi & Zehavi, 2017).

The training programs for PAs are closely linked to the medical profession. They are based on the curricula for physicians and their principles have been recognized by the American Medical Association. Currently, PAs in all of the US states can prescribe drugs, although with certain restrictions. It should be emphasized that the professional responsibility for the work of a PA is shared by the PA and the supervising physician (IMA, 2019).

The training of a PA is relatively short and the cost of employing one is lower than that of employing a physician. Thus, a PA can provide an immediate and low-cost solution to the shortage in medical manpower in the US and other countries, in view of the growing demand for healthcare services in high-income countries (Levi & Zehavi, 2017). However, there are indications in the professional literature that a lack of possibilities for professional promotion may lead to dissatisfaction and burnout among PAs. A 2018 survey in the US found that more than 75% of

PAs expressed satisfaction with their work; however, about 33% reported that they had left the profession at least once due to pressure and burnout. Only about 45% reported never having left the profession and about 13% were thinking about leaving the profession (Coplan et al., 2018). A study conducted in Israel among graduates of the first PA training program, which opened in 2016, showed a high degree of satisfaction with their new career and that they had successfully integrated into emergency medicine wards. However, the survey found disappointment among some of the graduates resulting from the gap between their expectations and the actual tasks assigned to them. Furthermore, some PAs found it hard to accept the limitations on their authority (Maoz-Breuer et al., 2019).

In view of the continuing shortage in the medical workforce, the Ministry of Health has been working over the past decade to formalize the status of the PA profession in Israel, in accordance with the recommendations of the professional committee examining this issue (Physician Assistant Committee, 2013). It first formalized the PA role by issuing regulations and publishing circulars that defined training requirements, work processes, chain of command, and the PA's responsibilities (IMA, 2019). In July 2023, the Ministry of Health completed the legislative process to create this role in Israel as part of the Regulation of the Practice of Health Professions Law, 2008.

According to the legislation, the name of the role (in Hebrew) was changed from physician assistant to physician associate. The law provides a PA with the authority to write an initial prescription for medications and even to decide on the conditions for providing a prescription for a dangerous drug (which was also granted to nurse practitioners). The law also specifies the education of a PA and practical training, including a master's degree and passing licensing tests given by the Ministry of Health. After receiving a license, the PA can work in any branch of medicine, but no residency training programs were defined. With respect

to supervision, a specialist will have to personally authorize the PA's work, and the PA will be allowed to carry out medical tasks within the expertise of that physician, and under his supervision. The physician can grant up to three personal authorizations to PAs, in no more than two medical specialties, and can change the personal authorization at any point in time. Currently, there are about one hundred PAs, most of them former paramedics, who are working in emergency medicine; in the future, the PA role may expand to additional areas of medicine.⁷

It is worth noting the spillover of the controversy over judicial reform to the regulation of the PA role. In response to a strike by the Israel Medical Association against the intention of the government to cancel the Reasonableness Standard, in July 2023, during a discussion of the regulation of the PA role, the Knesset Health Committee announced that it views the Israel Medical Association as a political organization rather than a professional one.⁸ Later in that discussion, the Committee decided to reduce the IMA's influence on the regulation of the profession. Accordingly, it was decided that the IMA representative on the Ministry of Health's advisory committee for regulating the profession would be replaced by a representative from academia, and, in addition, the exclusive authority of the IMA's Scientific Council to grant recognition to PA training programs was cancelled. This authority would be granted to an entity that would be authorized by the Ministry of Health. As a result, the IMA petitioned the Supreme Court in August 2023 claiming that the government decisions harm the healthcare system and are motivated by non-relevant considerations (IMA, 2023). The dispute between the government and the IMA is expected to delay the progress that has been achieved in establishing the PA role and disrupt its progress exactly at a time when the strengthening of the medical workforce in the healthcare system is badly needed.

7 [Knesset Health Committee, Protocol No. 69, June 27, 2023.](#)

8 [Knesset Health Committee, Protocol No. 92, July 20, 2023.](#)

Shortening the shifts of residents in the hospitals

The conflict over the number of continuous work hours that physicians and particularly residents are required to work has been on the public agenda for many years; nonetheless, a solution has yet to be found. Both sides have good arguments. Those who support a shortening of work hours point primarily to the drop in functionality and the fear of mistakes in judgment due to fatigue, while opponents express concern that the continuum of care and medical training will be compromised by reducing the time spent in the hospital.

In March 2022, the professional work group to plan and implement the shortening of physicians' shifts published its interim report. It included recommendations that led to important developments in this area.⁹ However, even at the stage of drafting the report, significant differences of opinion emerged and the report was published without the signatures of more than half of the group's members. At a later stage, and following political developments in Israel, the implementation of the plan presented in the report was deferred to September 2023. In March 2023, the Ministry of Health published a new plan that included several significant changes; however, it met strong opposition from *Mirsham*, the Medical Residents Association.¹⁰ Later, in July 2023, and following a process of consultation and solicitation of comments from the public, the Minister of Labor signed a general permit to employ physicians on the weekly day of rest and for overtime in medical enterprises, which formalized additional changes in the plan (Ministry of Labor, 2023). In August 2023, the IMA declared a work dispute due to a disagreement with the Ministry of Finance regarding the expected reduction in residents' salaries, and it appeared that an agreement would not be reached in time to enable implementation of the plan on the specified date. At the last minute, the Ministry of Finance and the IMA came to an understanding that the residents would work an additional shift in the middle of the week, and as a result their salaries would not be affected. The plan went into effect as planned in September 2023.

9 See the Ministry of Health website, [Interim Report for Implementation of the Plan to Shorten Hospital Shifts](#).

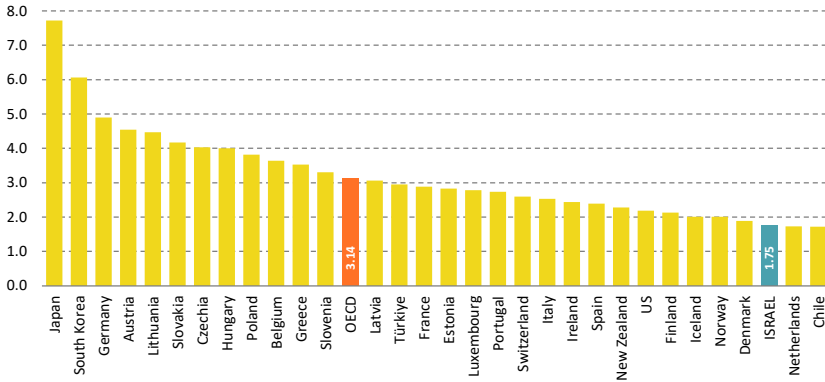
10 See the website of the Prime Minister's Office, Government Press Office, [News: A Plan Has Been Reached to Shorten Interns Hospital Shifts](#).

The range of the agreed-upon plan is more limited than originally intended by those who led the effort for change. According to the current plan, the mid-week shift will be cut from no more than 26 hours to no more than 21 hours, instead of the 18 hours agreed upon in the past. The implication of this change is that the physicians will not attend the morning shift on days that they are on duty, but instead, they will start their workday at 13:00 and will stay until the end of the night shift on that same day. The plan will be implemented first only in hospitals in the periphery (not including the Yoseftal Medical Center) and only in some of the departments (internal medicine, geriatrics, and emergency medicine). The next stage of implementation is unclear. It should be noted that there were many opponents who argued that the change might harm the healthcare system in the periphery as a result of the shortened morning shift and the lack of sufficient manpower to support the shortening of shifts. Nonetheless, this is an important and welcome step and is a milestone in one of the most complex and long-lived crises in the history of the healthcare system.

Hospital beds in general hospitals

In Israel, there were 2 hospital beds per 1,000 population in 2022, including beds for psychiatric hospitalization; not including beds for psychiatric hospitalization it was 1.77 beds per 1,000 population. This represents an almost negligible increase over 2021 (1.75 beds per 1,000 population, see Hillel & Haklai, 2022; OECD, 2023c). The absolute number of beds has generally been characterized by an upward trend over the years; however, in per capita terms it has been declining. This trend reflects the growing tendency, both in Israel and worldwide, toward transferring more and more care from the hospitals to the community. However, even though the trend in Israel is in line with those in other countries, the number of beds in Israel is significantly lower than the OECD average. As presented in Figure 9, the average number of beds in general hospitals in the OECD is 1.79 times higher than in Israel.

Figure 9. Number of general hospital beds per 1,000 population, international comparison, 2021

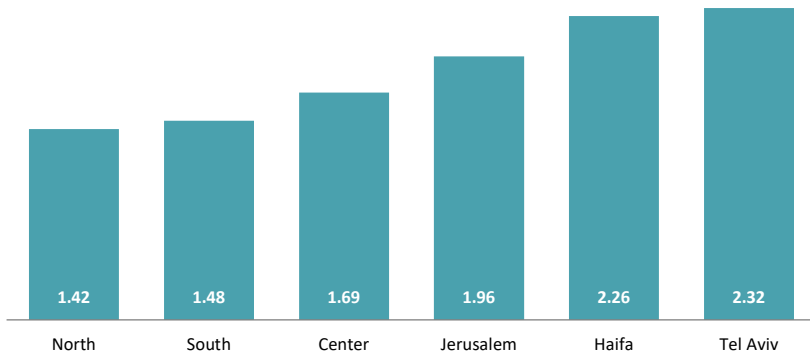


Note: Not including psychiatric hospitalization beds.

Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: OECD, 2023c

Apart from the low number of beds for general hospitalization, there is also an unequal geographic distribution of beds. As can be seen in Figure 10, the number of beds is highest in the Tel Aviv and Haifa regions while in the North and South it is the lowest (Ministry of Health, 2023e).

Figure 10. Number of general hospital beds per 1,000 population, by district, 2021



Note: Not including psychiatric hospitalization beds.

Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: OECD, 2023e

At the same time, there has also been a drop in the number of beds for geriatric hospitalization: 2.75 beds per 1,000 population in 2022, as compared to 3.07 in 2010. The number of rehabilitation beds has been stable, and in 2022, it was about 0.1 beds per 1,000 population, which is similar to what it was in 2010 and in 2000 (Hillel & Haklai, 2022).

The occupancy rate in general hospitalization in Israel was higher than that in the OECD countries in 2021: about 89% as compared to 82% in 2020 (OECD, 2023c). Thus, the occupancy rate approached its level prior to the pandemic, when it was more than 90% and sometimes more than 95%. The temporary drop in the occupancy rate in 2020 can be attributed to the reduced activity in the hospitals during the pandemic, particularly in its initial months, which was also the case in most of the OECD countries that year (OECD, 2023c).

On December 27, 2023, the Ministry of Health published its plan for hospital beds for the coming years. It includes an additional 1,790 acute hospital beds, 300 rehabilitation beds, and 245 psychiatric hospital beds. This plan was built within the multi-year strategic plan of the Ministry and has been recently updated following the needs that were uncovered during the war, with an emphasis on rehabilitation and mental health beds. According to the plan, by 2028, there will be a total of 17,500 general hospital beds — an increase of 11%. Due to population growth, though, the number of beds per capita will remain among the lowest in the OECD countries. With the completion of the plan in 2028, the rate of beds per 1,000 population will be 1.77.

Access to healthcare services

An important part of access to medical services is the length of waiting time for consultations in the community. Long waiting times lower the quality of medical service, raise the risk of complications and hospitalization, and constitute a burden on the healthcare system as a whole. Data provided by the Ministry of Health concerning waiting times for consultations in selected specializations show substantial variation across the professions and across regions.

A survey conducted by the Myers-JDC-Brookdale Institute concerning waiting times for medical consultations in the community among patients aged 22 and older, as part of the national initiative to measure waiting times in the community, showed that the average waiting time for a medical consultation ranged from 31 to 83 days. The survey also showed that overly long waiting

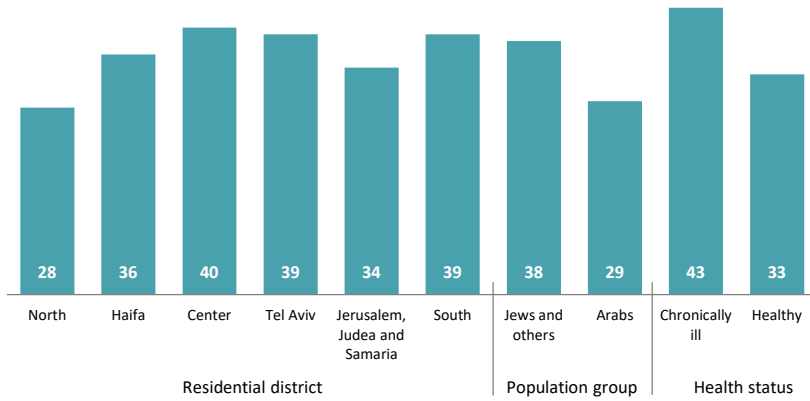
times was the most common reason cited for turning to private medicine, including to services provided by complementary healthcare services (*Shaban*). Respondents noted other considerations that influenced their decision when making an appointment for a consultation, including proximity of the consulting physician to place of residence (36%), the desire to make an appointment as soon as possible (55%), and the desire to meet with a particular physician (43%). Among those who wanted to make an appointment but ultimately did not, the main consideration was the long waiting period for an appointment, with only 3% citing a lack of an appropriate physician in the area as the reason. Among the respondents who did make an appointment for a medical consultation, the majority were satisfied with the accessibility and location of the physician, suggesting that geographic accessibility is not a barrier to making an appointment (Brammli-Greenberg et al., 2021).

An examination of waiting times for consultation services by patient's demographic and geographic characteristics as well as by their health status (Figure 11) shows that the longest waiting times are in the Center, in Tel Aviv, and in the South, in contrast to residents of the North who reported shorter waiting times (39–40 days compared to an average of 28 days). Jews and others (non-Arabs) reported longer waiting times than Arabs (38 days on average compared to 29 days). The longest waiting times were reported by chronically ill patients who use more consulting services than the rest of the population — an average of 43 days compared to 33 days among those who reported their health status was good. The analysis of patterns of use of consultant physicians (Figure 12) shows that, among women, chronically ill patients, and university graduates, there is a higher likelihood of reporting a need for consulting services while among patients who reported a very good health status, Arabs, and men, there is a lower likelihood (Brammli-Greenberg et al., 2021).

Given the shortage of consultant physicians in the North and South, it is possible that residents who turn to consultants less often use primary and emergency medicine facilities instead, or that they forego care completely due to the distance. Not seeking appropriate care is liable to create a false impression that beneficiaries are getting appropriate consultant care despite the small number of consultant physicians, while in actuality they are using other services and burdening the medical system.

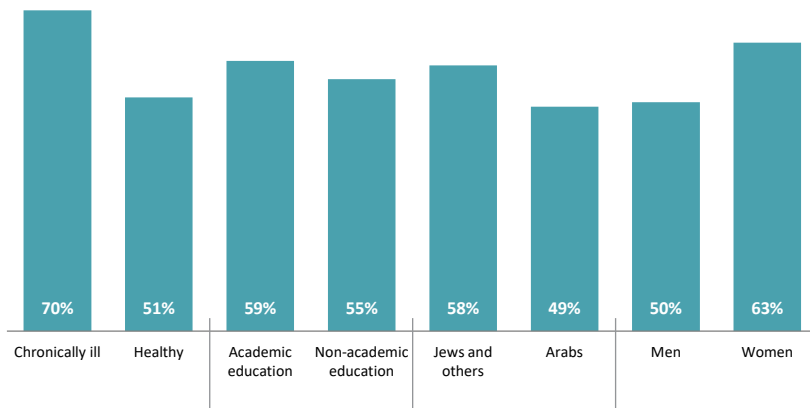
Figure 11. Average waiting time for a consultant, by health status, residential district, and sector, 2019-2020

Days



Source: Brammli-Greenberg et al., 2021

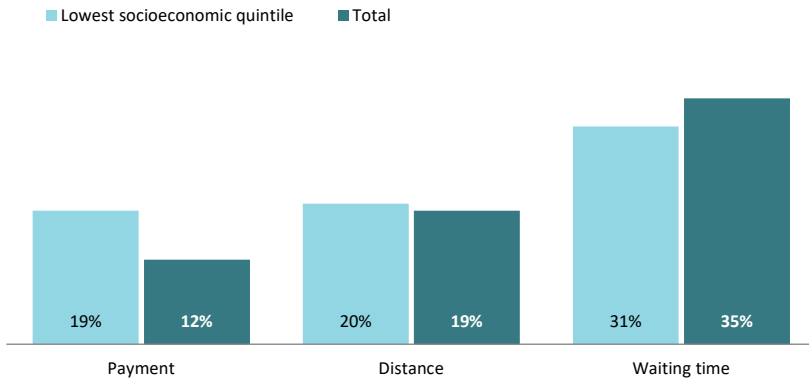
Figure 12. Share of those reporting a need for consultant services, 2019-2020



Source: Brammli-Greenberg et al., 2021

Another survey conducted by the Myers-JDC-Brookdale Institute in 2021–2022 examined healthcare system functionality from the perspective of consumers and showed that one-fifth of respondents did not seek medical care due to the distance from their place of residence, and, of those, 51% turned to private healthcare. Socioeconomic status was shown to affect seeking care (Figure 13): 12% of the respondents did not seek medical care because of an inability to pay, and this figure grew to 19% when considering only respondents from the lowest socioeconomic quintile (Laron et al., 2022)

Figure 13. Share of those foregoing medical care out of all survey respondents and out of those in the lowest quintile, by main reason, 2021–2022



Source: Laron et al., 2022

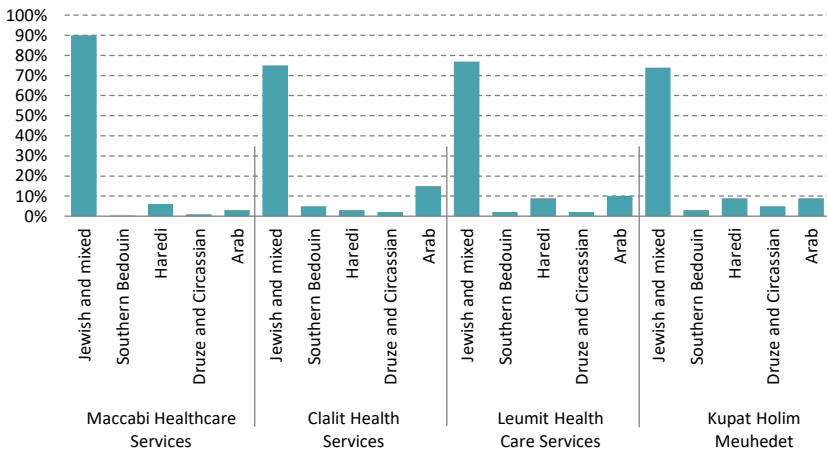
Community healthcare services and health fund expenditures

Health fund members are offered National Health Insurance services and complementary insurance for services (*Shaban*). A look at healthcare services in the community and the characteristics of the expenditure on them reveals large disparities according to region and population group with respect to the use of healthcare services and their quality.

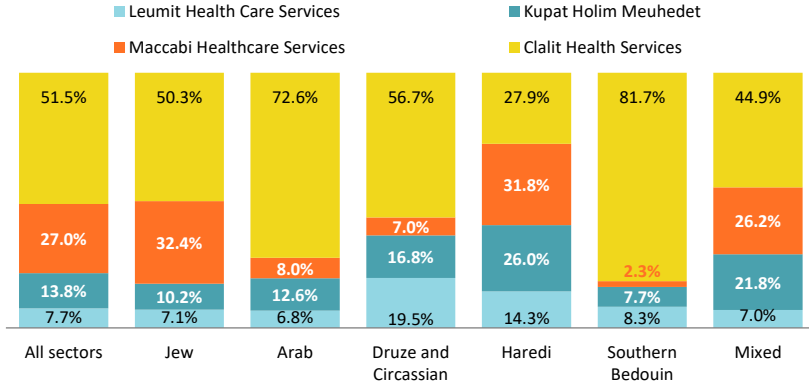
An analysis conducted by the Ministry of Health, using National Insurance Institute data on health fund members in 2021, combined with data provided by the Ministry of the Interior concerning the sector classification

of the locality, shows significant differences in the composition of members between the health funds (Figure 14 and 15). In the case of Clalit, Meuhedet, and Leumit, 74%–77% of the members live in Jewish or mixed cities, while in the case of Maccabi, the portion is about 90% (Figure 14). The distribution of the health funds according to sector (Figure 15) shows that a high proportion of members in Arab and Bedouin towns belong to Clalit while a low share belongs to Maccabi. In Druze and Circassian towns, there is a lower proportion of Maccabi members and a higher proportion of Meuhedet and Leumit members. In Haredi (ultra-Orthodox) localities, it appears that the distribution differs from the weighted average in all of the cities, and they appear to have the most equal distribution between the health funds (Ministry of Health, 2022a).

Figure 14. Distribution of health fund members, by sector and residential locality, 2021



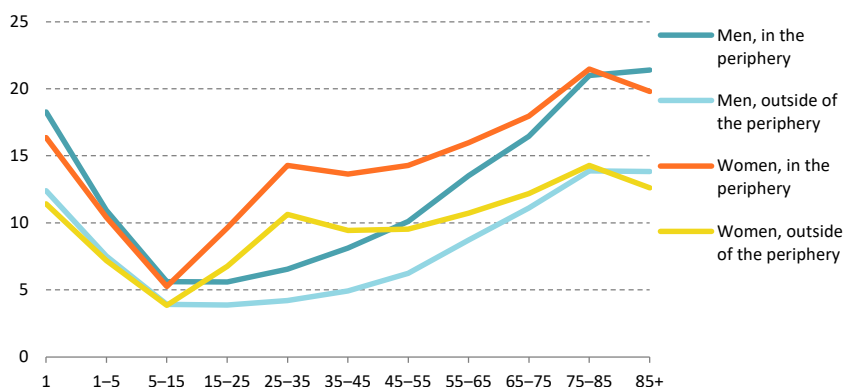
Source: Ministry of Health, 2022a

Figure 15. Distribution of health fund membership by sector, 2021

Source: Ministry of Health, 2022a

Another disparity in the pattern of healthcare consumption is between residents in the periphery and those in the rest of the country. An examination of the annual number of physician visits per member according to the health fund reports to the Ministry of Health for 2019 shows that residents of the periphery visit primary care physicians with greater frequency. Members of both genders and in all age groups had more primary care visits (which are not in the framework of consultations or a visit to a specialist) on average per year relative to their counterparts not living in the periphery (Figure 16). The largest gap was observed in the 75–85 age group. Among women, the gap was 6 annual visits while among men it was 7 (Ministry of Health, 2022a).

Figure 16. Average number of initial visits in the periphery and outside of it, by age and gender, 2019



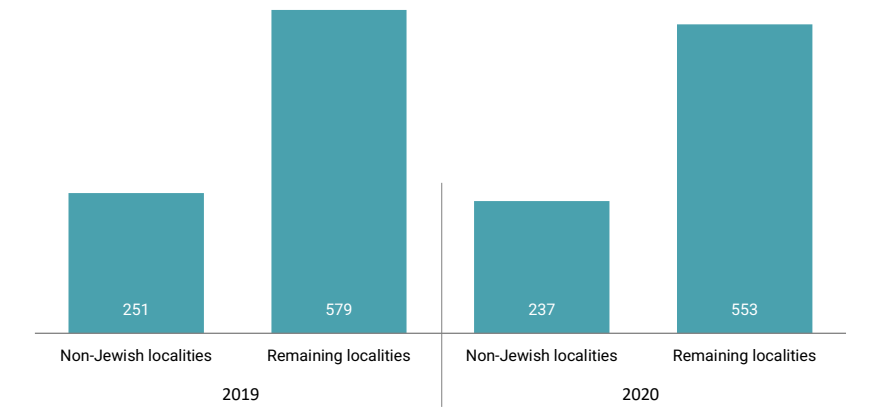
Source: Ministry of Health, 2022a

Regarding health fund expenditure on complementary health insurance, the Ministry of Health data for 2019–2020 show very large disparities between the health funds' expenditure on the Jewish population and its expenditure on the non-Jewish population. The Jewish population is characterized by a high rate of subscription to complementary insurance purchases. In 2020, at least 76% of the Jewish population had complementary insurance while only 46% of the non-Jewish population had it. It was also shown that the health funds spend more on complementary services for the population in Jewish localities and that the disparity in average annual medical expenditure per capita between Jewish and non-Jewish localities ranges from NIS 257 to NIS 361 (depending on the health fund). As shown in Figure 17, the annual complementary insurance cost per health fund member in a Jewish locality is 2.3 times that of a member in a non-Jewish city. The Ministry of Health report suggests that part of the gap in complementary service expenditure can be explained by the difference in age profiles between the populations; since the use of complementary insurance, together with the health fund expenditure, rises with age, the fact that the Arab population is significantly younger than the Jewish population means that it uses complementary insurance at a lower rate. While it would be worthwhile to examine the differences in a cross-section by age, it is likely that the age differences are not sufficient to explain the gap in health fund

expenditure between the two populations. The effect of factors related to supply and demand for these services among the various populations, such as accessibility, fit to the population, and health literacy, should also be examined.

In addition to the disparity between populations in complementary insurance, there is also a difference by region. An analysis of the data published in a 2020 public report on the health funds' complementary health insurance programs shows that there are more complementary insurance beneficiaries outside the periphery, and that there are particularly wide gaps by region in Leumit and Meuhedet (Ministry of Health, 2021c; 2022a).

Figure 17. Average medical expense per person in complementary insurance, by sector, 2019 and 2020



Note: Average expenditure of all health funds.

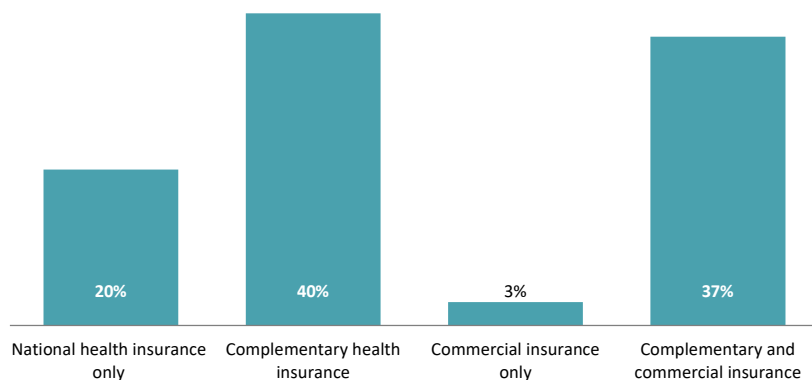
Source: Ministry of Health, 2022a

Reforms addressing health insurance duplication

There are three layers of health insurance in Israel. All residents have basic insurance as determined in the National Health Insurance Law, 1994, with an option to extend coverage through complementary insurance offered by the health funds, or insurance offered by private insurance companies. According to Ministry of Health data (Figure 18), about 80% of the public

have a complementary insurance policy. Of those, almost one-half (37% of the public) choose to purchase both complementary insurance and private insurance. In medical situations that are covered by both complementary and commercial insurance, a claim can be made to only one of them, leading to wasted resources. Moreover, since the cost of medical care in the case of commercial insurance is in general higher than in the case of complementary services, commercial insurance companies prefer to direct a beneficiary to his complementary coverage. This leads to lower rates of commercial insurance usage and an additional waste of resources.

Figure 18. Distribution of public health insurance holders by insurance type, 2020

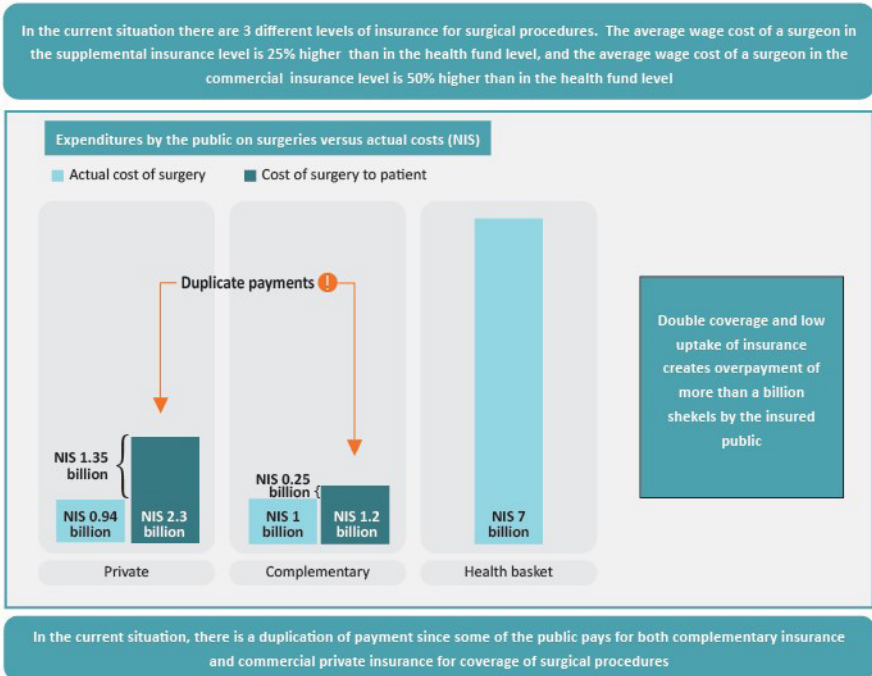


Source: Ash Committee Report, 2022

An example of the problematic nature of duplicate insurance is reflected in the report of the Independent Committee to Strengthen Healthcare Services in Israel and Regulate the Private Healthcare System (the Ash Committee), which looked also at surgery insurance policies. The data concerning surgery insurance policies show an excess expenditure of over one billion shekels by beneficiaries for the reasons outlined in Figure 19. The resulting competition for medical staff time between the public system on the one hand and the complementary service and the insurance companies on the other is also problematic and leads to price increases and difficulty in retaining medical staff, and in particular surgeons, in the public system for the entire workday.

This adverse effect on the public system, which is reflected in a lack of availability of physicians and longer waiting times, leads, in turn, to a widening of social gaps and greater inequality in access to healthcare services (Ash Committee Report, 2022).

Figure 19. The public's expenditure on surgeries relative to the actual cost of the service, 2022



Source: Ash Committee Report, 2022, Figure 3

In recent years, a number of steps have been taken to reduce the effect of insurance duplication in the private market. In October 2023, a reform initiated by the Capital Market Authority in the private health insurance market went into effect. Its goal was to facilitate comparison between the coverage of private insurance to that of complementary insurance and to reduce the extent of insurance duplication. The reform included tools for making information available to the public on the type of private insurance and its cost and the

adoption of a basic uniform policy that companies will be required to market first. This policy will include coverage of cases that are not covered by either National Health Insurance or complementary insurance and that are likely to financially bankrupt an individual. To that policy, an individual can add various extensions that are defined in the reform, thus making it easier to compare policies (Ash Committee Report, 2022; DoctorsOnly, 2023). Another reform is being promoted by the Ministry of Finance as part of the Arrangements Law for 2023. It seeks to reduce overlapping insurance coverage between two types of private insurance — the First Shekel insurance, which provides full coverage for surgery in Israel and is unrelated to complementary insurance, and the Supplementary Complementary insurance, which supplements the complementary coverage for surgery. The law requires that the private insurance companies pay the health funds for surgeries that are financed by a complementary program and which involve duplicate insurance for the policyholder. Similarly, they are required to transfer their customers from the First Shekel plan to a Supplementary Complementary plan.¹¹

These reforms focus on limiting duplications of insurance between complementary and private insurance but they do not relate to the public system in any way. The reduction in private activity is expected to lengthen waiting times and lower the level of service in the public healthcare system; thus, the overall success of these reforms is dependent to a large extent on strengthening the public system in parallel. In the Ash Committee report, it was recommended that over a billion shekels should be added to the annual budget base of the public healthcare system in order to finance specific measures to strengthen the system (Ash Committee Report, 2022).

11 Chapter 16 — Health Legislation Registry, June 6, 2023; Government Decision 198 from February 24, 2023, [Reducing the duplicate costs for consumers purchasing health insurance and commercial health insurance](#).

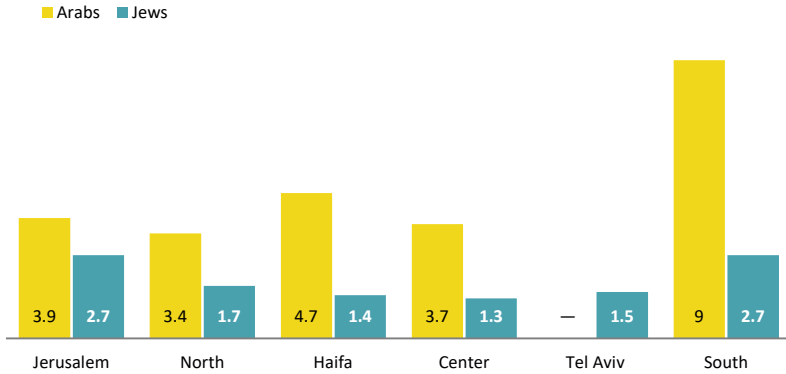
An overview of the health status of Israelis

In Israel, life expectancy at birth is relatively high compared to that in the OECD countries; according to 2022 data, Israel placed seventh among the OECD countries, with an average life expectancy of 82.9 years. It is expected that the numbers for 2023 will continue the upward trend observed as the pandemic tapered off. Life expectancy among women is higher than among men: 84.9 vs 80.9 years (OECD, 2023a). In addition to gender differences, there is a disparity in life expectancy also between population groups. Thus, Arab men have the lowest life expectancy while Jewish women have the highest. Education also affects life expectancy and there is a gap of 6.2 years in the case of women and 6.1 in the case of men favoring individuals with a post-secondary or academic education (Ministry of Health, 2022a). Israel also does well on the Healthy Life Expectancy (HALE) index, and, here again, there is a gender gap. In 2020, the gap in this index was 0.1 years higher for women (66.8 vs 66.7 years). Since 2015, there has been an upward trend in this index among both genders.

Mortality rates show large disparities across regions and population groups. In localities with over 10,000 residents, higher overall mortality rates were observed in those localities with a low socioeconomic ranking and those in the periphery. In a breakdown by population group, the localities with the highest mortality rates are primarily Arab; nonetheless, the list also includes the Jewish cities of Yeruham and Dimona. In contrast, the localities with the lowest mortality rates are more diverse and include some with a high and some with a low socioeconomic status, that are, for the most part, located in the center of the country (Ministry of Health, 2022a).

Another index characterized by disparities is infant mortality. In general, Israel is in a favorable position and its average infant mortality rate is low relative to the OECD average. Over the years, there has been a significant downward trend in infant mortality in both the Jewish and Arab sectors; however, there is still a significant gap between the two groups (Figure 20). In 2020, there were 1.6 deaths per 1,000 live births in the Jewish sector while there were 4.7 per 1,000 in the Arab sector. A breakdown by region (Figure 21) shows disparities also on a geographic basis. The South has the highest infant mortality rate, particularly among the Arab population (Figure 20). The lowest rates are in the Center and Tel Aviv (Ministry of Health, 2022a).

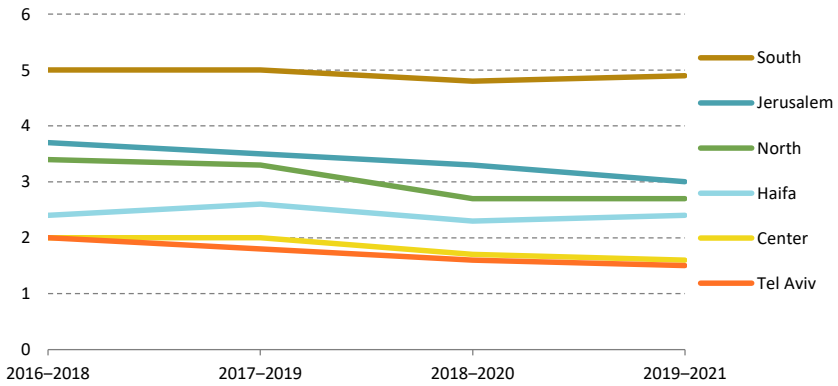
Figure 20. Infant mortality per 1,000 live births by district and sector, average for 2019–2021



Note: For the Arab sector in the Tel Aviv district, data were not published.

Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: CBS, 2023; Ministry of Health

Figure 21. Trends in infant mortality rates, multi-year average, by district



Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: CBS, 2023; Ministry of Health

Lifestyle and risk behaviors

Population lifestyle is closely associated with population health, for better and for worse. Risk behaviors adversely and immediately affect health and quality of life and raise the risk of health problems later in life. Information on the frequency of these behaviors helps the healthcare system direct prevention efforts and promote health, and at the same time to narrow gaps between population groups due to differences in lifestyle.

Smoking is one of the main causes of morbidity and mortality and is considered to be the primary factor in creating disparities in health outcomes. According to estimates, about 20% of the adult population in Israel smokes and about 8,000 deaths per year are caused by smoking. The harm from smoking not only affects smokers themselves — exposure to secondhand smoke poses a considerable risk and 10% of the deaths caused by smoking are attributable to it. In a 2020–2021 survey conducted as part of the National Biomonitoring Program in Israel, urine samples were tested for the concentration of nicotine components and it was found that 33% of children and 64.5% of adults who reported that they do not smoke were exposed to secondhand smoke (Ministry of Health, 2023a).

Studies have shown high rates of smoking among disadvantaged populations around the world. According to the 2022 report of the Minister of Health on smoking in Israel, smoking rates are highest among Arab men and individuals with lower levels of education (Ministry of Health 2023a). The monitoring of trends among smokers over time shows that smoking rates among men are twice those among women. Between 2015 and 2021, an increase in smoking was observed among both genders and in almost every population group. Many factors influence the connection between socioeconomic status and smoking, but it is particularly important to note the impact tobacco companies have by directing their sales efforts toward disadvantaged populations, using such methods as directed advertising and a high concentration of sales points in areas with low socioeconomic ranking. The State of Israel has signed an international covenant on tobacco control which sets out a series of strategies to reduce smoking (MPOWER), such as monitoring, creation of smoke-free spaces, support for smoking cessation programs, and the prohibition of advertising and marketing of tobacco products. Nonetheless, it was found that these strategies are effective primarily among populations with a higher socioeconomic status.

The only strategies that have proven to be effective in reducing the disparities in smoking are taxation and smoking cessation programs focused on disadvantaged populations.

The interim findings of a national study of risk behaviors among youth in Israel for 2022, which was conducted as part of an international survey (WHO-HBSC) and includes a comparison to the years 2019 and 2020, show that, since 2019, the percentage of students reporting that they smoke at least one cigarette per day has risen, and a connection was observed between a feeling of isolation and alienation among students and the risk of smoking. There is also a difference in the extent of smoking between students from different population groups. The largest jump in the reporting of smoking in the various years was recorded in the Arab sector and the highest percentage was recorded among students in the Arab sector in 2022. It is important to note that the introduction of electronic cigarettes into the market has had a negative effect on the fight against smoking among youth, since they increased the youth's exposure to smoking products while being perceived as having a lower risk. Nonetheless, in 2022 there was a significant drop in the percentage of students who smoke electronic cigarettes at least once a week (Ministry of Health, 2023a).

Another phenomenon of concern to the healthcare system is the increase in obesity and excess weight over the past two decades. This trend is associated with a lifestyle characterized by poor eating habits, a lack of physical activity, and more. Obesity and excess weight are the main causes of chronic illness and the fact that these trends are increasing among children is of particular concern, in view of the greater risk of obesity and medical complications later in life. During the pandemic (2020–2021), there was an increase in the obesity rate in Israel in almost every population group and every age group. A correlation has also been found between the rate of obesity and socioeconomic status among youth, adults, and the elderly, whereby obesity decreases as socioeconomic status increases. Among children, the data are somewhat different — children with both the lowest and the highest socioeconomic status have the lowest rates of obesity (Ministry of Health, 2023b).

Diabetes is a clear outcome of excess weight and is among the most common chronic illnesses. According to data provided by the Ministry of Health (2023b), between 2015 and 2021, the incidence of diabetes among the 18+ age group remained relatively stable, and, in 2021, the national incidence was 9.8%. In a breakdown by socioeconomic status, there was a small decline in

the incidence of diabetes during this period in all population groups, apart from the lowest one. As a result, the gap between the highest socioeconomic status group and the lowest has widened over the years. It was also found that a low socioeconomic status is associated with higher rates of morbidity and complications from diabetes. According to the data, the index of diabetic imbalance, which is a measure of the efficacy of care, increased between 2015 and 2021 for all population groups; however, the rates of imbalance were clearly higher among patients of low socioeconomic status. Until 2019, the gap between the population groups with respect to diabetic imbalance was narrowing; however, in 2021, the gap again widened (Ministry of Health, 2023b). According to the data of the National Diabetes Registry for 2021, the incidence of the disease was higher among residents of neighborhoods with a low socioeconomic status for all age groups. Disparities were also found based on region and population group: the highest incidence was found in the districts of Hadera, the Golan, Acco, and Yezre'el, and the incidence was significantly higher among Arabs than among Jews for all age groups. According to the data of the International Diabetes Federation for 2019, the age-adjusted rate of diabetes in Israel was higher than the average for Europe (IDF, 2019). The rate of mortality from diabetes in Israel is high relative to most of the OECD countries, and according to 2020 data Israel is located in seventh place with respect to mortality per 100,000 population on a standardized index (OECD, 2023c).

A healthy lifestyle also includes the use of preventive medical services, such as screening for early detection of preventable and curable cancers. These tests can significantly increase the effectiveness of care and provide an important tool for dealing with cancer incidence in Israel and reducing the burden on the healthcare system. The lack of access to testing and screening awareness in various regions is likely to worsen the prognosis of the disease and the mortality rate in those regions. Between 2015 and 2021, there was an increase in mammogram testing in all population groups apart from women in the lowest socioeconomic group, among whom there was, in fact, a decline that widened the health gaps across population groups. During this time, there was a major increase in screening for cervical cancer across the entire population, but relative gaps in the screening rate between women with a high socioeconomic status and those with a low socioeconomic status remained, and the absolute gap between the groups even widened. In 2021, 64.2% of the population in Israel underwent a test for early detection of intestinal cancer and the rate of testing rises with socioeconomic status.

The overuse of healthcare services is also associated with a health risk. A prime example, which could be prevented with appropriate regulation, is the improper use of antibiotics, which leads to the development of resistant strains of bacteria. This, in turn, leads to the appearance of serious morbidity and mortality and increases the likelihood of infectious disease. The rate of mortality from infectious diseases is high in Israel relative to the rest of the OECD countries, which emphasizes the importance of public information campaigns and promoting the wise use of these medications. The Defined Daily Doses (DDD) index is an international measure of the average daily maintenance dose of systemic antibiotic medications prescribed to adults. The trend in this metric in Israel between 2015 and 2021 shows an inverse relationship between socioeconomic status and consumption of antibiotics. The highest rates of consumption were found among patients from the lowest socioeconomic groups while the lowest were found among patients in the highest socioeconomic groups. At the same time, there has been a decline in the use of antibiotics in recent years, and surprisingly the largest decline between 2015 and 2019 was in the lowest socioeconomic group (Ministry of Health, 2023b).

The attitude towards personal health status, which is captured by the Health Self-Assessment indicator, provides another dimension — a subjective one — in evaluating the effect of lifestyle on health among the population. Israel is not ranked high relative to the OECD countries on this indicator; nonetheless, according to the Central Bureau of Statistics' Social Survey in 2020, the indicator is on an upward trajectory among most socioeconomic groups in Israel. It is worth noting that, for the first time, more Arabs than Jews assess their health as being very good and more low-income earners (up to NIS 2,000) reported a high health assessment than members of the middle class (in an age-adjusted comparison), although it may be that this finding is affected by the rise in the assessment of Arabs and Haredim who account for a large proportion of the low-earning population. Those who immigrated to Israel after 1990, widowers, and divorced men consistently report a particularly low health self-assessment (Ministry of Health, 2022a).

Responding to new strains of COVID-19

In May 2023, following three years in the shadow of the global COVID-19 pandemic, the head of the WHO announced that the state of international emergency has come to an end. This declaration marked the official shift to routine management of the virus in the global healthcare system (WHO, 2023). Preventing the spread of illness is no longer the main objective of the healthcare system and its efforts are directed toward protecting at-risk populations and monitoring patients in serious condition in order to allocate the appropriate resources and provide appropriate care.

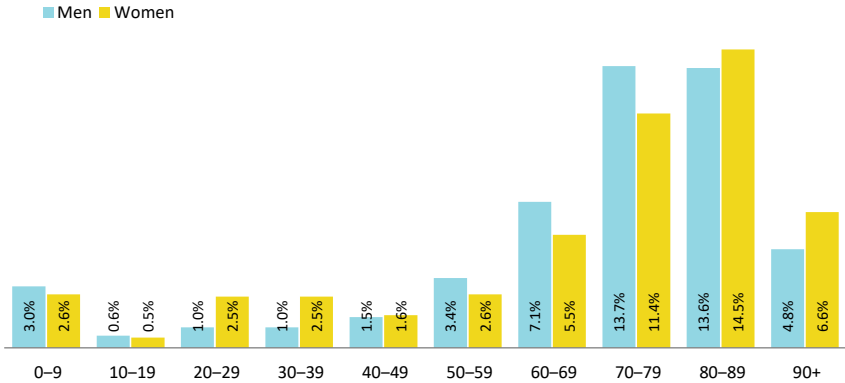
At this stage, there is no comprehensive monitoring like that performed at the height of the pandemic and the trends in morbidity can be ascertained primarily based on the changes in the number of seriously ill patients. After a continuous decline in their number since the beginning of the year, there was an approximately three-fold increase since June. A not insignificant increase was also observed in other countries, including the US, as well as the appearance of new sub-strains that are more infectious but similar in their clinical effect to earlier Omicron variants.

The Ministry of Health hospitalization statistics for COVID-19 patients show that most of those hospitalized are defined as being in good condition and only a minority are in moderate or serious condition.¹² The highest rates of hospitalization for both genders are to be found in the 60+ age group and are highest among the 80–89 age group (Figure 22). The data on hospitalized patients in serious condition and the number of deaths show a similar picture, with a peak among the 80–89 age group, and they provide evidence of the ongoing vulnerability of the elderly to the virus (Figure 23 and 24). An examination of mortality rates among elderly patients (aged 60+) by vaccination status (vaccinated, vaccination status expired, or unvaccinated) shows that mortality is highest among the unvaccinated, which indicates that the vaccination is effective in preventing morbidity and mortality even at this stage (Figure 25). The COVID-19 vaccinations are available to all members of the health funds, including vaccination for the new sub-strains of the Omicron variant, and the Ministry of Health recommends that the entire population be vaccinated, with emphasis on at-risk populations.¹³

12 See the Ministry of Health site, [Data World — COVID-19](#).

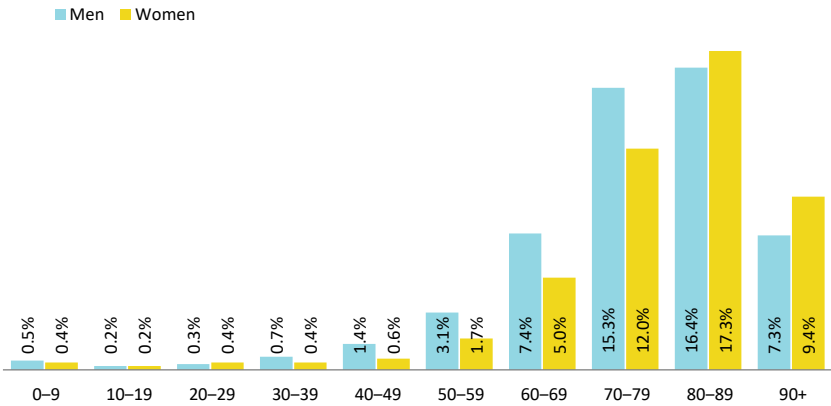
13 See the Ministry of Health site [Guidelines from the Ministry of Health Regarding the Use of the Vaccine for the New COVID-19 Sublineages](#).

Figure 22. Distribution of hospitalizations due to COVID-19, by age and gender, 2023

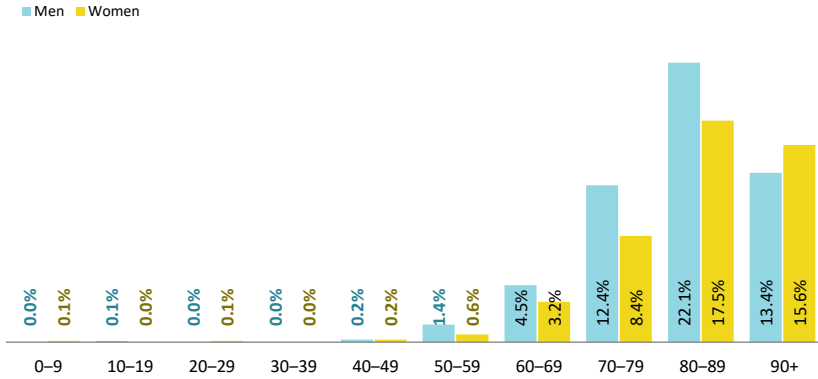


Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: CBS, 2023; Ministry of Health, Data World

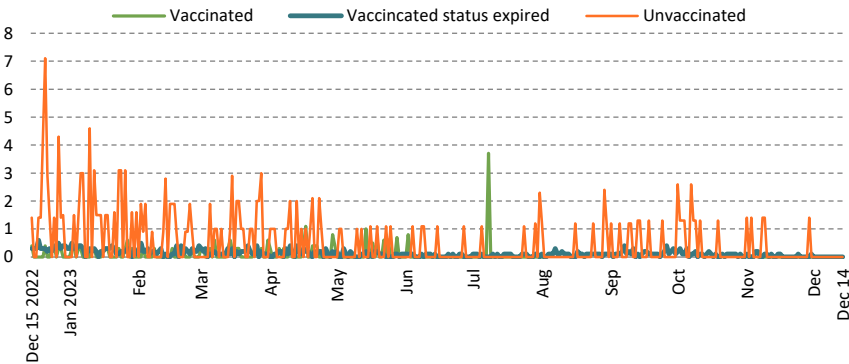
Figure 23. Distribution of hospitalizations of those in serious condition from COVID-19, by age and gender, 2023



Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: CBS, 2023; Ministry of Health, Data World

Figure 24. Distribution of deaths from COVID-19, by age and gender, 2023

Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: CBS, 2023; Ministry of Health, Data World

Figure 25. Deaths from COVID-19 per 100,000 population in the over 60 age group, by vaccination status, 2023

Source: Nadav Davidovitch, Natan Lev, and Baruch Levi, Taub Center | Data: CBS, 2023; Ministry of Health, Data World

The new normal

The COVID-19 pandemic was a unique crisis that led to far-reaching changes in life routines around the world. The adjustment period to the crisis and the tools developed to deal with it transitioned the world into the era of the *new normal*, a concept that relates to the new routines created as a result of the crisis and life alongside the crisis, while dealing with the continuing existential risk presented by the disease. The era of the new normal brought with it tools to deal with global crises and a renewed understanding of the central role played by social solidarity in responding to them. With respect to the healthcare system, emphasis was placed on developing the field of public health and dealing with the social and political contexts that have an impact on health (Boas & Davidovitch, 2022).

One of the insights that emerged in responding to the pandemic was the importance of the healthcare services on the regional level and the need to further promote healthcare in local governance. This approach rests on the fact that about 80% of the factors that affect health are related to social and individual variables that are affected by the local and regional environments rather than the activity of the healthcare system (Ministry of Health, 2021a). The implementation of programs such as the Traffic Light program, which emphasized the differential aspect of the response to the pandemic and reinforced the powers of the local authorities, reflects this understanding. The importance of regional efforts in normal times, as well as in emergencies, can be exemplified in the area of urban health. According to the WHO, urbanization is a global trend and more than 55% of the global population lives in urban areas. The characteristics of the urban environment are associated with the health of residents and affect a wide range of health metrics, such as chronic illness and infectious injuries or illnesses (WHO, 2021). The local authorities have an important role to play in promoting urban health in view of their influence on the design of spatial conditions and residential neighborhoods, and their ability to serve as an intermediary between national, professional, and local organizations while tailoring interventions to local characteristics (Ministry of Health, 2021b).

As part of the transition to the new normal, it is important to consider the challenge facing the healthcare system in the field of climate change. Climate change requires broad systemic planning in order to deal with excess morbidity and the expected burden on the system. Some of the scenarios worth

mentioning are the response to the morbidity accompanying high levels of respirable particles¹⁴ in Israel and preparing to deal with extreme heat waves (Weiss, 2023, pp. 72–75, and see also the chapter on the environmental health in this book).

Conclusion

The healthcare system in Israel is at a crossroads. After increasing public expenditure on healthcare during the pandemic, expenditure returned to the lower levels that characterized the past decade. Many insights emerged from the various parts of the healthcare system and important changes were initiated whose necessity became apparent with the end of the pandemic, such as the importance of a continuum of care, expansion of home hospitalization, the advantages of remote medicine when used wisely, and the need for better integration between the various parts of the healthcare system.

However, the exit from the pandemic also left the healthcare system with far-reaching challenges, including workforce burnout (Ministry of Health, 2022b) and a loss of confidence. The latter includes an erosion of principles that, in the past, were considered fundamental, such as routine vaccination at mother and baby clinics. Evidence for this is the decline in baby vaccination rates which were previously high (Ministry of Health, 2023c). The current war has added to all of this and its implications for the healthcare system are discussed in a separate chapter in this book.

As noted in the introduction, many claim that we are in a post-pandemic new normal era. Living in this era includes the understanding that uncertainty — also in healthcare — continues and requires that the healthcare system adjust to the new reality and operate based on long-term planning and the wise use of data. However, and as described in this review, many of the challenges faced by the system in the past remain with us: health inequality, a shortage in budgets and workforce, the interrelationships between the public and private systems, and the advancement of health in a situation where health is influenced not only by the healthcare system but also by broad socioeconomic variables. All of these challenges must be met.

14 Tiny particles found in the air that enter the respiratory system and pose a health risk. For the most part, these particles are created from natural sources, such as desert dust, and only a small number are from human activities (although exposure to them is much greater).

The need to strengthen the public healthcare system, as discussed in a number of position papers published by the Taub Center, still exists, as does the need for optimal planning of the most important resource in the healthcare system, namely its workforce. Although we live in an era of the new normal, it is tied to the old normal and the chronic problems of the system. The challenges described in this chapter — the aging of the population, health disparities, and the need to strengthen the workforce in the system — require wise management and the positioning of the healthcare system high on the national agenda.

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