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# The Paradox of Israel's Healthcare System: Between National Achievements and Ongoing Erosion

Nadav Davidovitch, Natan Lev, and Ofir Gonen

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# The Paradox of Israel's Healthcare System: Between National Achievements and Ongoing Erosion

Nadav Davidovitch, Natan Lev, and Ofir Gonen

## Introduction

The healthcare sector in Israel presents something of a paradox. In October 2025, the Ministry of Health held a press conference following the publication of an OECD comparative report on health indicators across countries. The data, referring to 2023, show that life expectancy in Israel rose to 83.8 years (85.7 for women and 81.7 for men), placing the country fourth among OECD nations — after Switzerland (84.3), Japan (84.1), and Spain (84.0). The nearly one-year jump in life expectancy between 2022 and 2023 is considered exceptionally positive, since, unlike other countries where a similar rise reflected a rebound from a sharp decline during the COVID-19 pandemic, Israel's drop during the pandemic was relatively moderate. As a result, the post-pandemic increase is even more striking relative to other countries.<sup>1</sup>

Why, then, is this seemingly a paradox? When these achievements are placed alongside investment figures — as will be shown in this chapter, and as past data also indicate — national healthcare expenditure in Israel is among the lowest among the high-income countries of the world, and current per capita

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1 See the Ministry of Health website, [Significant Increase in Life Expectancy in Israel](#).

healthcare spending in purchasing power terms is also lower than in most OECD countries. The common claim that Israel is a younger country, and therefore age adjustments are important, is indeed valid and necessary. However, comparative studies show that even after adjusting for the population's age structure and for long-term care expenditures, the Israeli system still spends less on healthcare — particularly public spending — than other developed systems, while achieving better health outcomes (Levy et al., 2022b).

The apparent paradox between relatively low healthcare spending and comparatively good health outcomes in Israel is not new; it has been discussed for many years. The healthcare system contributes only up to about 20% to overall health outcomes, whereas social, economic, environmental, and political factors play a far larger role (Marmot, 2011). Even so, the healthcare system in Israel is considered unique, including during the October 7th War — the longest war in the country's history. Despite the challenges, the system was among those that responded relatively well, from the first days of the war and to this day.

But can this resilience last forever? Insufficient investment is reflected, for example, in the lack of protective fortification at Soroka Medical Center (and many others, particularly in the periphery), which suffered severe damage during the war with Iran and is still struggling to receive the funding it needs for rebuilding, relying largely on donations. It is also reflected in the neglect of the Tipat Halav network (Family Care Centers) and the School Health Service, which face difficulty administering vaccinations on schedule and in managing vaccine hesitancy — factors that contributed, among other things, to a measles outbreak (Davidovitch et al., 2025; Levy et al., 2022a). Each case is complex and requires specific analysis, but, ultimately, when national investment in healthcare is low, the consequences are felt, and they disproportionately harm poor and marginalized populations.

The challenges of recent years have exposed the vulnerabilities of a system that has succeeded in relying on the *health paradox* for far too long. The medical workforce crisis is deepening: the number of active physicians stands at 3.5 per 1,000 people, compared with an OECD average of 3.9, and forecasts indicate that the situation is expected to worsen in the coming decade despite significant efforts by the Ministry of Health and other agencies. Although the number of nurses has increased in recent years (5.57 per 1,000 people), it remains far below the OECD average of 9.5. The shortage of general hospital

beds (1.76 per 1,000 people compared to 3.18 in the OECD) and psychiatric beds (0.37 compared to 0.70), together with long waiting times for specialist care — especially in critical areas such as neurology and endocrinology (around 50 days) — illustrate a system operating at the limits of its capacity.

The system now stands at a critical crossroads. The paradox of high life expectancy alongside low investment cannot persist. Israel's healthcare system requires substantial and sustained public investment — in the medical workforce (continued expansion of domestic training and increased job positions), in healthcare infrastructure with an emphasis on mental health, public health, and rehabilitation (areas that have been neglected for far too long), in hospital beds, medical equipment, and in reducing geographic, social, economic, and sectoral disparities. At the same time, the technological revolution must be harnessed cautiously and wisely: adopting AI tools and digital medicine that can streamline processes, improve diagnosis and treatment, and reduce burdens on medical teams, while ensuring privacy protection, data security, equitable access, and preservation of the central human relationship at the heart of medical care.

This chapter presents an in-depth overview of Israel's healthcare system in 2025, focusing on critical issues such as the workforce, expenditures, service availability, inequality reduction, population health, and the impacts of the war. The report also offers insights into possible pathways for addressing the challenges ahead, to ensure that the healthcare system can continue to serve all residents of Israel at a high level in the decades to come. This year's chapter includes spotlights on the emergence of the nurse practitioner profession and on the measles outbreak, which has thus far claimed the lives of twelve children.

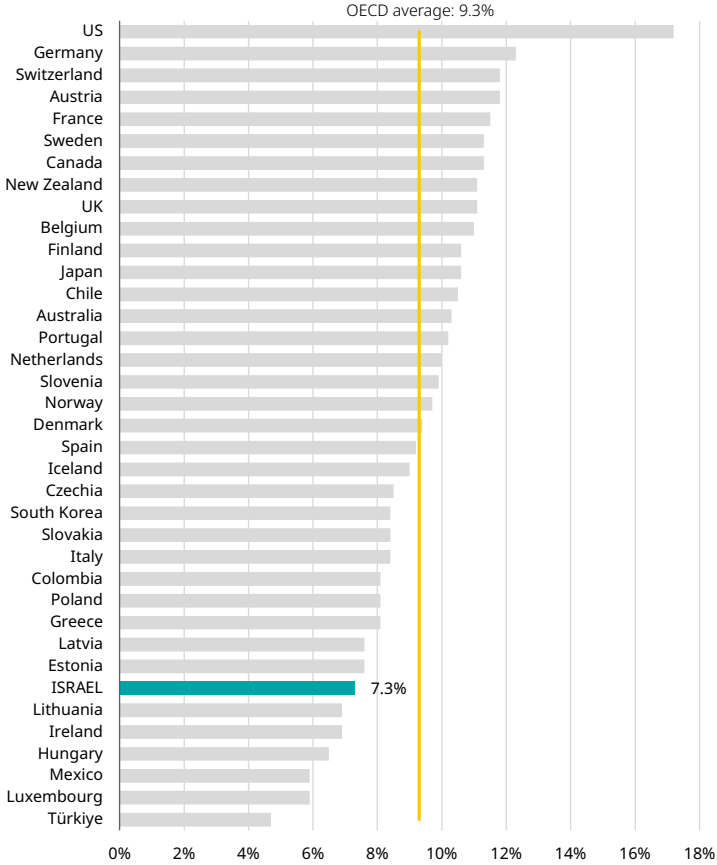
## Healthcare expenditure

In 2024, national healthcare expenditure in current prices totaled NIS 146 billion, an amount equal to 7.3% of GDP. Compared with 2023, this expenditure rose by 1.7% in constant prices, and per capita expenditure in constant prices increased by 0.37%. National healthcare expenditure as a share of GDP in 2024 was lower than in most OECD countries (Figure 1). Current per capita expenditure in purchasing power parity terms was also lower than in most OECD countries, standing at USD 3,941. Private expenditure accounted for 33.7% of national healthcare spending, government funding for 41.9%, and

the health tax for 23%. The remaining 1.4% came from foreign donations. The private and public shares of expenditure as a percentage of GDP remained stable compared with 2023, at 2.5% and 4.7%, respectively (CBS, 2025).

During the 2024 budget discussions, a proposal was introduced to increase the health tax in a differentiated manner, a change that would take effect in 2026. This increase was presented in the context of the decision to expand investment in mental healthcare — including expanding services, emphasizing the public system, and improving infrastructure and training — although in practice, the additional revenues will likely not be used directly for these purposes (Bin Nun et al., 2025). After many years in which mental healthcare suffered from neglect, it has recently received greater attention, including a budget-backed reform. However, despite the substantial health needs that have emerged due to the war — particularly in mental health — national expenditure, and especially its public component, continues to lag behind. Although we are after a two year war, the continuation of this situation erodes the healthcare system across all of its components: from funding for the benefits package and coping with population aging, including the long-standing crisis in long-term care insurance, to issues such as strengthening public health, building new hospitals, and increasing the number of beds at an appropriate pace, especially in the periphery (Davidovitch et al., 2025; Kaidar et al., 2024).

**Figure 1. National expenditure on healthcare as a percent of GDP**



Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: CBS

## The workforce

The quality and availability of the healthcare workforce are central factors shaping the state of healthcare services. In recent decades, and particularly in recent years, healthcare systems worldwide — and in Israel — have been contending with a rapid aging of the population and with an increase in the prevalence and complexity of chronic diseases (Ministry of Health, 2025a). More patients are living longer with multiple, complex conditions that require intensive diagnosis, treatment, and follow-up. This challenge is further compounded by a parallel trend: the aging and retirement of healthcare professionals and training levels that do not meet the system's needs (Nathanson et al., 2020; Segal et al., 2024).

Israel's healthcare system has been in a prolonged human resource crisis, despite more than two decades of discussions and policy initiatives to address it, including through Taub Center conferences and publications. The causes of the crisis resemble those seen in other healthcare systems worldwide, but Israel faces an additional challenge due to its historical reliance on graduates of overseas medical schools — some of which did not meet the training quality standards established by the Ministry of Health. To discontinue licensing graduates of these non-recognized institutions, whose training quality was deemed inadequate, and to improve the quality of medical care in Israel, the Ministry launched the Yatziv Reform. However, according to the Ministry's assessment, this reform is expected to exacerbate Israel's already low physician-to-population ratio temporarily until 2034. Even once the number of licensed physicians rises thanks to the gradual expansion of medical school slots in Israel, the gap in physicians per capita is not expected to close.<sup>2</sup>

The ongoing workforce crisis makes it difficult for the healthcare system to address existing gaps in service availability and accessibility and the disparities in population health. As part of the effort to respond to these challenges, strategic workforce planning, especially for the medical profession, has been high on the agenda of the Ministry of Health and policy makers for many years. As described in previous publications, this focus has intensified in recent

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2 See the Ministry of Health website, [New Physicians and Ministry Policy, Summary 2024](#).

years, with the establishment of various committees<sup>3</sup> and the publication of the OECD's 2023 report on optimal policies for medical workforce planning in Israel.

A new committee — the Committee for Addressing the Medical Workforce Crisis in the Healthcare System — now operates under the leadership of the Ministry of Health's Director General, Moshe Bar Siman Tov.<sup>4</sup> The committee is working to define mechanisms for meeting targets to increase the number of locally trained physicians, to establish a national body for medical workforce planning, to expand and regulate clinical training placements for medical students and create an efficient national mechanism to manage them (as shown in Figure 2, the allocation of hospital beds per medical student varies greatly across medical schools), and to significantly expand clinical training opportunities in community settings rather than only in hospitals — both for medical students and for specialties beyond family medicine. All of these steps require far-reaching changes and the cooperation of hospitals, health plans, universities (especially medical schools), the Council for Higher Education (CHE), the Planning and Budgeting Committee (PBC), the Scientific Council of the Israel Medical Association, and the Ministry of Finance.

At the end of October 2025, the Ministry of Health launched a new model that includes several key components: unified economic management for payment for clinical training slots; the establishment of training standards; centralized assignment of students to clinical sites; expansion of community-based training; exploration of afternoon training hours; the establishment of teaching authorities in hospitals; and incentives for training institutions to meet targets, strengthen medical education, and support clinical tutors (specialist physicians who supervise student groups during clinical rotations) (Brenner-Shalem et al., 2025). Since this model will influence the system only in the long term, the Ministry of Health, along with other relevant ministries — such as the Ministry of Aliyah and Integration and the Ministry of Finance — and various organizations, is also working on obtaining better information on Israelis studying medicine

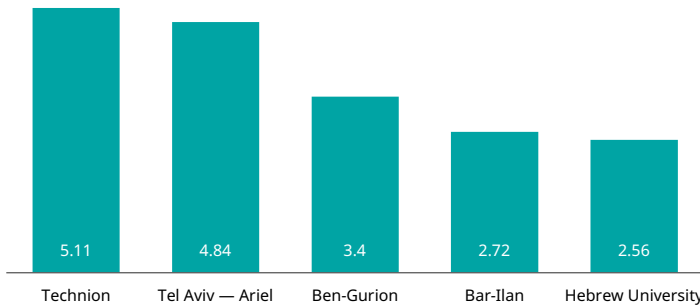
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3 For example, the Council for Higher Education committee chaired by Prof. Rafael Beyar (2022), which recommended expanding the capacity for medical students in clinical training sites and the Gamzu Committee (2022) for long-term medical workforce planning.

4 See the Ministry of Health website, [The Ministry of Health Establishes a Committee to Address the Shortage of Health Workforce in the Healthcare System](#).

abroad, to strengthen ties with them, and to ensure their return to Israel. In parallel with physician training, important steps are being taken to expand the workforce in other health professions, to regulate health professions not previously recognized in the law, and to promote professional development across the healthcare workforce.

**Figure 2. Number of hospital beds per medical student in Israeli university medical schools, 2022**



Notes: The figure relates only to major departments — internal medicine, surgery, and pediatrics. Tel Aviv University allocates beds for Ariel University.

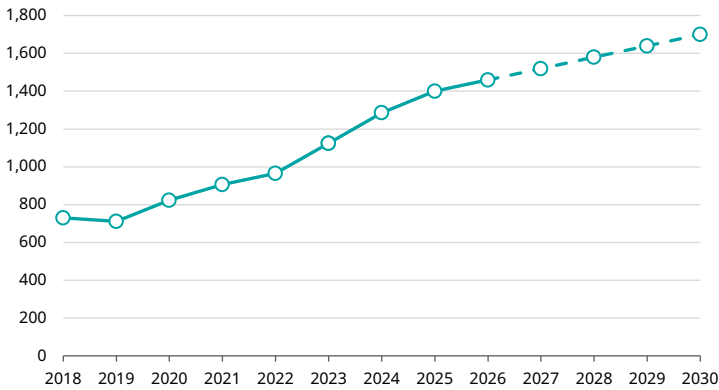
Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

The number of newly issued medical licenses continues the upward trend of recent years, with 2,495 new licenses granted in 2023 compared with 1,947 in 2022. Of these, 750 (30%) were issued to graduates of Israeli medical programs — a figure that reflects both an increase in the absolute number of licenses granted to Israeli-trained graduates and a decrease in their share of all licenses (672 licenses and 35%, respectively, in 2022). In contrast, both the number and share of licenses issued to students who studied abroad continue to rise, with the highest share (54%) going to students trained in Eastern European countries (Ministry of Health, 2024a). The increase in the number of licenses granted to graduates of Israeli medical programs stems from several measures implemented in recent years, including expanding the

number of students in Israeli medical programs and converting training tracks designed for foreign students into programs for local students. These steps are welcome, but they are still insufficient to ensure the training of a satisfactory number of medical professionals within Israel.

Despite the increase in the number of students beginning medical studies in Israel, it will take time before this growth is reflected in the number of new licenses. In the 2025–2026 academic year, approximately 1,400 new students began medical studies at various Israeli universities — a record high, following gradual increases in recent years (in 2018 the number was only 731). These figures align with the Ministry of Health’s goals to substantially expand medical training in Israel, including the establishment of new medical schools (at the University of Haifa, Reichman University, and the Weizmann Institute) and the expansion of existing programs. The Ministry’s targets for the coming years are to continue increasing the number of new medical students each year to 1,700 by 2030. The rise in the number of students is shown in Figure 3.

**Figure 3. Number of students beginning medical studies in Israel, 2018–2025, projections to 2030**



Note: Data from 2026 are based on projections.

Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: CBS

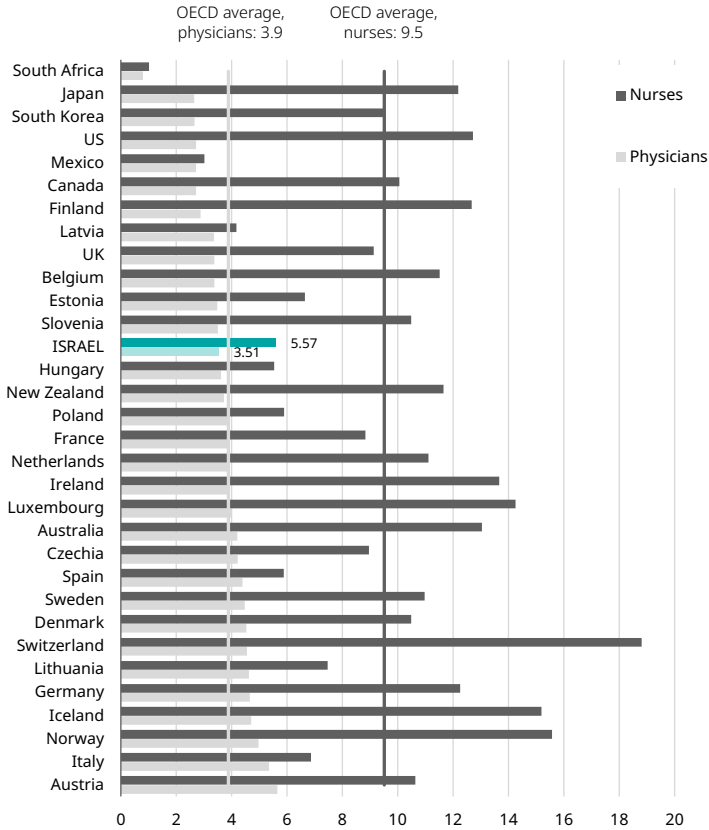
The short-term shortage — especially following the Yatziv Reform — is reflected, for example, in the fact that the number of medical school graduates in Israel in 2023 (7.2 per 100,000 people) remains well below the OECD average of 14.5 (OECD, 2023a). As shown in Figure 4, the number of active physicians in Israel is also lower than the OECD average — 3.5 compared with 3.9 per 1,000 population, respectively, in 2023 (OECD, 2023b). The number of specialist physicians up to age 67 has been rising steadily over the past five years, reaching 1.88 specialists per 1,000 people at the end of 2023. At that time, 21.8% of specialists were internists and 14.7% were specialist family physicians. The number of physicians in residency is also increasing: in 2023, 2,035 physicians began residency — a 54% increase compared with 2015 (Ministry of Health, 2024a). Over the past decade, certain specialties have seen substantial growth in the number of specialists, most notably pain medicine (ten-fold) and emergency medicine (two-and-a-half times), while in other fields — such as public health and psychiatry — the numbers have been declining (Ministry of Health, 2024a). Despite these encouraging increases in the numbers of specialists and residents, significant shortages persist, especially in specialties classified as being in severe shortage,<sup>5</sup> leading to heavy burdens both in hospitals and in community care.

The number of newly issued licenses in the nursing professions has also risen over the past decade, with 4,102 licenses granted in 2023 compared with 929 in 2010. The number of nurses per 1,000 population is likewise increasing, and the rate of licensed nurses up to age 67 reached 6.8 at the end of 2023, compared with 6.6 in 2022 (Ministry of Health, 2024a). One of the main contributors to this increase is the growth in the number of graduates of nursing programs in Israel, which stood at 32.1 per 100,000 population in 2023 — a figure still lower than the OECD average of 45.8. The number of active nurses in Israel in 2023 was also below the OECD average — 5.57 compared with 9.5 per 1,000 population, respectively (OECD, 2023c), as shown in Figure 4.

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5 Internal medicine, anesthesiology, general surgery, geriatrics, emergency medicine, physical medicine and rehabilitation, child and adolescent psychiatry, pathology, general intensive care, vascular surgery, neonatology, pediatric surgery, nuclear medicine, pediatric hemato-oncology, and pediatric intensive care.

**Figure 4. Number of physicians and nurses per 1,000 population, 2023 or the most current year**



Note: The figure for nurses in the United States includes practitioners who are not clinically active (management roles, etc.).

Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: OECD

A trend that greatly contributes to the development of the nursing workforce is the number of nurses completing advanced courses or clinical specialties. These nurses receive expanded clinical authority and thereby help the system cope with patient overload. At the end of 2023, there were 693 nurses with clinical specialties and 28,655 graduates of advanced programs (47% of all licensed nurses). Although the number of such nurses has been increasing,

the number of new authorizations for advanced programs has declined in recent years: in 2022, there were 2,070 newly authorized graduates compared with more than 3,000 in 2020 (Ministry of Health, 2024a).

## SPOTLIGHT

# Advanced and Specialist Nursing Roles in Israel

Eithan Brodsky and Nadav Davidovitch

### Background

A central component in redesigning the healthcare system and physicians' work is the shift from the traditional model — where a single physician holds sole responsibility for patient care — to a team-based approach in which responsibility and authority are shared among team members. In this model, physicians collaborate with nurse practitioners and physician assistants, with each professional contributing the skills and expertise in which they have a comparative advantage (Segal et al., 2024; Sguanci et al., 2025). Adopting this new operational paradigm in clinical medicine has the potential to significantly improve the quality and efficiency of care while helping the system cope with heavy workloads. This transition frees valuable physician time and enables the expansion of medical services both in in-person care and in telemedicine (Segal et al., 2024).

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Replacing the old paradigm — where the physician functioned as a sole provider who occasionally relied on other professionals — with a new one, in which the physician remains central but not exclusive within a team of peers, has been shown to improve equity and access to care (Nozu et al., 2024; Sguanci et al., 2025; Song et al., 2025). The primary goal of this section is to present the role of nurse practitioners (a spotlight on physician assistants appeared in the *State of the Nation Report 2023*, see Davidovitch et al., 2023, pp. 307–309).

## Definitions around the world

Advanced and specialist nursing roles have existed for decades in North America and Oceania and, in recent years, have been adopted in most European countries, as well as in China and East Asia (De Raeve et al., 2024; Nissanholtz-Gannot & Cohen, 2023; Song et al., 2025). Countries differ in both the titles they assign to these roles and the scope of professional authority and independence they grant. In some countries, these roles form a single, homogeneous group with uniform responsibilities; in others, they consist of several subgroups that differ in their fields of practice, professional identity, and their positioning relative to the medical profession.

Healthcare systems also vary in the baseline requirements for a registered nurse to become a nurse in an advanced specialty role (De Raeve et al., 2024; Nozu et al., 2024). In the absence of an international consensus regarding their scope of practice, the specific skills, competencies, and training associated with these roles are shaped by the national and local context in which they operate (ICN, 2020). Over time, as nurse practitioners have become an increasingly established and recognized professional group, a standard has emerged describing them as practitioners with advanced expert knowledge, complex decision-making

abilities, and the clinical competencies required for a wide range of nursing activities (ICN, 2020). In most countries, nurse practitioners are required to hold advanced academic degrees (master's level or above) and have substantial professional experience related to diagnosing and treating defined health conditions within their specialty areas (Ministry of Health, 2024d; Nathanson et al., 2020).

While role definitions and entry requirements are at various stages of development and implementation across countries, there is broad agreement that when roles and authorities are clearly defined — including lines of supervision under physicians — nurse practitioners contribute positively to healthcare systems. Their contributions are evident in expanded access to care, improved management of emergencies and chronic conditions that require coordination and continuity of care, better clinical outcomes, enhanced patient-centered care, and reduced health disparities (Mackavey et al., 2025; Nozu et al., 2024; Porter et al., 2024; Segal et al., 2024; Sguanci et al., 2025; Song et al., 2025). Their professional training enables them to perform tasks that were once exclusive to physicians, such as assisting with patient admissions and discharges, ordering imaging tests, and prescribing medications. In recent years, the Israeli Ministry of Health has gradually expanded nurses' authorities and established new advanced nursing roles (Carmeli, 2021). The process is advancing, though not without challenges — primarily due to tensions between the Ministry of Health and the Israel Medical Association regarding the supervision structure for nurse practitioners. Following a labor dispute and extensive discussions, an agreement was ultimately reached concerning community nurse practitioners, with an emphasis on maintaining physician oversight.<sup>6</sup>

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6 See the Ministry of Health website, [Community Nurse Practitioners](#).

## The profession's development in Israel

The first step in expanding nursing authority in Israel was the transfer of 61 exceptional procedures into the routine scope of practice for nurses; since then, many additional procedures have been delegated into the routine scope of practice for nurses. Since then, many additional procedures have been delegated to them, including the authority to decide on physical restraint of a patient, refer a patient for chest or skeletal imaging, initiate and discontinue oxygen therapy for adult inpatients, administer glucagon in life-threatening situations, and treat pressure ulcers with dressings and ointments.

In the next stage of the authority expansion process, the Ministry of Health promoted the integration of the nurse practitioner role across both community-based settings and defined hospital-based roles (Ministry of Health, 2024d). To this end, a dedicated track was established that allows experienced nurses with advanced academic training and appropriate preparation to specialize in designated advanced practice nursing fields. Training programs for nurse practitioners in Israel began in 2009–2010 (Nissanholtz-Gannot & Cohen, 2023). Several years later, the title “nurse practitioner” received formal legal and administrative recognition,<sup>7</sup> including the formalization of training procedures, licensing, and professional supervision by the medical director of the unit in which they work.

In 2023, another significant step was taken with an amendment to the Pharmacists Ordinance, enabling nurse practitioners to issue prescriptions for their patients in accordance with their specialty areas (Ministry of Health, 2024d; Nissanholtz-Gannot & Cohen, 2023). In a 2024 publication, the Ministry of Health outlined the core activities of nurse practitioners, based on

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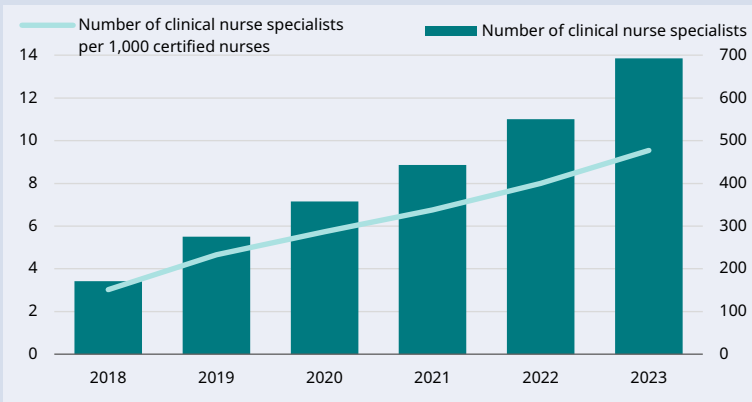
7 Public Health Regulations (Approval of the Nurse Specialist Degree), 2013.

authorities approved by the Director General. Their scope of practice is broader than that of a standard registered nurse. With authorization from the medical unit director or supervising physician, nurse practitioners may conduct clinical assessments, manage and stabilize chronic conditions to support daily functioning and quality of life, and provide counseling, guidance, and education to patients, families, and healthcare staff. They work to detect clinical deterioration as early as possible, refer patients for diagnostic work-ups, interventions, and follow-up, and develop treatment plans, including clinical and pharmacological instructions (Ministry of Health, 2024d). Their expanded training requirements reflect responsibilities beyond those of non-specialized registered nurses: at least one academic year in an approved advanced practice nursing program, a minimum of 400 hours of practical clinical training in the specialty area, and successful completion of a national licensing examination (Ministry of Health, 2024d; Nathanson et al., 2020).

The first specialty track to gain formal recognition in Israel was palliative care. Since then, additional specialty areas have been added, including geriatrics, oncology and hematology, diabetes, community care, neonatology, surgery, policy and administration, pain management, and rehabilitation (Nissanholtz-Gannot & Cohen, 2023; Segal et al., 2024). As of 2025, 18 specialty areas are active, and several more are under development (Knesset Health Committee, 2025). Nurse practitioners are key figures in ensuring the quality, continuity, and safety of care (Mackavey et al., 2025; Nissanholtz-Gannot & Cohen, 2023; Segal et al., 2024). Their integration improves resource utilization and frees physician time for the populations that need it most. In this way, the effective clinical time of physicians is preserved, while the overall quality of care improves (Segal et al., 2024). Expanding specialty areas and increasing the number of clinical nurse practitioners (Figure 5) creates an opportunity to strengthen the nursing

profession itself, enhancing its autonomy and fostering a distinct professional identity. Professional development pathways, expanded career horizons, and opportunities for empowerment and personal fulfillment also help reduce burnout and ensure a broader impact of nurses on the healthcare system and its ability to confront challenges and crises (Nissanholtz-Gannot & Cohen, 2023; Porat-Dahlerbruch et al., 2025b).

**Figure 5. Clinical nurse specialists**



Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

## Challenges and opportunities

Integrating the new role of nurse practitioners into the healthcare system is a complex, long-term, and dynamic process that requires substantial resource investment and cooperation from all stakeholders (Nissanholtz-Gannot & Cohen, 2023; Porat-Dahlerbruch et al., 2025b). Various voices — particularly within

the medical community and especially from medical associations and the Israeli Medical Association — have expressed concerns about ambiguity in role definitions and in the boundaries of the authority granted to nurse practitioners (Carmeli, 2021; Nof Sadeh et al., 2018), criticism regarding a mismatch between the scope and content of the training and the expanded authority, and concern that full professional autonomy might distance nurse practitioners from team-based care, contrary to the role's original intent (Nof Sadeh et al., 2018). Segal et al. (2024), who support the advancement and integration of the nurse practitioner role, note that physicians' support depends on nurse practitioners being an integral part of the care team alongside physicians and physician assistants, and on clearly defined and mutually agreed-upon role boundaries. Concerns can be mitigated through sustained collaboration between physicians and nurse practitioners, greater exposure to the certification process, and increased familiarity with the benefits of the role in improving care quality. Researchers recommend fostering open inter-professional dialogue and building trust between the medical establishment and nurse practitioners through joint professional forums and meetings. Healthcare organizations seeking to introduce the nurse practitioner role must promote cultural-organizational change that challenges traditional ideologies. At the same time, regulators will need to adjust policy — particularly legislation, oversight, financing, and staffing allocation. Such change requires close cooperation and commitment from professional and managerial leadership within the Ministry of Health and healthcare organizations, along with goodwill and partnership from the relevant professional associations (Porat-Dahlerbruch et al., 2025a; Segal et al., 2024).

The transplantation of the nurse practitioner model from Western countries into Israel is hindered by staffing gaps in Israel's nursing workforce. Current staffing formulas were

established in the late 1990s and no longer match the system's contemporary dynamism and challenges, including population aging and rising morbidity (Knesset Health Committee, 2025). In a system without sufficient baseline nursing positions, allocating dedicated posts for nurse practitioners presents a particular challenge. The number of designated positions remains low, despite broad agreement that adding such positions could reduce the need for physician posts and help alleviate physician workload (Nissanholtz-Gannot & Cohen, 2023). In practice, nurse practitioners are currently employed either in standard nursing positions or in temporary posts. This situation may result in nurse practitioners performing the same duties they carried out before obtaining their advanced certification, without formal recognition or corresponding authority. This undermines their motivation and limits institutions' ability to fully benefit from their advanced knowledge and skills. The lack of dedicated positions delays the system's ability to address precisely the clinical workload that the nurse practitioner role was created to alleviate (Knesset Health Committee, 2025).

There is now agreement within the Ministry of Health and the Ministry of Finance on the need for appropriate staffing frameworks, and a multi-year plan for gradual allocation of dedicated positions is in place. Due to the security and economic situation, fewer than half of the planned positions have actually been allocated, creating a gap between the number of trained nurse practitioners ready to work and the number of positions available to employ them (Knesset Health Committee, 2025). Even once the budgetary gap is addressed, additional steps will be required to ensure that the nurse practitioner role continues to be perceived by nurses as attractive and rewarding. These steps include improving compensation conditions and creating clearly defined career pathways and advancement opportunities (Nissanholtz-Gannot & Cohen, 2023).

## Recommendations for the future

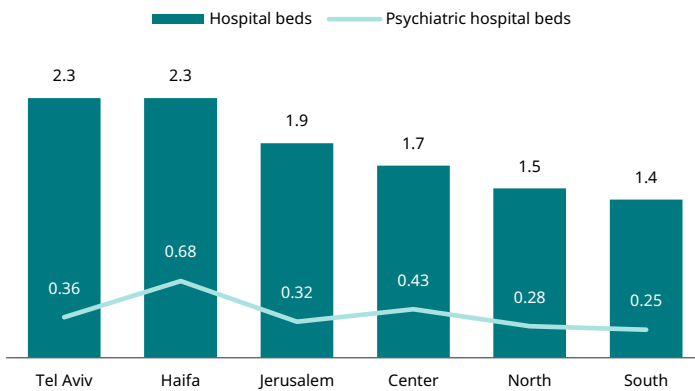
Population aging, the rise in chronic disease, and challenges posed by infectious diseases — such as antimicrobial resistance — or by climate change, all require out-of-the-box thinking and far-reaching system reforms, including a redesign of the care-delivery model. Present and future challenges demand the adoption and integration of a model of care based on partnership and team-based practice among physicians, physician assistants, and nurse practitioners (Segal et al., 2024). Continued, gradual, and well-planned implementation of the nurse practitioner role — together with appropriate allocation of dedicated positions and improved compensation for these nurses — will help increase their numbers. Clear delineation of their authority and responsibilities, combined with open communication with physicians and with the leadership of healthcare organizations, are key steps toward reducing resistance to the expansion of their scope of practice and to the evolving professional status of nursing.

## General hospital beds

Despite the increase in the absolute number of general hospital beds (excluding psychiatric beds) — from 15,497 in 2015 to 16,948 in 2023 — the number of beds per 1,000 population in Israel continues to decline, from 1.85 in 2015 to 1.76 in 2023. This figure is lower than the OECD average, which in 2023 stood at 3.18 beds per 1,000 population (OECD, 2023d). The number of psychiatric beds per 1,000 population is also in a continued downward trend: in 2023, it stood at 0.37 beds per 1,000, below the OECD average of 0.7 in that year (OECD, 2023d).

Examining the geographic distribution of general hospital beds reveals imbalances across districts (Figure 6). Periphery districts are characterized by a relatively low number of beds per 1,000 population; however, in these districts the bed rate has remained relatively stable, whereas in the rest of the districts it has eroded over time (Ministry of Health, 2025a). The geographic distribution of psychiatric beds is similarly uneven. In the Northern and Tel Aviv Districts the number of beds has remained relatively stable, while in the other districts the number of beds has declined over the years (Ministry of Health, 2025a).

**Figure 6. Hospital beds per 1,000 population, by district, 2023**



Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

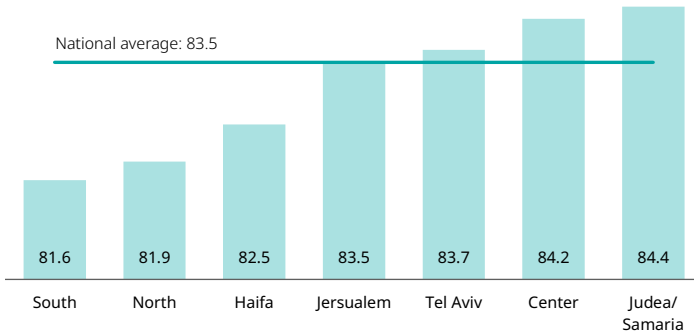
## Addressing health disparities

For two decades, the Ministry of Health has been working — together with partners within and outside the healthcare system — to reduce disparities in the availability and accessibility of healthcare services across population groups and to narrow health gaps reflected in health indicators. The Ministry's approach considers not only the healthcare system but also other systems such as education, welfare, employment, and the environment. One major reform advanced in recent years is the reform of the medical workforce, aimed at reducing disparities in the availability of medical personnel between the periphery and the center.

Life expectancy gaps at birth between the Arab and Jewish populations remain pronounced. In 2023, life expectancy in the Arab population was 80.7 years compared to 84.3 in the Jewish population (excluding war casualties). The gaps between men are larger than those between women: among men, the disparity continues to widen, while among women, it is gradually shrinking. Life expectancy among Arab men was the most severely affected during the COVID-19 pandemic and has only now returned to its pre-pandemic level, whereas life expectancy among the other groups (Jewish men and both groups of women) is substantially higher than it was before COVID-19 (Ministry of Health, 2025a). Significant disparities exist in mortality and infant mortality as well. In 2023, the mortality rate among Jews and others was 4.1 per 1,000 population (excluding war casualties), compared with 5.1 in the Arab population. Infant mortality per 1,000 live births was 1.9 among Jews and others, compared with 5.2 in the Arab population, and double that in the Bedouin population. Despite these substantial gaps, both populations have seen declining infant mortality rates over the past decade (Ministry of Health, 2025a).

In addition to disparities between population groups, there are marked geographic disparities in life expectancy and mortality. In 2021–2023, average life expectancy was highest in the Judea and Samaria District (84.4), while the Northern and Southern Districts had the lowest life expectancy (Figure 7). The Southern District also stands out negatively in infant mortality among the Arab population, with 9.2 deaths per 1,000 live births compared with the national Arab population average of 5.2 (Ministry of Health, 2025a).

**Figure 7. Life expectancy at birth, by district, 2021–2023 average**



Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

Given the growing demand for healthcare services — a trend reinforced by demographic growth — an extensive effort has been undertaken as part of the National Health Infrastructure Planning Program to forecast future demand and design a distribution of services that matches demographic expansion. As part of the program, an attempt was made to project population growth through 2030 by locality and age group, and to plan optimal infrastructure distribution for dialysis, pharmacies, and oncology services (Ministry of Health, 2025a). Another area currently under in-depth review is hospital-at-home services as an alternative to acute hospitalization, based on criteria set by the Ministry of Health. An analysis of hospital-at-home admissions showed that the introduction of a support-payment mechanism for the health plans in 2020 significantly increased the number of such hospitalizations. Most referrals (87%) came from the community rather than from hospitals, although, in the past year, hospitals have also begun to enter the field, initiating referrals for both adults and children. It is important to note that hospital-at-home services may widen disparities between populations: according to Ministry of Health data, the growth in hospital-at-home rates in the central region is faster than in the periphery (Schroeder et al., 2023).

The distribution of preventive health infrastructure is critical for reducing health disparities. The Tipat Halav network is a notable example of essential health infrastructure that serves as a key point for identifying and preventing health problems early in life and for supporting healthy development throughout the lifespan. The geographic distribution of clinics, examined in the National Health Infrastructure Planning Program, shows a generally positive picture in terms of service accessibility. In May 2024, Israel had 806 active clinics, and 92% of the population lived within walking distance of a Tipat Halav clinic (Ministry of Health, 2025a). However, as we reported in our policy paper on Tipat Halav (Davidovitch et al., 2025), severe staffing shortages and insufficient adaptation to demographic growth prevent the clinics from fulfilling their objectives.

In the field of rehabilitation, most services are provided in hospitals, though some are delivered in dedicated ambulatory centers. An analysis conducted as part of the National Health Infrastructure Planning Program showed that the central region has a large number of rehabilitation infrastructures — including day centers, hospitals, and clinics — while the periphery has almost none (Ministry of Health, 2025a).

Another field with significant gaps is cancer care. The increasing number of new cancer diagnoses each year, the long and complex treatments that patients undergo, and the resulting burden on the healthcare system emphasize the importance of appropriate distribution of oncology services. Today, most oncology care is delivered in specialized departments within general hospitals, creating challenges for patients who often must travel long distances for treatment. An analysis performed under the National Health Infrastructure Planning Program found that eight hospitals delivered 80% of infusion treatments. Moreover, an examination of travel distance from patients' residence to treatment centers showed that 39% of patients living in the Southern District travel far from home for treatment, compared with 18% in the Haifa District and 12% in the Northern District (Ministry of Health, 2025a).

As part of the systemic program to improve health in the Arab population, the Ministry published a support mechanism for health plans aimed at expanding services for Arab communities. A support mechanism was also issued for civil society organizations for prevention programs and health promotion, and 24 health units were established in Arab and Bedouin local authorities. In the health program to reduce disparities in the Haredi population,

many initiatives were advanced, including the operation of a mobile Tipat Halav clinic in neighborhoods with low vaccination coverage, dissemination of information on dental health, nutrition education programs for children, lifestyle workshops for students and teachers, and preparatory courses for training personnel in health professions (Ministry of Health, 2025a). A key component of these efforts is increasing the representation of health workers within the healthcare system — an ongoing process over the past decade, particularly among decision makers. Still, many barriers at the individual, community, and systemic levels require comprehensive attention (Dopelt et al., 2024). The Ministry of Health and various organizations, such as Sikkuy and the Abraham Initiatives, are promoting processes in partnership with many agents to address health needs in the Arab population (Shuster & Della, 2023). Among the Haredi population, health professionals are also organizing to promote change (Regev & Miletzky, 2024).

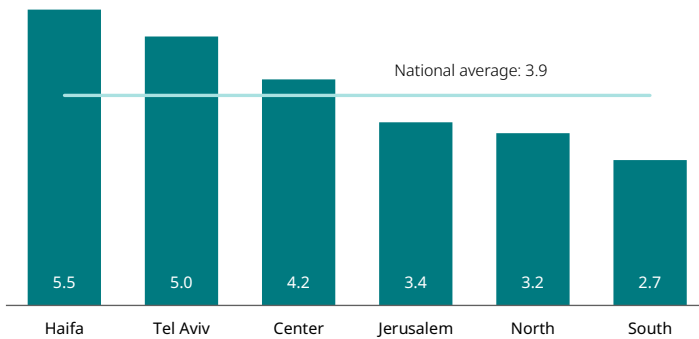
Another major initiative the ministry continues to promote is reducing inequity through the establishment of health units within regional clusters and by strengthening health promotion in local authorities. A regional cluster is an association of local authorities aimed at advancing regional development and achieving shared goals through pooled resources. In 2020, a call for proposals was issued to promote health and healthy-aging in seven clusters, funding the establishment of health units and the recruitment of regional health coordinators. The initiative was later expanded to all 12 clusters. The health units operate along five central axes: (1) establishing multisectoral partnerships for health promotion; (2) collecting and analyzing residents' health data; (3) engaging local authorities and community actors in health investment; (4) leveraging the scale advantages of the cluster to reduce costs and implement joint initiatives; and (5) establishing a regional infrastructure to improve access to healthcare services and promote health. By the end of 2023, 111 local authorities were participating in the initiative, which is estimated to reach approximately 3.2 million residents (Ministry of Health, 2025a).

## Availability and quality of healthcare services

The availability and quality of healthcare services are strongly influenced by inequities in the geographic distribution of the healthcare workforce. Examining the number of healthcare professionals across regions makes it possible to compare areas of the country and identify workforce disparities that affect healthcare delivery.

In 2021–2023, the average number of employed physicians per 1,000 residents was higher than the national average in the Haifa, Tel Aviv, and Central Districts, while in the Southern, Northern, and Jerusalem Districts it was lower (Figure 8). The average number of employed nurses per 1,000 residents during these years was also above the national average (5.4) in the Tel Aviv (7.7) and Haifa (6.9) Districts, and below it in the South (4.5), Jerusalem (4.8), Central (4.9), and Northern (5.2) Districts. Other health professions also exhibit substantial regional disparities (Ministry of Health, 2025a). This picture highlights the workforce gaps between geographic areas — particularly between periphery regions and the center — and underscores the need for strategic workforce planning that can address this challenge.

**Figure 8. Number of physicians per 1,000 population, by district, 2021–2023**

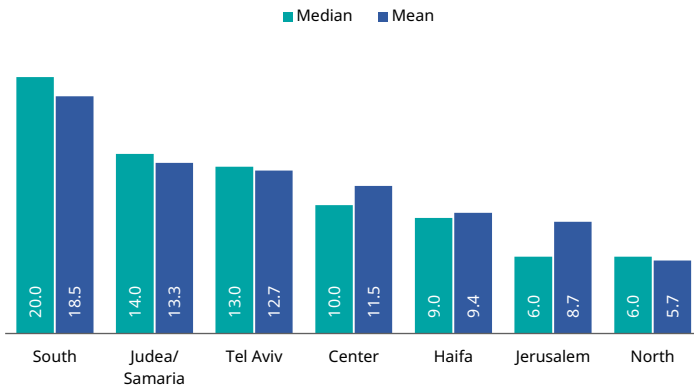


Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

Shortages in the healthcare workforce and its unequal geographic distribution are also reflected in waiting times for specialist care in the community. Figure 9 presents the waiting time (in days) to see any physician in a given geographic area, as measured by the Ministry of Health's National Program for Measuring Waiting Times in Healthcare between April and June 2025. The figure shows that substantial disparities persist, with the Southern District exhibiting the longest waiting times.

**Figure 9. Waiting time for a physician (median and mean), by district, April–June 2025**

Days



Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

Another area that reflects the quality of healthcare services is performance on quality indicators. As part of the National Quality Indicators Program for Community Healthcare, several measures are used to assess the utilization of preventive screening tests offered by the health plans. Among these are two simple yet critically important tests for health promotion: BMI measurement and smoking documentation. These assessments help identify patients at elevated risk due to lifestyle factors and enable early intervention to prevent morbidity. The rate of BMI measurement among adults aged 20–64 and children aged 7 has been declining since 2019; in 2023, the documentation rates in these age groups were 82.4% and 66.6%, respectively. Among adolescents aged 14–15,

there was a slight increase in completion rates, from 69.3% in 2022 to 70.4% in 2023, while the rate for adults aged 65 and older remained stable at 72.9%. The rate of smoking documentation among individuals aged 16–74 also continued its downward trend, from 79.7% in 2022 to 79% in 2023. The decline in these preventive care measures signals a persistent pattern of underutilization of health promotion services and calls for a strategic response by the healthcare system and the health plans to reverse this trend (Ministry of Health, 2024c).

## Reform of patient choice arrangements

In February 2024, the reform of patient choice arrangements vis-à-vis the healthcare plans came into effect. The goal of the reform was to expand the range of services available to insured individuals, improve access to large hospitals, and enhance the availability and transparency of information on service providers. These changes were intended to help shorten waiting times in the healthcare system and strengthen trust in the public system. The reform stipulated four areas exempt from any choice limitations — gynecological surgery, neurosurgery, inpatient mental health care, and IVF — allowing every patient to choose treatment at any medical center offering the relevant service. In addition, Meuhedet and Clalit healthcare funds were required to add several hospitals to their lists of available providers, and all information regarding choice options must now be accessible to patients both physically and digitally. Following the reform, improvements were indeed recorded in travel distance to hospitals among Clalit and Meuhedet healthcare fund members. The largest improvement was observed among Clalit members living in the periphery, who prior to the reform had to travel approximately 11.3 km more than Maccabi healthcare fund members but afterward only 1.6 km more (Ministry of Health, 2024b). In 2025, the average number of hospitals (including tertiary centers and private hospitals) offered by each healthcare plan to an insured person (adjusted for age and sex) was 21.1 in Leumit, 27 in Maccabi, 9.6 in Clalit, and 23.4 in Meuhedet (Schroeder et al., 2025).

Table 1 details the number of hospitals offered by each health plan, broken down by district. As shown, while Maccabi and Leumit healthcare funds exhibit almost no variation across districts, Clalit and Meuhedet healthcare funds show considerable variation, with the widest range of options available in the Northern District.

**Table 1. Healthcare fund hospitals, by district**

District	Clalit		Maccabi		Meuhedet		Leumit	
	Hospital	Referral center only	Hospital	Referral center only	Hospital	Referral center only	Hospital	Referral center only
North	8.7	2.4	21	6	19.3	5	16.1	5
South	7	2	21	6.4	17.6	5.4	16.3	5
Tel Aviv	6.2	2.6	21	6	17.3	5	16	5.3
Haifa	6.5	2.6	21	6	19	5	16	5
Jerusalem	7.3	4	21	6	18	5	16	5
Center	6.7	2	21	6	17.9	5	16	5
Judea/Samaria	6.8	3.1	21	6	17	5	16	5

Note: Fractional values represent the average number of hospitals per district.

Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

## Health status and lifestyle

Maintaining a healthy lifestyle is essential for reducing the risk of illness and associated complications. Smoking habits, dietary patterns, and levels of physical activity serve as important indicators of existing health risks. In addition, the prevalence of obesity and diabetes are indicators of additional morbidity and of preventable future complications.

For many years, the share of smokers in Israel has been rising across all population groups and both genders. In 2023, 29.3% of men and 13.7% of women smoked. Among men, there is an inverse correlation between socioeconomic status and smoking rates — the lower the socioeconomic ranking, the higher the smoking rate — while among women the pattern is reversed (Ministry of Health, 2024c).

After several years of a rise, 2023 saw a decline in the prevalence of overweight 7-year-olds, reaching 8.1%. Among adolescents aged 14–15, the overweight prevalence is rising, reaching 14.2% among boys and 12.1% among girls in 2023. Among adults aged 20–64, rates continued to increase, with rates of 23.3% for men and 27.1% for women. Among adults aged 65 and older, there is a decline: in 2023, prevalence was 26.7% among men and 35.3% among women. Across all age groups, the lowest overweight rates were found among men and women of higher socioeconomic status (Ministry of Health, 2024c).

The prevalence of diabetes among adults aged 18+ continues to rise, reaching 10.5% in 2023. In the Arab population, it is 1.6 times higher than the rate in the non-Haredi Jewish population<sup>8</sup> and the Haredi population. Geographically, the highest rate was recorded in the Nazareth subdistrict (14.4%) and the lowest in Tel Aviv (7.8%). The lowest prevalence was observed among men and women of the highest socioeconomic status (Ministry of Health, 2024c).

As noted in a Ministry of Health report on health equality in 2023, there are substantial gaps in health behaviors between the Arab population and the average in the overall population (Ministry of Health, 2025a). Smoking rates among Arab men are relatively high: 37.2% of Arab men aged 16–74 smoke, compared with 27.4% on average in the overall population. In contrast, smoking rates among Arab women are lower (5.4% compared with 16.4%). In terms of diet, the Arab population consumes more salty snacks, red and processed meat, and sugary drinks, and lower amounts of fish and vegetables. At the same time, consumption of fruits, whole grains, legumes, and olive oil is higher. Physical activity levels are lower: 34% of Arab adults aged 20+ engage in physical activity, compared with 60% in the Jewish population (Haredi and non-Haredi). With regard to obesity, in 2023, 10.4% of Arab 7-year-olds had obesity compared with 8.1% on average in the overall population, and higher rates were recorded among Arab adolescents and adults as well. Diabetes prevalence is also higher. The rate among those aged 45 and older in the Arab population is higher than the average rate for these ages in the total population: 26.4% versus 18.2%. Prevalence increases sharply with age — 49.5% of Arab adults aged 75+ are affected (Ministry of Health, 2025a). Poor glycemic control, as measured by HbA1c, was 1.7 times more common in the Arab population than on average in the overall population (Ministry of Health, 2024c).

The Haredi population is characterized by a distinctive lifestyle that shapes health behaviors and outcomes (Ministry of Health, 2025a). Dietary patterns include lower per capita consumption of fruits and vegetables and higher levels of sugary drinks, snacks, sweet baked goods, and candy than on average. This is reflected in the disproportionately high share of Haredi children in grades 1 and 7 who are under-height for age — twice the average rate. Only 26% of Haredi adults engage in regular physical activity (compared with 33% among non-Haredi Jews), and only 16% engage in vigorous activity (compared with 31%).

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8 The non-Haredi Jewish population includes the “Other” group (those with no religious classification). Comparisons with the Arab and Haredi populations follow the categorizations used in the original data sources.

Smoking rates among Haredi youth are particularly high: 54% of boys aged 12–18 in yeshiva high schools have tried smoking at least once (80% in dropout-prevention programs), and 11% smoke regularly (37% in dropout-prevention programs). Among students in higher yeshiva (ages 17–24), 77% have tried smoking and 32% are regular smokers (Ministry of Health, 2025a). This pattern reverses in adulthood: overall adult smoking rates in the Haredi population in 2023 were lower than in other population groups (Ministry of Health, 2024c). The Haredi population also has low vaccination coverage, due to logistical barriers, mistrust of the healthcare system, lack of knowledge, and some misinformation. Diabetes prevalence among Haredi adults aged 35–64 is slightly higher than among the Haredi and non-Haredi Jews, but among adults 65+ it is somewhat lower (Ministry of Health, 2025a).

## SPOTLIGHT

# Measles Outbreak in the Post-COVID Era

Efrat Sales, Natan Lev, and Nadav Davidovitch

The COVID-19 pandemic underscored the reality that only a coordinated international effort can prevent future outbreaks. The high level of global mobility in the modern era — marked by extensive travel and movement between countries — combined with climate change and its effects on biological and microbiological systems, creates conditions that require the establishment of global mechanisms for preventing and managing pandemics, as reflected in the World Health Organization's efforts to advance a global health agreement. However, this mode of action has not

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yet been fully internalized in practice, as demonstrated by the recurring waves of COVID-19 and by the resurgence of measles, which has reached Israel as well.

Since 2023, there has been an increase worldwide — including in Israel — in the incidence of vaccine-preventable diseases in general, and measles in particular. The rise in measles incidence in Israel was due to a wide range of factors, chiefly the arrival of ill tourists and visitors, infections among Israelis returning from abroad, and community spread among unvaccinated populations — particularly in parts of the Haredi community. A substantial outbreak occurred in April 2025: within fewer than eight months, there were 730 measles-related hospitalizations, most among children ages 1–4, as well as 12 deaths.<sup>9</sup> Apart from one who had only one vaccine out of two, none of the individuals who died had been vaccinated. The reported case count likely represents only the tip of the iceberg, as many cases — especially mild ones — are not reported.

Measles is one of the most contagious infectious diseases. It is transmitted through the air, primarily via tiny droplets expelled when an infected person coughs or sneezes, as well as through direct contact with respiratory secretions. The infectious period begins four days before the appearance of the rash and lasts until four days afterward.<sup>10</sup>

International health bodies, including the World Health Organization, the U.S. Centers for Disease Control and Prevention (CDC), and the OECD, emphasize that the most effective way to prevent and eliminate measles is through vaccination — which has saved an estimated 60 million children worldwide between 2000 and 2023. The vaccine consists of a live attenuated virus and is administered as part of the combined MMR vaccine (measles,

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9 For an updated status report, see [Tableau Public](#).

10 See the Ministry of Health website, [Measles](#).

mumps, rubella) or the MMRV vaccine, which also provides protection against varicella (chickenpox).<sup>11</sup>

The measles vaccine is highly effective, safe, and rarely associated with severe side effects. Since the virus is extremely contagious, achieving herd immunity requires vaccination coverage exceeding 95% of the population, delivered through two doses — a first dose at one year of age and a second dose in first grade. The MMR vaccine was approved by global regulatory authorities in the 1970s and introduced in Israel in 1988. The MMRV vaccine was approved globally in 2005 and introduced in Israel in 2007. According to the World Health Organization, about 84% of children worldwide are vaccinated with the first dose by age two, and 76% receive the second dose (Jones, 2025). Given the importance of monitoring vaccination rates, in 2015, Israel introduced a new indicator into its national quality measures: “Administration of one dose of MMR/MMRV to infants by 13 months in Family Care Centers.” According to a 2024 report, 66% of children aged 12–13 months met this benchmark (Ministry of Health, 2025b).

Despite consistent recommendations from global health authorities, researchers, and clinicians, the past decade has seen a decline in vaccination rates. This decline is attributed to vaccine hesitancy and refusal, armed conflicts and wars, and disruptions to health systems.

One of the main drivers of reduced vaccination rates in high-income countries — including Europe, the United States, Canada, and Israel — is parental vaccine hesitancy regarding the MMR vaccine. Two systematic reviews examining the psychological, social, and cultural factors shaping parents’ decisions to vaccinate (or not vaccinate) their children found that concerns about vaccine safety were the central reason for avoidance, particularly

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11 See the World Health Organization website, [Measles](#), as well as the CDC website, [Measles Symptoms and Complications](#).

the erroneous myth linking the MMR vaccine to autism. In addition, many parents report a lack of trust in the health system, government authorities, and pharmaceutical companies, driven by perceptions of insufficient transparency or suspected economic and political interests. Another common factor is the perception that measles is not a serious disease and therefore does not require urgent vaccination, especially in countries where it has become rare. Both reviews also highlight the influence of the social and community environment: parents are affected by the attitudes of friends, family, and ideological or religious groups that discourage vaccination. Overall, these findings suggest that hesitancy stems less from absolute opposition to vaccines and more from misinformation, misperceptions of risk, lack of trust, and social influences shaping parental views of vaccination (Novilla et al., 2023; Wilder-Smith & Qureshi, 2020).

In recent months, following the appointment of Robert Kennedy as the US Secretary of Health, his longstanding opposition to routine vaccinations has had tangible public health consequences. Kennedy has repeatedly cast doubt on the safety and effectiveness of routine vaccines in general and of the measles vaccine in particular. He has also promoted research purporting to link the measles vaccine to autism and encouraged the use of questionable remedies in the midst of a major measles outbreak in Texas. Through his actions and public statements, he has significantly undermined public confidence in routine immunization, and despite his short time in office, vaccination rates have already begun to decline (Woolf & Rosenthal, 2025).

Crises such as the COVID-19 pandemic, wars, and armed conflicts also contribute to drops in vaccination coverage. For example, according to World Health Organization data for the European region, the years preceding the COVID-19 pandemic saw a gradual increase in measles vaccination rates. However, during

the pandemic (2020–2021), there was a substantial decline in first-dose coverage — approximately 2.1 percentage points across all countries, with particularly sharp decreases in Eastern European countries such as Romania, Albania, and Moldova (Maugeri et al., 2024). Similarly, wars and armed conflicts have a major impact on vaccination rates. The Russia-Ukraine war that began in 2022 led to a marked decline in measles vaccination coverage. In Ukraine, MMR coverage fell from 88% to 74% or lower. This decline has been attributed to the destruction of medical infrastructure, the cessation of national immunization campaigns, population displacement, and lack of access to basic healthcare services (Badanta et al., 2024; Holt, 2024).

The reasons for declining vaccination rates during crises (pandemics and wars) stem from several key factors: the diversion of health system resources toward emergency response; disruptions in supply chains due to border closures and social distancing; parental reluctance to leave home (due to fear of shelling during wartime or fear of infection during COVID-19); and the widespread dissemination of misinformation on social media and online platforms. In addition, during these crises, health ministries were forced to close Family Care Centers or reassign health personnel to other roles, reducing availability and accessibility of routine preventive services (Badanta et al., 2024; Holt, 2024).

A major factor contributing to declining vaccination rates — both generally and during crises — is lack of trust in the health system and in government institutions. A study conducted in Germany among parents of young children found a strong connection between trust in the health system and government and vaccination decisions. When parents lacked trust in state institutions and healthcare authorities, vaccination rates fell — even for routine childhood vaccines. Parents who felt

that vaccination policies were imposed coercively or non-transparently expressed principled objections and used non-vaccination as a way to preserve their sense of autonomy. Furthermore, knowledge gaps and lack of access to reliable information among lower socioeconomic groups intensified feelings of alienation from the health system and increased skepticism toward vaccination policies. These findings highlight that government mandates alone are insufficient to achieve high vaccination coverage; effective immunization policy depends on trust-building, transparency, participatory communication, and culturally tailored information for all population groups (Neufeind et al., 2022).

This situation has led to a renewed global rise in measles outbreaks, particularly in low- and middle-income countries and in areas with low vaccination coverage. In recent years, recurrent outbreaks have also been observed in upper-middle-income countries.

According to the World Health Organization, in 2023, approximately 320,000 measles cases were reported worldwide — an increase of 1.8 times compared with just 170,000 cases in 2022. Another rise was observed in 2024, reaching roughly 360,000 cases (UNICEF, 2025). Although the number of measles cases in the WHO European Region declined steadily after 1997 — when about 216,000 cases were reported — and reached a low of only 4,440 cases in 2016, a resurgence occurred in 2018 and 2019, with 89,000 and 106,000 reported cases, respectively. Following declines in vaccination coverage during the COVID-19 pandemic, cases rose sharply again in 2023 and 2024. In 2024, roughly one-third of all global measles cases originated in the European Region — about 127,000 cases — double the number reported in 2023 and the highest figure since 1997. More than half of these cases required hospitalization, and 38 deaths were recorded (UNICEF, 2025).

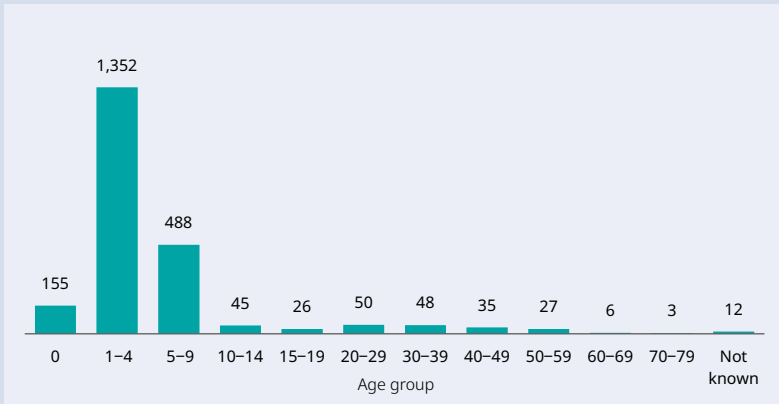
A similar pattern has been observed in the US. Although measles was declared eliminated in the US in 2000, declining vaccination rates in recent years have led to recurring outbreaks. For example, in 2022, about 28% of US parents expressed concerns about vaccine safety, compared with just 16% in 2019. In Texas, childhood vaccination coverage fell to 94.3% in 2023 — below the 95% threshold needed to maintain herd immunity. According to CDC data, in the first quarter of 2025, the United States experienced a steep rise in measles outbreaks, with 607 confirmed cases across multiple states; 97% of those infected were unvaccinated or had unknown vaccination status. The epicenter of the outbreak was Texas, which recorded 481 cases, including 56 hospitalizations and the death of an unvaccinated child. The outbreak spread to neighboring states such as New Mexico (54 cases) and Oklahoma (10 cases) (Kuppalli & Omer, 2025).

Israel has also seen an increase in measles cases in recent years. In 2018–2019, a nationwide outbreak occurred with approximately 4,300 cases reported to the Ministry of Health. High morbidity and disease burden were concentrated primarily in communities with low vaccination rates, most notably the Haredi population. Despite an extensive and effective public health response, the outbreak exposed vulnerable population groups and highlighted gaps and resource shortages within Israel's public healthcare system — both in terms of access to vaccination and in the system's capacity for targeted communication and rapid response in specific communities, such as the Haredi sector (Stein-Zamir & Levine, 2021).

In 2024 — and even more markedly in 2025 — a new measles outbreak emerged. From April 2025 to December 2025, roughly 2,000 measles cases were reported (Figure 10), the majority within the Haredi sector. Since the onset of the outbreak in April 2025, 730 patients were hospitalized, most of them children under 18, and 12 patients died. Importantly, according to Ministry of

Health estimates, actual morbidity since the start of the outbreak is substantially higher than reported and likely ranges between 5,000 and 9,000 cases.<sup>12</sup>

**Figure 10. Number of cases of measles during the measles outbreak, by age group, 2025**



Source: Nadav Davidovitch, Natan Lev, and Ofir Gonen, Taub Center | Data: Ministry of Health

In light of declining vaccination rates and the rise in measles outbreaks worldwide, it is crucial to develop strategies that promote vaccination uptake. A recommended approach is to shift responsibility and empower local actors in designing and implementing immunization programs, recognizing that many gaps in vaccination coverage originate at the regional or community level. Active involvement of local communities and their leadership — combined with improved data quality

<sup>12</sup> See DoctorsOnly website, [The Measles Outbreak in Israel Is the Most Tragic in the Western World](#), November 20, 2025.

and strengthened epidemiological surveillance — can help tailor vaccination-promotion strategies to the local demographic, cultural, social, linguistic, and geographic context (Cutts et al., 2021).

Increasing measles vaccination coverage requires the adoption of targeted strategies based on the “Three Cs” framework: convenience, complacency, and confidence. These strategies include improving access to vaccination services through community-based and mobile vaccination units that operate in areas with low coverage and are culturally and linguistically adapted to local populations. In parallel, dedicated catch-up campaigns for completing MMR vaccination are recommended, as well as the use of personalized reminder systems and digital information tools that provide parents with clear and reliable information about vaccine safety. Public trust must be strengthened through transparent communication, consistent messaging from experts and community figures, and open public dialogue during policy design. Ultimately, the success of such interventions depends on allocating dedicated resources, investing in research, and tailoring strategies to local needs, with the goal of rebuilding trust and preventing future measles outbreaks (Thompson et al., 2023).

A situation in which 12 children die from measles — a disease for which there is a safe and effective vaccine — is intolerable. The continued erosion of public health infrastructures is clearly evident here. Israel has, in effect, been pushed back decades in its measles control. These preventable deaths serve as a stark warning and underscore the urgent need to strengthen the public health system, which has been dangerously weakened in recent years.

## Conclusion

As this chapter has shown, many longstanding problems facing Israel's health system remain unresolved. The system is far from static — numerous reforms are underway in areas such as hospital choice arrangements for healthcare fund members, mental health services and the training of the medical workforce, alongside the emergence of new healthcare professions.

At the same time, the challenges of recent years — COVID-19, the longest war in the country's history and persistent political instability — are taking a clear toll. The resignation of the Shas ministers from the government, including the Minister of Health and the Chair of the Knesset Health Committee, has effectively left Israel without a full-time health minister, making it difficult to secure governmental attention and budgets for the sector. As of November, the Health Basket Committee had still not begun its work because there was no minister authorized to sign off on committee appointments. In previous years, too, deliberations were delayed due to the war, pushing back approval of the updated benefits basket and causing significant suffering for patients awaiting decisions.

The burnout survey conducted by the Ministry of Health since 2018 roughly every three years, and administered again during the recent war, indicates a sharp rise in burnout among Israel's health-system workforce — especially among resident physicians and nurses. The overall burnout index rose from 3.4 in 2021 to 3.6 in 2025 (on a scale of 1–7), and about 40% of workers are experiencing high levels of burnout, with a strong correlation between burnout and depressive symptoms. There are, however, some bright spots: despite high burnout, most workers still report meaning and satisfaction in their jobs, teamwork has improved and exposure to workplace violence has decreased.

Addressing the system's many challenges — including health and workforce disparities across regions and socioeconomic groups, implementing the national master plan for the healthcare system, and managing the crisis in long-term care insurance — requires integrated work across all parts of the system and the rebuilding of trust, both among stakeholders and between the system and the public.

The public continues to express relatively high trust in the healthcare system overall, but trust is not inexhaustible. Calls by members of Knesset to withdraw from the World Health Organization and the spread of conspiracy narratives — gaining new momentum since COVID-19 — demonstrate that assumptions once taken for granted can no longer be relied upon.

The core strength of Israel's health system lies in its workforce and in the public's trust. In recent years the system has shown repeatedly that it can rise to the occasion in emergencies, but it requires continuous, sustained effort — not just crisis-mode heroics. The paradox with which this chapter began — excellent health indicators by international standards paired with one of the lowest levels of public investment among OECD countries — is untenable. High vaccination rates and the return of Israeli medical students and trainees from abroad can no longer be taken for granted, especially at a time when international health collaborations are collapsing with increasing frequency. Health must be elevated as a national priority — both in public investment and in system management — so that Israel can continue to provide high-quality medical care and health-promotion services that enable well-being and prosperity.

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