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Israelâ??s healthcare financing model: Efficiency tested by structural pressures and conflict

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Israelâ??s healthcare system combines universal public coverage with regulated private participation, delivering strong outcomes at relatively low cost. However, underinvestment, workforce shortages, rising private spending, and wartime pressures are straining capacity, increasing inequality risks, and highlighting the need for stronger public healthcare financing and resilience.

Israel's healthcare financing model is one of the more efficient universal systems among high-income countries, delivering strong health outcomes with relatively moderate spending. Built on universal public coverage and regulated competition, the system has balanced equity with efficiency. But it is under growing strain from underinvestment, rising private spending and workforce shortages. The ongoing conflict has further increased demand for hospitals, rehabilitation, and mental health services, highlighting both the system's resilience and the need for continued strengthening of its healthcare financing.

Israel's healthcare financing model

Israel's healthcare system is often described as a model of regulated competition. Since the National Health Insurance Law of 1995, every resident has been entitled to a standardised basket of health services through one of four competing, non-profit health funds, known as Health Maintenance Organisations (HMOs), known locally as Kupat Holim, regardless of age, income, or pre-existing conditions. Financing comes mainly from a mix of income-related health taxes and government transfers, with capitation-style risk adjustment used to distribute funds to HMOs. The result has been broad coverage, relatively strong outcomes, and a system that has historically delivered good value for money.

At the same time, Israel's financing model has always contained a private layer. Most residents also buy supplementary insurance from their HMO, and many purchase commercial private insurance for faster access, more provider choice, or services outside the public basket. That dual structure has helped people obtain care that the public system does not fully

finance, but it has also steadily increased the role of private spending in total healthcare financing. This is the core tension in Israel today: the system remains universal on paper, but access increasingly depends on the ability to pay for add-ons.

Organisation for Economic Co-operation and Development (OECD) data show that all of the population is covered for a core set of services, and Israel performs better than the OECD 2025 average on many access and quality indicators, including preventable mortality (78 per 100K vs. OECD average of 145 per 100K), treatable mortality (56 per 100K vs. OECD's 77), breast-cancer screening (71 per cent of Israeli women screened vs. OECD average of 55 per cent) and, DTP vaccination (98 per cent of eligible children vaccinated vs. OECD's 93 per cent). Life expectancy was 83.8 years, well above the OECD average of 81.1 years, while per-capita health spending was still below the OECD norm. That combination suggests a system that has been comparatively efficient in translating modest spending into strong outcomes.

The financing architecture also supported stability. The public basket is updated through formal procedures, while supplementary coverage expands access without replacing the universal core. HMOs cannot deny supplementary insurance coverage on the basis of pre-existing conditions, which helps maintain broad participation. This structure has helped Israel avoid some of the inequities seen in systems that rely much more heavily on market-based insurance. In that sense, the financing system is resilient because it blends public solidarity with consumer choice.

Current financing pressures

Israel's healthcare system operates within a financing structure that balances public funding with voluntary private contributions. National health expenditure stands at approximately 7.6 per cent of GDP, below the OECD average of 9.6 per cent, reflecting a deliberate approach to resource allocation. Public funding accounts for around 4.7 per cent of GDP, supporting the core National Health Insurance framework, while households contribute through premiums and co-payments for supplementary services.

This financing mix enables broad coverage of essential services through mandatory prepayment while allowing flexibility for additional needs. Supplementary insurance from HMOs and commercial providers covers over 84 per cent of the population, offering expanded specialist access, private surgery options, advanced diagnostics, and treatments beyond the public basket. Such arrangements help manage demand across the system by providing faster pathways and greater choice, particularly for non-emergency care.

Households benefit from this dual structure, as it complements the universal public package with personalised options tailored to individual preferences. For example, families seeking shorter wait times or specific providers can access these through voluntary plans without compromising the baseline coverage guaranteed to all residents. The model thus distributes system pressures effectively, with private contributions supporting capacity in areas like elective procedures and specialised services. This model reduces waiting-time pressure for some patients, but it can also pull clinicians and activity away from the public sector, especially when hospitals and doctors can earn more in private channels.

The result is a financing feedback loop: public constraints encourage private use, which in turn can weaken public capacity. The public basket can also lag behind medical innovation if budget growth is too limited to absorb new drugs, devices, and services at the pace needed.

There is also a pricing issue. Private-sector prices have not been tightly controlled in the same way as public tariffs, and this has contributed to affordability concerns. The Taub Center, a renowned Israeli socioeconomic policy research institute, has warned that the growing share of private financing resembles an "Americanisation" trend, with rising prices and widening inequities. In financing terms, that means the private sector has become both a relief mechanism and a source of a slight drift away from universal public coverage. The challenge is therefore less about the existence of private finance and more about maintaining affordability and ensuring that public and private funding remain complementary rather than unevenly balanced.

What resilience means now

The recent conflicts have amplified Israel's pre-existing healthcare financing weaknesses. The healthcare system was already under pressure with constrained budgets and workforce shortages, and demand has since surged across trauma care, surgery, rehabilitation, prosthetics, and psychosocial services. At the same time, resources have been diverted toward emergency preparedness and continuity of care. While Israel is well-versed in mass casualty response, the scale and persistence of wartime demand have created a sustained financial and operational burden.

War-related costs are not limited to immediate care; long-term rehabilitation and follow-up needs continue to add pressure well beyond active conflict. Mental health illustrates this most clearly. Demand has risen sharply, with both civilians and soldiers requiring prolonged support. The Taub Center's 2025 assessment notes that while the system has "functioned well," early signs of strain are visible, including gaps in investment and pressure on critical services.

Israel has maintained coverage and avoided systemic disruption, but doing so requires significant resources - capacity, workforce, and flexible financing, all of which are harder to sustain under fiscal constraints. Without increased public investment, the system risks deeper reliance on private spending, potentially undermining equity despite preserving overall access.

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