Universal Entitlement Under Strain: The Long-Term Impact of Israel's National Health Insurance Reform on Health System Management and Organization.

Abstract

Background: This article examines the long-term impact of Israel's National Health Insurance (NHI) reform on the management and organization of the healthcare system.

Methods: The study uses a structured secondary policy-analysis design organized around five linked dimensions: universal entitlement, financing architecture, benefit-basket governance, institutional role allocation, and the public–private boundary of access. The source base combines the statutory framework, classic reform scholarship, later policy and evaluation literature, and the most recent official comparative indicators published by the OECD and the European Observatory on Health Systems and Policies.

Results: The evidence indicates that the reform achieved a historic normative breakthrough by universalizing legal entitlement and stabilizing a coherent public framework for healthcare provision. However, long-term pressures persisted in financing adequacy, basket updating, overlapping regulator–provider roles, workforce and infrastructure capacity, and the growing practical importance of supplementary and private channels. Recent comparative indicators show that Israel combines full coverage with relatively low mandatory prepayment, lower-than-OECD-average spending per capita, fewer nurses and hospital beds than the OECD average, and incomplete financial protection for part of the population.

Conclusion: Israel's NHI remains one of the country's major social-policy achievements, but its long-term success depends on stronger public investment, clearer governance boundaries, more predictable basket-updating mechanisms, and firmer protection of the public core of the system.

Keywords: Israel; National Health Insurance; health system reform; public management; health financing; governance; universal coverage

Introduction

Israel's National Health Insurance (NHI) Law, enacted in 1994 and implemented in 1995, transformed access to healthcare from a historically fragmented arrangement into a universal statutory entitlement. In institutional terms, the reform redefined the relationship among the state, the Ministry of Health, the four health funds, hospitals, and households by embedding coverage in law and by reorganizing the financing and governance framework through which care is delivered (State of Israel, 1994; Rosen et al., 2015).

The Israeli case remains important because it combines universal legal coverage with organizational pluralism. The health funds compete and innovate within a regulated national framework, while the Ministry of Health continues to play multiple roles in planning, regulation, purchasing, ownership and, in some domains, provision. This mixed structure has often generated impressive efficiency and innovation, yet it also creates recurring tensions concerning accountability, financing adequacy, and equal practical access (Chinitz, 1995; Feder-Bubis & Chinitz, 2010; Rosen et al., 2015).

The central question of this article is therefore not whether the NHI reform mattered—it clearly did—but how its long-term implementation reshaped the management and organization of the Israeli health system, and why important pressures persisted despite the achievement of formal universality. The argument

advanced here is that the reform succeeded at the level of legal entitlement and institutional stabilization, but that its long-term credibility depends on the ongoing managerial reproduction of universalism through financing, basket updating, workforce capacity, infrastructure, and governance discipline.

This article contributes by recasting the reform as a long-run public-management problem rather than as a one-time legislative event. It also strengthens the evidence base of that interpretation by integrating classic reform scholarship with the most recent official comparative indicators available for Israel. In doing so, the article positions the NHI reform as a case of qualified institutional success under sustained structural pressure.

Materials and Methods

This study used a structured secondary policy-analysis design. Its purpose was not to estimate causal effects econometrically, but to evaluate whether the historical development and current performance profile of the Israeli NHI system are consistent with an interpretation of durable universalism under managerial strain.

The source base was selected purposively to cover four layers of evidence: (1) the statutory framework created by the National Health Insurance Law; (2) classic scholarly analyses of the reform's political origins, financing logic and early implementation; (3) later policy and evaluation literature addressing institutional development, public–private financing, equity, waiting times, insurance literacy, and system drift; and (4) the most recent official comparative indicators published by the OECD and the European Observatory on Health Systems and Policies. Priority was given to official publications and peer-reviewed sources with direct relevance to entitlement, financing, governance, equity and system capacity (Chinitz, 1995; Gross et al., 1998; Chernichovsky, 2013; Horev & Avni, 2016; Shmueli, 2014; Green et al., 2017; Aiken & McHugh, 2014; Brammli-Greenberg, 2015; Treister-Goltzman & Peleg, 2023; Rosen et al., 2015; OECD, 2025; European Observatory on Health Systems and Policies, 2024).

The analysis was organized around five dimensions that together capture the managerial logic of the reform: universal entitlement, financing architecture, basket-of-services governance, institutional role allocation, and the public–private boundary of access. These dimensions were chosen because they connect legal design to operational reality. A reform can universalize coverage in law, yet still produce unequal practical access if financing adequacy, updating mechanisms, capacity planning and governance clarity weaken over time.

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

Historical and Institutional Background

The 1994 law did not emerge in a vacuum. Israeli healthcare developed through health funds, labour-movement institutions, public hospitals, and a patchwork of administrative and financing arrangements that produced important achievements but also left unresolved questions of entitlement, accountability and equity. The pre-reform system therefore combined service capacity with structural ambiguity: not all residents were covered on equal terms, and institutional responsibility remained diffuse (Chernichovsky, 1995; Chinitz, 1995).

The political breakthrough of the mid-1990s followed a long history of unsuccessful reform attempts. Scholarship on the period emphasizes both structural crisis and political entrepreneurship. The Netanyahu Commission helped redefine the debate by highlighting the lack of clarity regarding citizens' rights, the blurred allocation of responsibility among government, sickness funds and providers, and the need for a more coherent financing and governance structure (Chernichovsky, 1995; Chinitz, 1995).

Seen from a public-management perspective, the reform was therefore not simply about expanding insurance coverage. It was about codifying social rights, reallocating responsibility, and creating a more governable framework for managing a complex national health system. That historical origin remains important because many of the pressures visible today were already implicit in the design problem the reform sought to solve.

Reform Design and Managerial Logic

The NHI reform created universal statutory entitlement to a defined basket of services for all residents and assigned primary service delivery to the four health funds. Financing was reorganized through a combination of health-tax revenue, public transfers, and capitation-based allocation across the funds. In design terms, this represented a shift from fragmented affiliation-based arrangements to a rights-based national framework (State of Israel, 1994; Rosen et al., 2015).

From a managerial standpoint, the reform had four central ambitions. First, it sought to align solidarity with predictable financing. Second, it made the basket of services the operational core of entitlement. Third, it aimed to improve transparency and accountability by clarifying who was covered, what was covered, and how resources were distributed. Fourth, it attempted—at least in principle—to strengthen the Ministry of Health as a regulator and planner rather than a direct provider in all domains (Chernichovsky, 1995; Gross et al., 1998).

However, later scholarship shows that these ambitions were only partially realized. While universal insurance was successfully enacted, other structural reforms progressed unevenly. In particular, the Ministry of Health continued to occupy overlapping positions as regulator, owner and provider, and the public–private boundary of care remained politically and institutionally contested. The Israeli case therefore illustrates how punctuated reform and path dependency can coexist: a major breakthrough at the level of entitlement may occur alongside continuity in institutional structure and incentive problems (Feder-Bubis & Chinitz, 2010).

Table 1. Analytical Dimensions for Assessing the Long-Term Performance of Israel's NHI Reform

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

Financing, Benefit Design, and Governance Pressures

The financing architecture of NHI lies at the heart of the reform's long-term performance because financing is the point at which solidarity is translated into management. The original design linked entitlement to a public financing framework centred on earmarked health taxation and state participation. Yet later scholarship and official reviews make clear that financing adequacy remained politically contested, particularly as demography, technology and expectations increased the cost of sustaining the public core (Chernichovsky, 2013; Rosen et al., 2015).

The basket of services is equally central. It is not merely a legal inventory of covered services; it is the principal managerial instrument through which the state defines the real content of social rights. Where updating mechanisms become too dependent on annual negotiations, weak utilization data or fiscal restraint, the practical value of legal entitlement may erode. The question is therefore not only whether a basket exists, but whether it is governed in a sufficiently predictable, evidence-informed and transparent manner (Gross et al., 1998; Gannot et al., 2018).

A related pressure concerns the public–private boundary. Israeli healthcare remains universal in legal design, yet the expansion of voluntary health insurance, supplementary insurance, co-payments and private channels can widen the gap between formal entitlement and actual access. Policy analyses and survey-based studies suggest that the growth of supplementary and commercial insurance has been linked not only to financing patterns, but also to trust, choice, and unequal understanding of coverage across population groups (Bin Nun, 2013; Green et al., 2017; Niv-Yagoda, 2020). This does not amount to formal retrenchment, but it can create functional differentiation by waiting time, geography, capacity bottlenecks and the ability to bypass public queues. Such developments are especially important from a management perspective because they affect the political and operational resilience of the public system itself (Chernichovsky, 2013; European Observatory on Health Systems and Policies, 2024).

Governance compounds these financing pressures. A system in which the Ministry of Health continues to act in multiple roles may preserve administrative continuity, but it can also blur accountability and complicate long-term planning. In that sense, financing, basket governance and role clarity should not be

treated as separate issues. They are interdependent elements of whether universalism is robustly governed or only formally preserved.

Results

The reform produced several durable system-level outcomes. Universal statutory entitlement was established for all residents, the health funds were consolidated within a single national legal framework, and overt exclusion from basic insurance was substantially reduced. The result was a more coherent system architecture centred on four competing non-profit health plans operating under uniform statutory rules (Rosen et al., 2015; OECD, 2025).

Recent official comparative indicators show that Israel continues to provide 100% population coverage for a core set of services. At the same time, only 62% of total health spending is covered through mandatory prepayment, compared with an OECD average of 75%. Total health expenditure is 7.6% of GDP versus an OECD average of 9.3%, and health expenditure per capita stands at USD PPP 4,352 compared with an OECD average of USD PPP 5,967. Workforce and infrastructure indicators are also lower than the OECD average: Israel reports 3.5 practising doctors per 1,000 population versus 3.9 across the OECD, 5.6 practising nurses per 1,000 versus 9.2, and 3.0 hospital beds per 1,000 versus 4.2 (OECD, 2025).

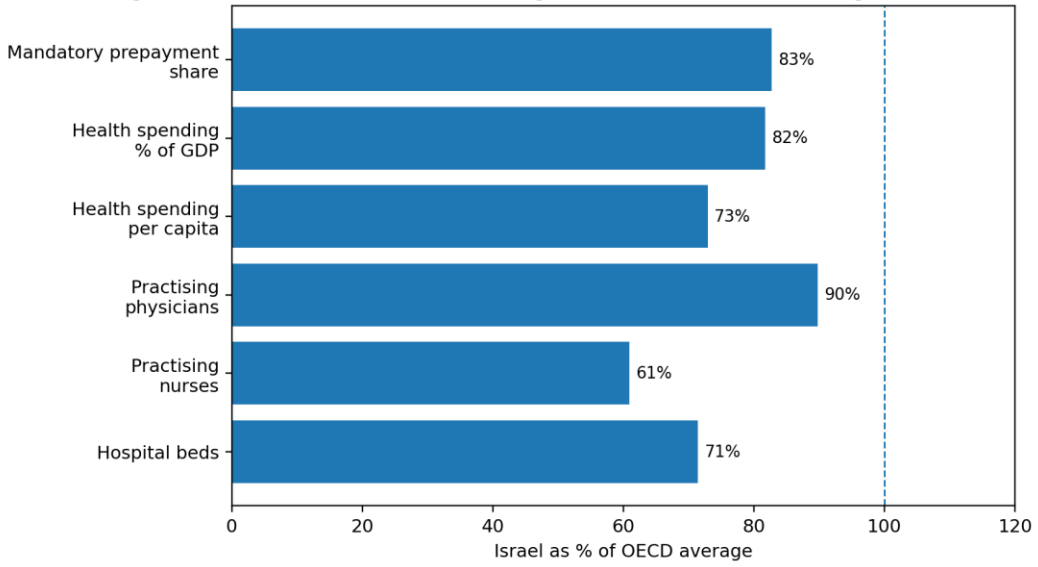
The 2024 Health Systems in Action profile reports additional indicators relevant to financial protection and service access. In 2021, 5.7% of households experienced catastrophic health spending, and 11% of adults reported unmet need due to cost. The same profile also documents regional disparities in service availability, particularly in the south, and describes waiting times and travel distance as factors associated with growing use of private care, often financed through voluntary insurance (European Observatory on Health Systems and Policies, 2024).

Taken together, the current indicator profile shows coexistence between universal legal coverage and below-OECD-average levels of several financing, workforce, and infrastructure measures relevant to practical access and system capacity.

Table 2. Selected Current Indicators Relevant to the Sustainability of Israel's Universal Health System

Indicator	Israel	Comparator	Reference year	Primary source
Population covered for a core set of services	100%	OECD average: 98%	2025	OECD
Mandatory prepayment share of health spending	62%	OECD average: 75%	2025	OECD
Health expenditure as % of GDP	7.6%	OECD average: 9.3%	2025	OECD
Health expenditure per capita (USD PPP)	$4,352	OECD average: $5,967	2025	OECD
Practising doctors per 1,000 population	3.5	OECD average: 3.9	2025	OECD
Practising nurses per 1,000 population	5.6	OECD average: 9.2	2025	OECD
Hospital beds per 1,000 population	3.0	OECD average: 4.2	2025	OECD
Households facing catastrophic health spending	5.7%	—	2021 (reported 2024)	European Observatory
Adults reporting unmet need due to cost	11%	—	2021 (reported 2024)	European Observatory

Figure 1. Israel Relative to OECD Average on Selected 2025 Financing and Resource Indicators



Source: Author calculation based on OECD Health at a Glance 2025: Israel and OECD averages.

Discussion

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

A second lesson concerns pluralism. Israel's model of universal entitlement combined with competing health plans has clear strengths. It can support responsiveness, innovation and strong primary care. However, pluralism is not neutral. Without sufficiently strong public financing and governance coordination, it can coexist with increasing differentiation in practical access. Where waiting times, geography, insurance supplementation and private options become more salient, a formally universal system may become progressively less equal in lived experience. This concern is strengthened by work on income-related inequality, policy efforts to mitigate health inequity, and evidence that insurance literacy and confidence in the public system are unevenly distributed across groups (Shmueli, 2014; Horev & Avni, 2016; Green et al., 2017; Niv-Yagoda, 2020).

A third lesson concerns the meaning of public management in healthcare. Budget formulas, benefit design, pricing processes and provider-role boundaries are not administrative details. They determine whether social rights remain credible under pressure. Israel's continuing strengths in coverage, quality and outcomes therefore should not be read as evidence that financing and capacity issues are secondary. Rather, they show that a high-performing system can still drift into segmentation if managerial reproduction of the public core becomes too weak or too reactive.

Limitations

This article has several limitations. First, it is a secondary policy analysis and therefore depends on the quality, scope and comparability of existing sources. It does not use individual-level administrative or clinical microdata and does not estimate causal effects.

Second, the article combines historical interpretation with current-system indicators. That design is useful for long-run policy analysis, but it means that some sections are more interpretive than statistical. Third, current comparative indicators inevitably compress internal variation by region, sector and social group. The article therefore should not be read as a substitute for detailed empirical work on waiting times, regional inequality, provider behaviour or household burden.

Finally, because the article prioritizes institutionally central sources, it gives greater weight to official publications and high-level policy analyses than to narrower sectoral studies. Future work could strengthen the evidence base by integrating longer financing series, more granular household expenditure data, and regional capacity measures.

Conclusion

Israel's National Health Insurance reform remains one of the country's major social-policy achievements. It universalized statutory entitlement, stabilized a coherent national framework, and embedded a public commitment to healthcare access that has endured for three decades.

Yet the long-term record also shows that universal entitlement is not equivalent to frictionless equality of access. A universal system must be continually sustained through financing adequacy, predictable basket

updating, role clarity, workforce development, and investment in material capacity. Where these supports weaken, universalism can remain intact in law while becoming more differentiated in practice.

The policy implication is therefore constructive rather than pessimistic. The historical success of NHI means that the core principles of solidarity and universality are not in question. The more urgent task is to govern those principles more effectively: to reinforce the public core, improve financial protection, reduce capacity bottlenecks, and ensure that the long-term management of the system matches the strength of its founding social commitment.

Acknowledgments

The author has no acknowledgments to report.

Funding

No external funding was received for the preparation of this manuscript.

Conflicts of Interest

The author declares no conflicts of interest.

Ethics Statement

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

Data Availability

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

References

Aiken, L. H., & McHugh, M. D. (2014). Is nursing shortage in Israel inevitable? *Israel Journal of Health Policy Research, 3*, Article 10. https://doi.org/10.1186/2045-4015-3-10

Bin Nun, G. (2013). Private health insurance policies in Israel: A report on the 2012 Dead Sea Conference. *Israel Journal of Health Policy Research, 2*, Article 25. https://doi.org/10.1186/2045-4015-2-25

Brammli-Greenberg, S. (2015). Inequalities in waiting times by socioeconomic status: A possible causal mechanism. *Israel Journal of Health Policy Research, 4*, Article 2. https://doi.org/10.1186/2045-4015-4-2

Chernichovsky, D. (1995). The political economy of health system reform in Israel. *Health Economics, 4*(2), 127–137. https://doi.org/10.1002/hec.4730040205

Chernichovsky, D. (2013). Reforms are needed to increase public funding and curb demand for private care in Israel's health system. *Health Affairs*, *32*(4), 724–733. https://doi.org/10.1377/hlthaff.2012.0283

Chinitz, D. (1995). Israel's health policy breakthrough: The politics of reform and the reform of politics. *Journal of Health Politics, Policy and Law, 20*(4), 909–932. https://doi.org/10.1215/03616878-20-4-909

European Observatory on Health Systems and Policies. (2024). Health systems in action: Israel. World Health Organization. Regional Office for Europe. https://eurohealthobservatory.who.int/publications/i/health-systems-in-action-israel-2024

Feder-Bubis, P., & Chinitz, D. (2010). Punctuated equilibrium and path dependency in coexistence: The Israeli health system and theories of change. *Journal of Health Politics, Policy and Law, 35*(4), 595–614. https://doi.org/10.1215/03616878-2010-018

Gannot, R. N., Rosen, B., & Chinitz, D. (2018). What should health insurance cover? A comparison of Israeli and US approaches to benefit design under national health reform. *Health Economics, Policy and Law, 13*(2), 189–208. https://doi.org/10.1017/S1744133117000287

Green, M. S., Hayek, S., Tarabeia, J., Yehia, M., & HaGani, N. (2017). A national survey of ethnic differences in knowledge and understanding of supplementary health insurance. *Israel Journal of Health Policy Research, 6*, Article 12. https://doi.org/10.1186/s13584-017-0137-4

Gross, R., Rosen, B., & Chinitz, D. (1998). Evaluating the Israeli health care reform: Strategy, challenges and lessons. *Health Policy, 45*(2), 99–117. https://doi.org/10.1016/S0168-8510(98)00030-X

Horev, T., & Avni, S. (2016). Strengthening the capacities of a national health authority in the effort to mitigate health inequity: The Israeli model. *Israel Journal of Health Policy Research, 5*, Article 19. https://doi.org/10.1186/s13584-016-0077-4

Niv-Yagoda, A. (2020). Association between trust in the public healthcare system and selecting a surgeon in public hospitals in Israel: A cross-sectional population study. *Israel Journal of Health Policy Research, 9*, Article 38. https://doi.org/10.1186/s13584-020-00396-z

OECD. (2025). Health at a Glance 2025: OECD indicators. OECD Publishing. https://doi.org/10.1787/8f9e3f98-en

OECD. (2025). Health at a Glance 2025: Israel. OECD Publishing. https://www.oecd.org/en/publications/health-at-a-glance-2025_15a55280-en/israel_b3600fbc-en.html

Rosen, B., Waitzberg, R., & Merkur, S. (2015). Israel: Health system review. *Health Systems in Transition, 17*(6), 1–212. https://eurohealthobservatory.who.int/publications/i/israel-health-system-review-2015

Shmueli, A. (2014). Income-related inequalities in health and health services use in Israel. *Israel Journal of Health Policy Research, 3*, Article 37. https://doi.org/10.1186/2045-4015-3-37

State of Israel. (1994). National Health Insurance Law, 5754–1994, Sefer HaHukim [Book of Laws], No. 1469, p. 156.

Treister-Goltzman, Y., & Peleg, R. (2023). The physician shortage in Israel and a policy proposal for improvement. *Israel Journal of Health Policy Research, 12*, Article 2. https://doi.org/10.1186/s13584-023-00552-1