Chapter 7

Welfare Issues

PART 1
INCOME AND EXPENSES OF YOUNG FAMILIES

- The war had unique negative impacts on the well-being of young working families due to the combination of reserve military service, increased childcare responsibilities, and working under the shadow of conflict.
- Improving the economic status of young working families has been a significant component of Israel's socioeconomic policy over the past decade, as reflected in various measures targeted at this demographic.
- The disposable income of young working families has consistently increased over recent decades, a result of rising economic incomes alongside policy changes that have increased disposable income as a share of total economic income.
- Total education expenditures as a share of disposable income have risen in recent decades. However, the increase in early childhood education expenses was halted at the beginning of the previous decade, thanks to government measures to reduce them.
- The proportion of young families living in owned housing has consistently declined over the years.

1. INTRODUCTION

This Chapter addresses the relative economic status of young families with children in Israel, where both parents are aged 25–40 and are employed (hereafter referred to as young working families). These families constitute a significant and important segment of the Israeli population, with a large portion belonging economically and socially to the middle class.[1] The parents in these families are in the midst of integrating and establishing themselves in the labor market while raising young children, which involves financial burdens and time investment. Liquidity constraints and inelastic demand for various consumption items (such as education, housing, and childcare) make it difficult for these households to smooth consumption over time.[2] Policymakers have also identified young families as a group on which to focus and work toward their economic well-being, especially following the social protests and the Trajtenberg Committee's conclusions. Indeed, significant policy changes over the past two decades have affected young families. Alongside broad policy measures affecting all households, specific policies have been implemented targeting families with children, particularly young families where both parents work. These include tax benefits for working parents, especially additional tax credits for children and the expansion of the earned income tax credit (negative income tax), subsidies for daycare centers and after-school programs, the implementation of free education laws for prekindergarten ages, and programs to subsidize home purchases.[3] Some of these benefits have been reduced in recent years. Brender and Strawczynski (2017)[4] examined government policy towards young parents up to 2012 compared to other countries and over time, and found that even after some policy changes took effect, the benefits provided to most family types in Israel remained lower than those given to similar family types in other OECD countries. The study found no significant deterioration over time in the economic status of young parents. It also found that in the housing market, the proportion of families living in rented accommodation increased, a trend not observed in other age groups.

The economic consequences of the war were felt across all households, but there were unique effects on young families where both parents work. These families experienced a combined economic impact: absences from work due to military reserves, which also affected the labor supply of spouses (Bank of Israel, 2023), absences due to limited educational framework activities, and the need to care for young children. Families with young children were also significantly affected by the

[1] For more discussion on the function and importance of the middle class in society, see Osnat Peled Levy (2020), "The Middle Class in Israel", Bank of Israel Review, 91: 109–150 (in Hebrew).

[2] Consumption smoothing is economic behavior in which people balance their consumption over time, through savings or credit, in order to maintain a stable standard of living despite changes in income. In most economic models, the assumption is that people benefit from consumption smoothing.

[3] Box 6.1 in the Bank of Israel Annual Report for 2017: "Increasing the Benefits to Working Parents as Part of the 'Net Family' Program"

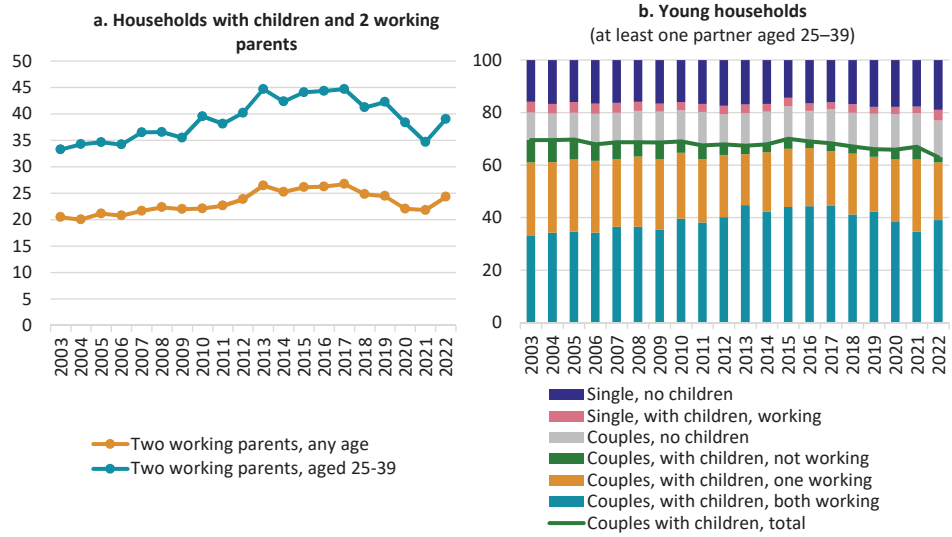
[4] A. Brender and M. Strawczynski (2017). "The Government's Policy Toward Young Parents", Economic Quarterly 61(3/4): 55–102.

psychological distress experienced by both the children and their parents.[5] These factors may have long-term effects on young families.

2. YOUNG FAMILIES IN WHICH BOTH PARENTS WORK

In 2022, there were approximately 890,000 households in Israel where the head of the household or their partner was aged 25–39.[6] About 40 percent of these households consisted of two working parents with children, and an additional 4 percent were single working parents. Over the years, employment rates for this group have increased, particularly with the entry of an additional earner from the household into the labor market, leading to a rise in the proportion of young families with two earners by 2017 (Figure 7.1). In recent years, especially during the COVID-19 pandemic, the proportion of these households decreased. However, in 2022, there was a slight increase.

Figure 7.1 | Selected Households as a Share of Households in their Age Group in Israel[a], 2003–2022 (percent)



[a] "Parents" relates to the head of household and spouse, in households where there are children up to age 17. In young households, the head of household and/or spouse is aged 25–39.

SOURCE: Based on Central Bureau of Statistics Household Expenditure Survey.

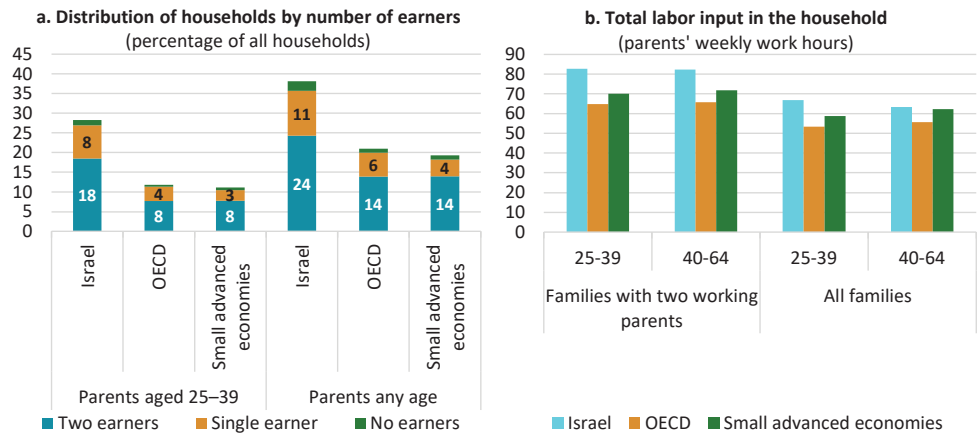
[5] See: D. Shay, C. Blank, C. Navon, and Y. Shavit (2024). "The Impact of the Israel-Gaza War on Young Children and Their Parents: Longitudinal Survey Findings Post-October 7th", Taub Center for Social Policy Studies in Israel. https://doi.org/10.5281/zenodo.13825741

[6] The head of the household is defined in income surveys as an individual aged 18 or older, selected based on their participation in the labor force and the extent of their employment (in order: employed full-time, over 35 hours, employed part-time, unemployed), regardless of age, gender, or income. If more than one person in the household fits this definition, the head of the household is considered to be the person whom the respondent identifies as such.

The proportion of young families with both parents working is higher in Israel than in other advanced economies.

The proportion of young families with both parents working is higher in Israel than in other advanced economies. This reflects Israel's age composition, the relatively high percentage of family households (as opposed to single-person households), and the high proportion of households with children. The younger age of parents at childbirth and the higher number of children per family also contribute to the high percentage of households with children in Israel (Figure 7.2). Among young families in Israel (as of 2019), the proportion of households with both parents working is higher than the OECD average, resulting in more working hours and a heavier burden on parents. It is important to note that even among families with both parents working, the number of working hours in Israel is significantly higher than in other OECD countries (see Figure 7.2).

Figure 7.2 | Scope of Employment of Families with Two Parents and Children[a], Israel and OECD, 2019



[a] "Parents" relates to the head of household and spouse, in households in which there are children up to age 17. In young households, the head of household and/or spouse is aged 25–39. In older households, both spouses are aged 40–64. "Other" households are those without children or those with single parents.
The OECD average is the simple average of OECD countries with available data in the LIS database for 2019, excluding Israel. Australia's data were completed with 2018 data. The average of the small advanced economies is the simple average of Austria, Belgium, Denmark, Netherlands, and Sweden.
SOURCE: Based on Luxembourg Income Study.

3. THE INCOME OF YOUNG FAMILIES WITH TWO EARNERS

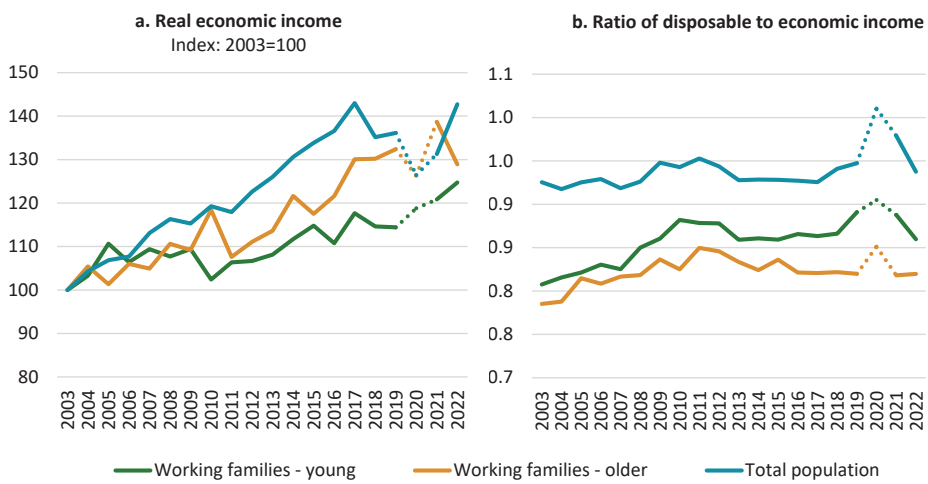
Since 2010, young working families' economic and disposable income have increased constantly, while the ratio between them has remained stable.

The real economic income[7] of young families with both parents working has consistently increased since 2010 (Panel A in Figure 7.3). At the beginning of this period, the growth rate of real economic income for young working families (with two working parents) was lower than that of the general population. This partly reflects changes in the composition of this group due to the inclusion of households with relatively low earning potential. This growth rate was also low relative to older

[7] The economic income of a household is its total income from employment (salaried or self-employed), capital, and private transfers—essentially all income derived from the free market, excluding government support or transfers.

families with two earners, indicating a slight erosion in their relative economic status. The growth rate of disposable income (after taxes and benefits) was faster than that of economic income, which may reflect changes in tax policy towards families. Significant tax changes between 2003 and 2010 favored families with two earners, resulting in a faster increase in their ratio of disposable income to economic income than the ratio among all households in the economy (Panel B in Figure 7.3). Since 2010, both economic and disposable incomes have steadily increased at similar rates, maintaining a stable ratio between them.

Figure 7.3 | Incomes of Selected Households[a], 2003–2022



[a] "Parents" relates to the head of household and spouse, in households where there are children up to age 17. In young households, the head of household and/or spouse is aged 25–39. In older households, both spouses are aged 40–64. Total population relates to all households in Israel, regardless of age or family status. During the COVID-19 period (2020–2021) incomes were affected by significant changes in the demographic composition of the labor force.

SOURCE: Based on Central Bureau of Statistics Household Expenditure Survey.

4. EXPENSES OF YOUNG FAMILIES

Young households in Israel, particularly those with children and dual earners, exhibit a distinct spending profile that imposes unique financial constraints. Unlike households without young children, where disposable income allows for greater budgetary flexibility, young families face a set of inflexible obligations that prioritize essential needs over deferred consumption or capital investments. As a result, their spending tends to focus on housing, education, and transportation, while their ability to allocate resources for savings or nonessential consumption is limited. Furthermore, their capacity to respond to changes in relative prices is often more restricted than that of other households.

In contrast to the general population of young families (households with children where at least one parent is aged 25–40), young families with two earners have expenses that are lower than their disposable income (which is higher than that of

single-earner families), allowing them to save. Consumption expenditure as a share of income for these households has remained constant over the years, despite increases in their disposable income and the extent of the parents' labor input, which typically leads to higher work-related expenses (particularly for childcare and transportation). The composition of their expenses has not changed significantly over the years. The proportion of spending on major categories within disposable income—housing (excluding mortgage payments), transportation, education[8], and food—has remained stable over most years. However, within housing expenses, the portion attributed to monetary expenditures, as opposed to imputed housing costs[9], has been increasing, thereby reducing these households' ability to save accordingly.

The share and composition of young working families' consumption expenditure remained stable over the years.

Figure 7.4 illustrates the expenditure composition of different types of households. It shows that the spending patterns of young working families are similar to those of all young families in most expenditure categories. However, young working families spend slightly less on food and slightly more on transportation. Compared to older working families (where the head of the household and their partner are aged 40–64), young working families spend more on education and clothing and footwear, and less on healthcare, food, and transportation. The portion allocated to housing expenses is similar, but for young working families, a larger share of the expenditure is monetary, primarily on rent, whereas for older working families, most of the expenditure is imputed for living in owned homes. Compared to the past, there is a noticeable increase in the monetary expenditure on housing, while the imputed expenditure for those living in owned homes has decreased, mainly due to the decline in homeownership rates.

The rate of monetary expenditure on rent increased over the years.

The education expenditure rate increased in recent decades, but the increase of expenditures on early childhood education was halted at the beginning of the previous decade.

Education expenses[10] are a significant part of the total expenditures for young families. According to Expenditure Survey data, almost all young families with working parents have some education expenses, and the portion of income allocated to this has increased, particularly at the beginning of the period (Figure 7.5). Part of the

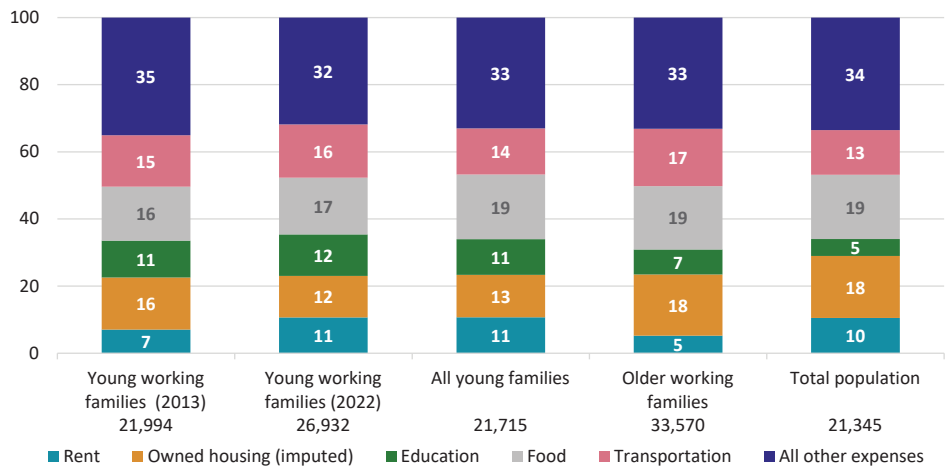
[8] In 2019, the definitions and classifications of various education expenditure categories were revised in expenditure surveys, preventing comparisons with previous years.

[9] The two main components of housing expenses are rent payments for rented apartments and the cost of consuming housing services in owned apartments. For rented apartments, the rent expense is directly obtained from the households living in them. For owned apartments, the consumption of housing services is calculated by imputing a weighted alternative rent for similarly sized apartments in the same or similar areas. (The imputed rent is also included in household income). Imputed rent data is obtained from three main sources: (a) the ongoing rent survey conducted for the Consumer Price Index; (b) rent data from households living in rented apartments from the Household Expenditure Survey itself; (c) additional sources outside the Central Bureau of Statistics. It should be noted that the housing expenses presented here do not include payments on mortgages and other housing loans, as these are considered part of savings.

[10] Education expenses include payments for educational services, comprising three main components: (a) direct payments to educational institutions and authorities; (b) expenses for educational activities after school hours—payments for extracurricular activities, after-school programs, private lessons, and exams; (c) indirect expenses for educational supplies. Due to changes made by the Central Bureau of Statistics in the definition and classification of various education expenditure components, it is not possible to track their development over time.

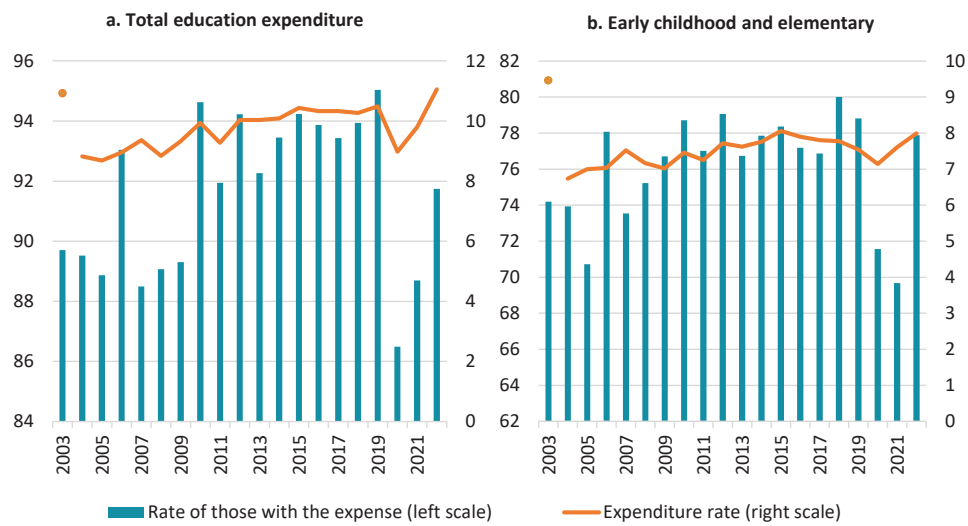
increase in expenses is due to the rise in the number of children in the household, especially young children up to age 4 who require close supervision, which is costly. However, this increase in family size does not fully explain the growth in education expenses.

Figure 7.4 | Distribution of Consumption Expenses of Selected Households[a], 2022
Expenditure items as a share of total expenditure[b] (percent)



[a] "Working families" are households with at least one child up to age 17 and two working parents. In young households, the head of household and/or spouse is aged 25–39. In older households, both spouses are aged 40–64. Total population relates to all households in Israel, regardless of age or family status.
[b] The bottom of the Figure shows the average disposable income of households in the group, in current prices.
SOURCE: Based on Central Bureau of Statistics Household Expenditure Survey.

Figure 7.5 | Education Expenditure Rates in Israel[a], 2003–2022
(young families with children and two working parents, percent)



[a] The household's expenditure rate is calculated as the percentage of its disposable income. The average is calculated for households whose expenditure on the relevant item is greater than zero.
SOURCE: Based on Central Bureau of Statistics Household Expenditure Survey.

A significant expenditure component for young families is education for young children and those in elementary school. At the beginning of the period, both the proportion of households with such expenses and the share of these expenses out of household economic income increased. This growth moderated and stabilized since 2012, likely due to policy measures implemented following the 2011 social protests and the implementation of some recommendations from the Trajtenberg Committee. Among other measures, the Free Compulsory Education Law was extended to prekindergarten ages, and eligibility for daycare subsidies was established based on parental employment. However, most households with two working parents do not receive subsidies because their income exceeds the set threshold. In other cases, excess demand for subsidized daycare and low availability prevent households from fully utilizing the benefit.[11] Additionally, a significant number of parents prefer private daycare centers, which may be perceived to be of higher quality.

The home ownership rate among young working families declined consistently over the years.

Another major component of expenditure for young households is housing. The increase in housing prices since 2007 has reduced the ability of young households to purchase homes[12], which is reflected in the decline in the proportion of young families living in owned housing (Figure 7.6) and, consequently, a decrease in the proportion of mortgage holders and an increase in the proportion of renters. Subsidized housing programs ("Buyer's Price," "Target Price") implemented by the government since the mid-2010s have helped increase the likelihood of young families purchasing a home. However, these programs have not fully offset the decline in homeownership rates.[13] Additionally, in recent years, there has been a slight increase in the proportion of households owning a property that is not used for their own residence.

The rate of young working families who live in a home they own is lower than in other OECD countries.

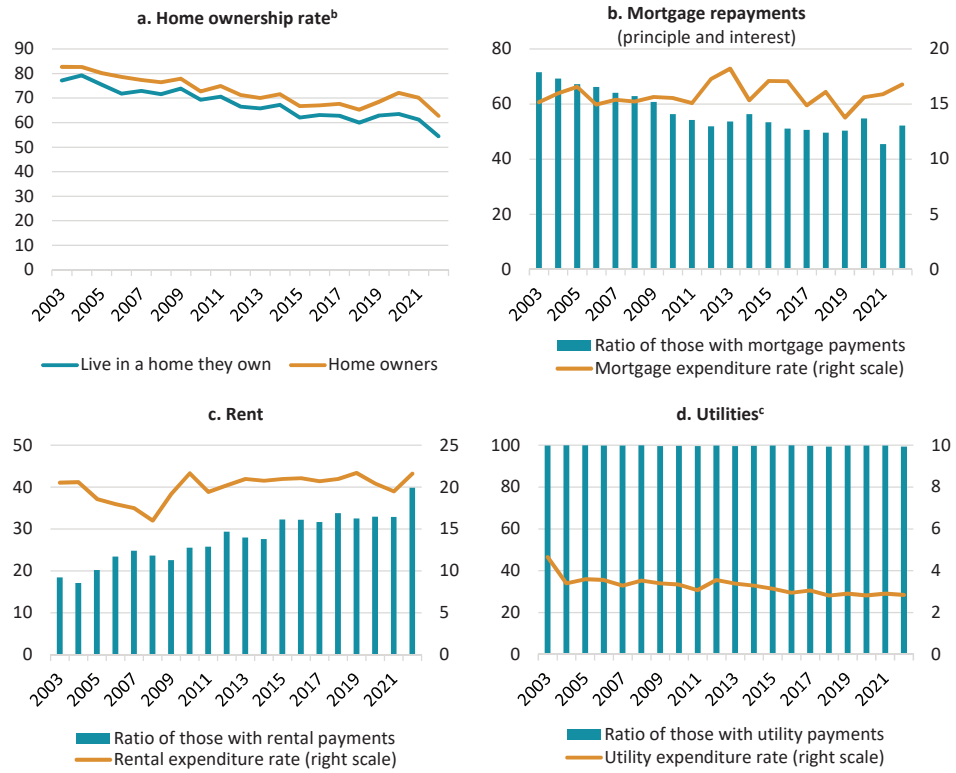
The proportion of young families with both parents working who live in homes they own is lower in Israel than in other OECD countries, particularly when compared to smaller and more advanced countries (Figure 7.7). This is despite the fact that the overall homeownership rate, especially among older families, is not low compared to these countries. In contrast to other countries, where young households with two earners typically exhibit higher homeownership rates than other households, Israel does not show a significant difference in homeownership rates among these groups.

[11] Ella Shachar (2012). "The Effect of Childcare Cost on the Labor Supply of Mothers with Young Children", Discussion Paper Series 2012.12, Bank of Israel Research Department (in Hebrew).

[12] Kyrill Shraberman (2018). "Rising Housing Prices and Their Impact on Households' Ability to Purchase A Home," a chapter from the State of the Nation Report 2018, Taub Center for Social Policy Studies in Israel.

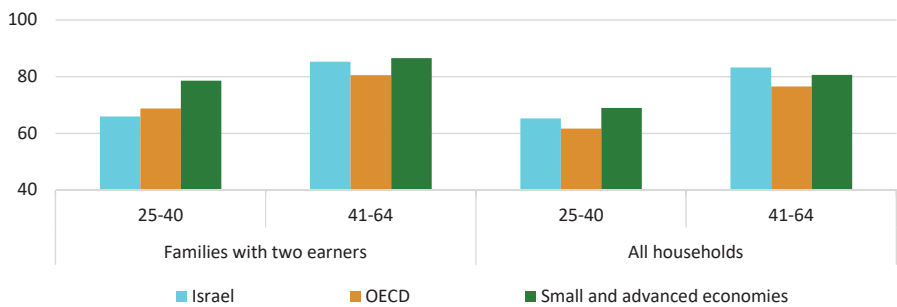
[13] Darin Vaisman (2023). "Buyer Characteristics and the Chances of Buying a First Home: 2012–15 Compared to 2016–19", Discussion Paper Series 2023.14, Bank of Israel Research Department. Many of the homes purchased through these programs have not yet been completed, so +buyers are renting other properties and do not benefit from rental income for the homes they have purchased.

Figure 7.6 | Housing Expenditure Rates in Israel[a], 2003–2022
(young families with children and two working parents, percent)



[a] The household's expenditure rate is calculated as the percentage of its disposable income. The average is calculated for households whose expenditure on the relevant item is greater than zero.
[b] Home ownership rate - Households that own a home, calculated as the sum of the percentage of households that live in a home they own and the percentage of households who do not live in a home they own but have rental income.
[c] Utilities include payments for water, electricity, and household gas and fuel.
SOURCE: Based on Central Bureau of Statistics Household Expenditure Survey.

Figure 7.7 | Rate of Those Living in a Home They Own[a], 2019
(Israel and OECD, percent)



[a] The rate of households living in a home they own, as a share of all households in the group. Families are households in which there are children up to age 17. In young households, the head of household and/or spouse is aged 25–40. In older households, both spouses are aged 41–64. The OECD average is the simple average of OECD countries with available data in the LIS database for 2019, excluding Israel. Australia's data were completed with 2018 data. The average of the small advanced economies is the simple average of Austria, Belgium, Denmark, Netherlands, and Sweden.
SOURCE: Based on Luxembourg Income Study.

PART 2
THE EXPECTED EFFECT OF THE "YATZIV" REFORM ON THE NUMBER AND QUALITY OF TRAINING OF PHYSICIANS IN ISRAEL

- The "Yatziv reform" to regulate medical studies at faculties abroad is expected to reduce the number of new medical license recipients by 400–600 per year beginning in 2026. The reform is expected to be felt particularly in the periphery areas of the country.
- In recent years, several measures have been implemented to significantly increase the number of new physicians. However, it should take several years from the impact of the reform—beginning in 2026—until these measures mature, which may lead to a shortage of new physicians in the coming years.
- The impact of the Yatziv reform and the anticipated increase in demand for physicians in the coming years, highlight the importance of implementing plans to increase the number of new physicians in Israel, with an emphasis on geographic dispersal.

1. BACKGROUND

The Israeli healthcare system relies heavily on physicians who studied medicine abroad.

In 2020, 58 percent of the physicians active in Israel were trained in other countries, an unusually high rate compared to other OECD countries (OECD, 2023). The group of physicians trained abroad includes new immigrants, but the majority are Israelis who traveled to study medicine abroad, primarily due to the high admission threshold for medical studies in Israel, a result of the limited number of places available for students in Israeli faculties. In this situation, the Israeli healthcare system relies heavily on physicians trained abroad, which has several disadvantages. For example, it is impossible to supervise the quality of training; the theoretical and clinical studies do not necessarily align with the standards of the Israeli healthcare system; and the probability of talented individuals emigrating from the country increases.

The Ministry of Health decided, as of 2019, to disqualify medical faculties abroad that provide a low level of clinical training ("Yatziv Reform").

The level of professional and academic training provided by institutions abroad where Israelis study varies, which affects the professionalism of their graduates. In 2017–2018, the Ministry of Health received complaints about interns lacking clinical experience, who were trained at some of the institutions abroad (Brenner Shalem et al., 2023).[1] In view of this, the Department for the Medical Professions at the Ministry of Health examined the medical studies institutions abroad and set the professional criteria required for their graduates to be able to work in Israel as physicians (hereinafter "Yatziv Reform").[2] According to the criteria, all institutions located in OECD countries and certain institutions in non-OECD countries (for example, several institutions in Jordan and Romania) were approved, while the rest were disqualified. Accordingly, it was decided that Israelis who began their studies in 2019 and onwards at nonapproved institutions would not be able to take the licensing exams in Israel. The impact of the reform is therefore expected to be felt starting in 2025[3], in two main ways—a decline in the number of new physicians and an improvement in the average quality of physician training due to the disqualification of weaker institutions.

This Section examines the expected effects of the reform and reviews the planned measures to address the anticipated decline in the number of new physicians, particularly in the periphery.

[1] Currently, the medical licensing exams are purely theoretical, and it is possible that for this reason they do not pose an effective barrier to physicians who have not undergone quality clinical training. The Ministry of Health is considering including clinical components in these exams in the future.

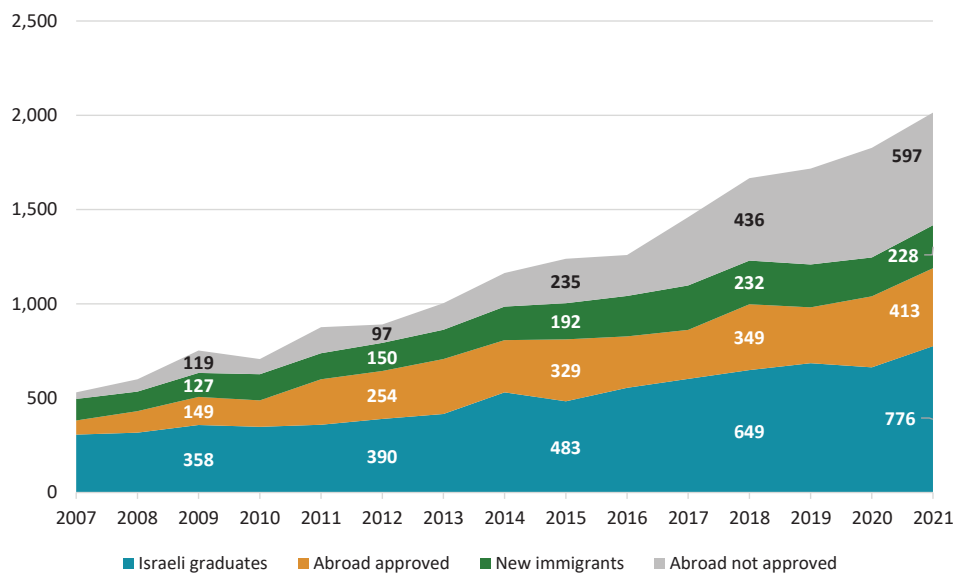
[2] The examination found that in some universities, the level of studies is insufficient and the clinical training is limited in scope or does not exist at all. Accordingly, only a small percentage of students at these universities succeed in passing the licensing exam, and even within this group, the low level of training is evident in their subsequent careers (Brenner Shalem, et al., 2023).

[3] Based on the track for physician training, the number of interns is expected to decline in 2025, and the number of potential medical residents is expected to decline in 2026.

2. THE EXPECTED IMPACT OF THE YATZIV REFORM ON THE FLOW OF NEW PHYSICIANS BEGINNING IN 2026

While the reform's contribution to improving the quality of medical training is widely acknowledged and clear, there is less clarity regarding its expected impact on the number of new physicians. In the years 2019–2021[4], the number of new physicians graduating from disqualified faculties was approximately 500–600 per year, accounting for about 30 percent of the new physicians who received licenses during those years (Figure 7.8). Given the upward trend observed in recent years, it is likely that this number increased beyond 600 in the years 2022–2024. The uncertainty regarding the reform's impact is due to the difficulty in predicting the proportion of physicians who, without the reform, would have studied at the disqualified institutions and, as a result of the reform, may forgo medical studies, versus those who will choose to study at approved institutions.[5]

Figure 7.8 | Number of New Physicians by Type of Educational Institution, 2007–2021*



* By licensing year.

SOURCE: Based on the Registry of Physicians, 2007–2021.

Despite the challenges, some insights into the expected decline in new physicians can be gleaned from analyzing the differences in psychometric exam scores among groups of physicians based on their place of study—Israeli faculties, approved foreign faculties, and foreign faculties disqualified by the reform. There are significant score

4 The last years for which there are full, detailed data.

5 This uncertainty is also related to data limitations, as there are no data on Israeli students studying medicine abroad until they return to Israel and take the licensing exams.

differences among these groups. Graduates from Israeli institutions have considerably higher scores and exam participation rates than those from approved foreign faculties, whose scores are significantly higher in turn than those from disqualified foreign faculties (Figure 7.9).[6,7] The large gaps to the detriment of graduates from nonapproved foreign faculties suggest that many who would have studied at these disqualified institutions in the absence of the reform might struggle to gain admission to approved foreign faculties, let alone in Israel. However, analysis by the 25th and 75th percentiles shows substantial overlap between graduates from nonapproved and approved foreign institutions. This indicates that some who would have studied at disqualified faculties in the absence of the reform might be able to gain admission to approved ones. Therefore, it is reasonable to expect that the reduction in the number of new physicians in the coming years due to the reform will be around 400–600—slightly less than the number of physicians who studied at disqualified faculties in recent years. This general estimate aligns with other assessments found in reports on the subject (e.g., Brener Shalem et al., 2023; Gamzu, 2022).

The assessment is that the number of new physicians will decline by about 400–600 per year due to the implementation of the Yatziv Reform, starting in 2026.

Two additional points emerge from the psychometric exam data. First, if exam performance reflects or correlates with the candidates' cognitive abilities, the Yatziv Reform is expected to improve the average level of physicians' abilities in Israel. Although the quality of care and professional level of physicians are influenced by many other factors, some of which are not observable in the data, these factors are likely correlated with cognitive abilities. Second, the significant score differences between graduates of Israeli institutions and those of foreign institutions (even approved ones) suggest that those who went abroad to study medicine are not necessarily those whose scores were close to the Israeli admission threshold. It appears that many talented Israelis forgo medical studies due to the high threshold, opting to study other fields or study medicine abroad without returning to Israel after graduation. This implies that the very high threshold for medical studies in Israel causes the healthcare system to lose many talented potential physicians.[8] This finding may support increasing the number of medical students in Israeli faculties as a primary means of increasing the number of physicians in Israel.

Increasing the number of medical students at Israeli faculties must be a central tool in increasing the number of physicians in Israel.

[6] A few graduates from Israeli faculties who did not take the psychometric exam likely studied in a four-year program for Bachelor's degree holders, where admission was based on their undergraduate achievements, which may not have required a psychometric exam.

[7] According to the distribution of psychometric test scores among all examinees, the median score for Israeli graduates (734) corresponds to the 99th percentile, the median score for graduates from approved foreign faculties (584) corresponds to around the 60th percentile, and the median score for graduates from nonapproved foreign faculties (479) corresponds to around the 27th percentile (Statistical Report on the Psychometric Exam by the National Institute for Testing and Evaluation, 2023).

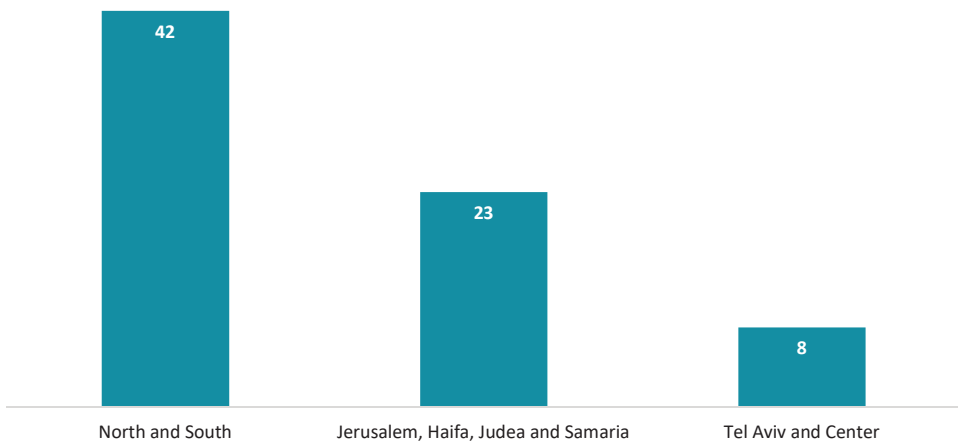
[8] This section focuses on the perspective of the healthcare system and does not address whether, from economic and other perspectives, it is preferable for these talented young individuals to specifically study medicine rather than other fields, such as engineering and sciences.

Figure 7.9 | Psychometric Scores by Type of Educational Institution*

* The figure shows the median scores (in the boxes) and the range of scores between the 25th and 75th percentiles, for physicians who obtained a license between 2007 and 2021. If a physician sat for the psychometric test more than once, the higher score is included in the calculation. The number in parentheses is the rate of those who sat for the psychometric test as a share of all license recipients.

SOURCE: Based on the Registry of Physicians and the Psychometrics file, 2007–2021.

Figure 7.10 | Rate of Physicians Who Graduated from Disqualified Institutions, by Residential District in 2022* (percent)



* Among physicians who obtained a license between 2007 and 2021.

SOURCE: Based on the Registry of Physicians and the Population Registry, 2007–2021.

3. EXPECTED IMPACT OF THE YATZIV REFORM – GEOGRAPHIC ANALYSIS

The prevalence of physicians from disqualified institutions is significantly higher in the northern and southern districts than in the central and Tel Aviv districts.

The geographic distribution of physicians trained at disqualified institutions is uneven. Notably, the prevalence of such physicians is significantly higher in the northern and southern districts than in the central and Tel Aviv districts (Figure 7.10).[9] This finding leads to two main insights. First, a relatively high proportion of physicians in peripheral areas have lower training levels than those in central areas, potentially affecting the quality of healthcare services in those regions. Second, without intervention, the reform's impact on the number of physicians is likely to be particularly pronounced in these areas. This is crucial because peripheral regions already suffer from a shortage of specialists (Zontag, 2025). In recent years, the Ministry of Health has taken several steps to increase the number of physicians in peripheral areas and improve their average quality.[10]

4. POLICY RECOMMENDATIONS

Most of the measures to increase the number of physicians will be felt only a few years after the reform's impact on the decline in their number.

In view of the expected decrease of 400–600 new physicians per year starting in 2026 due to the reform's implementation, the Ministry of Health has begun taking steps to increase the number of medical students in Israel, foster connections with Israeli students studying at approved institutions abroad, and encourage the immigration of physicians. Key measures taken since 2019 (when the Yatziv Reform began) include: opening a medical school in Ariel in 2019 (70 students), canceling programs for foreign students and converting infrastructure for use by Israeli students from 2023 (130 students), approving the opening of a private medical faculty at Reichman University in 2025 (80 students), providing conditional loans to students studying medicine at approved foreign faculties under the "Horizons" program starting in 2024 (100 students per year), and other smaller-scale programs. Additionally, two new medical faculties at the Weizmann Institute and the University of Haifa were recently approved and are expected to open in the coming years. According to the 2025 Economic Arrangements Law[11], there were 1,228 new medical students in Israel in the 2024 academic year, with plans to increase this number to 1,700 by 2027. The significant growth in recent years (Figure 7.8) and the planned increase in the coming years (according to the Economic Arrangements Law) are expected to largely mitigate the impact of the Yatziv Reform. However, as highlighted in several reports on the subject, there are additional factors emphasizing the need

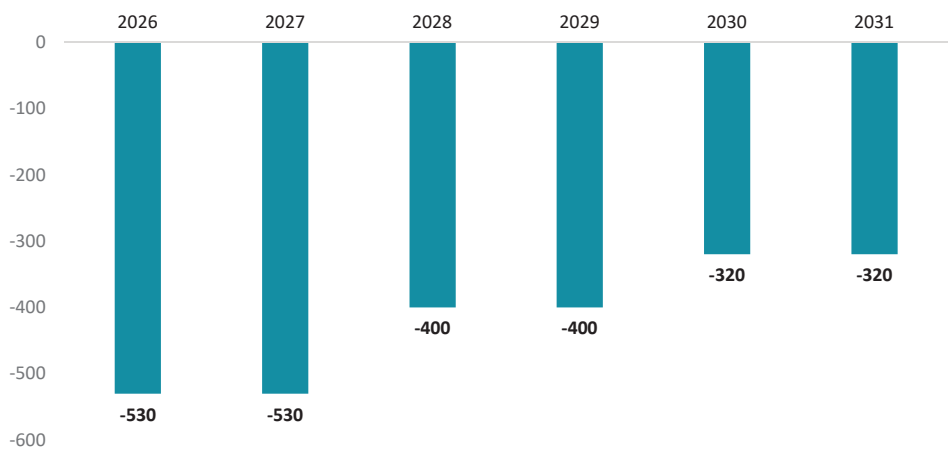
[9] The use of residence location (rather than workplace) is due to data limitations. Research published on the subject found that despite the possibility of commuting, there is a strong correlation between physicians' residence and workplace (Zontag, 2025).

[10] Programs include "Ilanot Tze'irim for Medicine," focusing on medical students from the periphery, "Northern and Southern Stars," encouraging outstanding residents to specialize in the periphery, and "Ofakim," providing conditional loans to Israelis studying medicine at quality faculties abroad, with plans to waive full or partial loan repayment for those who specialize in the periphery upon returning to Israel.

[11] One of the issues in the 2025 Economic Arrangements Law addresses steps to increase the number of physicians in Israel to address the expected shortage (at the time of writing, this issue in the Economic Arrangements Law has not yet been approved by the Knesset).

for measures to increase the number of physicians in Israel. These factors include population growth and aging, the age distribution of physicians in Israel indicating the expected retirement of many physicians in the coming years, the physician-to-population ratio, which is lower in Israel than the OECD average (3.48 compared to 3.7 in 2022), and other factors (Gamzu Committee Report, 2022; OECD, 2023). Additionally, it is important to review the program every few years and to update it according to various developments in the healthcare system. It should also be noted that there is a gap of several years between the expected impact of the reform (from 2026) and the maturation of most of the measures to increase the number of new physicians in Israel. This gap, illustrated in Figure 7.11, may create a temporary shortage in the coming years.

Figure 7.11 | Estimated Impact of the Yatziv Reform and Policy Measures to Increase the Number of Physicians in Israel on the number of New Physicians Expected, 2026–2031*



* The data in the Figure are based on the assumption that the reduction in the number of new physicians due to the reform will be about 600 per year.

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PART 3
THE LONG-TERM CARE INSURANCE CRISIS IN ISRAEL

» In most households where elderly individuals currently reside, the cost of long-term care, if needed, exceeds current income from wages, pensions, and allowances (including long-term care benefits) after deducting regular consumption expenses.

» Policy changes regarding eligibility for long-term care benefits and increased utilization of rights have doubled public spending on these benefits over the past decade to about 0.9 percent of GDP, an addition of approximately NIS 9 billion in 2024 terms.

» Changes related to eligibility and increased utilization in private long-term care insurance, held by more than half of the population, have increased claim payments. This issue is particularly challenging in group policies marketed through health funds, which are held by most policyholders. A significant concern about a prudential crisis in long-term care insurance necessitated stabilizing measures by the Capital Market, Insurance, and Savings Authority, which included reducing insurance coverage. However, these provided only a temporary solution.

1. INTRODUCTION

The rate of public expenditure on long-term care benefits doubled within a decade, while insurance company payouts for long-term care also grew.

In Israel, long-term care insurance consists of two tiers: public (first tier) and private (second) tier. The private tier is further divided into group insurance policies—marketed through health funds[1]—and individual insurance policies. In both the public and private tiers, claim payments to households have risen rapidly in recent years, driven by regulatory changes regarding eligibility and increased utilization of rights.

In the public tier, the National Insurance Institute's expenditure on long-term care benefits (which constitutes the majority of spending in this tier) doubled as a percentage of GDP between 2012 and 2024, reaching 0.9 percent of GDP (approximately NIS 18 billion). During roughly the same period, from 2012 to 2022, the proportion of the population aged 65 and over receiving long-term care benefits increased from 18 to 26 percent—a notable rise, especially since this rate remained stable (and even declined slightly between 2015 and 2018) from the early 2000s until 2018.

The crisis in private (group) long-term care insurance marketed by the health funds peaked at the end of 2024.

In the private tier, a significant problem with group long-term care insurance policies that had been developing in recent years due to a rapid increase in approved claims peaked in December 2024. Insurance companies, assessing an increased risk of the insured pool facing a future deficit, did not submit any proposal to renew the policy for members of the "Clalit" health fund—the largest among the long-term-care group policyholders.[2] This raised concerns that the "continuity clause" in the policy might need to be activated without renewal of the insurance. In such a scenario, the insurance company would be required to transfer policyholders to a continuation policy in a mutual insurance format, without new members joining, thereby deteriorating the rights of the insured.

The Capital Market, Insurance, and Savings Authority intervened in 2023–2024, tightening the conditions for recognizing insurance claims and reducing payouts.

The implementation of the continuity clause was postponed by two years (to the end of 2026) when, at the end of 2024, the Capital Market, Insurance, and Savings Authority's regulations came into effect. To prevent an immediate collapse of the insurance model, from 2024 onward the regulations also tightened the conditions for recognizing insurance claims, stipulated that after two years, insurance companies would no longer be required to include existing policyholders in a group continuation policy (if the insurance is not renewed for all policyholders in the existing policy), and drafted a clause to replace it. These are significant measures, because the long-term care insurance policies marketed by health funds are the only private policies available for new members in Israel, following the cessation of individual policy sales

[1] In the past, there were also group insurance policies offered through workplaces. These were discontinued in 2017, except for policies for IDF disabled veterans and retirees. Most of the policyholders from these workplace group policies transitioned to the group policies marketed by health funds. As a result, nearly all group insurance policies are now those marketed through the health funds.

[2] This occurred despite stabilizing measures implemented at the end of 2023, which partly included a 10 percent reduction in insurance benefits for policyholders receiving care at home. Details of these stabilizing measures can be found in the Regulatory Impact Assessment (RIA) report by the Capital Market, Insurance, and Savings Authority dated December 22, 2024 (in Hebrew).

in 2019 and the cancellation of group policies not through health funds, which were mostly purchased through employers, in 2017.

The reasons for the rapid increase in payments by the National Insurance Institute and insurance companies in both the public and private tiers, their importance for households, and suggested policy directions are outlined below.

2. LONG-TERM CARE SERVICES AND INSURANCE IN ISRAEL

The aging of the population is increasing the demand for more services for the elderly due to rising morbidity, which leads to cognitive decline and functional impairment—the prevalence of which significantly increases with age (Kedar, Davidovich, and Weiss, 2024). Long-term care spending is the fastest-growing public health expenditure in OECD countries, driven by three main factors: the aging process, rising service costs (particularly caregiver wages), and increased demand for higher quality services due to improved living standards (OECD, 2024). According to forecasts by the Israeli Central Bureau of Statistics, the proportion of those aged 65 and over in the population is expected to grow from about 12 percent in 2022 to about 14 percent in 2040, and the proportion of those aged 80 and over, who constitute about 57 percent of those eligible for first-tier payments, is expected to increase from about 3 percent in 2022 to about 5 percent in 2040. This process is expected to increase demand for long-term care services.

Most national long-term care expenditures in Israel are public, and these have grown rapidly.

Most long-term care services in Israel are provided in the community (rather than in institutions or nursing homes), reflecting the perception that aging at home or in one's social and family environment is preferable, both socially and health-wise.[3] The national expenditure on long-term care amounted to approximately NIS 24 billion in 2022 (about 1.25 percent of GDP, and continued to grow in the following two years), with about 70 percent being public expenditure and the rest private (Kedar, Davidovich, and Weiss, 2024).[4] A description of the entire long-term care service system can be found in Haran-Rosen, Cohen-Kovach, and Ramot-Nyska (2018).

Eligibility for long-term care benefits from the National Insurance Institute in the first insurance tier is subject to an income test and a functional ability examination.[5] The income test determines whether the benefit rate will be full, half, or zero, based on household income and composition (whether it is an individual or a couple). The level of the benefit is determined according to the degree of dependency as one of six levels, and assistance is provided for the duration of eligibility, which is not time-limited. In 2024, the distribution of beneficiaries and expenditures was as follows: about one-third received the benefit at the two lowest levels (16 percent of total

[3] The health benefits of community care are due to its potential contribution to slowing functional decline.

[4] National expenditure on long-term care is not officially published, so estimates must be relied upon. Haran-Rosen, Cohen-Kovach, and Ramot-Nyska (2018) estimated national long-term care expenditure in 2015 at about 1.2 percent of GDP, with about half being public expenditure.

[5] The income test includes income from labor, pensions, capital, and National Insurance allowances. For more details on the income and functional tests, see the National Insurance Institute (2024).

expenditure); about 40 percent received it at the two medium levels (42 percent of total expenditure); and slightly less than one-fifth (18 percent) received the benefit at the two highest levels (41 percent of total expenditure).

The number of holders of private long-term-care insurance policies (second tier) was over half of Israel's population at the end of 2023. Five million of the private long-term care policies were group policies, about 900,000 were individual policies, and some policyholders held both types. Nearly all group policies (about 4.9 million) were purchased through the health funds. These are structured as uniform group policies, whose terms are set, updated, and supervised by the Capital Market, Insurance, and Savings Authority. The policy terms are identical across health funds, with slight differences in pricing. The policies in the health funds provide a monthly payment of NIS 3,200–5,000 for community care and NIS 4,500–10,000 for institutional care, with payments limited to 5 years. Insurance payments are not income-dependent but are based on the client's age when joining the policy.[6]

3. THE ECONOMIC PROBLEM AT THE HOUSEHOLD LEVEL—THE COST OF COMMUNITY-BASED LONG-TERM CARE SERVICES RELATIVE TO INCOME

For the income deciles below the median, private expenditure on long-term care may be higher than disposable income.

Private expenditure on long-term care services can be very high relative to household income, especially for those requiring extensive assistance, and the funding issue is more severe for single-person households. We conducted a simulation[7] to examine the cost of long-term care relative to household income in a scenario where an elderly person employs a full-time home caregiver, whose assistance is needed for most of the day. This cost includes the caregiver's salary at the minimum wage level, with employment extending to weekends. The calculation also includes additional employment expenses, such as payments to the National Insurance Institute, mandatory pension contributions, and holiday pay. According to our estimates, this cost amounts to at least NIS 9,400 per month.

Based on our calculations, elderly individuals in households with incomes up to the fifth decile[8], as well as a small portion of those in the sixth decile (if they live alone) and most couple households up to the fifth decile, would be eligible for a full long-term care benefit. Those eligible for half the benefit include elderly individuals in the sixth to eighth deciles (and a few individuals in the ninth decile). According to reported incomes in the survey, elderly individuals in the ninth and tenth deciles would not be eligible for the benefit, nor would some couples in the eighth decile. It is important to note that income from current capital and asset returns may not be

[6] Payments decrease as the client's age upon joining the policy increases—in three tiers: those joining long-term care insurance up to age 49 receive the maximum payment, which decreases for those joining at ages 50–59, and decreases further for those joining at age 60 and above.

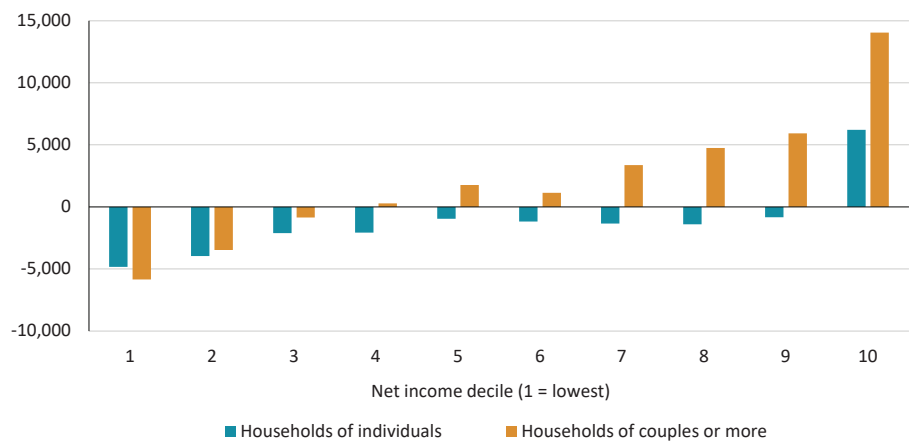
[7] The simulation was conducted using the Household Expenditure Surveys for 2019 (pre-COVID) and 2022, the latest year for which data are available. Calculations based on data from both years were necessary to avoid relying on a small number of observations.

[8] The decile division was conducted among households with at least one woman aged 62+ or one man aged 67+.

accurately reflected in the expenditure survey, and if so, actual income levels may be higher than reported. This affects eligibility for the benefit and the ability to bear long-term care expenses.

The cost (imputed, as outlined) of employing a full-time home caregiver exceeds the income of single-person households with below-median income, and for couples, the cost exceeds income only for households in the two lowest deciles.[9] However, considering household consumption expenditure and eligibility for long-term care benefits (assuming they receive one of the two highest benefit levels), only couple households in at least the fourth decile and single individuals in the tenth decile have sufficient current income to cover both consumption expenses and the cost of employing a caregiver. In some cases, the remaining current income is low (see Figure 7.12).[10] Therefore, noncurrent sources of funding, particularly long-term care benefits, are crucial for financing long-term care, along with private long-term care insurance payouts, savings, or family assistance in direct care or funding.

Figure 7.12 | Net Income Including Long-Term Care Benefits, and Excluding Private Insurance, Minus Consumption Expenditures and the Cost of Employing a Home Caregiver[a]
(NIS, 2022 prices)



[a] The cost of employing a caregiver assumes payment of minimum wage and employer's costs for pension, insurance, National Insurance, additional employer's costs, and an increment for weekend work. The long-term care benefit is the average benefit at Levels 5–6 that is added according to calculated eligibility rates.

SOURCE: Based on Central Bureau of Statistics Household Expenditure Surveys (2019, 2022).

[9] For calculating the expenditure burden, we assumed two types of households—single and couple—which form the basis for determining eligibility for long-term care benefits. We also assumed that the required expenditure on long-term care is the cost of employing a full-time home caregiver, assuming that households needing such extensive assistance would qualify for private insurance reimbursement if they hold such a policy. Long-term care benefits would also be available for less severe dependency.

[10] For the calculation, we attributed to households the long-term care benefit for which they would be eligible based on their income (full or partial benefit). The benefit used for the calculation is the average of levels 5–6.

4. THE LONG-TERM-CARE INSURANCE CRISIS

The increase in long-term care benefit payments resulted from policy changes, some legislated and others implemented through internal National Insurance Institute procedures.

Two components of national expenditure on long-term care have grown significantly in recent years: the National Insurance Institute's spending on long-term care benefits (the first tier) and insurance company claim payments (the second tier). These expenditures have increased at a faster rate than the growth of the elderly population and other age-related expenses (see Figure 7.13). Public benefit payments rose from about 0.5 percent of GDP in 2018 to about 0.9 percent of GDP in 2024, while private insurance payments increased from 0.2 percent of GDP to 0.3 percent of GDP over the same period.

The increase in long-term care benefit payments resulted from policy changes, some legislated and others implemented through internal National Insurance Institute procedures. These included the 2018 long-term care benefit reform and other developments: (1) Public criticism of the dependency assessment process (the ADL—Activities of Daily Living—assessment) led to legislative changes between 2008 and 2016, allowing dependency evaluation based on an examination by a physician chose by the applicant or medical documents reviewed with phone consultations (instead of physical assessments at the patient's home). Since the COVID-19 pandemic, this method has become the primary channel for determining functional eligibility for long-term care benefits. (2) Following the long-term-care benefits reform (2018), the option to receive all or part of the benefit in cash rather than in-kind services was expanded, aligning with trends in other countries (Tur-Sinai et al., 2021). (3) The utilization of rights increased due to the activities of private agencies and possibly due to policy changes within the reform regarding the reevaluation of applications following the deterioration of the elderly's condition, a reevaluation that in any case does not reduce benefits.

Insurance company payouts for long-term care increased in recent years, mainly for regulatory reasons, although other factors also contributed.

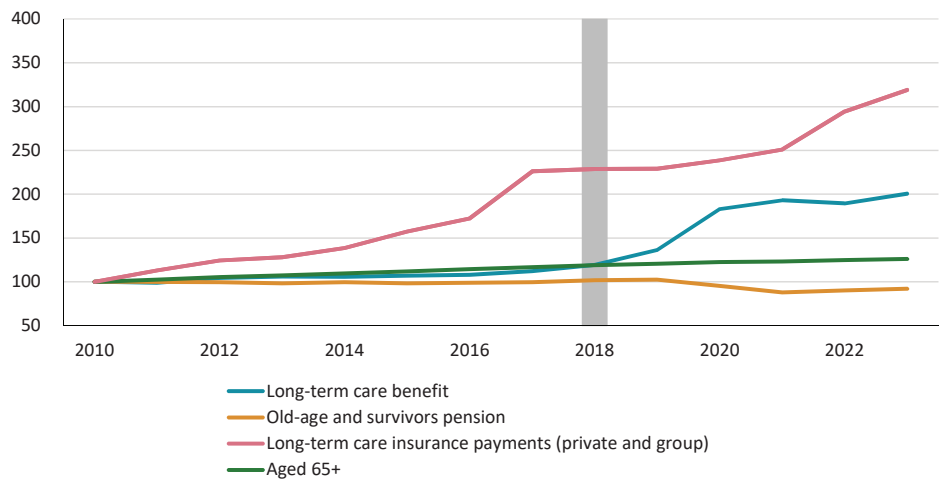
Regulatory changes also led to significant structural changes in the private long-term care insurance segment. The market share of group policies for health fund members grew after the Capital Market, Insurance, and Savings Authority instructed insurance companies to stop marketing group insurance other than through the health funds in 2017. These policies were canceled, and subsequently, in 2019, the sale of individual policies was also halted. Changes were also made in the claims approval process. In 2018, the Capital Market, Insurance, and Savings Authority instructed insurance companies[11] to recognize functional assessments conducted by another insurance company or the National Insurance Institute.[12] These assessments, as mentioned, were significantly eased, but this may have only partially influenced the increase in private insurance claim approvals, as insurance companies were allowed to require an additional functional assessment (which would be decisive for insurance purposes). Nonregulatory factors, such as the activities of rights

[11] Insurance Circular 2018-1-12 dated November 27, 2018, Capital Market, Insurance, and Savings Authority.

[12] The regulation stipulated that if the insurance company is not satisfied with assessments conducted by another entity, it must justify this and inform the policyholder of its considerations.

utilization agencies and increased life expectancy, likely also contributed to the rise in insurance payments (Capital Market, Insurance, and Savings Authority and the Budget Department, 2024). Due to the rapid increase in insurance expenditures, the directives were amended at the end of 2023 to stabilize group insurance funds by reducing insurance benefits by 10 percent for policyholders of all age groups receiving home care. At the end of 2024, the conditions for recognizing insurance claims were further tightened.

Figure 7.13 | **Public and Private Expenditures Related to Old Age and Those 65 and Over[a], 2010–2023** (index: 2010=100)



[a] The gray column denotes the start of implementation of the long-term care benefits reform. The expenditure variables are in percent of GDP

SOURCE: Based on National Insurance Institute, Central Bureau of Statistics, and Ministry of Finance.

5. POLICY DIRECTIONS

The extreme situation faced by Israel's private long-term care group insurance system is a result of the expanded recognition of long-term care insurance claims—a policy decision aimed at easing the burden on the elderly and their families. However, this has led to an actuarial problem. The measures taken at the end of 2024 to tighten the conditions for recognizing insurance claims in policies marketed to health fund members reflect an opposite approach: stabilizing the insurance by reducing policyholders' rights. However, this is only a temporary solution. The exacerbation of issues in private group insurance is also reflected in the increasing National Insurance Institute expenditure on long-term care.

In the absence of a further change in policy, public expenditures on long-term care benefits may reach 1.3 percent of GDP in 2040, compared with 0.9 percent of GDP currently.

According to our estimates, without further policy changes, if public spending on long-term care benefits grows in line with the population aged 65 and over, it will decline to about 0.8 percent of GDP by 2040. However, if it grows in line with the population aged 80 and over, who make up a larger share of beneficiaries, it will rise to 1.1 percent of GDP. If spending grows as it did on average from 2004 to 2018, before the reform that accelerated growth, it will reach 1.3 percent of GDP by 2040.[13] The current crisis necessitates examining the sustainability of existing models for funding long-term care services and determining eligibility to decide on actions to balance the actuarial situation of private (group) insurance and stabilize the National Insurance Institute's expenditure.

The sustainability of long-term care financing models and how eligibility for long-term care is determined in both tiers should be examined.

In the first tier, a key issue to reassess is the budgetary implications of the broad recognition (by the National Insurance Institute) of long-term care cases based on medical documents accompanied by phone calls rather than physical examinations. This recognition was central to recent policy changes and, alongside reducing the administrative burden on the public, likely contributed to increased benefit eligibility (and may also have contributed to some extent to the growth of private insurance, particularly group insurance). In recent years, several proposals have been made to change the first-tier long-term care benefit, some of which could lead to expenditure restraint, such as restructuring the benefit to become a deterioration prevention service benefit for levels 1–2, similar to the recommendation of the Committee for Preventing Functional Decline of Older Citizens in 2022. Additional steps that could help restrain long-term care benefit expenditure include financial incentives for the significant involvement of health funds in preventing functional decline in old age[14], changing the incentive structure for care companies to encourage them to prevent the deterioration of the elderly's condition, and examining the impact of rights utilization agencies.

Group insurance through the health funds achieved broad coverage of the population, and is very important.

Regarding the second tier (private), group insurance marketed through health funds has achieved very broad coverage of the population in Israel. However, due to the increased likelihood of claim recognition, as described above, concerns about its stability have grown. Given the broad coverage already existing for the population in Israel, a potential cancellation of long-term care insurance would significantly impact the funding and scope of services. Therefore, and due to the importance of these insurances, it is crucial to review and update the terms of group long-term care insurance in the next year or two, as stipulated by the Capital Market, Insurance, and Savings Authority. Alternatives to the current long-term-care insurance, if it turns out that insurance through the health funds is not sustainable, range from savings to individual or group insurance (mandatory or voluntary) policies. In examining possible

[13] These calculations are sensitive to assumptions about the growth rate of GDP in the coming years and the rate of expenditure growth. If GDP growth is lower, or expenditure grows rapidly, as it has in recent years, expenditure as a share of GDP will increase at a higher rate.

[14] This topic is discussed extensively by Horev, Kedar, and Hershkovitz (2011), as well as in the report by the Ministry of Welfare and Social Security, the National Insurance Institute, and the Ministry of Health (2022).

solutions, various aspects must be considered, including the following: mandatory insurance (progressive) already exists within the National Insurance framework, and its expansion is equivalent to raising taxes (due to the weak link between individual payments and accrued rights), while subsidizing the working-age population that works less. Mandatory savings could be similar in nature to existing mandatory pension savings, but a compulsory increase in it works against households' choice to smooth consumption over their lifetime. This option should be considered in view of the pension savings already accumulated by households. Furthermore, since a long-term care event is probabilistic, a model encouraging private savings for such an event would require individuals to allocate more from their current income than a model that distributes the risk among policyholders. Another essential issue to discuss is determining the eligibility conditions for activating insurance or consuming savings.

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