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SUMMARY

The population of Israel has increased almost six-fold since 1948, mainly as a result of immigration. The population is relatively young compared to those of other countries in the WHO European Region.

Life expectancy at birth in Israel was 76.6 years in 1992, which was close to the average of that of the European Union (EU). Male life expectancy was 74.7 years, the third highest among a reference group of 20 European countries1. In marked contrast, female life expectancy was 78.5 years and ranked sixteenth among these countries and well below the EU average of 80.0 years. Therefore, the difference in life expectancy between men and women is the smallest of the 20 reference countries. This pattern, of mortality for men being generally among the lowest and that for women among the highest of the reference countries, is also observed for all the main causes of death.

Infant mortality declined by 37% between 1982 and 1992, but remained the second highest among the reference countries. In 1993, however, the rate fell from 9.1 to 7.8 per 1000 live births.

The standardized death rate (SDR) for cardiovascular diseases in the group aged 0–64 was close to the average of the EU in 1992. The SDRs for ischaemic heart disease were the fifth highest of the reference countries for women but the eighth lowest for men. The SDRs for cerebrovascular disease in people aged 0–64 were close to the EU average for females, and below the average for males. For both these diseases, the SDRs for both men and women declined sharply between 1982 and 1992.

The SDR for cancer in people aged 0–64 was one of the lowest of the European reference countries. The overall cancer rate for men was the lowest among these countries, and the rate for women was close to the EU average. SDRs for external causes were below the EU average for men and close to the average for women. For suicide, Israeli males have a lower rate than the EU average (although it showed one of the biggest increases over the past 10 years – 43%) while the rate for females was closer to the average.

At the national level, health promotion programs have gained impetus during the last few years, and those emphasizing physical activity are increasing in popularity. The percentage of smokers in the population aged over 20 declined from 38% in 1973 to 31% in 1992. The decrease was greater in women. A number of new laws restricting smoking in public places and workplaces have recently been implemented. Alcohol consumption was the lowest among the reference countries in 1993. About 5.2% of the Jewish population aged over 18 used an illicit drug in 1992. A national anti-drug authority has been set up to supervise measures against illicit drug use.

People aged 20–74 who were on medication or special diets for the treatment of hypertension comprised 8.5% of the population. The prevalence of high serum cholesterol (equal to or greater than 240 mg/dl) in the working population aged 20–64 years was found to be 18.3%. Overweight is estimated to affect about 25% of the working population. Since the 1950s, the intake per head of total calories, fat, animal fat and protein has increased. The level of leisure-time physical activity in the population is low, and about 20% of people aged 14 years and over participated in such activity at least once a week.

Control of the environment is the joint responsibility of the Ministry of Health and the Ministry of Environment. The population’s awareness of environmental issues is growing, and air and water pollution are key issues.

Health care reform was recently initiated, and comprises three main components: the National Health Insurance Law, the withdrawal of the government from health care provision and the reorganization of the Ministry of Health. Health expenditure has continued to rise as a percentage of the gross domestic product, reaching 8.2% in 1993.

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1The 15 member states of the European Union (EU) plus Iceland, Israel, Malta, Norway, Switzerland.
The Country and Its People

Israel is a democracy with a one-chamber parliament, the Knesset. The 120 members of the Knesset are directly elected by the population aged 18 years and over, every four years. The government is elected by the Knesset and should have its support. The head of the State is the President, who has a representative role and is elected by the Knesset every five years. Local government is organized into three kinds of elected local authorities: 50 municipalities, 145 local councils and 57 regional councils for agricultural areas.

Demographic trends

In 1993 the population of Israel was 5,261,400, almost six times its size (805,000) at the establishment of the State in 1948. Both migration and natural increase determined this growth. Immigration was greater in the first years of the State; smaller, but still considerable immigration has continued. Jewish immigrants have come to Israel from all over the world. The last wave of immigration occurred in 1990–1993. The increase in the total population averaged 1.8% per year in 1983–1989 and 4.0% in 1990–1993.

The population density increased from 106 inhabitants per km2 in 1960 to 242 in 1993, and the urban population has risen from 85% to 91% of the total population during the last three decades.

During the last wave of immigration, the arrival of 539,900 new immigrants increased the resident population by 12%. Of these immigrants, 462,800 were from the former USSR and 28,700 from Ethiopia. In 1990–1993, the Jewish population had an average growth rate of 3.9% per year, of which immigration accounted for 69%. In contrast, only 8% of the annual increase of 1.5% was due to immigration in 1983–1989. For the non-Jewish population, immigration accounted for 26% of the overall increase of 4.2% per year in 1990–1993, but only 2.0% of the overall increase of 3% per year in 1983–1989.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population growth (%)</th>
<th>Migration balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Jews</td>
</tr>
<tr>
<td>1975</td>
<td>2.1</td>
<td>1.8</td>
</tr>
<tr>
<td>1980</td>
<td>2.2</td>
<td>2.0</td>
</tr>
<tr>
<td>1984</td>
<td>2.0</td>
<td>1.7</td>
</tr>
<tr>
<td>1987</td>
<td>1.7</td>
<td>1.5</td>
</tr>
<tr>
<td>1990</td>
<td>5.7</td>
<td>6.2</td>
</tr>
<tr>
<td>1991</td>
<td>4.9</td>
<td>5.0</td>
</tr>
<tr>
<td>1992</td>
<td>2.7</td>
<td>2.4</td>
</tr>
<tr>
<td>1993</td>
<td>2.5</td>
<td>2.2</td>
</tr>
<tr>
<td>1983–1989</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td>1990–1993</td>
<td>4.0</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Source: CBS, Statistical abstract of Israel
The natural increase in the non-Jewish population is nearly double that of the Jewish population, owing to high birth rates (the rates were 34.0 and 18.5 live births per 1000 population in 1993, respectively) and a low crude death rate owing to a younger age structure. In 1993, people under 15 comprised 40% of the non-Jewish population and 28% of the Jewish population; the figures for people 65 and over were 3% and 11%, respectively.

Although fertility rates are much higher among the Moslems and Druze than the Jews, the difference is considerably less than it was two or three decades ago. Fertility in Christians has fallen to a point close to the minimum required for generation replacement. In 1993, 112 000 live births were registered in Israel, of which 70% were in the Jewish population.
The population of Israel has become younger since 1970 and remains one of the youngest in the European Region, with marked differences between the age structure of the Jewish and non-Jewish populations. Nevertheless, the proportion of children under 15 years declined from 36% of the population in the 1960s to 30% in 1993. The proportion of people aged 65 and over nearly doubled from 5.0% in 1960 to 9.5% in 1993. The dependency ratio (the ratio of the population aged 0–14 years and 65 and over to the population aged 15–64 years) decreased from 41.8% in 1980 to 39.3% in 1993.

During the last decade, the group aged 35–45, the main age group of the labour force, grew by 63%. The other age groups, such as people aged 15–17 and the very old (75 and over), also increased significantly (40% and 53%, respectively).

The numbers of men and women among the elderly in Israel have been almost the same. By the year 2000, however, men are expected to comprise 42% of the elderly and women, 58% of the elderly and 60% of the very old.

### Ethnic profile

The population is extremely heterogeneous in ethnic origin and sociocultural background. The Jewish population constitutes the large majority: 81% in 1993. Most was Israeli born (61% in 1993 compared to 37% in 1960) and the rest was born in Europe or America (25% compared to 35% in 1960) and in Asia or Africa (14% compared to 28% in 1960). The non-Jewish population comprises Moslems and Christians, as well as a sizable Druze population.

### Household composition and family structure

Since 1960, the marriage rate has considerably decreased, falling from 7.8 per 1000 population in 1960 to 6.4 in 1993. Young people (mainly Jews) show a tendency to delay marriage. People aged 15 and over who never married comprised 33% of the population at the end of 1992, compared to 31% in 1983. The divorce rate was 1.3 per 1000 population in 1993, rising from 1.0 in 1960. The percentage of women who are divorced is almost twice as high as that of men, because men are more likely to remarry. The general fertility rate declined from 111.4 per 1000 women aged 15–44 in 1960 to 85.4 in 1993.

In 1993, families with children under 17 years comprised 54% of the 1 404 200 households, 10% of which were headed by single parents (8.7% in 1985). One-person households accounted for 15% of the total, 55% of this group was elderly. The
percentage of elderly people living alone increased from 41% in 1983 to 45% in 1993. These findings, however, do not necessarily indicate a lessening of family support. A national survey of the elderly, conducted in 1985, showed that more than 80% had children whom they saw at least once a week. Only 4% had children whom they saw less often than once a month.

The average household size was 3.6 people in 1993 (3.9 in 1961).

**Linguistic and education structure**

Israel is a multilingual society. The two official languages are Hebrew and Arabic. Other languages are widely spoken: English, French, Russian, Spanish and Yiddish. Hebrew is the language necessary for integration in the labour force and other areas of life.

Education is compulsory until age 16. The educational level of the Israeli population has steadily increased. The proportion of people with at least a basic education has increased from 65.3% to 85.3% over the last 30 years. Illiteracy has practically disappeared among younger age groups, although it still exists in a small proportion of the elderly, mainly among women.

In 1993, 18% of people aged over 15 were university graduates; the corresponding figure for women was 17%. Women comprised 54% of university students in 1992/1993, compared to 36% in 1964/1965. The general trend has been towards a more educated population. In 1993 the median number of years of formal education was 11.8, compared to 10.7 in 1980 and 8.8 in 1970.

**Economy**

The gross domestic product (GDP) at constant prices rose by 3.5% in 1993, in contrast to the relatively high growth rate of 6.5% in each of the previous three years. Between 1989 and 1993, the accumulated growth of the GDP reached 24%. During this period the population grew by 16%, so that the GDP per head rose by 7% in 1989–1993: nearly 2% per year.

Private consumption per head was 14% higher in 1993 than in 1989, with 3% growth per year. According to family expenditure surveys, the share of health expenditure in total expenditure increased from 5.3% in 1987 to 7.1% in 1993. This rise resulted from a combination of a high increase in prices and a high real increase in expenditure on health. The drop in the share of the food group on the one hand, and the rise in that of health group and education, culture and entertainment group on the other, are recognized occurrences in the process of a rise in the standard of living.

Immigration to Israel since 1990 raised the proportion of the population aged 15 years and over that was in the civilian labour force from 52% in 1992 to 54% in 1994. In general, women and old people have had more trouble finding jobs. To help overcome this disparity, many immigrants have attended special occupational training or retraining courses. The percentage of unemployed people among the civilian labour force was relatively high in the first years of the last wave of immigration and reached 11.2% in 1992. It decreased to 7.8% in 1994 and 6.3% in the middle of 1995: the lowest rate since 1989. The percentage of married women in the civilian labour force rose to 50.2% in 1993 from 41.6% in 1983.

The majority of the labour force is employed in the services sector (67%); 29% is in manufacturing and 4% in agriculture.

**Economic indicators, 1993 and 1994**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>1993</th>
<th>1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per head</td>
<td>US $12 205</td>
<td>US $13 644</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>10.0%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Inflation rate</td>
<td>11.2%</td>
<td>13.8%</td>
</tr>
</tbody>
</table>

Source: CBS, Statistical abstract of Israel
Many aspects of the health status of Israel’s population have improved in the last ten years, as illustrated by the chart showing Israel’s ranking for selected indicators among 20 countries of the European Region.

Seven indicators showed improvements between 1980 and 1992: life expectancy at birth and standardized death rates (SDRs) for cardiovascular diseases in general, ischaemic heart disease and cerebrovascular diseases in particular, all cancer, cancer of the trachea, bronchus and lung, and traffic accidents. Five indicators showed deterioration during this period; Israel still had high rates of infant and maternal mortality, and death from breast cancer. Mortality due to suicide and self-inflicted injury, external causes and cancer of the cervix also deteriorated, but remained under the average for the European Union (EU). The male/female difference in life expectancy at birth remained the lowest among the 20 countries. This is a matter of concern, since Israel’s ranking for female life expectancy was markedly worse than that for male life expectancy.

\[\text{Note: a) Lowest value observed among 20 European countries.} \]
\[\text{b) Highest value observed among 20 European countries.} \]
\[\text{c) 3 years moving averages.} \]
\[\text{d) SDR: Standardized death rate.} \]
Life expectancy

In 1992, life expectancy at birth was 76.6 years in Israel, which was close to the EU average. Life expectancy for men (74.7 years in 1992) ranked third among the reference countries, higher than the EU average. In contrast, female life expectancy (78.5 years) ranked sixteenth, well below the EU average of 80.0 years. Life expectancy at 65 years was 15.5 years for men and 17.6 years for women, with ranks similar to those for life expectancy at birth. Overall, life expectancy increased by a total of 3.3%, similar to the EU average (3.1%). During this period, the gain was slightly higher for women (3.4%) than men (3.2%).
The difference in life expectancy between males and females in Israel (3.8 years) remained lower than the EU average (6.8 years). The relatively low life expectancy for Israeli women has not been explained, although it appears to be related to relatively high mortality from cardiovascular diseases and breast cancer.

**Main causes of death**

Total age-adjusted mortality rates for population aged 0–64 years were lower in Israel than the EU average, although the male mortality rate was substantially lower and the female rate was substantially higher than this average. The age-adjusted mortality rate declined 18%, putting Israel in seventh place among the reference countries.

In males and females aged 1–34 years, the most common cause of death was external causes. Cardiovascular diseases were the most common cause in men aged 35 years and over, and in women aged 65 and over. For women aged 35–64, cancer was the most common cause of death.

Some outstanding features are evident. For both men and women, Israel has consistently high values for the category other diseases, which covers a large variety of causes including unknown or undefined symptoms and signs. In females and males aged 1–14 years, Israel has high rates for several categories, such as diseases of the digestive and nervous systems. Israeli women had the fifth highest death rate for cardiovascular diseases, a high rate for respiratory diseases for the group aged 35–64, and high rates for most categories in the group aged 65 and over. For men, the SDRs for these causes were low or close to the EU average.

<table>
<thead>
<tr>
<th>Cause</th>
<th>0–14</th>
<th>15–34</th>
<th>35–64</th>
<th>65+</th>
<th>0–14</th>
<th>15–34</th>
<th>35–64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular diseases</td>
<td>4</td>
<td>3</td>
<td>11</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Cancer</td>
<td>14</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>10</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>External causes</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>14</td>
<td>16</td>
<td>1</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Digestive diseases</td>
<td>9</td>
<td>7</td>
<td>10</td>
<td>3</td>
<td>18</td>
<td>11</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Nervous diseases</td>
<td>19</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>13</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>3</td>
<td>10</td>
<td>15</td>
<td>17</td>
<td>3</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>14</td>
<td>17</td>
<td>18</td>
<td>17</td>
<td>15</td>
<td>19</td>
<td>18</td>
</tr>
</tbody>
</table>
The charts below show age- and sex-specific death rates for the main causes of death in Israel in 1992. These SDRs are compared with the lowest corresponding rate observed in any of the reference countries, which can thus be considered as a reference value potentially attainable by the other countries. The sum of these minima, however, has to be considered as an artificial value which is sensitive to different national coding practices or coding errors. The dashed lines show the smallest overall SDRs observed in any one reference country.
Cardiovascular diseases

In Israel, the SDR for cardiovascular diseases in the group aged 0–64 was close to the EU average. The SDR for ischaemic heart disease in women was the fifth highest, while that for men was eighth lowest. The SDRs for cerebrovascular disease were close to the EU average in females aged 0–64, and below the average for males.

The SDR for ischaemic heart disease for the group aged 0–64 declined by 44% between 1982 and 1992, a decline of about 4% per year. The decline was 46% among females, the highest recorded among the reference countries, and 43% for males, the fourth highest. The SDR for cerebrovascular disease declined by 34% in males aged 0–64, which was close to the EU average, and by 51% in females, which was the highest recorded.

### Distribution of deaths (%) by cause, gender and age, 1992

<table>
<thead>
<tr>
<th>Cause</th>
<th>Males aged</th>
<th>Females aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular diseases</td>
<td>1.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Cancer</td>
<td>15.2</td>
<td>8.3</td>
</tr>
<tr>
<td>External causes</td>
<td>29.4</td>
<td>56.4</td>
</tr>
<tr>
<td>Congenital anomalies</td>
<td>8.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>3.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Other</td>
<td>42.2</td>
<td>28.4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Cancer

Israel’s SDR for cancer in people aged 0–64 was one of the lowest of the reference countries. The overall cancer rate for the male population was the lowest. SDRs for females were now close to the EU average. Lung cancer accounted for 20% of all cancer deaths in males, with SDRs similar to those observed at the end of the 1970s. For males up to the age of 64, SDRs for all cancers decreased substantially between 1970 and 1980, but remained stable in the 1980s. The SDR for breast cancer in females (21%)...
did not change between the end of the 1970s and 1992. This rate was the sixth highest among the reference countries, while the rates for uterine and lung cancer were among the lowest.

**External causes of death and injury**

The category of external causes covers all non-natural deaths that are due to accidents, poisoning, violent acts (homicide) and suicide. For all these causes, Israeli SDRs for all ages were below the EU average for males and close to the average for females in the last two decades. Although road traffic accidents are perceived as a major problem, in 1993...
Israel had the lowest SDR for this cause for females and the third lowest for males. Like most other countries, Israel had much higher rates for males (9.8 per 100,000) than for females (3.7) in 1992. For suicide, Israeli males had lower rates than the EU average, whereas those for females were closer to the average. Nevertheless, the rates for males showed one of the biggest increases (43%) of the last decade (see the Psychosocial and mental health).

**Psychosocial and mental health**

In recent years, the direct admissions rate from the community to psychiatric hospitals in Israel has been 2.7 per 1000 population, and 0.7 for first admissions. About two thirds of the patients are chronically ill, and hospitalized for more than one year. In 1993, people who had attempted suicide in the previous three months comprised 10% of admissions to psychiatric hospitals.
Public ambulatory mental health clinics have an annual utilization rate of 19 patients per 1000 population. A survey on the use of these services conducted in 1986 revealed high rates among single men and women, as well as divorced people. One third of the clinic population was diagnosed with psychotic disorders, mostly schizophrenia; 4% of clinic users acknowledged a suicide attempt in the previous six months.

At present, suicide rates are higher for men (13.0 per 100 000) than women (4.6). In the last 10 years, the suicide rate for women decreased by 2.2% while that for men increased by 43.6%. Both remained lower than the EU average. While women are twice as likely as men to attempt suicide, men are much more likely to succeed.

**AIDS**

Israel had the lowest rate of newly reported AIDS cases per 100 000 population and year among the 19 European countries. As of the end of October 1994, the number of AIDS cases diagnosed was 307 (a cumulative incidence of 6.1 per 100 000 population) 90% of which were in males; 73% of these patients were known to have died. Known cases of HIV numbered 1209. AIDS cases were distributed among homosexuals (40%), intravenous drug users (19%) and blood recipients, mostly people with haemophilia (14%). Most of the homosexuals and drug users with AIDS were infected outside Israel; haemophiliacs were infected by imported factor VIII concentrates before routine testing of blood donations began. Counselling and voluntary testing are available at some sites at no charge.
Disability

In 1993, the National Insurance Institute (NII) paid disability pensions to 1.6% of the total population, and benefits to 0.4% of the people aged 0–18. The Ministry of Defence pays the disability pensions for people disabled during military service.

During the past few years, special emphasis has been placed on developing services for disabled infants and children (aged 0–6). Diagnostic and treatment services were developed, and daycare centres and kindergartens established. The trend in policy has been to keep disabled children within their natural family setting and the regular school system. Training programmes and job placement services were set up for disabled people capable of entering the labour force.

Health of children and adolescents

The differences in the infant mortality rates in the EU have decreased by almost 35% over the last 10 years. For Israel, the infant mortality rate declined by 37% between 1982 and 1992, but remained the second highest among the reference countries: 9.1 per 1000 live births in 1992, compared to the EU average of 6.8. In 1993, however, the rate fell to 7.8 per 1000 live births. Nevertheless, the gap between the Jewish and the other population groups has not narrowed. The infant mortality among non-Jews (12.8) in 1993 was still more than twice that of Jews (5.7). The highest infant death rate is among babies with low birth weights (less than 2.5 kg): 77.7 deaths per 1000 births on average in 1992. In 1993, 7.4% of babies had birth weights under 2.5 kg.

The major causes of death in the group aged 1–14 are external causes (31%), cancer (14%) and congenital anomalies (8%). Israel is among the countries with high SDRs for diseases of the digestive system for boys aged under 15, and diseases of the respiratory system for girls, and for diseases of the nervous and sensory systems for both sexes.

Israel’s routine immunization schedule is amongst the most comprehensive in the western world. In 1993, coverage at age 2 years was 91% for diphtheria, tetanus and pertussis (DTP), 93% for oral (live attenuated, “Sabin”) polio vaccine and enhanced inactivated (“Salk”) polio vaccine, and 93% for measles, mumps and rubella (MMR). Coverage was slightly higher for non-Jews than Jews, although pockets of lower coverage exist in both groups. Limited outbreaks of pertussis, measles and rubella occur from time to time. Universal immunization of the newborn was instituted against hepatitis B in 1992, and against invasive Haemophilus influenzae type B in 1994.
In 1992, 4.2% of births in Israel were to women under 20 years of age. Of these, 7.1% were births to those who had not married. During the past few years, the rates of adolescent girls who apply for permission for termination of pregnancy have declined slightly. Close to 98% of these applications are approved, compared to an approval rate of 95% for all ages.

Health of women

On average, women live longer than men and have lower mortality rates for all causes of death. During the last 10 years, the female age-adjusted mortality rates in Israel decreased by 19%, which is close to the EU average. Female mortality levels vary greatly in the European Region. Of particular concern are the relatively high mortality rates and low life expectancy of women in Israel. As mentioned, the two main contributors appear to be cardiovascular diseases and cancer of the breast. Israeli women had the fourth highest position for mortality from cardiovascular diseases among the reference countries (38 deaths per 100 000 in contrast to the EU average of 32) and heart disease (15 deaths per 100 000 in contrast to the EU average of 12). Cancer of the breast is frequent among Israeli women (21.5 per 100 000 in contrast to the EU average of 19.8). Although the mortality rate for cervical cancer showed the highest rise of the last 10 years (46%), it remained one of the lowest (1.2 per 100 000).

In 1992, the maternal death rate was 5.45 per 100 000 live births. The Israeli moving average for the maternal death rate increased between 1979–1980 and 1990–1992; the rate for 1990–1992 was the ninth lowest among the reference countries. As to mortality from homicide and purposeful injury, Israeli women were ranked close to the EU average.

Hip fractures are common in elderly people. In 1987, two women for each man aged over 70 years were hospitalized in consequence of a hip fracture.

Most adult women in Israel have access to a range of modern contraceptive methods. A survey conducted in 1988 showed that 70% of married Jewish women used one of these, including the contraceptive pill (19%) and an IUD (38%). In 1992 the rate of termination of pregnancy was 13.7 per 1000 women aged 15–44, a slight decrease from 1989 (15.6). The maximum rate of applications to boards for termination of pregnancy was 20.5 per 1000 among women aged 25–34. About 60% of applications came from married women.
During the past few years awareness has increased of the need to help women who are subjected to violence in the family in particular and in society in general. In 1993, 2398 women approached the rape crisis centres for practical assistance. The centres use a non-judgmental, woman-to-woman approach. Currently six shelters exist for battered wives. The length of stay is about 3–6 months.
LIFESTYLE

Many of the established risk factors for disease are associated with various facets of lifestyle. Numerous health education and health promotion programmes have been instituted to improve the population’s health-related behaviour. In some areas, legislation and the creation of new organizational structures have accompanied these programmes. The major activities have focused on risk factors associated with the more common chronic diseases, such as cardiovascular diseases and cancer. Since no national health surveys have been carried out in Israel, the prevalence figures presented are based on estimates from various epidemiological studies and surveys on the use of health services.

Blood pressure

High blood pressure is one of the strongest risk factors for both coronary heart disease and cerebrovascular disease. According to the national survey on the use of health services in 1993, 8.5% of the population aged 20–74 (7.2% for men and 9.7% for women) was on medication or special diets for the treatment of hypertension. In a large study of the working population aged 20–64 years in 1985–1989, the prevalence of hypertension (defined as a blood pressure equal to or exceeding 160 mmHg systolic or 95 mmHg diastolic or the use of anti-hypertensive medication) was 11.0% in the group aged 20–64 years (12.2% for men and 8.3% for women). Various programmes, in both the community and workplace, for the early detection of hypertension have greatly increased the awareness and treatment of this condition.

Serum cholesterol

The study of the working population found the prevalence of high serum cholesterol (defined as a level equal to or greater than 240 mg/dl) to be 18.3% (20.1% in men and 13.5% in women). Community studies reach similar estimates. The prevalence of serum cholesterol of 260 mg/dl or more was 10.2% for men and 7.0% for women. Various bodies implement programmes for the early detection of high serum cholesterol, and the awareness and management of the condition have greatly increased.

Overweight

As in many other countries, the prevalence of overweight in Israel is high. Defining overweight as a body mass index over 28, the study on the working population estimated about 25.3% to be overweight (24.7% of men and 26.9% of women).

Overweight, high blood pressure and high serum cholesterol are closely associated with age, and the prevalence of all three could exceed 50% in people aged over 64 years.

Physical activity

The level of leisure-time physical activity in the Israeli population is low. In the study of the working population, about 14% reported participating in such activity more than once per week. Health promotion programmes emphasizing leisure-time physical activity are increasing in popularity. In the national survey of time utilization and lifestyle in Israel, conducted in 1991/1992, 20% of the population aged 14 years and over participated in such activity more
than once per week (24.6% of males and 16.5% of females). This percentage is higher among young people (38%) than adults (19%).

**Nutrition**

Since the 1950s, the intake per head of total calories, total fat, animal fat and protein has increased. In 1992, animal fat consumption was 42.6 g per head per day and the proportion of energy derived from total fat was 36.3%. The annual consumption of chocolate, sweets and jam per head rose from 7.8 kg in 1970 to 9.6 kg in 1990. The levels of the consumption of cereals (low) and sugar (high) are similar to those in northern European countries. The levels of the consumption of vegetables and fruits are high and similar to those in southern European countries.

In 1994, new legislation was approved to regulate the labelling of nutritional information on packaged food products (total calories, fat and saturated fat, nitrates, cholesterol, etc. per 100 g). The implementation of this legislation has been coordinated with a countrywide health promotion programme on nutrition; it addresses a wide range of groups (schoolchildren, pregnant women, young families and mature and elderly adults).

*Remark: Fat of animal origin includes that in meat, fish, eggs and dairy products.*

**Changing proportions of main dietary components in total calorie intake 1949/50–1990**

<table>
<thead>
<tr>
<th>Year</th>
<th>Carbohydrate</th>
<th>Protein</th>
<th>Other fat</th>
<th>Animal fat</th>
</tr>
</thead>
<tbody>
<tr>
<td>1949/50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1959/60</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1969/70</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1979/80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: CBS, Statistical abstract of Israel*

**Changing patterns of food consumption in Europe, 1970–1990**

- **Cereals**
- **Animal fats**
- **Vegetables and fruits**
- **Sugar**


- **NORTH**: Denmark, Finland, Iceland, Norway, Sweden.
- **SOUTH**: Greece, Italy, Portugal, Spain.
**Alcohol consumption**

Alcohol consumption is very low. In 1993, Israel had the lowest alcohol consumption of 19 countries of the European Region. In surveys, about 40% of the adult population reported drinking an alcoholic beverage at least once a week. The figure for teenagers is estimated to be 20%. Surveys indicate that alcohol consumption is more frequent among lower social strata and particularly among illicit drug users. In 1992, the average consumption of alcoholic beverages was 11 litres per head for beer, 5 litres for wine and 1 litre for spirits. Beer is the most popular alcoholic beverage with teenagers.

In 1994, the number of in-patient beds available for alcohol detoxification was 38, an increase of 10 from the previous year.

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**Tobacco consumption**

The percentage of smokers in the population aged over 20, declined from 38% (41% for men and 36% for women) in 1973 to 31% in 1992. The decrease is greater in women (25% in 1992). A number of new laws, restricting smoking in public places and workplaces, were recently implemented.

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![Percentage of smokers in the population by sex, 1973–1992](chart)

Source: Israel Institute of Applied Social Research, 1992

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![Annual alcohol consumption, litres of pure alcohol per head, 1992](chart)


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![Percentage change over the last ten years](chart)
**Health promotion**

On the national level, health promotion has gained impetus during the last few years. The Ministry of Health set up a steering committee that determines policy and priorities in the funding of new projects. The budget is currently invested in operating intervention projects. The following describes some of the major activities.

The sub-district health offices operate projects by the family health centres on subjects such as nutrition and accident prevention. They organize health fairs and conduct training courses for young people, young mothers and the elderly. In 1994, 5 community recreation centres began health promotion programmes, and another 15 are anticipated to participate. The programmes deal with subjects as nutrition, physical activity, etc. and their target populations include both the people who visit the centres, and other groups in the community, such as workers.

The Israel Defense Force is conducting a project on the “healthy military base”. Career soldiers undergo medical examinations and participate in workshops on healthy nutrition habits, physical activity and smoking cessation. The project is evaluated by means of a control group.

The General Sick Fund operates projects on healthy nutrition, mainly in workplaces and among young people. A town in the south of the country was chosen for a community intervention project. The activities address various groups, including young people, adults, elderly people and workers. All the activities are coordinated through the local health authority.

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**Illicit drug use**

A national anti-drug authority, with representation from relevant government agencies, has been set up to supervise measures against illicit drug use. The authority’s functions include initiating policy in the fields of prevention, information, education, treatment, rehabilitation and law enforcement.

In the past three years, the capacity for treating illicit drug abusers has been substantially expanded. In 1992, 28 trained physicians were assigned to work in over 50 localities. At present, 85 beds are available for in-patient detoxification. Seven rehabilitation day centres were opened for follow-up treatment of detoxified drug addicts, as well as seven regional methadone maintenance centres. The treatment component of all existing maintenance centres has been significantly augmented.

According to a survey by the anti-drug authority, 5.2% of the Jewish population aged over 18 used an illicit drug in 1992. The percentage of illicit drug use is lower among adult women (5.9% in 1989 and 4.9 % in 1992) than men (7.3% in 1989 and 5.4% in 1992). The survey showed a decrease in the percentage of illicit drug use in all age groups from 1989 to 1992.

In 1992, the police investigated 6581 case files related to the use of dangerous drugs and 3529 case files related to drug trafficking.
ENVIRONMENT AND HEALTH

Control of the environment in Israel is the joint responsibility of the Ministries of Health and of the Environment.

Waste disposal and recycling

In 1992, the total quantity of waste produced in the country was 3.1 million tonnes, and it has increased at an annual rate of 2%. Each person in Israel produces about 1.6 kg solid waste a day. In a country with meager land resources on the one hand, and ever-increasing quantities of refuse on the other, sound management of solid waste is imperative.

Within the next three years most of the country’s small garbage dumps will be closed. They will be replaced by sites that will be converted into central landfills, including one for the metropolitan area of Tel Aviv.

The cost of solid waste disposal is expected to increase. Recycling can be an economical solution for part of the problem. Today, 6% of domestic waste is recycled. The total percentage is higher, owing to recycling during the production process. The goal is to recycle 25% of waste by the year 2000.

Regulations require that all hazardous waste be properly treated, recycled or deposited at one site. In 1993, 48 500 tonnes of hazardous waste reached this site. The current site endangers the groundwater and rivers, so a new site is planned.

Water and sanitation

Almost all households in Israel (99.8%) are connected to the water supply network. About two thirds of the water in Israel is pumped from the Sea of Galilee and the aquifer. Water from the Sea of Galilee is transported to the south of the country by means of the national water system; a new filtration procedure is planned. Flood waters are used to replenish the aquifer. Nearly half of the population (43%) receives fluoridated water and an effort is being made to extend the fluoridation to the entire population.

Wastewater from households, agriculture and industry may pollute the water sources. As water is so scarce, considerable efforts are made to prevent such pollution, and effluents are recycled for secondary use. Administrative authorities have been established to control the contamination of groundwater and rivers by effluents, and to promote the restoration of the rivers. Increased awareness has resulted in improvements in existing water treatment plants and in the planning of new plants that conform to the new standards on effluents. Investment in these plants has been extensive in recent years. The main use of treated effluents is in agriculture. Standards of effluent quality are strictly kept to prevent threats to health and damage to crops.

Water for domestic use is inspected and tested for bacteria in compliance with national standards, and according to the recommendations of WHO. In the past few years, the quality of water in Israel has substantially improved. In 1993, only 4% of all test results indicated a possibility of contamination. Fuel disposal and agricultural procedures may cause additional contamination of water. Water is tested for various chemicals, according to the established standards, which are constantly updated.
Most households dispose of sewage through a central sewage system. Some small settlements use septic tanks and cesspools, but they are gradually being linked to the central sewage system.

**Air pollution**

The main sources of air pollution are energy production, transport and industry. Israel’s air quality policy is based on the following elements: prevention of air pollution through the integration of environmental considerations and physical planning, monitoring and intermittent control systems, legislation and enforcement (including ambient and emission standards), the reduction of pollution sources, and the reduction of pollutant emissions from motor vehicles. According to this policy a new programme for the control of air quality was completed in 1994.

Israel’s energy economy is based on fossil fuels, mainly oil and coal. Data on the amount of pollutants emitted into the atmosphere from fuel combustion show significant declines in levels of sulfur oxides and lead, increased emissions of carbon dioxide, carbon monoxide, nitrogen oxides and hydrocarbons, and no significant change in concentrations of suspended particulate matter.

In 1994, 63 air monitoring stations were operating in Israel. All of them monitor sulfur dioxide. Nitrogen oxides and particulate matter are monitored in most, and ozone and/or carbon monoxide in a few. A new network monitors airborne chemicals at the hazardous waste disposal site. The limited information available indicates that sulfur dioxide levels are mostly below regulation limits, nitrogen dioxide is significantly above the limits in some areas, and ozone levels are mostly above the recommended limits.

The monitoring network, as it is today, is not comprehensive enough for formulating a national air quality management programme. Consequently Israel has recently prepared a preliminary programme for a multimillion-dollar national air monitoring system with a central data storage and display centre. The national system will be based on three levels of activity: individual stations, regional control centres and a national data processing centre. The types of station will vary according to the nature of the pollutants. Some 50 stations are planned, in addition to the 63 stations currently in operation. The project will be implemented over a three-year period.

**Farmland contamination**

Three major groups of pollutants endanger farmland: fertilizers, heavy metals, and pesticide and other organic additives.

Modern agriculture requires the use of large amounts of fertilizers. Overuse or improper management result in soil pollution, mostly with nitrates. The pollution of drinking-water sources by nitrates leaching from farmland soil has been already observed, and the accumulation of nitrates in edible crops is an obvious danger.

The main source of heavy metals in farmland is irrigation with polluted water or application of contaminated solid additives. The high pH value in soil in Israel reduces the danger of plant uptake of and water contamination by heavy metals.

The use of pesticides imposes an obvious danger of toxic traces remaining on edible crops, and poses a risk to farmers. Residues in soil may reach water sources or be taken up by crops or other members of the soil biota, thus reaching the food chain.

**Food control**

The Food Administration of the Ministry of Health is responsible for control of food quality. Its functions include: the approval and supervision of food production plants, preparation of procedural guidelines, training of food professionals and preparation of legislation.

**Housing**

In 1993, about 70% of the population owned its housing, the figure for the most recent immigrants, who arrived in 1992, was 18%. The average number of people per room was estimated at 1.1 for the total...
population and 1.3 for the new immigrants. The number of homeless is estimated at less than 1000. A government programme combines government guarantees to the bank system and direct subsides to newly married couples, new immigrants and other persons who need help in obtaining housing.

**Occupational health**

Occupational health in Israel is under the supervision of the Ministry of Labour and Welfare. Its main activities include monitoring workplaces for the enforcement of labour laws, and providing training and guidance on occupational safety and hygiene. The occupational medicine departments of the various sickness funds are responsible for pre-employment medical examinations, periodic medical check-ups for workers exposed to hazards in the workplace, evaluation of the suitability of workers to particular jobs and recommendations for rehabilitation of workers following illness or injury. Worker compensation is paid by the NII.

In all medium-size and large industrial plants, environmental surveillance for occupational hazards is carried out according to international standards

During 1993, 86 400 people (4.9% of all employees, a rise from 4.4% in 1991) were recognized as injured in work-related accidents and paid benefits under the National Insurance Law. This corresponds to a rate of 1642 per 100 000 population. Most (94%) of these accidents were due to external causes. In 1993, males comprised 82% of the injured employees but only 61% of the employee population. In 1994, 65 people died as a result of work-related accidents was, a rate of 1.23 per 100 000 population.

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**Occupational accident death rates per 100 000 population and total number, 1991–1993**

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of fatal accidents</th>
<th>Deaths per 100 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>2660</td>
<td>2.66</td>
</tr>
<tr>
<td>Italy</td>
<td>1937</td>
<td>1.93</td>
</tr>
<tr>
<td>Spain</td>
<td>1116</td>
<td>1.11</td>
</tr>
<tr>
<td>EU</td>
<td>7949</td>
<td>0.79</td>
</tr>
<tr>
<td>Austria</td>
<td>171</td>
<td>0.17</td>
</tr>
<tr>
<td>France</td>
<td>1082</td>
<td>1.08</td>
</tr>
<tr>
<td>Switzerland</td>
<td>130</td>
<td>0.13</td>
</tr>
<tr>
<td>Ireland</td>
<td>64</td>
<td>0.06</td>
</tr>
<tr>
<td>Portugal</td>
<td>168</td>
<td>0.17</td>
</tr>
<tr>
<td>Luxembour</td>
<td>18</td>
<td>0.02</td>
</tr>
<tr>
<td>Norway</td>
<td>61</td>
<td>0.06</td>
</tr>
<tr>
<td>Belgium</td>
<td>138</td>
<td>0.14</td>
</tr>
<tr>
<td>Finland</td>
<td>64</td>
<td>0.06</td>
</tr>
<tr>
<td>Israel</td>
<td>65</td>
<td>0.07</td>
</tr>
<tr>
<td>Denmark</td>
<td>61</td>
<td>0.06</td>
</tr>
<tr>
<td>Sweden</td>
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<tr>
<td>Greece</td>
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<td>0.09</td>
</tr>
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<td>Malta</td>
<td>1</td>
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<tr>
<td>United Kingdom</td>
<td>258</td>
<td>0.26</td>
</tr>
<tr>
<td>Netherlands</td>
<td>43</td>
<td>0.04</td>
</tr>
</tbody>
</table>

* Territorial boundaries before 3/10/90

*Source: ILO 1994*
HEALTH SYSTEM AND HEALTH SERVICES

Health care reform

The health care system in Israel is now in the midst of a long process of reform in both concepts and services. This process began recently, after many years of political and professional debate, and comprises three main components:

• the National Health Insurance Law

• the withdrawal of the government from health care provision

• the reorganization of the Ministry of Health.

In June 1994, the Knesset passed a National Health Insurance Law that went into effect in January 1995. It made the provision of health services the responsibility of the central government. Under the new Law, all residents of Israel must be insured by one of the authorized sickness funds that operate in the country. The funds must provide the basic package of services defined by the Law. The NII handles the centralized collection of health insurance premiums and allocates resources to the various sickness funds according to a capitation formula. Every insured person has the right to choose his or her sickness fund. Each fund is obliged to accept any resident of Israel as an insured member, regardless of age or physical or mental condition.

The Ministry of Health owns and operates hospitals: 23% of the general hospitals, 50% of the mental hospitals and 4% of the geriatric hospitals. The remainder are non-profit or profit-making institutions. In the new system, the government hospitals will become self-financing non-profit institutions. The Ministry of Health will continue to supervise and control hospitals, but not to run them.

The Ministry will no longer be responsible for the day-to-day operation of health services. All its functions will focus on policy-making, long-term planning, the setting of standards, quality control and quality assurance, and the collection and evaluation of essential data. The reorganization of the Ministry of Health has resulted in the establishment of new departments such as those dealing with the issues of standards.

Health expenditure and financing

In 1993, health expenditure on was 8.1% of GDP, the highest rate in recent years; this figure was 7.8% in 1992 and 7.4% in 1988. The expenditure per head in 1993 was 2% higher than in 1989, before the recent wave of immigration. The expenditure on health per head reached an average of US $940 per year in 1990–1991. The chart below shows a comparison of health expenditure as percentage of the GDP in Israel with that of some countries in the Organisation for Economic Co-operation and Development (OECD) in 1992.

In 1993, households financed 52% of national expenditure on health, including health insurance premiums and out-of-pocket fees, compared to 32% in 1984. This rise was due to an increase in premiums and fees. Households’ payment to sickness funds comprised 12% of health expenditure in 1984 and 25% in 1993. The reduction in the proportion of health care costs funded from general taxation has put an increasing burden on households. Out-of-pocket fees paid by households to purchase medicines and medical services provided by private physicians, clinics and dentists accounted for 20% of health expenditure in 1984 and 27% in 1993. Government financing decreased from 52% of national
Expenditure on health in 1984 to 44% in 1993. This financing includes the parallel tax, which accounted for 22% of the health expenditure in 1984 and 24% in 1993.

Expenditure on hospitals continues to take up the principal part of health expenditure. This percentage rose continuously until 1980, when it reached 47% of current expenditure. A decreasing trend began in 1980; in 1992 expenditure on hospitals reached the level of 42%. Expenditure on community clinics and preventive medicine has remained constant for the last decade, hovering at 33% and increasing to 35% at the beginning of the 1990s.

In 1992, the current cost per day of hospitalization rose 4% more than the rise in the consumer price index. This rise was especially notable in general hospitals; expenditure on them is 4.5 times that on hospitals for the mentally and chronically ill.

**Out-patient health care**

At the community level, primary health care is given in the following locations:

- sickness fund clinics
- hospital out-patient clinics and emergency rooms
- private clinics
- family health centres, which provide preventive health services.

In general, the sickness funds operate primary health care in Israel. Each fund organizes the ambulatory services through its clinics and physicians, or by
purchasing services. Payments from the membership cover most of health services, including out-patient and in-patient services and medicines. Each person is free to choose any physician, general practitioner or specialist affiliated to the sickness fund. Usually, an affiliated physician does not receive fees per visit by the patient, but a salary or reimbursement from the sickness fund.

The national survey on the use of health services, conducted in the first quarter of 1993, showed that 83% of the most recent visits to a family practitioner took place at sickness fund clinics, 12% at private clinics and 3% at hospital outpatient clinics or emergency rooms. For visits to specialists, 61% of patients attended sickness fund clinics, 21% attended hospital outpatient clinics or emergency rooms and 16% went to private clinics.

In the first quarter of 1993, there was an average of 2.5 visits per person to a physician (1.9 visits to a family practitioner and 0.6 visits to a specialist). The numbers of visits for infants (0–4 years) and elderly people (aged 65 and over) were higher (4.3 and 5.1 visits, respectively) than for other groups. In the same period, there were an average of 0.6 visits per person to dentists and 0.3 visits to nurses. Women and girls visited physicians more often (2.8 visits) than men and boys (2.2); this difference was greatest among those aged 15–44 (women made two thirds more visits).

Family health centres are operated by the government, local authorities or sickness funds, according to an agreed geographical division. Israel has a network of these centres throughout the country. About 1000 are located in urban areas, and a public health care nurse visits small and peripheral localities at least once every two weeks. The services provided consist of physicians’ examinations, developmental examinations, monitoring of breastfeeding, vaccination and the provision of guidance and advice to mothers.

Local authorities are responsible for the provision of health care services for schoolchildren; the funding comes from parents.

**In-patient health care**

In 1990, the main causes of hospitalization were: complications of pregnancy, childbirth and puerperium (18%); cardiovascular diseases (14%); symptoms, signs and ill-defined conditions (10%); diseases of the digestive system (7%); diseases of the respiratory system (7%); diseases of the genitourinary system (7%); injury and poisoning (6%); cancer (5%) and other (26%).

Of the total number of hospital beds in 1993, 40% were for short-term care, 36% for geriatric care, 22% for psychiatric care and 2% for rehabilitation. (The corresponding distribution in 1970 was: 47%, 18%, 33% and 2%.) Between 1970 and 1993 general hospital beds declined from 3.24 to 2.43 per 1000 population. Geriatric beds rose from 20 per 1000 people aged 65 and over in 1988 to 23 in 1993. For psychiatric care, the number of beds fell from 1.6 per 1000 population in 1988 to 1.3 in 1993.

In 1993, the bed occupancy rate was 92% for short-stay hospitals, 88% for psychiatric hospitals and 96% for geriatric institutions.

The average length of stay was 4.7 days in general wards, 134.5 days in psychiatric wards and 170.3 days in long-term wards. The average length of stay in short-stay wards has fallen from 9.5 to 4.7 days over the last three decades.

In 1993, more than 1 million discharges from general hospitals were recorded. The rate of discharges was 171 per 1000 population. This rate has substantially increased from 122.1 in 1968.
Medical personnel

At the end of 1993, there were, on average, 4.6 physicians and 1.3 dentists per 1000 population. Among the physicians, 9193 (38%) are specialists and among the dentists 412 (6%). The proportion of specialists is higher in urban areas. At the end of 1993, about 22% of physicians and dentists were immigrants who arrived in 1989–1993 and received licences to practice in Israel.
REFERENCES


Central Bureau of Statistics (CBS):

- Statistical abstract of Israel (1994 and selected years).


Ministry of Labor and Social Affairs, Demographic Center. The population of Israel (1994).

Ministry of Health, Hospitalization institutions and day-care units in Israel 1993 (1994).


The source for all data used in the charts is – unless otherwise mentioned – the HFA-Database (WHO Regional Office for Europe).
METHODOLOGICAL REMARKS

Highlights on Health provide an overview of the country’s situation as regards the population’s health and the main factors related to it. Based on international comparisons, they present a summary assessment of the strengths and weaknesses, of what has been achieved so far and what could be improved in the future.

To make the comparisons as valid as possible, data for each indicator have been taken from one common international source (e.g. WHO, OECD, International Labour Office) or from Eurostat (the Statistical Office of the European Communities), whenever possible, to ensure that the data have been harmonized in one consistent way. It should also be noted that other factors such as culture and language can at times potentially influence the data.

A special case of comparison is when each country is given a rank order. Although useful as a summary measure, ranks can be misleading and should be interpreted with caution especially if used only by themselves, as they are sensitive to small differences in the value of an indicator. Also, when used to give an assessment of trends (e.g. the table at start of Health Status section) ranks can hide quite important changes on the level of an individual country. Therefore, we have also used bar charts (when changes over a relatively short period are shown) or line charts, which show time trends from 1970 on. Line charts present the trends for all the reference countries and the EU average, although only the country referred to in a specific “Highlights” (in this case Israel) and the EU average are identified. This enables the country’s evolution to be followed in relation to that of other countries and to recognise how it performs in relation to observable clusters and/or the main trend.

Where relevant for trend comparisons and where possible, data for Germany up to 1990 refer to the Federal Republic in its current territorial boundaries.

Unless otherwise mentioned the source of all data used in the charts is the WHO Regional Office for Europe’s HFA statistical database.
**Cardiovascular diseases (CVD):** all diseases of the circulatory system, including coronary heart disease and cerebrovascular diseases.

**Dependency ratio:** The ratio of the population defined as dependent (those under 15 and those over 64 years of life) to the working-age population, aged 15–64 years.

**Incidence:** the rate of new cases of a disease occurring in a population during a period (usually per year and 100 000 population).

**Infant mortality rate (IMR):** the yearly number of deaths of children aged less than one year per 1000 live births.

**Life expectancy at birth:** An estimate of the average number of years a newborn can expect to live provided that the prevailing age-specific patterns of mortality at the time of birth were to stay the same throughout the child’s life.

**Prevalence:** the rate of all cases of a disease or of people with a risk factor counted in a population in a given time or period.

**Purchasing power parity (PPP):** method of standardization of a country’s currency exchange rate, based on a comparison of the number of units of that currency required to purchase the same representative basket of goods and services in a reference country and its currency (usually US$).

**Standardized death rate (SDR):** a death rate (usually per 100 000 population) adjusted to the age structure of a standard European population.

**Total fertility rate (TFR):** the average number of children that would be born alive per woman during her lifetime, if she were to bear children at each age in accord with prevailing age-specific birth rates.