Private Expenditures on Healthcare in Israel

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Abstract

This chapter examines two aspects of household private expenditure on healthcare: out-of-pocket expenditures and premiums for supplementary and commercial insurance. The average monthly household private expenditure on healthcare is NIS 906 (2014 prices), which is 5.9 percent of the average net monetary income of households, compared to 3.9 percent of income in 1997. Out-of-pocket spending including copayments, supplementary care (primarily dental care), parallel treatments to those available through the public system, as well as the purchase of goods and services (like eyeglasses) amounts to 61 percent of the total household private expenditure on healthcare. The rest (39 percent) is spent on health insurance.

Household income is linked to all the components of private expenditure except for copayments. The burden of spending (the level of expenditure on healthcare relative to net income) lessens as household income rises. The total monthly expenditure on private medical services is 9.7 percent of disposable monetary income in the lowest income quintile and 4.7 percent for the highest income quintile. When the influence of various socio-demographic variables are controlled for, expenditure on supplementary insurance, and particularly on copayments, is related to household size (in standardized persons.)

Expenditure on supplementary treatments, not included in the public health basket (primarily dental care), and on parallel treatments to those available through public care, is higher in places where the availability of public services is lower. This is particularly true in the Arab Israeli sector, and to some extent in the Haredi (ultra-Orthodox) sector. Expenditure on insurance, particularly supplementary, stems from benefit considerations: those who purchase them have higher relative needs (the elderly), and stand to benefit from increased accessibility and use of these services. In addition, copayments for treatments in public healthcare are particularly high for weaker populations and the elderly. All of these factors create gaps in accessibility within the public sector healthcare system.

Introduction

National health expenditures can be divided into two categories: public spending, financed by the state, and private spending, financed by citizens, directly out-of-pocket or through insurance. Private expenditures on health services are commonly seen as an expression of individual consumer freedom of choice. At the same time, this spending is susceptible to the failings of the free market in health insurance and medical services. Furthermore, private spending contributes to increased inequality and social disparities, particularly given the association between poor health and poverty (Arrow, 1963). Due to these effects and the perception that healthcare cannot be regarded as a good based exclusively on free-market rules, there is relatively heavy public involvement in healthcare systems in welfare states.

Israel's National Health Insurance Law, enacted in 1995, is intended to ensure universal access to quality medical services. However, in the years since its enactment, and particularly since the Economic Arrangements Law of 1997, the share of the public budget used to fund the healthcare system has decreased while the share of the private budget has increased. This process is reflected in the data presented in Figure 1. Per capita public spending on health rose from NIS 4,819 (in 2014 prices) in 1995 to NIS 6,377 in 2014, with an average annual increase of some 1.3 percent. In contrast, private spending rose during the same period from a total of NIS 2,247 (in 2014 prices) to NIS 3,634, an average annual increase of 2.6 percent — in other words, twice the rate of growth in public spending. As noted in the introduction to the health section in this volume, real expenditures on healthcare per standardized person are lower than the figures presented here, which are per capita figures, because of demographic changes in the makeup of the population and changes in the price of healthcare in relation to the price of other goods and services.

Figure 1. Per capita expenditure on healthcare
By funding, in 2014 prices, NIS
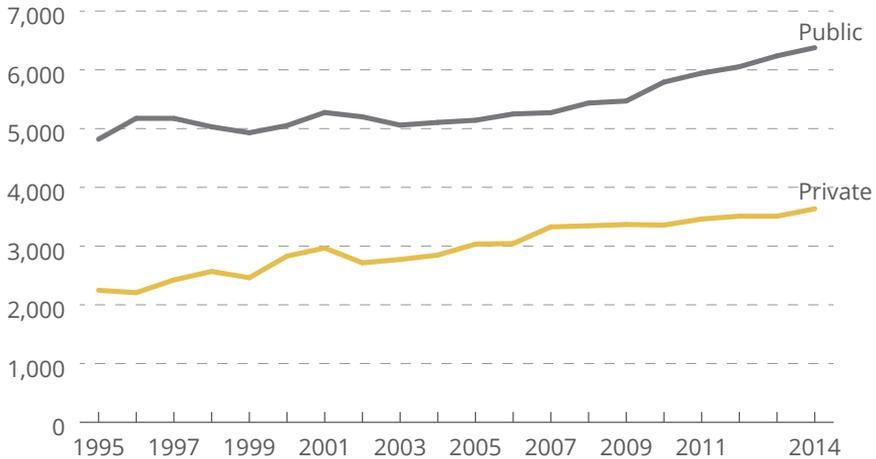
Source: Dov Chernichovsky, Haim Bleikh and Eitan Regev, Taub Center.
Data: Central Bureau of Statistics, *Statistical Abstract of Israel 2016.*

Figure 2. Share of monthly expenditure on healthcare
As a percent of household monetary disposable income
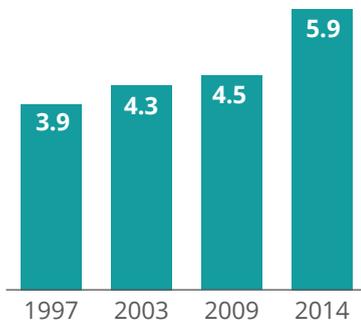
Source: Guy Navon and Dov Chernichovsky, Bank of Israel (2012), updated.
Data: Central Bureau of Statistics, Expenditure Survey.

As the share of public spending has declined, the weight of private spending in the average household budget has increased, from 3.9 percent in 1997 to 5.9 percent in 2014 (Figure 2).

This chapter will examine the structure of private healthcare spending in Israel and analyze changes in the level of this spending according to several socioeconomic household variables. The data come from a sample of 8,261 households from the Central Bureau of Statistics survey of family expenditures for 2014. Our goal is to examine the impact of this spending on equality and access to medical services and the implications for the public healthcare system's functioning.

This chapter extends previous work on this subject (Chernichovsky, 2007; Navon and Chernichovsky, 2013).

1. The components of private spending on healthcare

Navon and Chernichovsky (2013) and Chernichovsky (forthcoming) divide private spending into two basic components: direct, out-of-pocket expenditures and health insurance. Direct, out-of-pocket expenses for medical services are further classified into four main categories:

1. **Copayments**. Expenditures required for individuals to exercise a right or public entitlement. These are not determined by an individual's decision but, rather, by the doctors (though, of course, every person has the right not to purchase the treatment or medication offered, even though they are covered by the public health system). It is customary to exempt low-income groups from these expenses (Chernichovsky, 2013).

2. **Supplementary goods and services**. Expenditures that supplement the services included in the public health basket, such as dental care for adults in Israel. For budgetary and other reasons, these services or treatments are not included in the public healthcare system. However, since the public has an interest in them, in various countries there is a tendency to recognize these expenditures, or expenditures on insurance for them, for tax credit purposes.

3. **Parallel goods and services**. Expenditures for services, such as privately funded elective surgery, that are similar to services partially or fully funded by the public services. These expenditures, when necessary, are liable to present a serious problem because the public health system is perceived negatively and, as a result, citizens choose a private service, something they see as unavoidable. The problem is even more serious when the choice is based on the recommendation of the publicly funded service provider, which refers a patient to privately funded treatment. This is not uncommon in Israel.

4. **Consumption services and goods**. Expenditures for health-related services that are not considered medical (such as hygiene products) and that are not subsidized.

There are three types of health insurance in Israel:

- **Supplementary group insurance** (additional health services or "Shaban"). This insurance is provided by the four health funds (HMOs) overseeing the provision of entitled care in Israel. It is considered semi-private because the health funds are obligated to insure every person without underwriting, and cannot set a personal premium but must charge a set premium for each age group.

- **Commercial insurance**. This refers to personal insurance or insurance through an employer, which in most cases requires a declaration of health status and an individualized process to determine the premium.

- **Group dental insurance and long-term care insurance**. These are generally offered to people working for large employers.

The various kinds of private spending, based on data from the survey, are shown in Appendix Table 1.

Breakdown of expenditures among components

Total average monthly private household spending on healthcare is NIS 906, which, as noted, is about 5.9 percent of the average net household monetary income. The proportion of out-of-pocket expenditures (on supplementary and parallel services, consumption goods, and copayments) out of total healthcare spending is 61 percent, and the remainder (39 percent) is devoted to insurance payments (Figure 3).

Figure 3. Distribution (percent) of private expenditure on healthcare, 2014

Including monthly average household expenditure

Long-term, dental, other
NIS 43

Parallel
NIS 49

Copayments
NIS 91

Commercial insurance
NIS 101

Consumption
NIS 135

Supplemental treatments
NIS 257

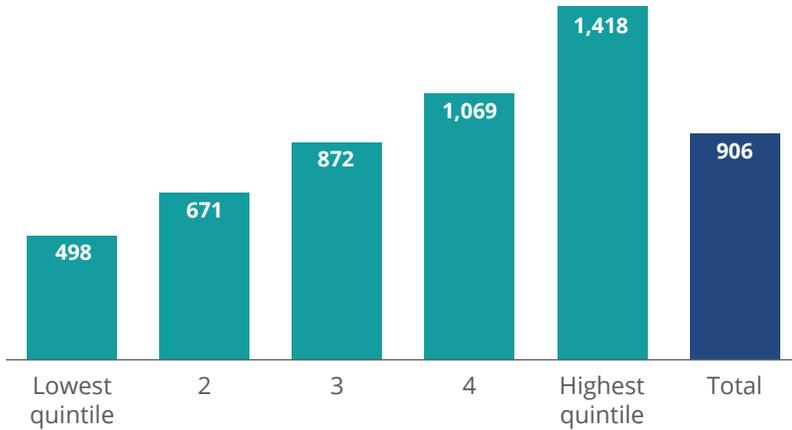Supplementary insurance
NIS 193

6 5
10
30
12
15 22
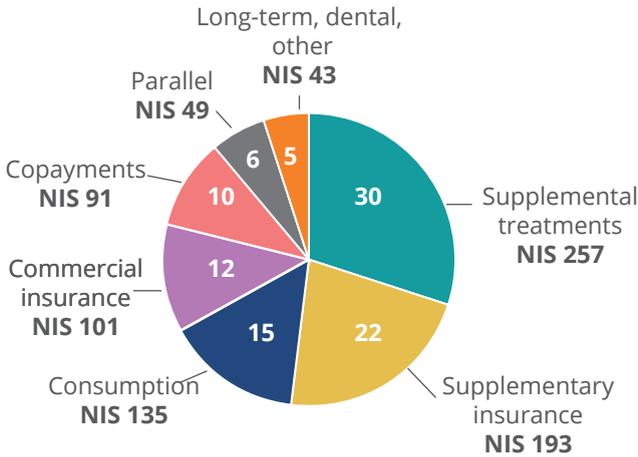
Source: Dov Chernichovsky, Haim Bleikh and Eitan Regev.
Data: Central Bureau of Statistics, Expenditure Survey.

The most significant out-of-pocket expenditure is for supplementary care, which accounts for 30 percent of total private spending. Copayments make up 10 percent and parallel care only about 6 percent. Spending on supplementary insurance constitutes 22 percent of total private expenditures and spending on commercial insurance is 12 percent.

2. Breakdown of household spending on healthcare

As expected, private spending on medical services increases with income (Figure 4). Households in the highest income quintile spend an average of NIS 1,418 a month on private medical services, while households in the lowest income quintile spend about one-third of this amount (an average of NIS 498 per month).

Figure 4. Average monthly expenditure on healthcare, 2014
By household income quintile, NIS

Household income quintile is calculated by monetary disposable income per standardized person. Source: Dov Chernichovsky, Haim Bleikh and Eitan Regev, Taub Center.
Data: Central Bureau of Statistics, Expenditure Survey.

As Figure 5 shows, the dominant item in direct, out-of-pocket expenditures is supplementary medical services — an average of NIS 257. Next are consumption services (NIS 134), copayments (NIS 91), and parallel medical services (NIS 49).

Figure 5. Average monthly out-of-pocket expenditures on healthcare services, 2014

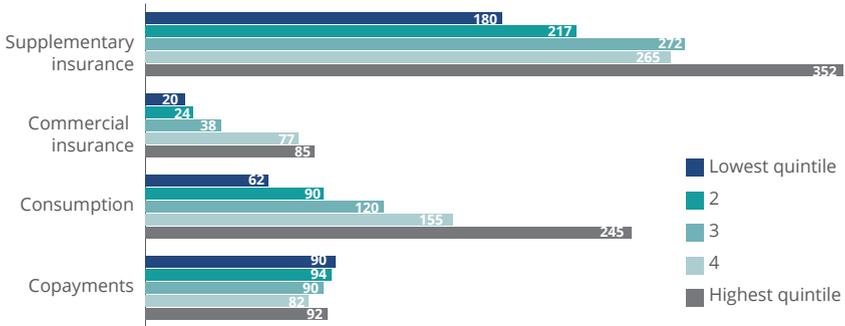**By household income quintile and type of expenditure, NIS**

Household income quintile is calculated by monetary disposable income per standardized person.
Source: Dov Chernichovsky, Haim Bleikh and Eitan Regev, Taub Center.
Data: Central Bureau of Statistics, Expenditure Survey.

The breakdown of expenditures differs significantly among the different quintiles. The expenditure most affected by income level is supplementary medical services, which is primarily dental care. In contrast, spending on copayments is hardly affected by income level. These figures mean that private spending contributes to widening the gaps between the health services enjoyed by each quintile.

The amount spent on copayments is almost equal in all households, meaning that the relative burden is greater among lower-income households, since the expenditures are a greater proportion of their income. At the same time, the disparities in the purchase of supplementary services show that most of the public does not seem to consider publicly funded services to be sufficient, and that individuals who can afford to pay privately to receive similar services do so.

Average spending on supplementary insurance is NIS 193 a month, and on private commercial insurance, NIS 101 (Figure 6). The standard deviation by income quintile is larger for commercial insurance than supplementary insurance (76.3 and 59.7, respectively); this figure indicates that income

level has a greater influence on spending for commercial insurance than supplementary insurance provided by the health funds. In fact,

supplementary insurance, which is held by about 80 percent of households, appears to be the norm, while the distribution of commercial insurance is about half that (40 percent) (Chernichovsky and Bowers, 2016).

Figure 6. Average monthly expenditure on health insurance, 2014

By household income quintile and type of insurance, NIS
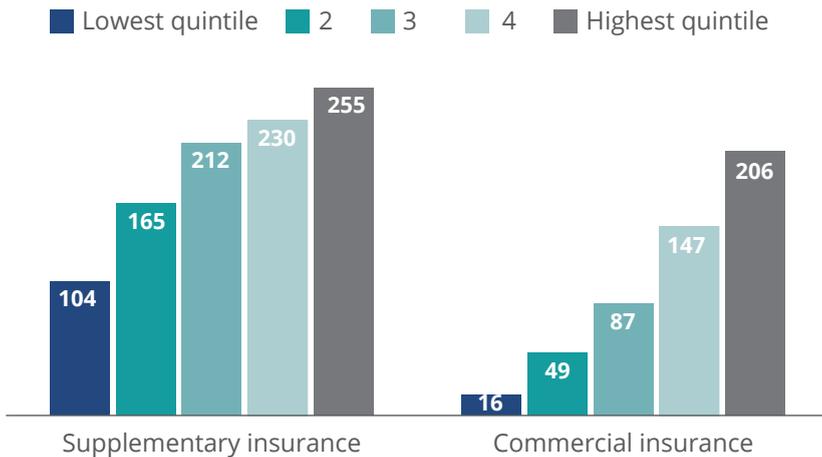
Household income quintile is calculated by monetary disposable income per standardized person.
Source: Dov Chernichovsky, Haim Bleikh and Eitan Regev, Taub Center.
Data: Central Bureau of Statistics, Expenditure Survey.

As expected, low-income households have the highest expenditure burden (the percentage of disposable household income used for the various components of private expenditures on healthcare). This declines as income rises (Figure 7). For the lowest income quintile, the total monthly expenditure on private health services is 9.7 percent of total monetary disposable income, compared with 4.7 percent for the highest quintile. In this context, what stands out is the relatively high spending burden for copayments, which are a necessary expense for patients wishing to exercise their right to healthcare through the public health system: some 2 percent of disposable income for the lowest quintile compared with some 0.3 percent for the highest.

Figure 7. Share of household expenditure on healthcare, 2014

As a percent of disposable monetary income, by household income quintile and type of expenditure
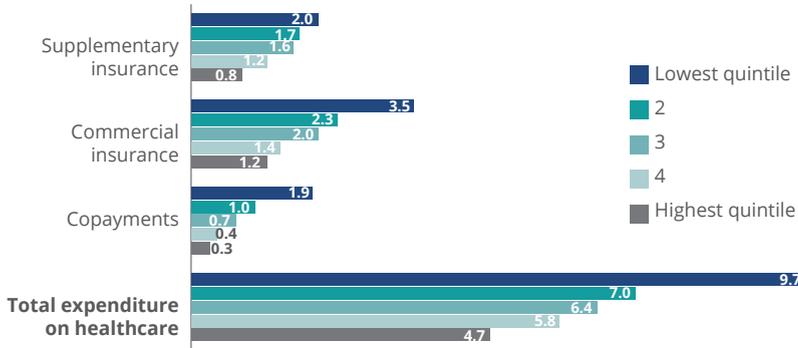
Household income quintile is calculated by monetary disposable income per standardized person.
The overall burden is not equal to the total of other overall expenses since two expenditure categories (consumption and other insurances) are not included in the figure.
Source: Dov Chernichovsky, Haim Bleikh and Eitan Regev, Taub Center.
Data: Central Bureau of Statistics, Expenditure Survey.

3. Breakdown of private spending: Multivariate analysis

To examine the correlation between the level of private expenditures and socioeconomic and demographic household variables, a multivariate analysis was conducted on the survey data using Tobit regressions (for details on the results of the regressions, see Appendix Table 2). The findings of the analysis substantiate and reinforce the results presented above regarding the effect of income on the various types of private healthcare spending. They also add insights about how the characteristics of the household and the head of household influence spending.

Spending on medical insurance

The findings clearly highlight the differences between supplementary and commercial insurance. As noted, the two types of insurance are positively correlated with income, but the change in the distribution of commercial insurance accompanying a change in income level is about three times greater than with supplementary insurance (shown also in Figure 6). Furthermore, the head of household's educational level has a positive influence on the purchase of commercial insurance, but its effect on the purchase of supplementary insurance is not significant.

The findings are compatible with the fact that supplementary insurance has public characteristics and is, therefore, more accessible. In addition, we should not rule out the hypothesis that supplementary insurance encourages and enables moral hazard: individuals who need treatment can purchase such insurance after the fact, when they know that they need it. This claim is supported by the finding that spending on supplementary insurance increases when the household's level of medical needs increases. No statistical connection was found between medical needs and spending on commercial insurance. The positive effect of education on commercial insurance spending can also be attributed to the fact that employers in organized work places, which usually have more educated workers, support such insurance.

A breakdown of insurance by population groups (excluding all other variables) found that Arab Israelis are less likely than Jews to purchase insurance, particularly commercial insurance. This can be explained by the limited possibilities of using health insurance in Arab Israeli communities, and perhaps also by their lack of awareness of the issue of potential need for private medical insurance. In the Jewish population, the Haredim — the ultra-Orthodox — purchase less commercial insurance on average than others, perhaps because they rely on *gemachs* (interest-free loan societies) and mutual aid within their communities, which is a kind of self-insurance.

As a rule, residence in the periphery of the country has a statistically non-significant but negative effect on purchase of commercial insurance and a statistically significant negative effect on purchase of supplementary insurance. This finding may reinforce the hypothesis that purchase of insurance is less likely when there is less ability to take advantage of it.

Direct, out–of–pocket spending

Generally, private spending on healthcare is positively correlated with household medical needs (as measured in budget lines by family size and household members' age and gender — see footnote 3) as well as income level. The educational level of the head of household does not have a statistically significant effect on direct, out-of-pocket spending. Multivariate analysis confirmed that spending on copayments is not, in fact, correlated with household income level, but is positively correlated with the household's level of medical need.

At the top of the hierarchy of spending on copayments are Arab Israelis, followed by non-Haredi Jews and finally, Haredim. This can be explained by the relatively low level of health among non-Haredi Jews and Arab Israelis relative to the Haredi population. Having supplementary health insurance has a positive effect on the level of spending on copayments, which can be attributed to the fact that insurance encourages the use of services.

When all other variables are constant, spending on supplementary services (primarily dental care) is most affected by the level of household income, as previously noted, and is also positively correlated with the education level of the head of household for a given income level. This finding — as well as the positive effect of income on spending levels — may result from the fact that as the education level rises, so does awareness of the importance of health services that are not in the public basket of services, particularly dental care. In contrast, spending on supplementary services is statistically correlated with household size and with the medical needs of family members.

If variables not connected to sector are excluded, Arab Israelis spend a larger amount than Jews on supplementary services, perhaps because of a lack of public medical services in their communities and a lower level of health.

Having commercial insurance has a positive association with spending on supplementary care. This may be because people with health problems anticipate higher healthcare expenditures, and so tend to purchase insurance at a higher rate. Another possibility is that this insurance involves copayments, which those not insured do not pay.

Expenditures on parallel care are especially interesting, since they involve forgoing care in the public health system in favor of similar care that is privately financed. As expected, there is a connection between an increasing income level and the choice to forgo use of the public health system. In contrast, the education level of the head of household has no statistical

correlation with spending on parallel care; likewise, there is no correlation between the medical needs of the household and the purchase of parallel services. However, these findings imply that the more educated population does not perceive parallel services as better than services provided by the public health system, but perhaps only as more convenient and contingent on the ability to pay.

Spending by Haredim on parallel treatments is higher than that of the other two groups (controlling for the effect of other variables). This could be a result of the arrangements for private medical care within the community, which serves as a substitute for the public healthcare system. Spending for parallel care is positively correlated with the purchase of insurance, supplementary or commercial. In other words, having these types of insurance encourages people to pay for healthcare rather than using their right to healthcare through the public system. In fact, it may be that this is one of the reasons to purchase insurance in advance, and the public health system itself encourages those with insurance to receive parallel care privately.

Summary and conclusions

The findings point to several challenges facing the system. First, the relatively high levels of spending on parallel and supplementary care by those with high incomes (and in the second case, with high levels of education) support the hypothesis that from their perspective, the public health system does not provide satisfactory types or quality of care. Moreover, it is possible that the demand for private services by those with high income levels encourages service providers to offer these services since these populations have the ability to pay through direct, out-of-pocket payments or because they have a higher proportion of people insured relative to those who are uninsured and cannot pay with low income and lower educational levels.

Expenditures on copayments are a type of regressive tax. Those who are most in need, especially the elderly, bear a greater economic burden than the other groups (and spend more than others in absolute terms when income is held constant). The situation is similar with respect to Arab Israelis and Haredim, though to a lesser extent: when all other variables, including income, are held constant, these groups spend more out-of-pocket, in absolute terms, for copayments because publicly funded care is relatively less available. This contradicts the concept of social justice and equality that underlies the National Health Insurance Law.

Like direct, out-of-pocket expenditures, the distribution of private insurance is dependent on income level. As a result, it increases disparities in the system, particularly given that having insurance is positively correlated with direct, out-of-pocket spending.

Thus, the increasing role played by private spending in financing healthcare in Israel, as well as the arrangements enabling insured persons to use their supplementary insurance only in private institutions, reflect a certain dissatisfaction with the public health system and contribute to its inefficiency and to increased disparities in healthcare accessibility.

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Appendix

Appendix Table 1. Classification of private expenditure on healthcare and average monthly monetary expenditure
Expenditure Survey 2014 Table 4.1, NIS

Copayment	**90.8**
Medications purchased at the health fund	6.1
Prescription medications purchased at the health fund	35.9
Prescription medications purchased at a pharmacy	48.4
Prescription medications purchased, place of purchase unknown	0.4
Consumption	**134.5**
Psychological or psychiatric treatment*	8.5
Aesthetic treatment	7.7
Cotton balls, feminine hygiene products, bandages	12.8
Other medical needs	3.0
Eye glasses and lenses (including prescription sunglasses(	45.6
Contact lenses	4.3
Sunglasses (non-prescription)	7.6
Oral hygiene products (including toothbrushes and toothpaste)	15.5
Non-prescription vitamins	10.6
Allergy medication	18.8
Parallel	**48.8**
Payments to private doctor and specialists at the health fund	14.9
Payment for private surgery	16.3
Lab work and X-rays	7.6
Private nurse, ambulance, emergency room	2.4
Rehabilitation and developmental treatments	7.6

* This section is divided equally between consumption and supplementary.

Appendix Table 1. (continued) **Classification of private expenditure on healthcare and average monthly monetary expenditure**
Expenditure Survey 2014 Table 4.1, NIS

Supplementary	257.0
Dental care	149.7
Orthodontics	13.4
Oral and maxillofacial surgery	49.6
Dental X-rays in a dental X-ray facility	2.7
Psychological or psychiatric treatment	8.5
Dietician (through the health fund)	2.0
Medications purchased at a pharmacy	6.3
Rehabiliation or medical appartus	5.0
Non-prescription medications purchased at the health fund	3.5
Non-prescription medications purchased at a pharmacy	15.8
Non-prescription medications place of purchase unknown	0.6
Insurances	337.3
Supplementary insurance	193.1
Commercial insurance	101.0
Long-term care insurance	23.0
Dental insurance	12.0
Other insurance	8.2

Multivariate Analysis

The estimated equation is:

$$(1) \quad y_{i,j} = \alpha_j + \beta x_{i,j} + \gamma z_j + \varepsilon_{i,j}$$

where $y_{i,j}$ denotes the monetary outlay (in shekels) of household i for spending category j for healthcare and $x_{i,j}$ is the vector of variables that characterize the household and explain the expenditure. To reduce possible bias stemming from the fact that at any point in time, a relatively large number of households do not report spending at all, all equations were estimated using the Tobit method (Zellner, 1962).

In addressing spending on insurance, there is a challenge in estimating the influences on private expenditures. On the one hand, insurance is influenced by health status and socioeconomic variables. At the same time, insurance affects consumption of medical services and expenditures on these services because it reduces the costs of private care. To examine the specific influence of insurance, we used the Tobit method to estimate the effect of socioeconomic variables on purchase of insurance, then a dummy variable was used for possession of insurance (= 1). The goal was to monitor, to the extent possible, the effect of insurance on spending. The results of the statistical estimate are shown in the table.

We will elaborate on two of the independent variables in the table: standardized persons and periphery of area of residence. The first reflects the demographic profile of the household in persons weighted according to the Israeli capitation formula. This is an estimate of the household's medical needs, which reflects both household size in number of persons and a breakdown by age. It should be noted that the simple statistical correlation between this variable and the age of the head of household is 0.8.

As for the periphery variable, according to the Central Bureau of Statistics (2008), the periphery of a town or city is based on:

- the local authority's potential accessibility index, which ranks local authorities by their proximity to all other local authorities in Israel relative to the size of their population;

- the local authority's proximity to the border of the Tel Aviv district, with greater proximity giving a higher value.

A periphery index was determined for every household according to place of residence. For purposes of the estimates in this chapter, the indices were converted to dummy variables with a value of 1 (if the household is in a certain periphery) and a value of 0 (if it is not). Tel Aviv is the area that is not included in the estimate and to which the other areas are compared for purposes of evaluating the effect of availability of medical services.

Appendix Table 2. Regression coefficients with the Tobit method

Total private expenditure for medical services and its components dependent variables, standard deviation in parentheses

Explana-tory variable	Dependent variables						Total private spending
	Insurances		Out-of-pocket expenditure				
	Supple-mentary	Com-mercial	Co-payment	Supple-mentary services	Parallel services	Total out-of-pocket	
	1	2	3	4	5	6	7
Characteristics of head of household							
Male (=1)	3.88	3.00	-33.02	-30.53	-38.93	-90.84*	-44.82
	(4.81))	(13.94)	(18.73)	(51.57)	(42.58)	(36.63)	(36.10)
Years of schooling	0.25	12.09**	-3.34	20.37**	2.43	7.22	10.03
	(0.59)	(1.67)	(2.29)	(7.42)	(6.08)	(5.55)	(5.57)
Arab Israeli (=1)	-124.33**	-412.82**	188.51**	688.86**	122.65	414.23**	31.35
	(9.34)	(37.18)	(32.31)	(160.92)	(65.09)	(105.05)	(78.32)
Haredi (=1)	8.11	-354.63**	-16.82	281.37**	420.12**	187.67*	-28.29
	(10.20)	(41.57)	(38.63)	(111.78)	(138.18)	(85.67)	(75.24)
Household characteristics							
Members adjusted for medical needs	37.70**	1.67	122.04**	58.12*	37.69	141.82**	222.68**
	(2.33)	(6.62)	(9.23)	(25.66)	(20.82)	(19.63)	(20.10)
Log of disposable monetary income	96.69**	275.20**	7.64	362.34**	158.77**	319.67**	529.79**
	(3.85)	(14.64)	(14.53)	(45.44)	(38.76)	(30.51)	(30.82)
Residence in the periphery							
High periphery (=1)	18.77	-51.66	-61.77	122.51	22.54	93.60	82.64
	(10.10)	(37.50)	(42.75)	(147.07)	(92.52)	(100.44)	(92.49)
Medium (=1)	-4.47	-13.78	-5.71	-49.54	139.19**	-47.15	-60.50
	(5.39)	(15.49)	(22.16)	(56.71)	(48.19)	(39.62)	(38.54)

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Total private expenditure for medical services and its components dependent variables, standard deviation in parentheses

Explana-tory variable	Dependent variables						
	Insurances		Out-of-pocket expenditure				Total private spending
	Supple-mentary	Com-mercial	Co-payment	Supple-mentary services	Parallel services	Total out-of-pocket	
	1	2	3	4	5	6	7
Residence in the periphery (continued)							
Center (=1)	21.11**	-46.06*	5.13	-120.49	-66.79	-42.62	-73.02
	(6.94)	(19.41)	(26.48)	(72.08)	(67.21)	(51.15)	(49.23)
Regular (=1)	-23.57**	-10.35	-15.4	237.16	190.18*	219.53*	131.54
	(8.05)	(25.70)	(31.53)	(136.74)	(73.58)	(102.74)	(97.35)
Insurance							
Supple-mentary (Yes=1)			56.70*	124.28	251.60**	109.17	
			(26.58)	(93.68)	(70.48)	(58.97)	
Commer-cial (Yes=1)			21.40	230.20**	212.53**	248.94	
			(20.50)-	(80.35)	(58.98)	(57.24)	
Intercept	-767.45 **	-2896.87 ***	-551.14 **	-4705.12 **	-3102.10 **	-3126.26 **	-4460.51 **
	(35.65)	(142.96)	(140.69)	(518.40)	(499.22)	(292.98)	(286.82)
Pseudo R²	0.0243	0.0399	0.0079	0.0050	0.0053	0.0039	0.0059

* Significance level of 5%; ** significance level of 1%.

A resident of the periphery is categorized under High periphery or periphery.

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Total private expenditure for medical services and its components dependent variables, standard deviation in parentheses

Explana-tory variable	Dependent variables						
	Insurances		Out-of-pocket expenditure				Total private spending
	Supple-mentary	Com-mercial	Co-payment	Supple-mentary services	Parallel services	Total out-of-pocket	
	1	2	3	4	5	6	7
Characteristics of head of household							
Male (=1)	4.67	10.44	-12.74	0.81	-3.73	-76.24	-42.70
	(1.13)	(0.83)	(-0.79)	(0.02)	(-0.09)	(-2.34)	(-1.31)
Years of schooling	0.324	10.93	-4.47	16.80	-2.00	6.62	9.80
	(0.64)	(6.77)	(-2.30)	(3.09)	(-0.42)	(1.68)	(2.48)
Arab Israeli (=1)	-117.74	-443.31	196.65	683.16	135.15	425.23	45.15
	(-17.85)	(-14.24)	(7.62)	(160.92)	(2.01)	(87.13)	(0.92)
Haredi (=1)	3.81	-430.71	-100.51	109.28	250.12	139.20	-34.07
	(0.36)	(-10.13)	(-2.25)	(0.94)	(2.68)	(1.65)	(0.40)
Household characteristics							
Members adjusted for medical needs	36.54	-4.71	107.16	25.22	1.37	129.83	220.10
	(19.24)	(-0.69)	(14.83)	(1.19)	(0.08)	(8.67)	(14.71)
Log of disposable monetary income	95.68	278.72	6.40	353.18	171.37	306.54	525.88
	(34.84)	(29.11)	(0.55)	(10.72)	(5.85)	(13.15)	(24.62)
Residence in the periphery							
High (=1)	16.91	-77.89	-97.73	32.30	-60.28	80.32	85.13
	(1.71)	(-2.42)	(-2.42)	(0.29)	(-0.62)	(1.03)	(1.09)
Moder-ate(=1)	-6.93	-25.82	-32.11	-89.85	79.80	-57.52	-64.78
	(-1.50)	(-1.84)	(-1.77)	(-1.78)	(1.82)	(-1.59)	(-1.79)

Appendix Table 3. Regression coefficients with the Tobit method
Total private expenditure for medical services and its components dependent variables, standard deviation in parentheses

Explana-tory variable	Dependent variables						
	Insurances		Out-of-pocket expenditure				Total private spending
	Supple-mentary	Com-mercial	Co-payment	Supple-mentary services	Parallel services	Total out-of-pocket	
	1	2	3	4	5	6	7
Residence in the periphery (continued)							
Center(=1)	19.38	-55.05	-2.81	-137.17	-81.75	-38.59	-70.63
	(3.34)	(-3.16)	(-0.12)	(-2.13)	(-1.42)	(-0.84)	(-1.54)
Regular (=1)			-58.94	134.17	63.93	187.12	119.48
			(-2.10)	(1.76)	(0.96)	(3.38)	(2.14)
Insurance purchase							
Supple-mentary (Yes=1)			51.48	142.81	251.63	111.60	
			(2.14)	(2.09)	(3.91)	(2.34)	
Commer-cial (Yes=1)			15.38	199.68	197.75	240.42	
			(0.87)	(4.17)	(4.81)	(6.94)	
Pseudo R²	0.0243	0.0406	0.0070	0.0047	0.0046	0.0036	0.0057

The variable is given a value of 0 if it is different.