

Women and health in Israel

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Introduction

WHO defines health as “a complete state of physical, mental and social wellbeing, and not merely the absence of disease or infirmity”.¹ This broad definition includes physical and mental health, but also socioeconomic standing and access to resources such as health care and safety. In this Viewpoint, we present a holistic picture of women's health within the Israeli societal and cultural context, taking these factors into account.

Because of its volatile and insecure geographical position, direct and indirect exposure to violence is common in Israel, with most adult men and women participating in mandatory army service. This political context affects health outcomes for women and the resources available for health care. Around US\$23 billion—or nearly 8% of the total gross domestic product (GDP)—is allocated to the Ministry of Defence. Governments that spend a high proportion of their GDP on security do so at the expense of social welfare provisions. This allocation of funds affects the resources that are available for health in general, and for women's health in particular. Israel's health expenditure per person is one of the lowest of all Organisation for Economic Co-operation and Development (OECD) countries, and quite a small proportion of the GDP (7%) is spent on health.²

Israeli women are socialised within a pro-natal, family-oriented culture and a national ethos that emphasises and encourages family life. As such, women have an average of three children (although Muslims [average 3·35 children per woman] and orthodox Jews [6·5] have more children)—a high number compared with other OECD states (in which the average number of children per woman is 1·7).² Women's health information resources are available online, in academic centres, or in clinics that focus mainly on fertility and motherhood (appendix pp 1–3).

Advances and challenges in women's health

Life expectancy

The life expectancy at birth for Israeli women is 84 years, ranking 11th in the world, and men's life expectancy is 80 years, ranking fourth worldwide.³ Although Israeli women's life expectancy is high when compared with other women globally, the differential international ranking between Israeli men and women suggests poorer health in women than in men. Disparities also exist in life expectancy between Israeli Jewish and Israeli Arab women. For Arab Israeli women, life expectancy in 2010 was 81 years of age, and for Arab men, 77 years.⁴ Reasons for the overall high life expectancy in Israeli citizens have puzzled scientists because Israeli life can be stressful (eg, due to continuous exposure to the intractable Israeli–Palestinian conflict), and no genetic explanation for the relatively high life expectancy has

been found. One potential explanation might be linked to the provision of social support and a family-oriented culture. This hypothesis has been corroborated internationally. For example, a longitudinal study that followed Harvard graduates for more than 75 years reported significant associations between wellbeing and high-quality social relationships and networks.⁵

Morbidity and mortality

Compared with findings from international surveys, Israeli women show a variable prevalence of diabetes, cardiovascular disease, and obesity compared with other countries.² In 2008, nearly 30% of Israeli women were categorised as obese and almost 20% had high blood pressure.³ However, Israeli women have quite low mortality rates for stroke, heart disease, and cervical cancer (the age-standardised mortality rate for ischaemic heart disease per 100 000 women in Israel in 2008 was significantly lower [43] than the average for women in OECD states [60], and similarly for stroke [23 vs 42, respectively]),⁶ but high rates of breast cancer (80·5 per 100 000 women compared to the average for OECD states of 74·2) and mortality from this disease.² For example, of 35 OECD countries, Israel has the fifth highest mortality rate for breast cancer, an issue that is dealt with elsewhere in this Series.⁷

Importantly, most international health surveys report on the incidences and mortality rates for heart disease, stroke, cancer, and diabetes. On the basis of these metrics, overall, men tend to be sicker than women² and Israeli women have quite good health compared with their international female counterparts. However, Israeli women report a significantly higher prevalence of chronic health disorders when compared with men and women in other countries. These conditions include fibromyalgia, chronic fatigue syndrome, and migraine headaches, all of which cause pain and reduced quality of life for women and can lead to disability. As such, international comparisons of health outcomes can present an incomplete picture when analysing sex differences in overall health.

Reproductive health

Given the emphasis on family and pro-natality, Israel excels in the area of fertility. It is one of the few countries in the world that provides unlimited free fertility treatments (including in-vitro fertilisation) for women up to the age of 45 years (for up to two children). In some cases of repeated failed treatments, a meeting is called to discuss further treatment. Israel is also one of only a few countries worldwide that will provide fertility treatments free of charge even when there is only a small chance of success. In 2013, there were 39174 treatment cycles

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in Israel, resulting in 9583 pregnancies, and 7312 livebirths.⁸ Although the availability of fertility treatments is a major step forward in provision of women's health needs in Israel, there are also potentially adverse health consequences to these treatments, including multiple embryo pregnancies and prematurity. In addition to the physical side-effects of failed fertility treatments, these can be accompanied by depression and stress. Moreover, the long-term negative physical effects of undergoing several treatment cycles are not known.

In the context of oncology and fertility, one recent discovery is a new compound synthesised in Israel, AS101, that will be added to chemotherapy treatments to prevent infertility in young patients with cancer.⁹ So far, AS101 has been tested in animals⁸ and is now undergoing clinical trials for use in reducing the negative effect of chemotherapy on the fertility of cancer patients.¹⁰

Reproductive policies in Israel are inconsistent. Although the pro-natal ethos allows for generous fertility policies, the duration of paid maternity leave is quite short at 14 weeks and child care is expensive. Moreover, unlike most European countries where contraception is covered by health insurance (eg, Belgium, Denmark, Spain, and the UK), contraception is not covered by the national health insurance plan in Israel. Although the vast majority of abortion requests are granted, women are required to appear before a committee comprising two physicians and a social worker on a case-by-case basis to seek permission for the procedure. Acceptable reasons for an abortion to be granted include any physical or mental danger to the mother (eg, mental or physical distress, unmarried mother, incest, or rape) or to the fetus.

Violence against women

Statistics about violence against women in Israel are difficult to access because many crimes are not reported, and those that are, do not often end in convictions. In 2015, 3727 sex offence cases were opened and 12333 new cases of violent crimes against women reported.¹¹ Between 2013 and 2015, 72 women were murdered in Israel, of whom around half were killed by their partner.¹² More than a third of those murdered were Arab women, and about a fifth were new immigrants from the former Soviet Union or Ethiopia. These murder statistics do not include a substantial number of "honour killings" of Arab women in Israeli society that often go unreported.¹¹ Overall, reported rates of violence against women in Israel are similar to those in other OECD states. However, since 2007, the incidence of violence against women has increased by about 7% every year.¹³ Of these new cases, 2% occur in the context of domestic violence. In 2014, the rates of sexual assaults were, on average, 10% higher in Israel than in other OECD countries.¹³

Another source of data on violence against women comes from the Association of Rape and Crisis Centers

in Israel. According to their data, in 2012, they received 40000 calls seeking help. Of these 40000 calls, nearly 34% reported a rape or an attempted rape. Another 24% reported incest, and 13% reported indecent assault.¹⁴

Similar to other nations, incidences of domestic violence including battery and murder increase in Israel during times of war and active conflict. For example, during the military conflict in southern Israel and Gaza strip in July, 2014, the support centre for victims of sexual violence in Beer Sheva reported that nearly 1500 people approached them during the first month of the conflict—a 60% increase in the number of calls recorded just a month earlier in June, 2014, before the conflict began.¹⁵ During the same period, another Israeli non-governmental organisation reported a 20% increase in number of women calling the hotline for the first time and a 30% increase in the number of women seeking shelter.¹⁵

In the year 2000, the Israeli Government successfully launched a programme to identify domestic violence victims through the health-care system. This programme has been established in hospitals, mother and child clinics, and in community clinics with the purpose of identifying women who are victims of domestic violence in order to provide immediate emotional and practical support by a trained social worker, and to plan for community treatment services and follow-up.¹⁶

Mental health

As is the case in other high-income countries, women in Israel have higher rates of internalising disorders such as mood and anxiety disorders than men,¹⁷ whereas men tend to exhibit more externalising disorders such as alcohol and substance misuse.¹⁷ These differences also vary by ethnic origin and social class.¹⁸ For example, according to the Israeli component of the World Mental Health Survey of non-institutionalised adults that included a representative sample of the Israeli population, the prevalence rate for mood and anxiety disorders in the preceding 12 months was higher in Arab women (10·5% [95% CI 7·3–14·8]) than in their Jewish counterparts (7·1% [5·9–8·5]).¹⁹ Intense chronic pain, sometimes an indicator of mental health distress, is reported more frequently by Israeli women than by Israeli men,¹⁹ or by women in 15 European countries including Norway, Germany, Italy, and the UK.²⁰ Women suffer more disability than men as a result of this pain, including lost work days and job losses.²¹

The gender role hypothesis proposes that differences in emotional distress between men and women are culturally construed and emerge from differential socialisation into gender roles; women are taught to be caretakers and as a result interdependent, whereas men are taught to be providers and are therefore socialised to be independent and competitive. These social roles affect the types of stressors and coping mechanisms that men and women use. They also affect the social structures

within which they are raised, especially the opportunities and barriers they face as a result of their sex. Within the Israeli context, Jewish Israeli women face security-related stressors, such as dealing with wars and terror attacks and their children and spouses being in the military, whereas Arab women fear their children will be involved in—or exposed to—political violence and exposure to discrimination. Although stress and worry for children serving in the military or for Arab youth who might be involved in political violence have health consequences on Israeli women that include panic attacks, insomnia, physical pain, and anxiety,²¹ the full health effects of this worry have not yet been evaluated extensively. Moreover, some research has shown that conflict-related stress is associated with a statistically significant increase in miscarriages.²²

One study examining Israeli women during times of conflict found that the injunction on women to take care of others (eg, children or parents) during times of conflict increased their levels of stress and anxiety, and affected their health and wellbeing.²³ Israeli studies that have assessed the wives of soldiers who returned from combat or who suffered from post-traumatic stress disorder reported that these women had high levels of anxiety and distress in coping with day-to-day life when their spouses returned.²⁴ Solomon and Ginzburg²⁵ referred to a phenomenon as “vicarious traumatising” to indicate that those who are in close contact with a traumatised individual as a result of war and military service might also experience intense emotional distress and become traumatised themselves. The increased risk for mental distress in women belonging to disadvantaged social groups can be attributed to their double minority status as both women and as ethnic minorities in the militarised Israeli society and patriarchal traditional Arab culture.²⁶

Unlike in other countries, Israeli adult women do not report significantly different rates of mental health services use compared with men. However, ethnic differences do exist, with some data showing that Arab women tend to use mental health services less frequently than Arab men.^{18,27} Among the reasons for the underuse of services for Arab women are stigma associated with mental illness, paucity of culturally sensitive services, tendency to rely on informal support systems, and traditional beliefs concerning the nature of mental illness (eg, attribution to ones sins) rather than the bio-psychosocial model.²⁷

Importantly, little attention is paid to women’s specific needs in the delivery of mental health care. Existing services focus solely on mental health concerns related to pregnancy and motherhood and to war and terror-related trauma. The mental health reform that was instituted in 2015 in Israel²⁸ offers an opportunity to change the way in which women’s mental health services are programmed and delivered because it emphasises community-based treatment and rehabilitation.

Recommendations

Although these examples of advances in fertility, countering domestic violence, and offering specialised mental health services for women are promising, major gaps remain that still need to be addressed. Most high-income countries have either a government minister, an office for women’s health, or both, that focuses on health and illness as they pertain to women and their needs (appendix p 4). What these offices have in common is their mission that includes research into women’s health concerns, prevention, education, and emphasis on changes at both a small and large scale to improve women’s health. Such changes can include the provision of more specialised services for women (ie, gender-sensitive physical and mental health clinics), and devising policy that addresses the deep causes of ill health ascertained through studies of antecedents and social determinants of women’s health. The Israeli Ministry of Health currently has a National Council for Women’s Health that meets periodically (every 3 months). One substantial step forward should be the creation of a more formal governmental office or a department within the Ministry of Health that will ensure a gender-sensitive health budget and decision making.

We propose several concrete recommendations to improve the status of women’s health in Israel (panel).

Panel: Ten recommendations for improving women’s health in Israel

- 1 Institute a formal governmental office or a department within the Ministry of Health focusing on gender and health with a specific focus on women’s health concerns and emphasis on changes at both the micro and macro levels
- 2 Establish a gender-sensitive budget that includes allocation of funds solely for the promotion and treatment of women’s health
- 3 Extend paid maternity leave from 14 weeks to 6 months and mandate reproductive freedom for all Israeli women by including contraception under the health insurance plan and removing barriers to abortion such as the need to appear before a committee
- 4 Funding and institution of gender-sensitive medicine that includes training, research, and application of gender-sensitive diagnoses, treatment, and follow-up for women (eg, providing gender-sensitive physical and mental health clinics and training students and physicians in how to identify diseases that present differently in women, etc)
- 5 Ensure that all health policy decisions include a diverse group of men and women and an ethnically diverse group of decision makers that are representative of the Israeli population
- 6 Institute a strategic focus on reducing health inequalities among all ethnic groups and between men and women in Israel with the specific aim of reducing health inequities between Jewish and Arab women
- 7 Mandate that all funded health research includes a representative sample of the population, with a specific focus on ensuring gender equality in research samples
- 8 Increase the number of resources (ie, material and emotional support) available for victims of violence; increase sentences against violent offenders against women; and institute a nationwide violence prevention programme that begins in childhood
- 9 Institute formal policy to reduce poverty and the inequality gap between men and women, especially as it pertains to equal pay for equal work, equal opportunities for advancement in the workplace, and provision of high-quality, subsidised child care
- 10 Focus and target health resources towards vulnerable female populations across the lifespan, including minority groups, children, adolescents, and older adults

These recommendations, although specific to the Israeli context, are also global in their orientation towards improving women's health and can be applied to all nations within their local contexts. These recommendations take the WHO definition of health as their foundation and focus on the broad physical, mental, and social wellbeing of women. Finally, we propose that Israel should become a more pro-woman society. For example, one of our recommendations involves increasing paid maternity leave from 14 weeks to 6 months. Although at first this factor seems to be unrelated to women's health, the difficulties that Israeli women face in balancing work and home life are tremendous, and many of the health outcomes we described in this Viewpoint—such as chronic pain, depression, and anxiety—are directly affected by this overwork, which is further complicated by stress-inducing factors unique to Israel. This situation is a global phenomenon for women. For example, compelling evidence suggests that assisting women with child care duties reduces burnout in female employees. In a meta-analysis of 183 burnout studies,²⁹ the authors reported that women in the USA who had short maternity leaves and conservative family care policies had significantly more burnout than their counterparts in the EU where maternity leave and child care is generous and widely accessible. In conclusion, improving women's health locally in Israel and globally across the world must take a broader view of women's health and wellbeing and include within its scope and mission the emotional, physical, mental, and social wellbeing of its female citizens.

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