

**Background Paper for
The Shared Homeland Paradigm Project:**

Healthcare

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The views and opinions expressed in this publication are those of the authors and do not necessarily reflect the position of the Shared Homeland Paradigm project.

Executive Summary

Health is a fundamental human right, yet healthcare planning is usually overlooked when discussing possible solutions for Israel-Palestine. In regions marked by protracted conflict, healthcare systems are often among the first institutions to suffer and the last to recover. The delivery of health services in such settings is shaped not only by resource scarcity and infrastructural damage but also by deep political divisions, fragmented governance, and social distrust. Despite these challenges, various models around the world have emerged that aim to meet the urgent medical needs of affected populations.

This paper aims to explore five models of healthcare systems, that differ by the circumstances in which they were built, all with some parallels to the Israeli-Palestinian conflict and relevance to a future Palestinian-Israeli Union:

1. *Building a healthcare system under foreign occupation* – Israel’s healthcare system was almost entirely up and running prior to 1948, and was built mostly through Jewish philanthropy under the Ottoman era and later the British Mandate. Its unique funding model that utilizes four competing health maintenance organizations also predated the establishment of the state. The Israeli model is a good practical example on how to use limited resources to build an accessible healthcare system under an oppressive rule, and later consolidate it to one accessible, equitable and efficient system.
2. *Building a healthcare system following liberation from occupation* – Estonia has one of the best post-Soviet-era healthcare systems thanks to a major transition to a social health insurance-based system in the 1990s. This system is centralized, with the Estonian Health Insurance Fund acting as the primary purchaser of services through public funding. This transition has led Estonia to close significant health gaps compared to the European Union (EU) average in less than 30 years, and acts as a role model on how to transition from a fragmented hospital-centered system to a centralized prevention-centered system.
3. *Reforming a healthcare system following unification to one sovereign state* – Germany’s healthcare system is one of the best performing in the world, despite the need to unify its two healthcare systems after the collapse of the Soviet Union and the fall of the Berlin Wall. Amazingly, only 20 years following unification, the health indices in East Germany have caught up with those in West Germany, despite previous significant health gaps and core differences in the structures and management of the two systems. This model can be a good example of unifying two totally different healthcare systems into one, with the benefit of the public in mind.

4. *Standardizing healthcare systems following unification of multiple sovereign states* – In the EU, each member state has its own independent social healthcare system, and its regulation, funding, and maintenance are under the responsibility of its government. At the same time, the EU has its own health policy which is designed to direct its member states' policies, including legislation on health and shared agencies – such as the European Centre for Disease Prevention & Control (ECDC) and the European Medicines Agency (EMA) – to support all national governments on health issues. This model should be considered for allowing free movement of goods, services, capital, and people, while maintaining sovereignty of independent states.
5. *Recovering a healthcare system post-genocide* – Rwanda's life expectancy has doubled since the genocide in 1994, and its child mortality has fallen by more than 60%. This success is a result of community-based health insurance programs, heavy foreign and domestic investments in building healthcare infrastructure and training medical staff, and the reconciliation programs which affected mental health delivery and outcomes significantly. Given the current genocide and near-total collapse of the healthcare system in Gaza, many lessons can be learnt from the story of Rwanda.

These models were all chosen based on their relevance and uniqueness, but also because of their focus on accessibility and fairness, which should be a key factor in any envisioned future healthcare system. Given the focused scope of this paper, many other relevant models will not be discussed to avoid redundancy (e.g., Northern Ireland, post-apartheid South Africa), but should be considered for an in-depth exploration in the future.

Introduction

*“Of all the forms of inequality,
injustice in healthcare is the most shocking and inhumane.”*

- Dr. Martin Luther King Jr.

Health is a fundamental human right and a basic need, although it is commonly overlooked and taken for granted – individually, socially and politically. The COVID-19 pandemic was an obvious example of how all life systems shut down when health was on the line, and was a global test for all countries’ healthcare systems. Not surprisingly, the crisis surfaced every systemic flaw, proving that the quality and equality of a country’s healthcare system are directly correlated with health outcomes, and reflect its social strength, cohesion and solidarity. In the case of Israel-Palestine, the pronounced health disparities between Israelis and Palestinians are the result of the extremely fragmented healthcare system(s) existing between the Jordanian River and the Mediterranean Sea (Abu Fraiha, 2023).

The fragmentation of the healthcare system mirrors the fragmentation of land and governance. Consequently, the health services available to an individual are heavily affected by their residency and/or citizenship status. In Israel proper, the National Health Insurance Law (NHIL, 1994) states that every Israeli resident is eligible to receive basic health services, which are almost entirely funded by the government and provided by four health maintenance organizations (HMOs). This includes Palestinian citizens of Israel (PCIs) and residents of East Jerusalem (who are not citizens), although not all Palestinians living in East Jerusalem have the privilege of traveling into Israel to receive care. In contradiction to the NHIL, East Jerusalem is the only territory in which Israeli HMOs are allowed to provide their services through private ownership. As a result, only a minority of the 88 clinics/centers in East Jerusalem are publicly owned and operated by the HMOs themselves, while the rest are highly profit-oriented and not subjected to any professional supervision or regulation (Imam and Hamdan, 2021).

The Palestinians living in the West Bank are subject to the Israeli military court system, and since they do not carry any residency or citizenship status, their healthcare services are provided by the Palestinian Authority (PA), according to the Oslo Accords (“Israeli-Palestinian Interim Agreement Annex III - Protocol Concerning Civil Affairs; Article 17 - Health,” 1995). However, Israel’s complete control over points of entry, natural resources (including water), and sources of revenue have led the Palestinian Ministry of Health (PMoH) to depend heavily on non-governmental organizations and facilities external to the territories (specifically in East Jerusalem, Israel, Egypt, and Jordan) (WHO, 2023). Since October 7, 2023, access to healthcare had worsened further due to 909 attacks on healthcare in the West Bank, including 214 health

facilities and 618 ambulances, with 249 healthcare workers detained.¹ In addition, frequent closures of roads and towns in the West Bank make it extremely difficult to seek medical care, and the continuation of withholding tax revenues intended for the occupied Palestinian territories doesn't allow the PMoH to rebuild the damaged system. In Gaza, after 17 years of siege and two devastating years of war, the healthcare system had been grossly extinguished. Out of 128 health service delivery units², only one is still fully functional, 43 are partially functional, and 84 are either non-functional or completely destroyed (WHO, 2025). As the war comes to an end, the issue of governance in Gaza is still unclear, resulting in uncertainty regarding the pathway to rebuild its basic life infrastructure.

Any future healthcare system in the shared homeland of Israelis and Palestinians must be based on values of equality, freedom, justice and partnership, with the attempt to correct systemic failures of the current fragmented and unjust system. That is to say, that all residents and citizens of the shared homeland should be eligible to receive high-quality healthcare which is accessible, affordable and non-discriminating, regardless of their residency or citizenship, socioeconomic, employment, place of residence or education status. They all should be free to receive care everywhere they wish to between the Jordanian River and the Mediterranean Sea, and free to choose providers and insurers based on their needs and medical conditions, essentially requiring freedom of movement and economic freedom for all. The system should also be based on the concept of social justice – acknowledging the past systemic failures and power imbalance that led to the current gaps and differences in health outcomes, and strive to fix them in order to close these gaps. Therefore, the system should be focused on prevention programs as well as on heavily investing in previously underserved and oppressed communities. Lastly, the system should be based on Israeli-Palestinian partnership, with mutual sharing and development of knowledge, resources and policies.

In order to envision a better and equal healthcare system for both Israelis and Palestinians, this paper aims to explore five different models of healthcare systems, that differ by the circumstances in which they were built, all with some parallels to the Israeli-Palestinian conflict and relevance to a future Palestinian-Israeli Union. They were all chosen to be explored because they are all based on universal insurance policies with public funding, all showed improvements in health outcomes over the years, and have robust outpatient practices, providing the minimally required characteristics of a fair system. Nevertheless, each model provides possible solution/s to the expected challenges of the future healthcare system in Israel-Palestine, namely:

¹ Adapted from the WHO database on September 24, 2025. Available at:

<https://app.powerbi.com/view?r=eyJoiODAxNTYzMDYtMjQ3YS00OTMzLTkxMWQ0OTU1NWEmZmE5NTMwIiwidCI6ImY2MTBjMGI3LWJkMjQ0NGZOS04MTBiLTNkYzI4MGFmYjU5MCIslmMiOjh9>

² Includes hospitals, field hospitals, governmental primary healthcare centers and UNRWA health centers.

(1) infrastructure funding and rebuilding, (2) regulation over separate sovereign entities, (3) addressing large influx of immigrants or fast increase in population, (4) unification of different health systems, (5) building trust in the system following a traumatic past, (6) increasing access to care, and (7) implementing health policies in times of uncertainty. Each model will be shortly explained through its historical context, current status, health indices, organizational structure, and lessons that can be learned for the Israeli-Palestinian case.

Building a Healthcare System Under Foreign Occupation – The Israeli Healthcare System

Israel's healthcare system is well-known for its efficiency and high-quality services. Despite being a universally funded system, its annual expenditure is only ~8% of Israel's gross domestic product (GDP), 20% lower than the average for the member states in the Organization for Economic Cooperation and Development (OECD) (Levi and Davidovitch, 2022). It has less doctors and nurses per capita, less hospital beds and imaging machinery, and yet its health outcomes are significantly better than the OECD average, including lower infant mortality rate, higher life expectancy and higher healthy life expectancy (Davidovitch and Lev, 2024) (**Figure 1**). One of the reasons for this phenomenon is the system's unique structure of government-funded competition between four HMOs. Given that almost all health services are funded by the NHIL, and every HMO is obliged to provide the same care and is reimbursed per capita regardless of prior medical issues of its members, the HMOs end up competing on the quality of care provided and on innovations in access to care.

Israel – Health System Review

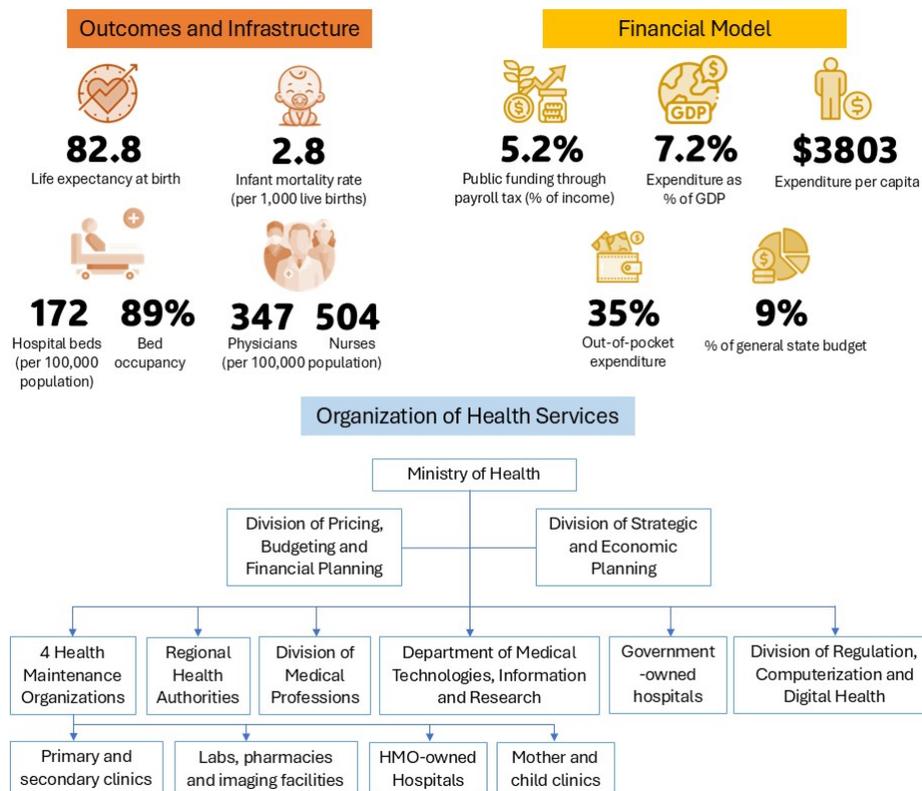


Figure 1 – A Snapshot of Israel’s Healthcare System

Source: Davidovitch, N. and Lev, N. (2024) *The Healthcare System in Israel, 2024: Between Resilience and Continued Challenges*, Policy Paper No. Jerusalem. Available at: <https://doi.org/10.5281/zenodo.14568456>.

Surprisingly, most of this structure already existed prior to 1948 (Clarfield *et al.*, 2017). Under the Ottoman Empire, most healthcare services in historic Palestine were provided by religious organizations – Christian missions and Jewish non-profit charities, mostly in Nazareth and Jerusalem to serve foreign pilgrims. The first modern hospitals were built by the second half of the 19th century by Jewish philanthropists – predominantly the Rothchild family and Hadassah Women’s Zionist Organization of America. Hadassah’s philanthropy was heavily invested in healthcare in the next decades, leading to the establishment of a national network of mother and child clinics, pharmacies, prevention programs and medical schools. In the beginning of the 20th century, the HMOs were all founded as workers cooperatives – Sick Funds – to provide egalitarian health services to members on the basis of monthly payments, which laid the basis to Israel’s widespread primary care and to the NHIL. The largest and wealthiest HMO – Clalit – started to build its own hospitals in 1924. Under the British Mandate, Jewish philanthropy grew significantly to support refugees fleeing Europe in the 1930s, and the British were building and operating new public and military hospitals in new cities to attend the growing needs. After the

establishment of the state of Israel in 1948, the British and Hadassah gradually transferred their infrastructure to the new Israeli government (Clarfield *et al.*, 2017).

The Israeli model has several advantages. First, its establishment based on philanthropic funds and cooperatives created a healthcare system that is focused on primary care and prevention. This allowed the flexibility needed to attend to the millions of refugees who arrived to Israel after 1948, as well as to treat the residents of the West Bank and Gaza after the six-day war in 1967. As a matter of fact, before healthcare responsibilities were transferred to the PA in 1994, Israel extended its vaccinations program to the occupied territories, as well as its mother and child care, which led to a significant reduction in infant mortality and incidence of preventable diseases (WHO, 1995; Gordon, 1997). New clinics were built, hospitals' infrastructure was upgraded, and complementary services were given in Israeli facilities as needed. Palestinian health care workers were able to travel and receive training in Israel, which allowed a significant increase in the amount of Palestinian health professionals by 1994 (WHO, 1995; Gordon, 1997; Clarfield *et al.*, 2017). Second, the Israeli model also exemplifies that health infrastructure can be built regardless of sovereignty, as long as there is enough financial support and that the development isn't actively being blocked by the sovereign. Third, the Israeli healthcare system is governmentally-funded with universal insurance, which makes it affordable and equitable – two core principles that should be the basis for any future system.

However, the Israeli model still embodies some challenges, especially in regard to the Palestinians. First, the historic investment in healthcare was for Jews only, and only decades later expanded to include Palestinians. Therefore, the current system is a result of almost two centuries of separated healthcare systems for Jews and Arabs, which created significant disparities in health outcomes and in access to health. Furthermore, the founding of the HMOs in historic Palestine, starting in the early 1910s, was not only exclusive for Jews but also politically affiliated. The first HMO (Clalit) was affiliated with worker unions and later to The Labor Party, obliging any worker who wanted an affordable health insurance to both be a union member and be affiliated with the party. As a result, Hadassah organization founded an alternative HMO (The Amamit Sick Fund, which later became Me'uhedet) to provide care for farmers in rural areas. Two other HMOs were established to allow affiliations with The Revisionist Party (The National Sick Fund, or Leumit) and non-affiliation (Maccabi) (Arian, 1981). Arabs were allowed to be members of these HMOs only since 1952, and the vast majority joined Clalit because of its political affiliation and the monopoly of the socialist Labor Party in the work market. In addition, the pre-1948 competition between the HMOs led to geographic arrangements that eventually divided the market between them. This geographic division still exists nowadays within Israel, limiting individuals' ability to choose insurance freely,

and creating local monopolies (e.g., Clalit in the periphery of the country, especially in PCI's towns). Moreover, this politicization of healthcare contributed to the consolidation of power by the Labor Party, and did not allow for fair allotment of resources between the HMOs (and therefore, their members) until 1994. This is a risky road that lays the infrastructure for systemic discrimination and inequality based on ethnicity, political affiliation, place of residence and employment status, and should be avoided in any future system.

Second, the Israeli government still owns and manages many of the hospitals, which contradicts its role as a funder and regulator. This creates a governance structure that is prone to conflict of interests. Lastly, a fully publicly funded system requires significant funds, which results in a constantly underfunded and overwhelmed system.

Building a Healthcare System Following Liberation from Occupation – The Estonian Healthcare System

After centuries of foreign rule, Estonia finally regained full independence in 1991, after the collapse of the Soviet Union. Nevertheless, in less than 30 years Estonia has become one of the world's leaders in digital health³. By 2021, its life expectancy rose in 7.5 years, more than any other EU country (OECD and WHO, 2021). Although most of its health outcomes are still somewhat lower than the OECD average, they still represent a significant gap narrowing compared to the stronger OECD members (**Figure 2**). Nowadays, Estonia has a centralized healthcare system, funded largely through payroll taxes that are pooled into The Estonian Health Insurance Fund (EHIF), that is the major organization that manages Estonia's health services. All major hospitals are publicly owned, and provide both inpatient and outpatient specialist care. Most primary and dental care providers are private (Kasekamp *et al.*, 2025). Yet the biggest advantages of Estonia's healthcare system are its integrated digital services and public health reforms.

Under German occupation in the beginning of the 20th century, Estonia had a highly decentralized health system, which was mostly developed and managed locally and comprised of private hospitals, municipal hospitals and state-owned hospitals (Koppel *et al.*, 2008). Health insurance was mostly regionally organized and covered employees and their families. In the 1940s, under the Soviet occupation, the healthcare system became fully funded by the state, switching from an almost fully private system to a completely public system with central planning. However, it stayed overly regionally fragmented, focused on increasing hospital beds and surgical

³ Digital health refers to the use of information and communication technologies – such as mobile applications, telemedicine, wearable devices, electronic health records, artificial intelligence, and data analytics – to deliver, support, and improve healthcare, public health, and health system performance by enabling prevention, diagnosis, treatment, monitoring and patient engagement.

specialties, and neglected preventive programs, leading to a stagnation in mortality rates for almost 40 years (Koppel *et al.*, 2008; Sakkeus and Karelson, 2012). While in the 1930s the life expectancy in Estonia matched that of the Scandinavian countries, by the time the Soviets left Estonia in 1994, life expectancy at birth in Estonia was 66.6 years, ten years lower than the average in Scandinavia and eight years less than the European Union average (Figure 3) (Koppel *et al.*, 2008).

Trends in Estonian Health Outcomes Compared to the European Union and Latvia

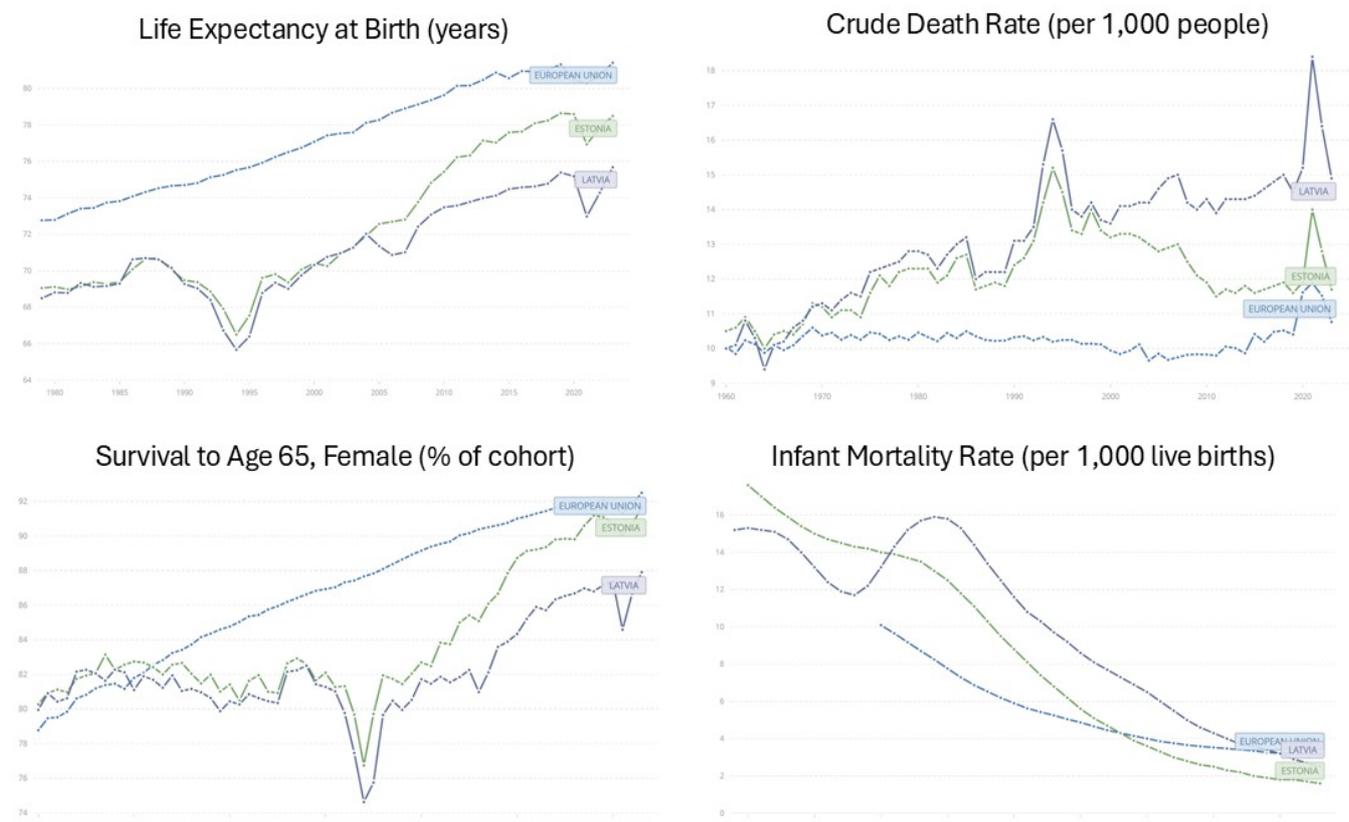


Figure 2 – Trends in Estonian Health Outcomes Compared to the European Union and Latvia

This figure depicts the trends in several health outcomes in Estonia, the European Union average and Latvia through time. Latvia was chosen to be depicted here as a comparison to Estonia because it shares a border with Estonia and was ruled by the Soviet Union as well and regained independence in 1991, the same year Estonia got its independency and three years prior to the withdrawal of the Soviet Regime from the region in 1994. These graphs demonstrate Estonia’s capability to close gaps with the European Union, while Latvia lags behind, with the exception of infant mortality rate. It should be noted, that the peak in crude death rate in all three entities in 2020-2021 is explained by the COVID-19 pandemic.

Source: World Bank Group Data at <https://data.worldbank.org/>

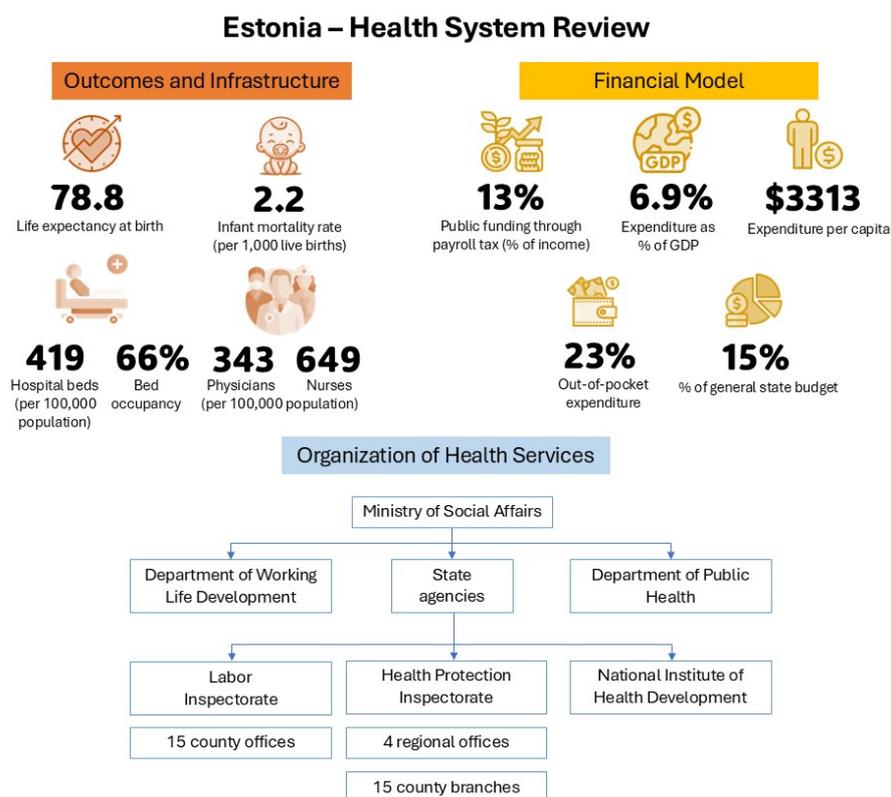


Figure 3 – A Snapshot of Estonia’s Healthcare System

Sources:

1. Kasekamp, K. *et al.* (2025) *Estonia - Health System Summary 2024 (updated)*. Copenhagen. Available at: <https://iris.who.int/server/api/core/bitstreams/fb684821-5020-4541-bb1c-4ddc64425308/content> (Accessed: October 18, 2025).
2. Pölluste, K., Männik, G. and Axelsson, R. (2005) “Public Health Reforms in Estonia: Impact on the Health of the Population,” *British Medical Journal*. BMJ Publishing Group, pp. 210–213. Available at: <https://doi.org/10.1136/bmj.331.7510.210>.

In the beginning of the 1990s, the new Estonian government made it a priority to leverage both its young and newly democratic status and the innovative potential of the internet in order to reconstruct its governmental structure and digitize all of its public services (Widén and Haseltine, 2015). For example, the Ministry of Social Affairs was created by merging the former ministries of Health, Social Welfare and Labor, which resulted in the creation of two synergistic departments – the Department of Public Health and the Department of Working Life Development – responsible together for health promotion, disease prevention, environmental health, communicable disease control, occupational health, and safety issues (Pölluste, Männik and Axelsson, 2005). The focus has shifted towards prevention, and the heavy investment in new technologies led to the creation of a central digital health database and easily accessible and highly secure electronic health charts. The digital system has led to shorter waiting times to access health services, simplified permit applications and medical appointments, and reduced administrative burden for companies, employees and individuals (Widén and Haseltine, 2015). Most importantly, the

digital system made it easier for Estonia to launch health promotion initiatives such as HIV prevention, children and adolescent health programs, tuberculosis prevention and treatment etc. (Põlluste, Männik and Axelsson, 2005). During the COVID-19 pandemic, Estonia leveraged its extensive digital platform to tackle COVID-19 education, testing, contact tracing, and vaccinations (OECD and WHO, 2021).

The Estonian model is a strong example of leveraging the end of occupation to completely rethink the entire governmental system in order to serve its residents and citizens. By digitizing services and synergizing regulatory departments, they were able to simplify bureaucracy, increase access to healthcare, reduce costs and improve health outcomes. However, it should be noted that this is more easily implemented in a small population of 1.3 million people who mostly speak one language. Therefore, adapting this model in a land of more than 14 million people who speak mainly two different languages may be challenging. In fact, the Russian-speaking minority in Estonia is suffering from worse health outcomes compared to the Estonian majority, despite similar access to care, due to the lack of use of the Russian language in the healthcare system (Poleshchuk, 2016).

Furthermore, Estonia is also an example of how to reconcile conflicts regarding citizenship and residency post-occupation, which is critical for access to health. Following Estonia's independence, many former Russian-speaking citizens of the Soviet Union found themselves stateless, as the Estonian government only recognized the citizenship of those who had pre-occupation citizenship and their direct descendants, and denied it from those who arrived after 1940. In 1993, the Estonian Parliament passed The Citizenship Act, which standardizes the naturalization process for non-citizens, requiring mainly residency in Estonia for at least two years since its independence, knowledge of the Estonian language, and a pledge of loyalty to the country (Ludwikowski, 1996; Kemp and Hague, 2001). This was perceived as a discriminatory law against the Russian-speaking minority, and in order to prevent an armed conflict the Conference for Security and Cooperation in Europe (CSCE) got involved and led to a significant compromise of both sides: the Estonian government promised that all non-citizens would be eligible to apply for citizenship and that the language exams would not be too complicated, and the Russian-speaking authorities committed to respect the territorial integrity of Estonia and abide by its rule of law and Supreme Court (Khrychikov and Miall, 2002). As a result, the percentage of non-citizens in Estonia dropped from 32% in 1992 to 8% in 2007 (Freedom House, 2008). This contributed to the centralization of the healthcare system and allowed public insurance coverage for more than 95% of the population.

Reforming a Healthcare System Following Unification to One Sovereign State – The German Healthcare System

When envisioning a future healthcare system in Israel-Palestine, maybe the most interesting model to explore is the German healthcare system post-unification. For nearly 45 years, East and West Germany had distinctively separate healthcare systems, with different political and financial models, which needed to be reorganized after the fall of the Berlin Wall in 1989.

The German healthcare system has always been a model for Western modern medicine, ever since the passage of the National Health Insurance Law in 1883, which established the “Bismarckian Social Security System” that promoted state-operated health services. Many of the current Western healthcare systems are inspired by and based on this idea of solidarity and universal health insurance in which all insured persons contribute to the funding of the system through their income, regardless of their health risks, and in return they are entitled to receive services according to their medical needs (Busse *et al.*, 2017). When World War II ended in 1945, Germany was divided and split between the Soviet Union and the Allies. Communism was introduced to East Germany and as a result, the healthcare system became fully centralized and all services were nationalized. Private and independent practices were prohibited, and instead the Soviets opened polyclinics – outpatient clinics that combined multiple specialist departments, special dispensaries and counseling centers. In the meantime, in West Germany, the original pre-war healthcare system continued to operate as a decentralized self-governing system (Ryu, 2013). During the 45 years of separation, due to underfunding, personnel shortage and lack of access to modern equipment, East Germany had fallen behind West Germany in terms of health outcomes (Gjonca, Brockmann and Maier, 2000; Koch *et al.*, 2019; Simpson *et al.*, 2024) (Figure 4).

Trends in Health Outcomes in East and West Germany

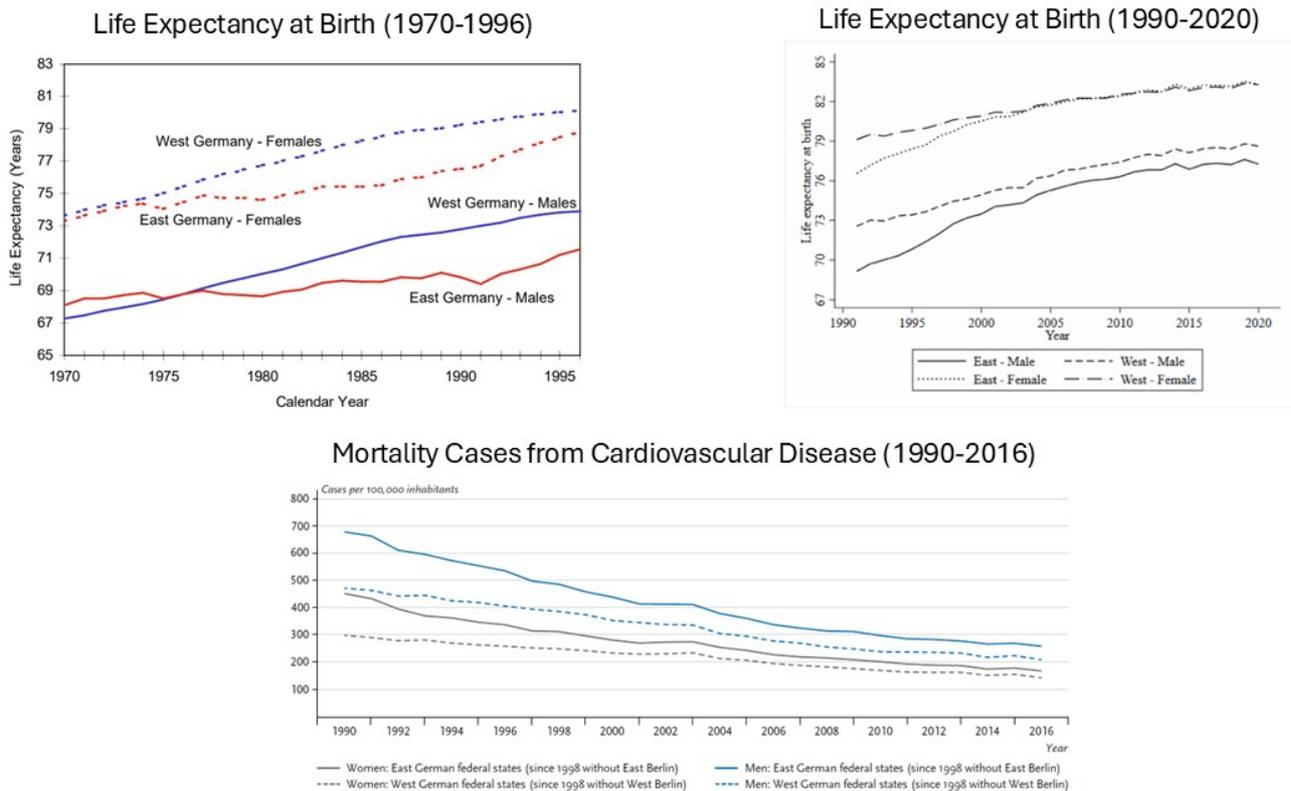


Figure 4 – Trends in East and West Germany’s Health Outcomes Before and After Reunification

The left upper panel shows the separation in life expectancy at birth for both men and women between East and West Germany during the division years. Despite similar life expectancy in the beginning of the 1970s, from around 1975 the life expectancy in East Germany plateaus while the life expectancy in West Germany continues to rise, opening a gap between the two populations. The right upper panel shows the trends in life expectancy for men and women after reunification, with a demonstration of gap narrowing and closure by 2005, with some residual difference in life expectancy for men between East and West Germany. The lower panel shows the gaps in mortality from cardiovascular diseases in the beginning of the 1990s, and the significant narrowing of these gaps in both men and women in East and West Germany by 2016.

Sources:

1. Gjonca, A., Brockmann, H., & Maier, H. (2000). Old-Age Mortality in Germany prior to and after Reunification. *Demographic Research*, 3. <https://doi.org/10.4054/demres.2000.3.1>
2. Simpson, J., Albani, V., Kingston, A., & Bamba, C. (2024). Closing the life expectancy gap: An ecological study of the factors associated with smaller regional health inequalities in post-reunification Germany. *Social Science and Medicine*, 362. <https://doi.org/10.1016/j.socscimed.2024.117436>
3. Koch, R., Lampert, T., Müters, S., Kuntz, B., Dahm, S., & Nowossadeck, E. (2019). 30 Years After the Fall of the Berlin Wall: Regional Health Differences in Germany. *Journal of Health Monitoring*, 2019(S2), 4. <https://doi.org/10.25646/6077>

The dramatic political change in East Germany after the fall of the Berlin wall in 1989 led to rapid economic and public health crisis. The freedom to move and work in West Germany pushed many healthcare workers to leave East Germany, which worsened the crisis. As a result, in March 1990, the Ministry of Health in East Germany decided to significantly increase salaries within the healthcare system as an incentive to stay (Ryu, 2013). At the same time, negotiations on re-unifications had started between the two governments (East and West Germany) and included discussions on integrating the financial and social systems of both countries. Specific conversations were held with the focus of integrating the healthcare systems, involving health and public policy experts. Opinions of experts ranged from rejection of “anything socialist” to a call to preserve the decades of work

on the East German system and leverage its accomplishments, such as the polyclinics, the daycare institutions and the decommercialization of medicine, with the acknowledgement that even the system in West Germany requires reforms (Schirmer, 1993). On the other hand, they were met with the counter-argument that there are no need, time or funds to experiment when West Germany has an already proven successful healthcare system. Further changes and reforms can be implemented when needed for the entire unified Germany. The main dispute was in regard to enabling private funds and insurance companies to enter East Germany. Eventually, given time pressure due to the financial crisis at the time, the conclusions from other negotiation talks on related systems such as education, finances, law and welfare that were needed to be integrated as well, and the understanding that West Germany will have to invest significantly in East Germany, a decision was made to impose West German practices and regulation on East Germany. This included the implementation of universal health insurance and multiple Sickness Funds in East Germany (as opposed to one centralized insurance plan, funded by the government), with increasing salaries for healthcare workers, in order to build up the needed infrastructure. In fact, the significant commitment of funds and manpower by West Germany was only possible because everyone knew that West Germany's practices were to be transferred as is. It made it easier for healthcare workers to move from West to East, with the understanding that they will practice in a familiar system (Schirmer, 1993). Polyclinics, initially planned to be preserved, eventually were kept for a limited period of five years (Schirmer, 1993; Ryu, 2013). On the other hand, private practices and pharmacies were allowed in East Germany after a few years. Consequently, access to healthcare increased in East Germany, and already in 1992 there are reports on high patient's satisfaction from the quality of care and the newly equipped facilities (Schirmer, 1993; Lüschen, Niemann and Apelt, 1997).

Today, Germany is one of the world leaders in modern medicine, research and medical technologies. Its health outcomes are among the best in the world, and higher than the OECD average (Blümel *et al.*, 2024) (**Figure 5**). In 30 years, health gaps between East and West Germany have diminished significantly (Grigoriev and Pechholdová, 2017; Koch *et al.*, 2019). This is probably due to the fact that both healthcare systems originated from the same Bismarckian socialist system, and both had already excellent medical professionals and facilities in place prior to re-unification. Additionally, the significant influx of funds and talent from West to East Germany played a significant role in this successful re-unification of the healthcare system.

The German model fits beautifully into the Israeli-Palestinian context and correlates with the discussion on the Israeli healthcare system above. Both Israel and the occupied Palestinian territories have excellent health professionals who receive

high-quality training, and this can be leveraged in a situation of unification (or open borders), just as it was in Germany. Another important factor that made the German case a success is the significant investments done by the stronger and more stable entity, in this case West Germany. In Israel-Palestine, this can be considered as reparations for previous wrong-doings or simply fair distribution of investments based on financial capacity when building new systems and infrastructures. These investments also caused West Germany to have more skin in the game, which strengthened the commitment for successful transition and pushed professionals from West Germany to open new practices in East Germany, knowing that they will be supported.

At the same time, a few challenges should be taken into account. First, when one stronger system absorbs the other, it doesn't fix the problems and shortcomings of the former. The Israeli healthcare system may have advantages over the Palestinian one, but it also already has systemic failures that lead to discrimination, especially against Palestinians. Second, the expansion of the West German system to East Germany led to a situation in which almost all managing positions in East Germany were taken by professionals from West Germany. This perpetuated unfair power dynamics, and in the case of Israel-Palestine it should be avoided at all costs. Lastly, the German model depended on negotiations that discussed not only healthcare but also other systems that corresponds with it, and eventually the integration succeeded thanks to its compatibility with the implemented legal, political and economic frameworks. A confederation of two sovereign countries which can have different legal, political and economic systems may not be similar to the unification of two countries into one.

Germany – Health System Review

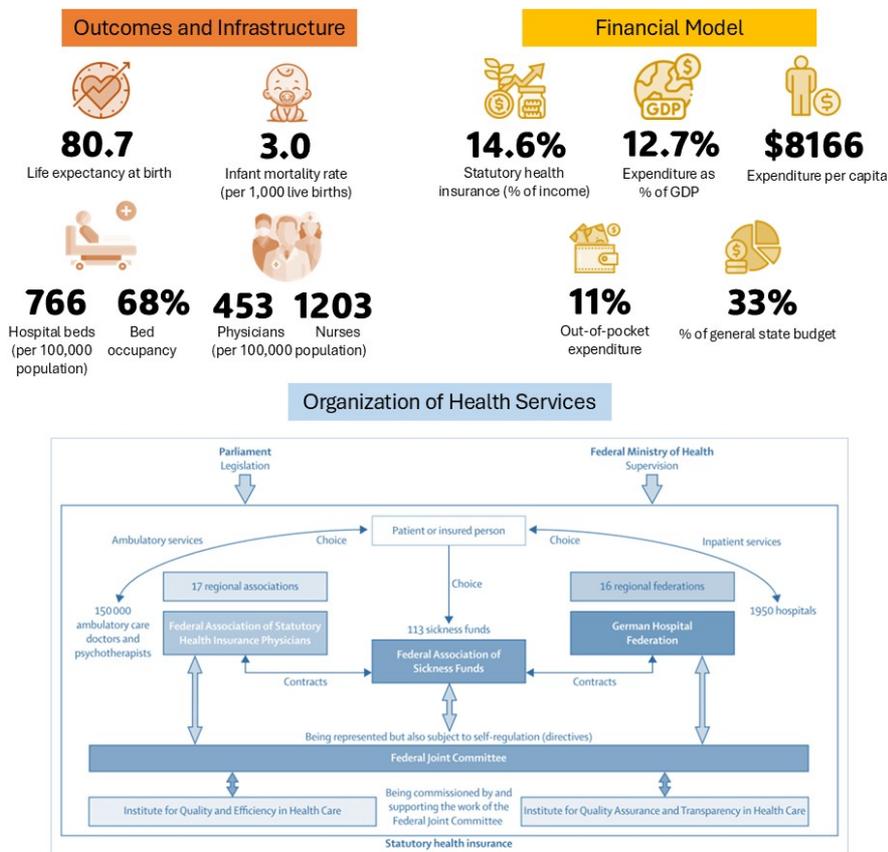


Figure 5 – A Snapshot of Germany’s Healthcare System

Sources:

1. Blümel, M. *et al.* (2024) *Germany - Health System Summary 2024*. Copenhagen. Available at: <https://p4h.world/app/uploads/2025/08/Germany-health-system-summary-2024.x14225.pdf> (Accessed: October 19, 2025).
2. Busse, R. *et al.* (2017) “Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition,” *The Lancet*. Lancet Publishing Group, pp. 882–897. Available at: [https://doi.org/10.1016/S0140-6736\(17\)31280-1](https://doi.org/10.1016/S0140-6736(17)31280-1).

Standardizing Healthcare Systems Following Unification of Multiple Sovereign States – The European Union’s Healthcare System

By the end of World War II, when plans were made to rebuild Europe, a European union and integration were thought to be an antidote to the isolating nationalism that led to the war. As a result, the Treaty of Brussels was signed in March 1948, and the Council of Europe was founded in 1949 with the goal of bringing the sovereign states of Europe together to plan and share policies, including those related to health.

Within the EU, each member state maintains an autonomous social healthcare system, with responsibility for its regulation, financing, and administration vested in the respective national government. Nonetheless, the EU possesses a supranational health policy framework intended to coordinate, complement, and guide national health strategies. This framework encompasses EU-wide legislation and a range of

shared institutions – such as the European Centre for Disease Prevention and Control (ECDC) and the European Medicines Agency (EMA) – which collectively support member states in addressing public health challenges and ensuring policy coherence across the Union (EU, 2022) (**Figure 6**).

According to the EU's official position, the Union does not supplant national health policies but rather complements them by assisting member governments in attaining shared objectives, pooling resources, and confronting transnational health issues. In addition to establishing EU-wide regulatory standards for health-related goods and services⁴, the Union provides financial support for health initiatives across member states. The principal objectives of EU health policy include safeguarding and promoting population health, ensuring equitable access to high-quality and efficient healthcare for all EU citizens, and coordinating responses to significant cross-border health threats.

This institutional arrangement is underpinned by seven foundational principles of European integration (Greer *et al.*, 2022):

1. **Harmonization** – the establishment of common regulatory and technical standards (e.g. basic requirements for medical education and training);
2. **Mutual recognition** – the prohibition of discrimination against goods, services, capital, or citizens from other member states (e.g. a physician with a medical license from an EU country can work anywhere in the EU);
3. **Country of origin principle** – the acceptance of products and services deemed compliant in one member state as valid in all others (e.g. a prescription from a doctor in one EU country is valid in all other EU countries);
4. **Direct effect** – the immediate applicability of EU law within member jurisdictions (e.g. citizens of the EU can claim immediate medical treatments in any EU country, overriding national rules that may hinder access);
5. **Supremacy of EU law** – the precedence of EU legislation over conflicting national laws (e.g. citizens can enforce data protection of their medical records in their own country based on the General Data Protection Regulation of the EU);
6. **Subsidiarity** – the principle that EU intervention is justified only when objectives cannot be effectively achieved at the national level (e.g. each

member state has its own vaccination regulation and strategy, but the EU implemented a centralized intervention and strategy during the COVID-19 pandemic);

7. **Decentralized enforcement** – the implementation and monitoring of EU legislation by national authorities (e.g. a medical device must meet EU-wide essential requirements, but enforcement of any violations is under the responsibility of the member state).

As a result of this governance model, EU member states retain the flexibility to design healthcare systems that address local priorities, while simultaneously adhering to unified standards for medical education, professional accreditation, pharmaceutical regulation, environmental health, and public health interventions. These common frameworks facilitate policy convergence and enable the provision of cross-border healthcare services, wherein citizens may access medical treatment in other EU countries with financial reimbursement from their home systems (Greer *et al.*, 2022).

A comparable institutional model could be envisioned for a future Palestinian–Israeli Union (PIU). The adoption of these foundational principles would enable the free movement of goods, services, capital, and people, thereby enhancing healthcare accessibility and integration throughout the Union. Each constituent entity would maintain its own healthcare system – with independent authority over financing, workforce management, infrastructure, and legal frameworks – while residents of the PIU would be entitled to seek affordable, high-quality care from any accredited provider within the Union. Furthermore, the PIU would be able to establish harmonized standards for healthcare quality, medical licensing, and the regulation of food and pharmaceuticals, administered by joint institutions composed of Israeli and Palestinian representatives with equal decision-making authority.

European Union Health System Structure

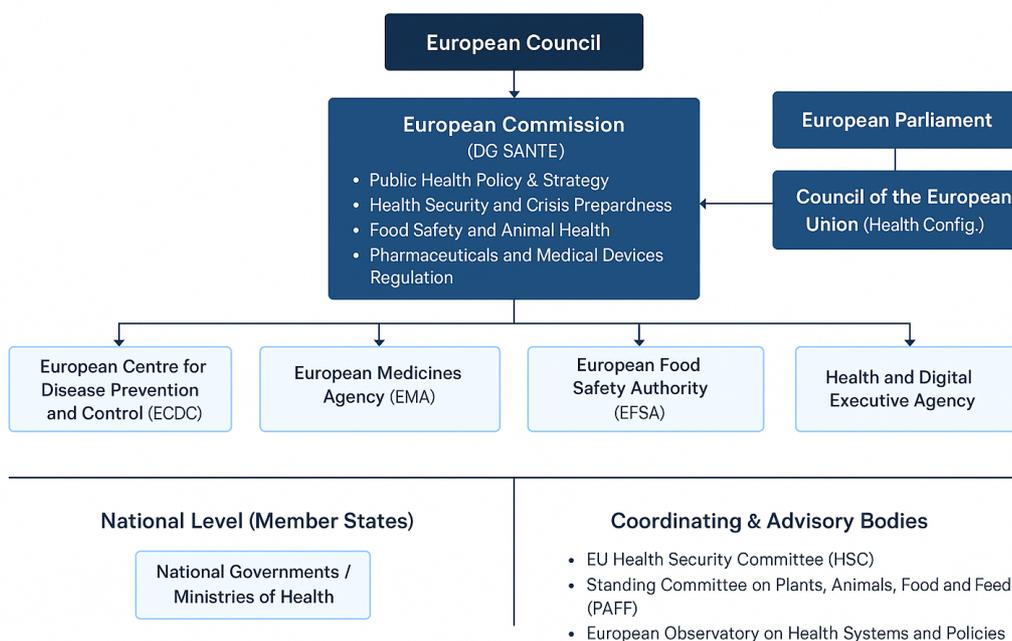


Figure 6 – Organizational Chart for the Structure of the European Union Health System

Source: Greer, S.L. *et al.* (2022) *Everything you always wanted to know about European Union health policy but were afraid to ask*. 3rd ed. The European Observatory on Health Systems and Policies. Available at:

<https://apps.who.int/iris/rest/bitstreams/1423267/retrieve>.

Recovering a Healthcare System Post-Genocide – The Rwandan Healthcare System

Rebuilding and reimagining healthcare in Israel-Palestine cannot be discussed without acknowledging the near-total destruction of the healthcare infrastructure in Gaza. It poses a significant challenge that cannot be overlooked. Therefore, it is critical to examine rebuilding of healthcare systems in war-torn areas. The Rwandan case can be such a model to explore.

When the Rwandan genocide ended in mid-July 1994, its healthcare system was facing total collapse. Many of the healthcare facilities were looted or destroyed (C Vickery, 1994). More than 80% of Rwanda's health professionals were either killed or escaped to the refugee camps in Zaire (Eriksson *et al.*, 1996). Those remaining were mostly junior workers, with low level experience and training, and the senior ones in Zaire were not allowed to return by active Hutu militias who continued to operate and terrorize them. It should also be noted, that many health professionals took active part in the genocide, especially senior leaders, which caused a devastating break of trust between the community and the healthcare system (C Vickery, 1994). After the Tutsi captured Kigali, hundreds of thousands of Hutus fled into Zaire in less than a week, resulting in a major humanitarian crisis with the spread of many infectious diseases and insufficient supply of water and food. Almost 50,000 people died in the refugee camps in the month that followed the ceasefire (Willis and Levy, 2000).

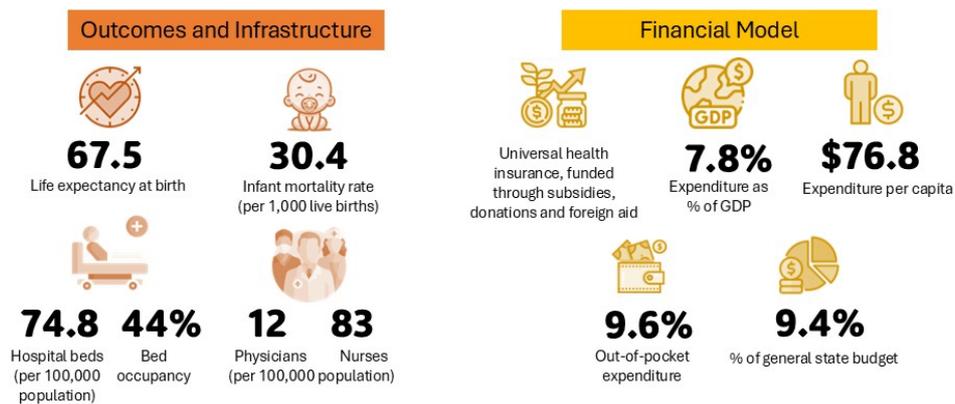
In order to rehabilitate the healthcare system, a few steps were taken. First, the urgent humanitarian needs had to be addressed. Significant influx of funds, equipment, medications and trained professionals arrived in Rwanda thanks to external donors, international non-governmental organizations (NGOs) and formal agencies. The World Health Organization supported the Rwandan Ministry of Health in reconstituting public health program such as replenishing vaccine stocks, implementing safe blood supply, rebuilding clean water and sanitation systems, and establishing HIV prevention programs (Eriksson *et al.*, 1996). In the following years, the Rwandan government had decided to invest heavily in community-based healthcare, to allow for better access to health in rural areas and train health professionals to focus on public health (Uwishema, 2023). It also invested in information systems and technology to better collect data, improve policy decision-making and increase the system's effectiveness in tackling diseases (Binagwaho *et al.*, 2014). Finally, a significant effort was made to deal with the trauma of the genocide through introducing a national mental health policy in 1995, less than a year after the genocide (Sabey, 2022; Yarlagadda, 2022). Community health workers were trained to provide mental healthcare, professionals were trained in newly opened psychology departments in universities, and the national health insurance was expanded to cover mental health issues. Additionally, many NGOs implemented therapy and counselling programs, as well as community-based healing programs that were focused on reconciliation and were encouraged by the government (Sabey, 2022).

In the 30 years that passed since the genocide, life expectancy in Rwanda increased by more than 20 years (**Figure 7**), maternal and child mortality decreased by more than 20%, and incidence of infectious diseases such as HIV, malaria and tuberculosis continue to decline (WHO, 2024). With its clear vision and policy implementation, Rwanda was able to outperform its neighboring countries in Africa, and narrow the gaps with high-income countries (Dhillon and Phillips, 2015). However, Rwanda still faces a severe shortage in healthcare workers, challenges with equipment and medication availability, and significant disparities and inequalities between rural and urban areas (Balkrishnan, Selden and Rusingiza, 2025).

The healthcare system in Gaza will probably need a similarly robust rebuilding plan. Similar to post-genocide Rwanda, Gaza's healthcare workforce is based mainly on untrained junior personnel, its equipment and facilities are almost completely destroyed, and the devastating housing and sanitation conditions lead to a continuously humanitarian and public health crisis. Therefore, there is a dire need for significant investments for the rebuilding of medical facilities, training medical personnel, facilitating entrance of food, medications and experts, and promoting comprehensive community-based public health initiatives to implement

prevention programs. Special efforts should be made to implement mental health programs as well, to address the significant trauma of the genocide survivors in Gaza. All of these actions were taken successfully in Rwanda, which received major international support, both financially and professionally. In Gaza, however, because the political dispute is not over after the ceasefire, the rebuilding plans are still withheld. Israel has complete control over entrance of funds, equipment and manpower to Gaza, and just recently announced that it halts the work of 37 international aid agencies in Gaza (Burke, 2025). Hence, any rebuilding of the healthcare system in Gaza (and any other civil system, for that matter) cannot be fulfilled while Israel continues to hold control over exits and entrances to the Gaza Strip.

Rwanda – Health System Review



Organization of Health Services

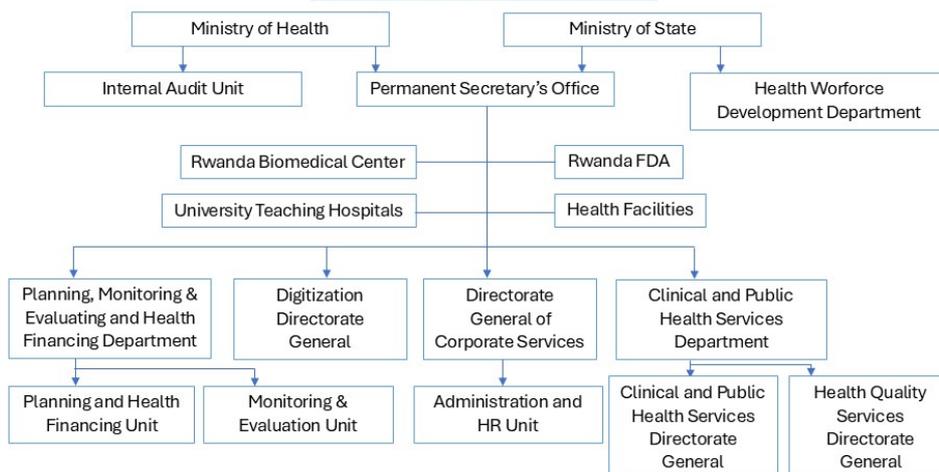


Figure 7 – A Snapshot of Rwanda’s Healthcare System

Sources:

1. MOH Rwanda (2021) *Rwanda Health Sector Performance Report*. Available at: https://www.moh.gov.rw/fileadmin/user_upload/Moh/Publications/Reports/Health_sector_performance_Report_FY_2019-2020.pdf (Accessed: October 21, 2025).
3. MOH Rwanda (2024) *MOH Rwanda Organizational Structure*, <https://newmoh.prod.risa.rw/about/organizational-structure>. Available at: <https://newmoh.prod.risa.rw/about/organizational-structure> (Accessed: October 21, 2025).
4. WHO (2024) *WHO data - Rwanda 2024*. Available at: <https://data.who.int/countries/646> (Accessed: October 20, 2025).
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6. *World Bank Group Data - Rwanda (2022)* <https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=RW>. Available at: <https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=RW> (Accessed: October 21, 2025).

Discussion

Through exploring different models of healthcare systems in times of transition, this paper is trying to collect possible pathways to address current and future challenges of the Israeli-Palestinian healthcare systems. All of these models have a few concepts and strategies in common that should be emphasized – they all invest in public health and preventive medicine, have universal and/or mandatory health insurance, permit freedom of choice between healthcare providers, and leverage innovation and external funds to the benefit of the system. This way, they all at least strive to provide equitable and affordable healthcare to their residents. Table 1 provides a summarizing comparison between the five models, while Table 2 focuses on expected challenges in the future healthcare system of Israel-Palestine, and the possible solutions that can be adapted from the aforementioned models.

Table 1 – Summary of All Five Models

Model	Historic Context	Organizational Structure	Financial Model	Relevance to Israel-Palestine	Advantages	Disadvantages
Israel	First hospitals and HMOs were established under the Ottoman Empire through philanthropy and cooperatives, respectively. During 1930-1948, most of the private institutions and networks were transferred to the management of Israeli authorities	<u>Regulatory entity</u> : Ministry of Health <u>Care delivery</u> : Mostly public services through HMOs, and private providers to a lesser extent <u>Personnel training</u> : centralized and strict supervision, small number of authorized programs in	<u>Funding policy</u> : public funding through state budget and a dedicated health tax (5.17% of income) <u>Insurance policy</u> : universal insurance for all residents. HMOs can offer premium additional services with additional pay, and individuals can purchase private insurance as well <u>Out-of-pocket expenditure</u> : 34.8%	This is the strong and established healthcare system in the region It was started under occupying regimes through external aid and philanthropy, exemplifying a model which enables to start building a future system for a shared homeland right now.	Publicly funded system (affordable) Operates in both Hebrew and Arabic High-quality care Easily scalable and duplicated Prioritizes prevention	Has ingrained systemic discrimination against minorities Multiple roles of the Ministry of Health as funder, regulator and provider of care. Generally underfunded and understaffed system

		universities and clinical practices	<u>Payment policy:</u> HMOs receive funds per capita, and re-imburements per service			
Estonia	Regaining independence after a century of foreign occupation, Estonia decided to prioritize trust and transparency between the public and the government. It had digitized and simplified all governmental services, including health records and delivery. It also combined health regulation with employment and welfare, to prioritize preventive medicine in all walks of life.	<u>Regulatory entity:</u> Ministry of Social Affairs <u>Care delivery:</u> mostly private providers, and some services are delivered publicly through state agencies. <u>Personnel training:</u> centralized and strict supervision, small number of authorized programs in universities and clinical practices	<u>Funding policy:</u> public funding through a payroll tax (13% of income) <u>Insurance policy:</u> all residents and citizens are insured through the Estonian Health Insurance Fund (EHIF) and it is the sole buyer of health services. <u>Out-of-pocket expenditure:</u> 23% <u>Payment policy:</u> fee-for-service (EHIF pays the providers based on agreements)	A model of rethinking governance when transitioning from occupation to democracy, with an emphasis on trust and transparency. A model of how to solve the problem of a fragmented regional care delivery,	Publicly funded system (affordable) Easily accessible Prioritizes prevention Strong digital infrastructure that protects personal data An example on how to leverage an already centralized system to benefit the public and still allow for freedom of choice between providers and freedom of providers to work privately.	Operates in one language (Estonian) Still has significant internal health gap related to socioeconomic status Generally underfunded and understaffed system
Germany	The unification of East and West Germany in 1990 led to a series of negotiations to discuss the unification of all social systems. A decision was made to expand the healthcare system of West Germany to East Germany with minimal amendments.	<u>Regulatory entity:</u> Federal Ministry of Health <u>Care delivery:</u> ambulatory services are mostly private for-profit providers, while inpatient services are public non-profit and for-profit providers. <u>Personnel training:</u> high-quality high-capacity programs with high percentage of international students.	<u>Funding policy:</u> public funding through a payroll tax (14.6% of income), and sickness funds can charge additional payments <u>Insurance policy:</u> universal compulsory insurance for all residents through employment and 95 different sickness funds + possibility for private insurance <u>Out-of-pocket expenditure:</u> 11% <u>Payment policy:</u> fee-for-service and contact capitation for outpatient services, and global diagnosis-related payment for inpatient services	A model of unification of two different health systems. This model is fundamentally based on open borders and freedom of movement of people, goods and services. Significant investment from West Germany in the development of East Germany was needed.	Publicly funded system (affordable) High-quality care Prioritizes prevention	Operates mostly in one language (German) Very strict data regulations that make it challenging to implement public policies
European Union	The EU was founded after World War II to create a shared policy for Europe that will encourage collaboration as opposed to division.	The European Council oversees the European Commission, which is the executive arm	EU's institutions are funded by member states' contributions based on gross national income. Every member state is	Provides a compelling model for collaboration in health policies and care delivery between multiple sovereign countries	Keeps the independence and sovereignty of each country Provides differential support to	Difficulty bridging between different health systems The EU has minimal enforcement capacity of its policies

		of the EU. The European Commission is responsible for EU's strategy development and implementation, including health strategies. Every member state has its own health system and regulation, but they all must comply with EU-wide regulations.	responsible of funding its own healthcare system.	that have open borders and freedom of movement.	individual countries based on their needs A model of shared regulatory institutions that can provide a guiding public health policy Allows significant access to care with patients able to receive care anywhere, and providers able to deliver care anywhere in the EU	
Rwanda	After the genocide in 1994, Rwanda used external aid to invest in its community-based healthcare system, with a special emphasis on mental health.	<u>Regulatory entity:</u> Ministry of Health <u>Care delivery:</u> Public services through village health workers, health centers, district hospitals and national referral hospitals <u>Personnel training:</u> only two universities provide medical training	<u>Funding policy:</u> mostly reliant on external aid <u>Insurance policy:</u> universal insurance, through a system of health insurance providers, mostly based on subsidies and a small annual fee <u>Out-of-pocket expenditure:</u> 9.6% <u>Payment policy:</u> fee-for-services and pay-for-performance (the insurance providers re-imburse the clinical provider)	Addresses the issue of rebuilding a healthcare system post-genocide A model of using community-based programs to rebuild trust in the system and address traumatic events.	Publicly funded system (affordable) Easily accessible Prioritizes prevention and mental health Easily scalable and duplicated Leverages workers in local communities to provide high-access to care Operates mainly in one language (Kinyarwanda)	Non-sustainable financial model Severely underfunded and understaffed system Poor data quality and management

Table 2 – Expected Challenges in the Future Healthcare System and Possible Solutions

Challenge	Model Solution	Possible adaptation in Israel-Palestine	Comments
Infrastructure funding and rebuilding	Israel – mostly through private philanthropy and NGOs	Philanthropy	Not sustainable in the long-term, but can philanthropy, foreign aid and reparations can be leveraged in the short-term, until the system is financially independent. Another option for long-term funding is collaborations with the for-
	Germany – influx of funds, equipment and manpower from West Germany to East Germany	Reparations (or significant investments) from Israel to Palestine dedicated for building infrastructure.	

	Rwanda – mostly philanthropy and foreign aid	Foreign aid can also take the form of reparations from other countries.	profit medical industry, locally and internationally.
Training medical professionals	Israel – citizens can be trained either locally or internationally, but they are subjected to the same licensing requirements when graduating, under the supervision and qualification of the Ministry of Health.	Cross-border training, with licensing per local regulations of each state.	Essential requirements for this model to work are complete freedom of movement of people, funds and equipment in the shared homeland (i.e. open or no borders), and mutual control and partnership over the transfer of resources, goods and services, based on equal distribution of power rather than supremacy.
	EU – standardization of requirements for medical education and training for all EU members. An EU medical license applies in all EU member states.	Each sovereign state may have its own regulation regarding professionals licensing and training, which must comply with the requirements of an overseeing regulatory body which is shared by Israel and Palestine.	
Regulation over separate sovereign entities	EU – the seven foundational principles of European integration	Each sovereign state would maintain its own healthcare system – with independent authority over financing, workforce management, infrastructure, and legal frameworks – while residents of the shared homeland would be entitled to seek affordable, high-quality care from any accredited provider within the borders.	This concept mandates shared institutions and committees that will be jointly led and managed.
Addressing large influx of new patients	Israel – cooperative-led sick funds + rapid credentialing of returning health professionals	Expanding the HMOs to the entire shared homeland and allowing each returning resident/citizen to be eligible for health services by paying a dedicated tax. Implementing a policy for a rapid qualification and certification process for incoming healthcare workers, to answer the increase in demand.	Any large influx of new patients can only be addressed by a system that is based more on outpatient community-based services than on inpatient hospital-based services. The current facilities in Israel-Palestine are already overwhelmed, underfunded and understaffed, so a shift must be taken towards more preventive measures, and incentivizing home- and outpatient care.
	Rwanda – community-based healthcare (training local community workers in basic care delivery)	Training laymen to provide basic care in rural areas, giving more responsibilities to local nurses, and incentivizing physicians to work in the community.	
	Estonia – complete digitization of healthcare and governmental services	Allow easy access to medical records online, with easily operated appointment scheduling system, notifications for tests due, and strict data protection policies.	

Unification and integration of different health systems	Germany – expansion of the system of West Germany to East Germany with minimal amendments	Expansion of Israeli HMOs to the entire shared homeland, while heavily investing and rebuilding infrastructure in the previously occupied territories.	Essential requirements for this model to work are complete freedom of movement of people, funds and equipment in the shared homeland (i.e. open or no borders), and mutual control and partnership over the transfer of resources, goods and services, based on equal distribution of power rather than supremacy. It also requires heavy investments in previously underserved areas.
	EU – unification of only policy-making and regulation entities, without unification of the individual systems.	Each sovereign state would maintain its own healthcare system – with independent authority over financing, workforce management, infrastructure, and legal frameworks – while complying with the shared regulatory bodies of both states.	
	Unification and integration of different health systems	Estonia – allowing care delivery to remain fragmented and decentralized while the payment, insurance, documentation and regulation systems become centralized.	
Building trust in the system	Estonia – prioritizing trust and transparency through open digital governance while personal data is completely owned by the citizens.	Digitizing government services, including health, to the benefit of the public, with strict data protection regulations and constant tracking data access and usage by governmental and external actors.	After decades of Israeli surveillance over Palestinians using digital technologies, this specific model may be perceived as suspicious. The Germans chose to not digitize their system because of their past, leading to a privacy-promoting yet very inefficient health system. Therefore, transparency in data ownership and privileges must be a priority in adapting such a model.
	Rwanda – investing in local communities, public health, mental health and reconciliation process.	Investing in local communities, public health, mental health and reconciliation process. Publicly acknowledging the traumas of the past and their impact on health, with allocating public funding dedicated to treat them.	Acknowledgement of past wrongdoings must be a pillar in any future agreement, and should also be taught in future medical school to address the health impact of conflict-related traumas, individual and collective, physical and mental.

When focusing on specific expected challenges in Israel-Palestine, some of them can find resolution by adapting these described models. First, the challenge of building infrastructure and training health professionals to increase access to care can be addressed even prior to any peace agreement by using philanthropy, foreign aid and cooperatives, as in the cases of Israel and Rwanda. Training professionals can happen across borders, as learnt from the EU model, with a unified supervising

licensing authority. Even in our current reality, as of October 2025, more than half of Israeli physicians each year are trained abroad, Palestinian health workers still receive training in Israel or by Israeli professionals, and some PCIs are studying in Palestinian universities to be certified as doctors, nurses, physical therapists, dentists and psychologists. This multilateral movement of knowledge and skills should be encouraged and expanded, but must be based on total freedom of movement for all citizens and residents of the region. Furthermore, Israel's case shows that philanthropy and local leadership can be leveraged to build medical schools, local clinics and even Sick Funds which can later help fund the independent system. Reparations should also come into account when considering funding of system rehabilitation, as was the case in post-Apartheid South Africa (Knaggs, 2021).

Second, a major challenge of overwhelming the Israeli-Palestinian system is expected in case of large influx of returning refugees acting upon their right of return. Both the Israeli and Rwandan models, which are community-based and require minimal out-of-pocket participation in paying for health services, are flexible and easily implemented anywhere, and were shown to be successful in dealing with surprisingly high increase in numbers of patients in a short period of time. The Estonian model, which is a great example of innovation in governance, exemplifies that digitization of healthcare and other government services allows for more efficiency, accessibility and affordability, and can be easily scaled up.

Third, the challenge of unifying a fragmented healthcare system in the case of a shared homeland – especially in the case of two sovereign states or a confederation – may be the most difficult one to address. However, the German model shows that it is not only possible, but can actually lead to better health outcomes and erasure of prior health disparities. Yet, the way the Germans chose to do so was by totally consuming one health system by another, which was reasonable in the case of Germany as a one sovereign state which had a similar Bismarckian system before World War II. In the case of Israel-Palestine, it is reasonable to envision an expansion of the Israeli health system and HMOs to the Palestinian territories in the short-term, possibly led by health professionals who are PCIs, while at the same time heavily investing and rebuilding the Palestinian health infrastructure, as explained previously. Nevertheless, Palestinians, as free citizens of their own state, should be still able to manage and govern their own health system. The Palestinians have proven that despite their many challenges with living under occupation and martial law, they were able to build a strong medical education and training system, that also collaborates with other international universities, and attracts PCIs to study in its institutions. Its insurance policies are comprehensive and generous, its processes of data documentation and reporting are meticulous and well-established, and the implementation of public health policies is efficient when

uninterrupted by Israeli interventions. Hence, there are some aspects of the Palestinian health system that should be considered worth preserving, especially its main use of the Arabic language for personnel training and care delivery, and should be taken into account when considering unification.

The EU model gives a good example of how different sovereign states can design their own systems, while still comply with a unifying health regulation of the Union. Estonia and Germany are both members of the EU, and have different health system structure and regulation, but they both comply with EU-wide regulation. A similar model of such regulation, although organized completely differently, is the model of the United States of America, in which each state is entitled to regulate any activity related to health and welfare, including professional licensing, while the federal government is responsible to regulate any constitutional and interstate issues, such as commerce, impose taxes, and implement federal programs regarding public health such as approving new drugs and technologies, fund research and monitor diseases (Gatter, 2007; Field, 2017).

Fourth, as is expected after more than a century of violent conflict and oppression, lack of trust in governmental bodies, and specifically in what can be perceived as extension arms of a previously occupying force, may pose a significant obstacle to build a prosperous health system. Healthcare is based fundamentally on trust between patients and providers, between colleagues and teams from different disciplines, and between the public and decision makers. Medical mistrust was shown to be associated with worse health outcomes (Birkhäuser *et al.*, 2017; Souvatzi *et al.*, 2024; Shukla, Schilt-Solberg and Gibson-Scipio, 2025), and it is already prevalent in the Palestinian minority within Israel proper (Hermesh, Rosenthal and Davidovitch, 2020; Dahdal *et al.*, 2021; Even and Shvarts, 2023). However, Rwanda's case is an incredible role model on how investing in local communities, public health, mental health and reconciliation processes can rebuilt the lost trust and lead to improved health outcomes (Binagwaho and Frisch, 2019). In Estonia, after centuries of occupation, they have decided to make trust and transparency a first priority. Therefore, they have designed a digital system that is *“highly transparent and health professionals can communicate easily with patients. Moreover, patients are empowered to ‘lock’ and ‘unlock’ their own data thereby deciding who has access to their data. Moreover, being highly people-centered, citizens are also involved in key decisions about the system. Trustworthiness is built into the system’s design. Every time someone accesses a patient’s information, it is logged. No one can check the medical records just for curiosity”* (Directorate General of Human Rights and Rule of Law, 2023). In the context of Israel-Palestine, health harbors an opportunity to build trust among communities in conflict, which should be taken into

consideration unhesitatingly even prior to any future agreement (Landesman, Rubinstein and Englander, 2024; Abu Fraiha *et al.*, 2025).

Finally, there are still a few obstacles and challenges that are left unanswered. First, none of these models deal with unifying health systems that operate in two different languages. Language is a critical aspect of providing care, especially in some language-sensitive services such as mental health, speech therapy and child development. The current Israeli and Palestinian health systems operate quite separately in Hebrew and Arabic, respectively, and even though the vast majority of health professionals can practice medicine in English, most of the patients (both Israelis and Palestinians) do not speak English. This may also pose a challenge on regulation, training, licensing and information systems. In the short-term, PCIs can play a significant role in the unification of the systems, as they are mostly fluent in both Arabic and Hebrew and are familiar with both societies. The EU model that focuses on overseeing and regulating separate but intertwined systems is another possible solution. Other models, that were not explored in this paper, offer another solution – a bilingual/multilingual system such as in Canada (English and French), Switzerland (German, French, Italian and Romansh) and Belgium (Dutch, French and German), where many citizens are fluent in more than one language. In the long-term, major efforts should be made into making the Israeli-Palestinian shared homeland a bilingual homeland in which all citizens speak both Arabic and Hebrew.

Additionally, in each of these models, as well as in any other country, there are still significant health disparities that originate from social determinants of health (e.g., socioeconomic status, education level, employment, housing etc.) and political determinants of health (e.g., exposure to crime and violence, access to political power and influence, eligibility to vote, ability to actively participate in policy making etc.). These are expected to stay in any future configuration of Israel-Palestine as a result of decades of occupation, and specifically keep the Palestinians lagging behind the Israelis in health outcomes and access to care due to prior discriminatory policies of structural violence. This is also relying on the fact that the healthcare system is heavily dependent on policies regarding education, transfer of goods and funds, access to resources, and freedom of movement. All these should be taken into account in any future planning of the Israeli-Palestinian healthcare system, which must be based on principles of equality, affordability, accessibility, high quality and professionalism.

Recommendations

In an attempt to integrate the models and their adaptations discussed in this paper, a few recommendations regarding the future PIU can be offered:

- Foundational principles – Any future solution and design for the PIU's healthcare system must rely on three major concepts: (1) freedom of movement for all within the shared homeland; (2) eligibility to access all healthcare facilities and insurance options, regardless of citizenship status and place of residence; and (3) reparation payments and investments in the Palestinian healthcare system.
- Two independent and integrated systems – similar to the EU framework, each member state of the PIU will have its own established and independent healthcare system, with its own funding, staff, equipment, facilities, and legislation, but any resident of the union will be able to reach out to any health provider in the PIU and receive good quality and affordable care. The PIU will have unified standards for quality care, medical licensing, and food and drug administration, decided upon and regulated by shared institutions run by representatives of both Palestine and Israel with equal representation.
- Funding infrastructure – in the short-term, prior to any peace agreement, philanthropy, foreign aid and NGOs can be leveraged to build a strong healthcare infrastructure (hospitals, clinics, medical schools, labs etc.) in the current Palestinian territories, which can be transferred to the management of the Palestinian State once it gains independence. Cross-border transfer of knowledge and skills can continue and should be encouraged, supported and increased.
- Open borders and freedom of movement – in the immediate period after establishing a formal union, the first step that must be taken is opening the borders and allowing the Palestinians to receive care under the currently established Palestinian and Israeli healthcare systems. Israeli HMOs should be allowed to enter the Palestinian territories, build clinics and hospitals, and recruit patients, and Palestinian citizens should be allowed to enter Israel to receive care in high-quality facilities. Ambulances should be allowed to reach any area within the PIU territory.
- Leveraging technology and digitization – using the help of technology and telemedicine, and relying on Arabic-speaking professionals in both Israel and Palestine, access to healthcare can be provided for all PIU residents. It can

help overcoming the deep disparities between the two nations when it comes to healthcare and health indices, as well as promoting a universal healthcare system. Digitization can also promote transparency, but must come hand in hand with strict data protection policies.

- Shared public health institutions – these should be established to design common public health policies, including controlling communicable diseases, executing preventive programs, regulating cross-border health services, setting a unified standard for healthcare in the PIU, and promoting communication and collaboration between health providers.
- Financial model – In addition to having a universal insurance policy and public funding for the healthcare system, there should be a financial model in place to compensate for the decades of discrimination, destruction of hospitals, clinics and labs in the occupied Palestinian territories, killings of medical personnel, and denial of permission to access health facilities. Furthermore, the future sustainable funding model of both Israeli and Palestinian healthcare systems should be publicly funded with a differential formula that considers the economic and health disparities between the two nations.
- Community-based approach – similar to the Rwandan case, significant support should be given to establish local community-based practices that will focus on disease prevention as well as on mental health support. Special consideration should be given to a reconciliation process that addressed the health impact of past traumas.
- Bilingual system – the PIU's health system should strive to operate both in Arabic and Hebrew, and this should at least be required of health care workers working in both these systems.

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