60 Years of Health in Israel

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Message from the Minister of Health

This year, Israel is celebrating her 60th anniversary, and this is a fitting time to pause a moment and to look with pride at our achievements, particularly in the area of health.

Since the establishment of the State of Israel in 1948 the population has grown considerably. The waves of immigrants from Yemen, Iraq, Morocco, Ethiopia, Eastern Europe and the former Soviet Union as well as many western countries have created a complex and richly diverse population. Today, 60 years later, the population of Israel comprises over 7 million, and the health status of the population is continually improving.

Since 1995, with the introduction of the National Health Insurance Law, all residents of Israel have health insurance. The health system has become more efficient, the quality and diversity of health services has improved, and gaps in health status have narrowed. The overriding goal of the health system is the assurance of the right to health and to health services of all individuals in a just and equitable manner.

This publication, which has been prepared especially for the 60th anniversary of the State of Israel, presents data on selected health indicators and health-related behaviors, reflecting the impressive improvement in the health status of the population. Among the achievements of the health system are a steady increase in life expectancy and a corresponding significant decline in infant mortality and mortality from chronic and infectious diseases.

These successes and many others are the achievements of the entire health system and all its dedicated workers. In the name of the citizens of Israel I thank you all.

Sincerely,

Yaakov Ben-Yizri
Minister of Health
Message from the Director-General, Ministry of Health

On the sixtieth anniversary of the State of Israel, we take this opportunity to examine the achievements of the health system and the results of our labors.

In this special publication, the Israel Center for Disease Control has analysed and presented data on various health indices which describe the health status of the population and the trends and changes which have taken place over the past 60 years.

It is with great pride and satisfaction that we examine these data. A small country coping with large waves of immigration and with a myriad of challenges, whose population has multiplied more than 8-fold during the years, provides its residents with high quality health services and ranks highly among other countries with respect to most of the accepted health indices.

The standards of health care in Israel are on a par with those of leading countries in the world. High levels of professional medical care, of technology, methods of treatment and outcome assessment are among the features that are presented in the present publication.

The data indicate improving trends throughout the years, and this is not something that can be taken for granted. Every change is an expression of the effort invested in achieving this goal which includes important aspects of planning, policy, and investment of resources. Above all, the impressive achievements of the Israeli health system reflect the high personal and professional caliber of its workers, who work tirelessly towards the improvement and promotion of health.
All branches and sections of the health system continue to strive towards improving and promoting health, reducing morbidity and narrowing health disparities, thus contributing to the quality of life and general satisfaction of the population.

I would like to thank the Israel Center for Disease Control for collecting, analysing and presenting these important data on health in Israel and for the production of this special publication. Above all, I thank the health professionals, the medical teams and the health administrators whose work has resulted in the impressive achievements reflected in these pages.

Professor Avi Israeli

Director-General
Israel Ministry of Health
Introduction

We are pleased to present this special booklet on the occasion of the 60th anniversary of the independence of the State of Israel. This publication describes the health status of the population of Israel and the changes that have taken place in the 60 years that have passed since the establishment of the State. The information presented here includes data on basic health indicators such as fertility rates, life expectancy and infant mortality; data describing trends in morbidity and mortality from chronic and infectious disease; and data on behaviors and lifestyles associated with individual and population health.

During the first years of the State, the health system confronted challenges such as the urgent need to provide basic health services for the waves of immigrants and war refugees; epidemics of contagious diseases; limited resources and an incomplete infrastructure. The health system succeeded in meeting these challenges of the burgeoning State through the establishment of a comprehensive set of preventive health services for the entire population as well as a network of hospitals with the highest professional and academic standards.

Over the course of the past sixty years there have been impressive achievements in health, such as the marked improvement in life expectancy and the sharp decline in infant mortality and in mortality from cardiovascular and infectious diseases, in all population groups. However, the health system still faces many challenges in the years ahead, such as the introduction of new technologies and medications, effective health promotion and the reduction of health inequalities between the various population groups.

Professor Manfred Green
Director, Israel Center for Disease Control
1. Population Growth

Since the establishment of the State of Israel the population has grown considerably, from 872,700 in 1948 to 7,116,600 in 2006. The rate of population growth is higher among the Arab population than in the Jewish population. The Jewish population has grown approximately 7-fold, from 716,700 in 1948 to 5,703,300 in 2006. The Arab population has grown 9-fold, from 156,000 in 1948 to 1,413,300 in 2006 (Figure 1). The population characterized as "other", which comprises non-Arab Christians and individuals of undefined religious affiliation, numbered 309,900 at the end of 2006.

* "Others" - non-Arab Christians and individuals of undefined religious affiliation. Until 1995, "others" were included in the Arab population. From 1995, "others" are grouped together with the Jewish population.
2. Life Expectancy

2.1 Trends in life expectancy by sex

Life expectancy at birth is an indicator which estimates the average number of years an individual born in a certain year will live, with the assumption that mortality rates will remain constant throughout his life. Since the 1950’s, life expectancy in Israel increased by 11 years in men and by 12 years in women. In 2006, average life expectancy at birth was 78.4 for men and 82.2 for women, in comparison with the 1950’s, when life expectancy was 67.2 and 70.1 years, respectively (Figure 2). This increase can be attributed mainly to the decline in infant mortality and in mortality from cardiovascular and infectious diseases.

Figure 2: Life expectancy at birth in Israel, 1950-2006*

*Until the 1970’s, the data do not include the Arab population.
From the 1970’s onwards, the data include all population groups in Israel.
2.2 Trends in life expectancy by population group

The increasing trend in life expectancy is evident in all population groups in Israel. Life expectancy is still lower in the Arab population in comparison with the Jewish population (Figures 3 and 4). The closing of this gap remains an important challenge in the following years.

Figure 3: Life expectancy at birth by sex and population group, 1971-2006

Figure 4: Life expectancy at birth by sex and population group, 2006
2.3 Life expectancy - comparison with selected countries

Life expectancy among men in Israel is high in comparison with other western countries (Figure 5a). Life expectancy of women is ranked lower, relative to women in other western countries (Figure 5b). The life expectancy differential between men and women is smaller in Israel than in other countries.

**Figure 5a: Life expectancy at birth in Israel among men, comparison with selected countries, 2004**

<table>
<thead>
<tr>
<th>Country</th>
<th>Life expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iceland</td>
<td>79.0</td>
</tr>
<tr>
<td>Switzerland</td>
<td>78.8</td>
</tr>
<tr>
<td>Sweden</td>
<td>78.3</td>
</tr>
<tr>
<td>Israel</td>
<td>78.0</td>
</tr>
<tr>
<td>Norway</td>
<td>77.7</td>
</tr>
<tr>
<td>Malta</td>
<td>77.4</td>
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<tr>
<td>Spain</td>
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<tr>
<td>Holland</td>
<td>77.0</td>
</tr>
<tr>
<td>Cyprus</td>
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</tr>
<tr>
<td>France</td>
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</tr>
<tr>
<td>U.K.</td>
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</tr>
<tr>
<td>Greece</td>
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<td>Germany</td>
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<td>Austria</td>
<td>76.5</td>
</tr>
<tr>
<td>Ireland</td>
<td>76.5</td>
</tr>
<tr>
<td>Luxembourg</td>
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<tr>
<td>Finland</td>
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<tr>
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<tr>
<td>U.S.A.</td>
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</table>

*Life expectancy*
Figure 5b: Life expectancy at birth in Israel among women, comparison with selected countries, 2004

<table>
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<tr>
<th>Country</th>
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<tbody>
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<tr>
<td>Switzerland</td>
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<tr>
<td>Spain</td>
<td>83.9</td>
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<td>Iceland</td>
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<td>Luxembourg</td>
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<td>82.5</td>
</tr>
<tr>
<td><strong>Israel</strong></td>
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<td>Slovenia</td>
<td>80.9</td>
</tr>
<tr>
<td>U.S.A.</td>
<td>80.1</td>
</tr>
</tbody>
</table>
3. Fertility

Trends in fertility

The total fertility rate expresses the average number of children a woman is expected to bear in her lifetime. Since the 1950’s, the total fertility rate has declined by about 25% (Figure 6). The decline is steeper among Moslem women than among Jewish women. In 2006, the total fertility rate was 3.97 among Moslem women, 2.75 among Jewish women, 2.64 among Druze women and 2.14 among Arab-Christian women (Figure 7).

Figure 6: Total fertility rate in Israel, 1955-2006

Figure 7: Total fertility rate by population group, 2006
4. Health of Children and Youth

4.1 Trends in infant mortality

Since the establishment of the State of Israel there has been a dramatic decline in rates of infant (<1 year) mortality in all population groups in Israel (Figure 8). This decline can be attributed to the improvement in maternal health and in prenatal and perinatal medical care, and to the economic, social and environmental changes leading to higher standards of living. Between 2004-2005, the overall rate of infant mortality declined by an additional 5%. In the Jewish population there was no significant change, however, in the Arab population mortality rates declined by 11%.

Figure 8: Infant mortality in Israel, 1955-2006 (rate per 1,000 live births)
4.2 Trends in infant mortality by population group

Over the past 30 years there has been a marked decline in rates of infant mortality in all population groups. Notwithstanding this decline, disparities remain between infant mortality rates in different population groups. In 2000-2004, the infant mortality rate per 1,000 live births was 3.8 in the Jewish population, 2.8 in the Arab-Christian population, 5.9 in the Druze population and 8.8 in the Moslem population (Figure 9).

Figure 9: Infant mortality by population group, 1970-1974 and 2000-2004 (rate per 1,000 live births)
4.3 Leading causes of death — infants

In the Jewish population, prematurity is the leading cause of infant mortality (Figure 10). Close to half (47.8%) of infant deaths in Jewish infants in 2005 were due to prematurity, in comparison with 30.4% of all deaths among Arab infants. The leading cause of infant mortality in the Arab population is congenital anomalies, which were responsible for 38.6% of all infant deaths (Figure 11). In the Jewish population, 31.4% of all infant deaths were due to congenital anomalies (Figure 10). Mortality due to SIDS and external causes is higher in the Arab population than in the Jewish population. These differences present a challenge in the attempt to narrow the gaps between the various population groups.
4.4 Leading causes of death — children and youth

The most common cause of death in children and youth (ages 1-19) is accidents, which in 2004 were responsible for 167 deaths in this age group (31% of all deaths). The second leading cause of death in this age group is cancer, which was responsible in 2004 for 13% of all deaths (70 deaths). Suicide is the third leading cause of death (39 deaths in 2004) (Figure 12).

Figure 12: Leading causes of death in children and youth (aged 1-19), 2004 (percentage of total deaths from all causes)
4.5 External injuries in children

According to data from the National Trauma Registry, falls are the most common cause of injury in children (aged 0-17), except in the oldest age group (15-17 years). Falls comprise 39% of all injuries in children who are hospitalized following injury. The percentage of children injured by falls and burns declines with age, while the percentage of children injured in traffic accidents increases with age (Figure 13).

Figure 13: External injuries among children by age group — distribution by type of injury. National Trauma Registry, 2004 (percentages)
4.6 Children injured in traffic accidents

The number of children injured in traffic accidents during the past 5 years has stayed relatively constant, and numbers more than 5,000 per year. At the beginning of the 1990’s there was an increasing trend in the number of children injured in traffic accidents, which peaked in 1998 with 7,261 injured (a rate of 356 per 100,000). Thereafter, the number of children injured in traffic accidents declined, and since 2000, the number has stabilized at approximately 5,400 per year (a rate of approximately 242.1 per 100,000). In 2005, 5,362 children were injured in traffic accidents (Figure 14).

Figure 14: Children aged 0-17 injured in traffic accidents, 1991-2005 (numbers and rates per 100,000)
4.7 Vaccination coverage

Vaccination coverage refers to the proportion of children born in a specific year who were immunized, as a percentage of the total number of children born during that year who were registered in the district health offices. In 2004, the percentage of vaccination coverage among children reaching the age of two years was very high (above 90%), in both the Jewish and the Arab sectors. In the Arab sector, the vaccination coverage was higher than in the Jewish sector (Figure 15).

Figure 15: Vaccination coverage at age two years in Israel by population group, 2004 age cohort (percentages)

<table>
<thead>
<tr>
<th>Vaccination</th>
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<th>Arabs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBV 3</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>MMR 1</td>
<td>97</td>
<td>98</td>
</tr>
<tr>
<td>OPV 3</td>
<td>93</td>
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<td>IPV 3</td>
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<td>97</td>
</tr>
<tr>
<td>Hib 4</td>
<td>94</td>
<td>97</td>
</tr>
<tr>
<td>DTP 4</td>
<td>94</td>
<td>97</td>
</tr>
</tbody>
</table>

HBV 3 | 3 doses of Viral Hepatitis B vaccine
MMR 1 | 1 dose of Measles-Mumps-Rubella vaccine
OPV 3 | 3 doses of Poliomyelitis vaccine (oral live attenuated)
IPV 3 | 3 doses of Poliomyelitis vaccine (inactivated)
Hib 4 | 4 doses of Haemophilus Influenzae b vaccine
DTP 4 | 4 doses of Diphtheria-Tetanus-Pertussis vaccine
4.8 Trends in vaccine-preventable diseases

Rubella

Following an outbreak of rubella in 1972, the vaccination of all 12-year-old girls was initiated in 1973. Rates of rubella were very low during the period 1973-1977. In 1978-79 there was another outbreak, and incidence rates reached a peak of 960 per 100,000. Thereafter, rates declined, with the exception of smaller outbreaks in 1984, 1987 and 1992. In 1988 the vaccination schedule was changed with the introduction of the MMR (Measles-Mumps-Rubella) vaccine complex, which was administered to all infants at age 15 months. In 1994 the vaccination schedule was changed again, and the MMR vaccine was administered at 12 months, with a booster dose at age 6 years. Since then, rates have been consistently very low and in 2006 there were only 3 cases (Figure 16).

Figure 16: Incidence of rubella in Israel, 1970-2006
(number of cases and rates per 100,000)
Mumps

Following the introduction of the mumps vaccine in 1988, incidence rates dropped considerably, from 158 per 100,000 in 1988 to 7 per 100,000 in 1990. In 1995, one year after the initiation of the booster vaccine at age 6, rates declined sharply to 2 cases per 100,000. In 1998 and in 2005 there were small outbreaks, with 106 and 109 cases respectively. In 2007 incidence had dropped to 7 cases, a rate of 0.1 per 100,000 (Figure 17).

Figure 17: Incidence of mumps in Israel, 1977-2007 (number of cases and rates per 100,000)
Measles

In 1967 the measles vaccine was included in the vaccination schedule. From the end of 1988, the measles vaccine was administered as part of the triple MMR (Measles-Mumps-Rubella) complex, and from 1990, a booster dose was added at age 6 (which was replaced in 1994 by the MMR complex.) In addition, during the years 1991-1995 a second, "catch-up" dose was given to children in 6th, 7th and 8th grades. However, periodic outbreaks of measles still occurred, and relatively high rates were reported in 1975, 1982, 1985 and 1994. Thereafter, incidence rates declined. In 2007 there was a further outbreak of measles which continued during 2008 (Figure 18).

Figure 18: Incidence of measles in Israel, 1967-2007
(number of cases and rates per 100,000)
Haemophilus influenzae b meningitis

1981-1992, rates of H. influenzae b meningitis varied between 1.8-2.4 per 100,000. After introduction of the vaccine into the vaccination schedule for infants in 1994, incidence rates dropped dramatically. In 2006 the rate was 0.07 per 100,000 (Figure 19).

Figure 19: Incidence of haemophilus influenzae b meningitis in Israel, 1970-2006 (number of cases and rates per 100,000)
Viral hepatitis A

During the 1990’s rates of viral hepatitis A reached 71 per 100,000 (over 4,000 cases per year). In 1999, vaccination was introduced for infants at age 18 months with a second dose at age 24-30 months. This was followed by a sharp decline in rates, reaching 2.2 per 100,000 in 2007 (Figure 20).

Figure 20: Incidence of viral hepatitis A in Israel, 1992-2007
(number of cases and rates per 100,000)
4.9 Trends in smoking among youth in Israel

The findings of the Health Behavior in School Children (HBSC) surveys conducted in 1998, 2002, 2004 and 2006 among school-going youth aged 11-16, indicate a decline in rates of smoking (at least once a week) in both genders, among both Jewish and Arab youth. The highest rates were consistently found among Arab boys, and the lowest rates were among Arab girls. In both population groups, rates were higher in boys than girls, and this difference was more pronounced in the Arab population. Rates of smoking are higher among Arab boys than Jewish boys, and rates are higher among Jewish girls than Arab girls. In 2006, rates of smoking (at least once a week) were: among Jewish boys – 6.8%; among Jewish girls – 4.1%; among Arab boys – 12.6%; and among Arab girls 2.6% (Figure 21).

Figure 21: Smoking* among youth aged 11-16, by sex and population group, 1998, 2002, 2004 and 2006 (percentages)

*at least once per week
4.10 Obesity in youth

The Body Mass Index (BMI) is an indicator of obesity, and is calculated as body weight in kilograms, divided by height squared, in meters. BMI can be expressed as percentiles: an individual is considered at risk for overweight when his/her BMI percentile lies between 85-95%. Obesity is defined as BMI percentile greater than 95%. In the MABAT Youth Survey, conducted in 2003-2004 among 6th-12th grade students, weight and height were directly measured. Highest rates of overweight were found among Arab girls (15.6%), while highest rates of obesity were found among Arab boys (9.3%) (Figure 22).

Figure 22: Overweight and obesity among youth aged 12-18, by sex and population group, 2003-2004 (percentages)
4.11 Dieting behaviors among youth

In the HBSC (Health Behaviors in School Children) survey conducted in 2006 among youth aged 11-16, 15.9% of youth reported that they were currently dieting (any kind of diet). The percentage of girls who were dieting was almost twice as high as the percentage of boys. Among Jewish girls, 22.4% were dieting, while among Arab girls, 15.6% were dieting. The rates of dieting were 9.1% among Jewish boys and 9.5% among Arab boys (Figure 23).

Figure 23: Dieting among youth aged 11-16, by population group and sex, 2006 (percentages)
5. Leading causes of death

The leading cause of death in Israel since 1999, is cancer. Cancer was recorded as the cause of 24.6% of total deaths in 2004, as compared with 17.2% of total deaths 30 years earlier, in 1974. The second leading cause of death is heart disease. In 2004, 19.5% of total deaths were attributed to heart disease, as compared with 32.3% of deaths in 1974. Mortality from stroke declined, as compared with 1974, however, mortality from diabetes increased markedly (a 83% increase), as did mortality from kidney disease (Figure 24).

Figure 24: Leading causes of death in Israel, 1974 and 2004 (percentages of total deaths from all causes)
6. Trends in Mortality from Selected Causes

In this chapter trends in leading causes of mortality are presented. In order to control for the effects of the different age distributions between population sub-groups and the changing age distribution over the years, mortality rates are age-adjusted.

6.1 Heart disease

Over the past twenty-five years mortality from heart disease has declined steadily among both men and women in Israel, a trend which is similar to that observed in general in the western world. This decline may be attributed both to the introduction of modern medical technologies and medications for the management of heart disease, and to lifestyle changes including a reduction in smoking, improvement in nutrition and increased physical activity, as well as to social and environmental changes. Heart disease mortality rates in Israel are consistently higher among men than women, but this gap has narrowed with the years (Figure 25).

![Figure 25: Mortality from heart disease in Israel, by sex 1979-2004 (age-adjusted rates per 100,000)](chart.png)
6.2 Cancer

In the early 1990’s there was an increasing trend in mortality from cancer. During the past decade, mortality rates declined by 13% in men and 14% in women. Cancer mortality rates are higher in men than in women (Figure 26).

The most common cancer among men is prostate cancer, followed by colorectal cancer. Among women, the most common cancer is breast cancer, and the second most common is colorectal cancer. The cancer causing the greatest number of deaths in men is lung cancer, and in women, breast cancer.

Figure 26: Mortality from cancer in Israel, by sex 1979-2004 (age-adjusted rates per 100,000)
**Lung cancer**

During the 25-year period between 1979-2004, lung cancer mortality rates were stable among Jewish men. During the same time period, there was a 64% increase in lung cancer mortality rates among Arab men (Figure 27).

**Figure 27: Lung cancer mortality among men in Israel by population group, 1979-2004 (age-adjusted rates per 100,000)**

**Breast cancer**

During the 25 years between 1979-2004, breast cancer mortality rates declined by 13% among Jewish women. During the same period, there was a 53% increase in breast cancer mortality rates among Arab women (Figure 28).

**Figure 28: Breast cancer mortality among women in Israel by population group, 1979-2004 (age-adjusted rates per 100,000)**
6.3 Stroke

During the last 25 years there has been a significant decline in mortality from stroke, among both men and women (Figure 29). Among the factors explaining this decline are the improved management of hypertension, as well as lifestyle changes, including healthier nutrition and decreased rates of smoking. In addition, medical treatment for stroke has improved in recent years.

Figure 29: Mortality from stroke in Israel, 1979-2004
(age-adjusted rates per 100,000)
7. Health Behaviors in Adults

7.1 Trends in smoking

Smoking is seen as the most important behavioral risk factor for morbidity and mortality. Arab men have higher rates of smoking than Jewish men, whereas Jewish women smoke at higher rates than Arab women (Figure 30). During the past 25 years smoking rates have declined in Israel, among both men and women, Jews and Arabs. Increased awareness of the dangers of smoking as well as legislation restricting smoking in public places and places of work have contributed to this decline.

Figure 30: Smoking among adults (aged 18 and above) in Israel, by sex and population group, 1980-2007* (percentages)

* data on smoking in the Arab population are available from 1996 only
7.2 Physical activity

Regular physical activity is known to be an important factor in the prevention of many chronic diseases and in the promotion of physical and mental health. In the "Health Knowledge, Attitudes and Behaviors" survey of 2006, only 40% of men and 36% of women reported engaging in regular physical activity (3 or more times a week, for at least 20 minutes each time) (Figure 31). Increasing the rates of physical activity in the population is a challenge facing the health system in the years to come.

Figure 31: Regular physical activity*, by sex, 2006 (percentages)

* 3 times a week or more, at least 20 minutes each time
7.3 Obesity

Body Mass Index (BMI) is calculated as body weight in kilograms, divided by height squared, in meters. According to the classification of the World Health Organization, obesity is defined as BMI equal to or greater than 30.

The data presented are based on self-reported height and weight, in the INHIS national survey of Israelis aged 21 or above conducted in 2004. Among men, rates of obesity increased with age until ages 55-64, and from age 65, obesity rates declined. Among women, rates of obesity continued to increase with age until ages 65-74, and among women aged 75 or above, a slight decrease was noted. From the age of 45, rates of obesity were higher in women than in men (Figure 32).

Figure 32: Obesity (BMI≥30) by sex and age, 2004 (percentages)