

Policy Responses to the Rise in Autism Diagnoses in Childhood: Across the Spectrum

Conclusions and Recommendations for Israel

This summary document complements the output of a comparative project, made possible by a financial contribution from Israel, comparing trends in the number of children diagnosed with autism spectrum disorder (ASD) in selected OECD countries and benefits and services available for them. The summary looks at the project's findings from the perspective of Israel and provides a series of actionable policy recommendations for Israel.

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Introduction

This document summarises the findings from a comparative project on policies and practices in selected OECD countries for children with autism spectrum disorder (ASD), from the point of view of Israel, and provides a set of policy recommendations Israel could implement in response to the sharp increase over the past two decades in the number of children under age 18 diagnosed with ASD. The full findings from this project, including a comparative data and policy analysis across ten OECD countries and in-depth case studies for five of these countries, can be found in the OECD report “Policy Responses to the Rise in Autism Diagnoses in Childhood: Across the Spectrum” (OECD, 2026).

ASD is a neurological and developmental condition affecting how people interact, communicate, learn, and behave. As the name indicates, it exists on a spectrum with hugely varying levels of support needs. Having autism or having an ASD diagnosis, therefore, does not necessarily mean having a disability; it means the brain works in a way that is (slightly) different from other people. As ASD exists on a spectrum with a broad range of support need levels, some people with low support needs may not consider themselves as having a disability. Nonetheless, as the number of children diagnosed with ASD has increased significantly, there have been ramifications in terms of demands for support, including for disability payments, and the quality of support that is offered.

Autism trends and diagnosing in Israel compared to other OECD countries

Autism diagnoses have risen dramatically in Israel, and other OECD countries

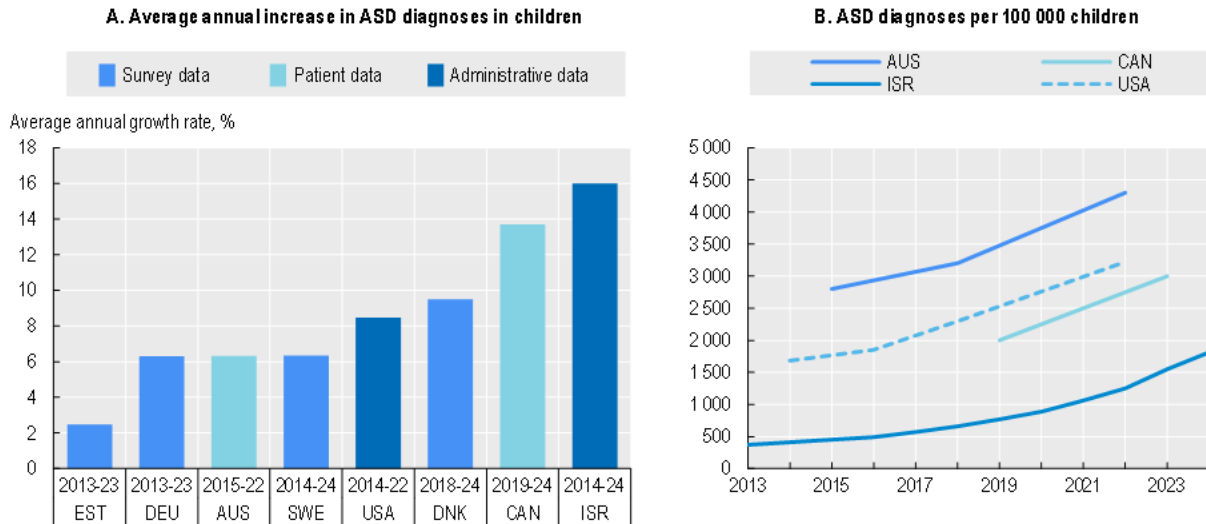
Israel has experienced a dramatic surge in ASD diagnoses over the past 15 years, with the number of children under age 18 diagnosed with ASD increasing eightfold between 2011 and 2024. Children registered in Israel’s National Insurance Institute (NII) as receiving a Disabled Child Allowance with an ASD diagnosis (noting that all children with an autism diagnosis are entitled to such an allowance) shows an increase in the number of children registered with ASD from 7 292 in 2011 to 60 195 in 2024.

This pattern of exponential growth in ASD diagnoses in children is not unique to Israel, however. Rates of detection of ASD amongst children in other countries have increased significantly, too, with average annual rates of growth in the past decade across a selection of OECD countries of around 6-10%, corresponding to a 2.5 to four-fold increase in 15 years (Figure 1, Panel A). Data also show that the speed or slope of change was very similar in all countries with comparable data sources, and that rates of detection of ASD seem to be converging to the same high level (Figure 1, Panel B).

It is important to understand the context of rising ASD rates in Israel and other countries. The most robust evidence at the time of writing points strongly to a sharp increase in the *detection* and *diagnosis* of ASD, rather than a particularly significant increase in the underlying rate of autism prevalence in the population. Factors driving increased detection of ASD include changing diagnostic understanding and inclusion of more forms of related conditions under a single “autism spectrum disorder” diagnosis; earlier age of first diagnosis for ASD and more girls as well as more adults in later life being diagnosed with ASD; and increased awareness of ASD and associated falling stigma around a diagnosis of ASD, which may have led to greater diagnosis-seeking or help-seeking by persons displaying signs of autism or their caregivers.

Figure 1. Rates of detection of autism in children are increasing fast everywhere

Average annual growth in children diagnosed with ASD (panel A) and rate of ASD diagnoses per 100 000 children (panel B) in selected OECD countries for available years and age ranges



Notes: Because of differences in the nature of the data, rates should be compared with caution. Data refers to available years and the most relevant available source and indicator (survey data for Australia and Canada, administrative data for Israel and the United States, and patient records for the other countries). Data refers to ages 5-14 for Australia, ages 1-17 for Canada, ages 0-14 for Estonia, ages 0-19 for Germany, ages 0-18 for Israel, ages 4-19 for the Netherlands, ages 0-19 for Sweden, all ages in Denmark, and children aged 8 for the United States.

Sources: Survey of Disability, Ageing and Carers (Australia), Health Survey on Children and Youth (Canada), National Patient Register (Denmark), National Institute for Health Development (Estonia), Federal Statistical Office (Germany), Ministry of Finance (Israel), Health and Welfare Statistical Database (Sweden), Centers for Disease Control and Prevention (United States).

Israel should not expect a slowdown in ASD diagnoses in the near term

It could be reasonably assumed that ASD diagnoses in children in Israel will continue to rise in the coming years, for two reasons. First, other OECD countries already have higher levels of ASD detection in children; for instance, while today 1.44% of all children in Israel receive a Disabled Child Allowance with an autism diagnosis, the comparable share in Australia is 2.41%. The rate of increase in ASD detection in Israel is comparable to other OECD countries but started several years later. Second, within-population data for Israel suggests that important differences exist in the diagnosis rate among different population groups, pointing to potential gaps in some population groups. More specifically, in Israel fewer children have been diagnosed with ASD and receive the Disabled Child Allowance amongst the lowest socio-economic clusters (especially deciles 1 to 3). This stands in contrast to most other OECD countries, where children in less-affluent families tend to have higher rates of detected ASD.

Diagnostic practices in Israel are generally well-aligned with other OECD countries

In Israel, as in other OECD countries, autism diagnoses can be established by both public and private assessors. The fast growth in the number of children seeking a diagnosis has led to capacity restrictions in the public assessment system in many countries and a corresponding increase in the share of diagnoses provided by the private sector. Hard evidence on this is unavailable but the share of private diagnoses seems particularly high in Israel, where concerns have been raised about parental pressure on doctors and developmental psychologists in the private sector driven by the comprehensive set of benefits and services coming with a diagnosis. While in all other countries studied access to support is determined predominantly by the child's needs, Israel stands out as the only country in which the diagnosis alone

guarantees access to ASD-related services and benefits. This makes a diagnosis more important in Israel than elsewhere and makes assessors – public or private – the sole gatekeepers to public support that children and families can receive.

Diagnosing ASD follows strict legal guidance, regardless of whether diagnosis is established by a public or a private provider. To qualify for relevant state aid, including the Disabled Child Allowance, a child's autism diagnosis must follow the requirements set out in the Ministry of Health Circular No. 15 of 2013. Unlike other OECD countries, in Israel steps taken as part of autism assessment for children are not issued as a guideline or set of recommendations by a public health institution but diagnosing professionals must follow the assessment process set out in the Circular which emphasises that a diagnosis should be based on a comprehensive view of the child's situation, considering medical, emotional, communicative, social, cognitive and functional aspects. The Circular requires the evaluation to be performed by medical professionals with a specialisation in child and adolescent psychiatry, developmental paediatrics (with at least three years of experience), child development or neurology, and include an assessment conducted by a clinical psychologist trained in child or developmental psychology. The diagnosis must align with the criteria of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). In Israel, concrete tools are recommended for each part of the assessment process but, unlike other international guidelines (such as Germany's S3 guidelines or the UK's NICE guidelines, which are both evidence-based and requiring a process of consensus by doctors), the Circular does not specify whether these tools should be complementary to the diagnostic process or the main basis for the final diagnosis.

Supports for children with autism in Israel compared to other OECD countries

Disability allowance claims for children with ASD are rising fast in Israel

In terms of financial support for families, Israel offers a single allowance for children with disability. The Disabled Child Allowance is a monthly, non-means-tested benefit provided to parents of a child with disability, administered by Israel's National Insurance Institute (NII). Children with an ASD diagnosis are automatically entitled to 100% of the benefit worth NIS 3 694 in 2025, around 27% of the average monthly wage, with no further assessment of support needs or functional impairment required. Children who are assessed as needing intensive support in everyday activities may receive an allowance at a higher rate, up to 235%. A family with two or more children with disability is entitled to a 50% increase in the benefit amount for each child, calculated according to the benefit rate determined for each individual child.

Children classified under the eligibility category "autism" are the largest group of recipients of a Disabled Child Allowance. In 2024, over 60 000 children received an allowance with an autism diagnosis, compared to less than 10 000 a decade ago. From 2012 to 2024, the total number of children receiving a Disabled Child Allowance increased almost fivefold, from over 30 000 to over 150 000, and the share of autism diagnoses in total reciprocity numbers increased from 25% to 39%.

While this document looks at children with ASD, it is worth mentioning that there is a second group that has been rising fast in the past decade, in parallel to the ASD group: children "needing supervision" (the majority of which are children with allergies requiring monitoring to enable an immediate response in the event of a severe allergic reaction). The sudden growth in this group, to over 40 000 children in 2024 (from 2% of the entire reciprocity population in 2012 to 28% in 2024) calls for a project of its own. Commonalities with the ASD group in drivers of the observed trend and maybe also in policy responses are likely.

Israel's financial benefits for children with ASD stand out in several ways

Allocation of disability benefits for children with ASD in Israel stands out in an international comparison in three significant ways:

- First, Israel is an outlier in its reliance on a medical diagnosis in assessing entitlement to financial support for children with disability and their families. OECD countries tend to have different forms of financial support – Carer Allowances, Disabled Child Allowances, Additional Cost Allowances – all of which have some component of support needs assessment, irrespective of the child's age, considering the child's level of functioning and needs in daily life, such as self-care, communication, and social interaction. Amongst all OECD countries studied, only Israel relies primarily on medical diagnosis, rather than needs assessments, to establish entitlement to financial (and also any other) support.
- Second, financial benefits for children with ASD in Israel are not means tested and do not depend upon parental or caregivers' employment status. In most OECD countries, the level of financial support for a child with ASD also relies upon either real or assessed parental employment capacity. These benefits are intended to compensate for reduced paid employment because of caring responsibilities. Israel does not include parental employment capacity in their ASD benefit entitlement assessment.
- Third, compared with other countries benefits in Israel are more generous for children with mild support needs and less generous for those with severe support needs. Because most OECD countries determine entitlement to different forms of financial benefits by a child's needs for care, children with ASD with more severe support needs receive higher (or even much higher) levels of financial support than those with mild support needs. In Israel, on the contrary, children with ASD receive similar level of support across the spectrum, largely irrespective of the child's support needs.

Israel has comprehensive services for children with ASD especially in early years

Israel demonstrates a strong commitment to early childhood support for children with ASD through the healthcare system. Through its Early Childhood Programme, children with ASD aged 0-3 years are entitled to placement in a rehabilitation day-care center, where they receive up to 14 hours of therapy per week. A child with ASD of kindergarten age (4-6 years) may either attend a special "communication" kindergarten, where they receive the same 14 weekly hours of therapy provided under the Early Childhood Programme on-site, or attend a regular kindergarten and receive a personalized "basket of services" that may include therapy sessions. From the age of seven, children with ASD can access up to three hours of therapy per week through the public health system, provided via Health Maintenance Organisations, in addition to various extra education resources provided in the form of, e.g. smaller class sizes, longer school days, one-on-one teaching assistants, or transportation to and from school.

What sets Israel's special education system apart is the decisive role that medical diagnoses play in determining both school placement and the range of educational supports available to a child with disability. Not only is medical documentation required to access special education, whether in the form of a personal support basket or through attendance in a special education class, but each class is specifically designated for one type of medical condition or disability. Accordingly, there are separate special education classes for children with ASD, developmental delay, speech delay, mild intellectual disability, hearing impairment, cerebral palsy, rare diseases, and borderline intellectual functioning, among others. The same approach extends to the personal service baskets available to children in mainstream education. Every child is categorized according to their specific medical condition, which largely determines the number of weekly support hours they are entitled to.

Such a highly standardized, diagnosis-based approach to special education as well as therapeutic service provision is rather unique across OECD countries. While the personalised approach should be praised, Israel's model risks creating imbalances in service distribution, potentially over-servicing children with relatively low support needs and under-servicing those with substantial needs – mirroring Israel's approach

to providing Child Disability Allowance. This risk is particularly likely for conditions such as ASD, which encompass a wide spectrum of functioning abilities and support needs.

How Israel is and isn't an outlier compared to other OECD countries

The OECD report “Policy responses to the Rise in Autism Diagnoses in Childhood: Across the Spectrum” (OECD, 2026) identifies several areas in which Israel does not appear as an outlier.

- First, rates of ASD diagnosis are rising in all OECD countries, and the increase is driven by the same factors everywhere, i.e. a shift in diagnostics to a spectrum with the inclusion of several low-prevalence diagnoses under the ASD umbrella and rising awareness of ASD going together with falling stigma. Israel is not the country with the highest rates of ASD detection (of the countries reviewed, Australia and the Netherlands have higher rates) and not necessarily the country with the fastest growth over a longer period either. The increase started later in Israel than in countries like Australia, Canada or the United States and therefore was more compressed but Israel does neither seem to have reached its “peak” nor is it clear if the speed of increase will flatten soon.
- Second, because of the fast rise in the number of families seeking an ASD diagnosis and corresponding support, public diagnosing is reaching its capacity limit in many OECD countries and the role of the private market for obtaining a diagnosis is increasing, including in Israel. Even so, however, diagnostic tools and guidelines on how autism is to be diagnosed, including by involving a multi-disciplinary team of expert assessors, appear strong and robust everywhere, with no difference for public or private assessors. Diagnostic approaches also appear similar across the countries under review, with all countries – including Israel – having moved towards international best practice.
- Third, all reviewed OECD countries, like Israel, are providing a wide range of benefits and services to children with ASD and their families – one comparative study found that across 20 countries children with ASD on average receive about nine hours of therapy per week – with implications for the public purse and both the availability and the quality of services offered where rates of needs and eligibility (not only rates of diagnosis) rise.

At the same time, the comparative OECD report singles out ASD policies in Israel in some critical ways.

- First, Israel is unique in its reliance on diagnosis alone to determine if and how much support a child with ASD receives. This is equally true for eligibility for Disabled Child Allowance and most ASD-related therapies and services. All other OECD countries under review base entitlements partially if not fully on the child's assessed level of support needs. There is strong reason to believe that the particularly rapid increase in autism diagnoses in Israel is partly driven by the direct entitlement to benefits.
- Second, related to its medical approach and the focus on diagnosis alone, Israel applies a meticulously standardized system of supports and services, entitling every child with ASD to basically the same number of therapy hours, largely irrespective of the child's needs.
- Third, Israel's supports are universal; Israel is not means testing any of its supports or linking them to parental employment, unlike some other countries, nor linking them to a child's actual needs.

The peculiarities of Israel's system have far-reaching consequences. First, seeking a diagnosis seems attractive in Israel, despite any negative consequences of disability labelling in childhood and adolescence. This contributes to the fast rise in privately provided ASD diagnoses in response to capacity constraints in the public assessment system. Second, in Israel public spending on financial benefits and ASD services mechanically increases in parallel to the rise in the number of diagnoses, even in a situation in which the number of children with high support needs remains unchanged. Third, this makes the Israeli system dysfunctional as service provision and service quality cannot keep up with the growth in service demand, with potentially strong repercussions for those needing support most who are competing over the same resources with those with mild support needs. Under the reality of limited resources, standardizing service

hours for all children with a diagnosis in the manner done in Israel unavoidably leads to lower availability of treatment hours for those with high support needs.

The consequences of Israel's system peculiarities on overall public spending on ASD are unclear. A family with a child with ASD with low support needs will receive more support in Israel than in any of the other countries reviewed. A family with a child with ASD with high support needs, however, will receive better if not much better support in some other countries, such as Denmark or Sweden. Data do not allow an overall assessment of the investment and total costs different countries are facing. Because of the high spending for the large number of children with ASD with only mild support needs, overall, Israel may nevertheless spend more than some other countries. However, the generous service entitlement in Israel for children with ASD with mild support needs has repercussions on the availability and quality of therapies and supports for children with ASD with high support needs and through general capacity constraints in the healthcare system potentially also for children with high support needs with a diagnosis other than ASD.

Future-proofing Israel's services and benefits to help children with ASD thrive

Israel ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) more than a decade ago, in 2012, but has not since made the necessary shift away from a predominantly medical view of disability to a view that emphasises people's functioning, capacity, and participation. The UNCRPD requires a big cultural shift that is difficult for all countries and with implications for all disability policies and practices. The continued predominantly medical focus is at the heart of most of the problems Israel's disability policy is facing today, including its policies for children with ASD. Implementing the following recommendations would ensure Israel can keep the multiple strengths in its current system while rectifying maldevelopments and ensuring adequate support for children with disability, including with ASD, with greatest needs.

Recommendation 1:

De-couple entitlement to disability payments and disability services from clinical diagnosis by introducing a needs and functioning assessment

Israel should look to de-couple eligibility for disability benefits and disability services from the ASD diagnosis (or, from any diagnosis) and introduce an assessment based on the child's level of needs and functioning. Compared with other OECD countries, Israel is an outlier in basing entitlement to all public benefits and services for children with ASD and their families (and children with disability more generally) solely on the presence of a diagnosis, rather than on an assessment of the child's needs and the level of support required. Beyond being misaligned with contemporary disability policy approaches – which increasingly emphasise functioning, participation, and capacity rather than medical labels – the Israeli model presents two key challenges. First, it risks allocating resources inefficiently, as benefits and services may be awarded to children and families with relatively lower levels of need while providing insufficient support to those facing greater needs. Second, strong reliance on diagnosis as a gateway to public benefits and services, as discussed in Recommendation 2 below, shifts diagnostic providers away from their primary role as clinical experts and towards an unintended function as arbiters of access to public support. Decoupling eligibility for benefits and supports from an ASD diagnosis might reduce incentives to seek a diagnosis and would help reduce any incentives for inaccurate diagnoses.

Concretely, to ensure that public resources benefit those who need them most, Israel should:

- Move towards a needs-based policy framework aligned with today's disability model, ensuring that families of children with higher needs can access higher-intensity services and receive higher benefits, compared to children with lower needs. This should include assessing the impact of such a shift on benefit and service allocation.

- Make use of existing tools to assess levels of functioning and support needs where possible. While Israel could draw from experiences in other OECD countries, in terms of the general approach and the tools they use, it could also build on a needs assessment tool available (but in practice not implemented) for its own education system.
- Introduce a system of status and entitlement reassessment. While medical reassessment has shown to be unnecessary, as ASD is a lifetime disorder in most cases, the necessary shift to a functioning perspective should go hand in hand with a reassessment of a child's needs. Early investment in children is expected to reduce needs and corresponding support as children grow older, and periodic reassessment of needs and functioning capacity can account for this.
- Based on the level of a child's needs, move away from providing the same service basket with the same number of therapy hours and the same level of educational support for every child with an ASD diagnosis. Support should be flexible over time, in line with actual needs.
- Reconsider available disability payments. Other countries often offer a less generous general child disability payment which can, however, often be combined with an additional cost allowance which covers extra costs from the child's disability or a carer allowance which compensates caregivers (mostly parents) for lost earnings. Combinations of different payments with distinct purposes address a child's needs and the family's situation in a more effective and efficient way.

Recommendation 2:

Encourage all providers of a diagnosis to follow the same diagnostic standards for ASD

Israel should ensure that all public and private providers of a diagnosis adhere to consistent diagnostic standards. The recent increases in ASD diagnoses are in line with experiences in other OECD countries, and do not necessarily indicate that newer diagnoses are inaccurate or inappropriate. Nonetheless, good practice would be to promote consistent adherence to clear diagnostic guidelines and regulatory standards across all ASD diagnostic providers. At present, Israel has recommended tools for ASD diagnosis, but the guidance could be more specific and prescriptive.

As in many other countries, there is a growing market for private ASD diagnoses in Israel, particularly in contexts where waiting times for public-sector assessments are lengthy. The fact that an ASD diagnosis automatically confers eligibility for certain financial benefits will provide additional incentives for individuals in Israel to seek a rapid diagnosis and implies that decisions by private doctors can lead to a rapid increase in public spending, with no possibility for Israel to ensure public resources are properly used. Nonetheless, mandating that all ASD diagnoses be conducted exclusively by public-sector providers would likely place substantial additional capacity pressure on an already stretched system. Instead, policy efforts may have to focus on ensuring the quality, integrity and accountability of diagnoses across public and private providers. Clearer diagnostic guidance would help with this objective and, where concerns arise about over-diagnosis or potential fraud by private (or maybe also public) providers, regulatory investigation and/or requirements for a secondary clinical opinion are necessary and already possible options.

Concretely, to ensure all providers offering ASD diagnostics follow best practice, Israel should:

- Develop more detailed and specific guidance for ASD diagnosis, public or private, for example by drawing on the United Kingdom's NICE guidelines as a reference point.
- If there are documented concerns regarding the quality of private diagnoses, increase the resources of one of the public institutions for systematic or at least random reviews – given that the NII can already reassess diagnoses and deny claims to disability payments or services – to assure all assessors strictly adhere to the current guidelines and regulations.
- When a diagnosis will no longer be the only condition for access to disability benefits and services, consider additional ways of ensuring full accountability of assessors for their decisions. This could

for instance be done by benchmarking each assessor's decisions against the national and possibly regional averages and sharing this information across assessors. Another option could be restricting eligibility for disability benefits and services to assessments by publicly approved assessors operating under agreements and regulation of the public healthcare system.

Recommendation 3:

Recognise the need for a sustainable approach to benefits and services for ASD

ASD diagnoses have risen in Israel, like in all OECD countries for which meaningful data is available. The rise in ASD diagnoses in Israel has immediate economic consequences; an ASD diagnosis leads to a direct entitlement to financial benefits, even for children with only mild functioning impairment. Demand for services for children with ASD has increased in parallel, again including for children with comparatively mild support needs. Israel can reasonably expect a continued increase in ASD cases; some key population groups (e.g. population groups with lower socio-economic status) are still under-represented in diagnoses, and total rates of ASD per population are still lower in Israel than in peer-countries such as Australia and the United States. Consequently, Israel should look to plan for a system that effectively serves the group of children with ASD, prioritising those with severe support needs, and remains sustainable and effective even if the number of children with an ASD diagnosis continues to increase.

Concretely, to ensure sustainable and effective benefits and services for ASD, Israel should:

- Undertake a representative population survey to estimate the prevalence of ASD in the Israeli child and adult population. The United Kingdom's Adult Psychiatric Morbidity Survey, which saw a third wave in 2022-23, would be a good model to follow. The UK survey uses the ADOS instrument to estimate ASD prevalence in a representative sample of the population over age 16.
- Forecast a range of scenarios for the growth in ASD diagnoses in Israel, and the likelihoods of different scenarios, based on experiences in other OECD countries and on realistic assumptions about higher diagnosis rates in currently less-represented population groups.
- Assess the sustainability of the existing services and benefits and of the service-delivery model if ASD diagnoses were to continue to grow, with focus on service costs and workforce capacity.
- Start preparing for continued growth in ASD diagnoses now by prioritising training and recruitment for some key workforce categories and considering how finite resources can be best distributed, prioritising children with severe support needs.
- Evaluate the wider increase in the number of children with disability (and associate services and benefits) in Israel, not only children with ASD. Understanding the reasons behind these wider disability developments could have implications also for policies for children with ASD.

Recommendation 4:

Acknowledge the comprehensive set of services Israel's system provides while ensuring they deliver effectively for all

It is important to recognise that on its own merits, and compared to other OECD countries, the services and benefits package that Israel provides to children with ASD (and their families) is comprehensive. Israel's distinctive approach to determining eligibility for allowances and services means that all children with ASD can access a wide range of benefits and services solely based on a formal ASD diagnosis. This structure results in comparatively generous support for children with mild support needs. In addition, nearly all services relevant to children with ASD, including therapeutic and educational supports, are provided free of charge. Some features of the way in which the system is designed also take pressure off parents and caregivers (e.g. speech and language therapy or physiotherapy for children in pre-school settings are offered on-site), making both entitlement and access to support comparatively straightforward at least

when experiences in other countries are considered. Taken together, total monthly public expenditure on disability allowances, education supports, and therapeutic services for a child with mild support needs is estimated at NIS 12 859, which comes close to the average monthly wage in Israel.

However, support for children with ASD and severe support needs, for example where one parent has had to stop working entirely to provide full-time care, is comparatively less generous in Israel. Disabled Child Allowance in Israel can be paid at a higher rate (i.e. 235% of the basic rate) for a child with severe needs, but this seems rarely the case for children with ASD. In addition, therapeutic and educational support levels remain unchanged compared to those for children with mild or moderate support needs. Accordingly, the overall level of public support varies little across different levels of support needs – which is in stark contrast to most other OECD countries in which children with severe support needs and their families may receive a multiple of the support available for those with mild-to-moderate needs. Automatic entitlements – for example, in Israel children with ASD under age 7 are systematically entitled to 14 hours of therapeutic services per week – is not the most efficient way to distribute public resources and may be incentivising service use without demonstrated therapeutic benefits in some cases.

Concretely, to ensure that ASD services are delivering effectively for all, Israel should:

- Ensure that the service package offered aligns with best available evidence for therapeutic outcomes, including for children with varying degrees of functioning capacity and support needs. This assessment could be undertaken in parallel with Recommendation 5. Evaluate outcomes from existing services, and solicit the views of medical professionals, researchers, social workers and educators, and service users (families, children).
- Undertake a service-user survey for ASD services to assess the extent to which existing services meet the needs of the child and their family. The [PaRIS survey](#) recently developed by the OECD on patient-reported experience and outcome measures can serve as an example. Given Israel's generous service package, it is vital to ensure the existing therapeutic offer is well-aligned with families' needs, and children's best outcomes. Particular attention should be paid to the feedback of families of children with severe support needs, and children over age 7, for whom the service offer is comparatively less generous.
- Assess whether the current structure of Israel's ASD support meets families' needs through a survey of families and caregivers, see for instance a [recent survey](#) in the United Kingdom. Critical questions to explore could include: whether service funding allocation means some parents are less likely to work (to take their child to services) even if their child has comparatively mild support needs; which aspects of the system are most time-intensive for families and caregivers; how straightforward it is for families to make the transition from early years kindergarten to school settings; and if services meet the needs of girls and different ethnic groups.

Recommendation 5:

Evaluate outcomes from existing ASD supports rigorously and comprehensively

Israel has a comprehensive ASD support structure for children in their early years, with a broad offer of various therapies, dedicated kindergartens and extensive funding for services. The focus on children in very early years – from as young as 18 months – also stands out for Israel. This approach is aligned with an expectation that early, comprehensive intervention for young children diagnosed with ASD contributes to better outcomes in the medium-to-long term, although the system encourages early diagnosing more than early intervention. At present, however, evidence on the impact of early intervention for children with ASD on outcomes later in life is scarce, both in Israel and in the international scientific literature. Israel should prioritise tracking and evaluating outcomes from services for (young) children with ASD; doing so would make vital contributions to global understanding of support for ASD, securing best outcomes for

children with ASD in Israel and globally, and help Israel tailor limited resources towards the most effective interventions and support packages.

Concretely, to ensure that ASD services are delivering effectively for all, Israel should:

- Evaluate functioning, skills, and well-being of children diagnosed with ASD over their lifetime, as systematically as possible. This evaluation should include careful accounting of which services and supports children are receiving. Ideally, such assessment should start at diagnosis and follow children through to early adulthood, to account for the transition from school to work and for early labour market outcomes for young people with an ASD diagnosis. Following all children with ASD is impossible but Israel could identify a representative population cohort to follow over time, with due consideration to ethical and privacy concerns for young people with ASD and their families. This would be pioneering work as no OECD country is doing this at the national level thus far.
- Ensure evaluations of services and supports include an assessment of impacts on children with comparatively mild support needs, including as part of early intervention, to assess whether the services and support package that Israel offers could be more tailored to those with more severe needs without negatively impacting overall outcomes.
- Evaluate the impacts of service use and financial supports on the well-being and employment status of caregivers of children with ASD, to ensure that existing support is serving the entire ASD community and not only the children with an ASD diagnosis.