EMRO

HEALTH SYSTEM PROFILE

PALESTINE

Regional Health Systems Observatory
World Health Organization

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FOREWORD

Health systems are undergoing rapid change and the requirements for conforming to the new challenges of changing demographics, disease patterns, emerging and re emerging diseases coupled with rising costs of health care delivery have forced a comprehensive review of health systems and their functioning. As the countries examine their health systems in greater depth to adjust to new demands, the number and complexities of problems identified increases. Some health systems fail to provide the essential services and some are creaking under the strain of inefficient provision of services. A number of issues including governance in health, financing of health care, human resource imbalances, access and quality of health services, along with the impacts of reforms in other areas of the economies significantly affect the ability of health systems to deliver.

Decision-makers at all levels need to appraise the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings. Meaningful, comparable information on health system performance, and on key factors that explain performance variation, can strengthen the scientific foundations of health policy at international and national levels. Comparison of performance across countries and over time can provide important insights into policies that improve performance and those that do not.

The WHO regional office for Eastern Mediterranean has taken an initiative to develop a Regional Health Systems Observatory, whose main purpose is to contribute to the improvement of health system performance and outcomes in the countries of the EM region, in terms of better health, fair financing and responsiveness of health systems. This will be achieved through the following closely inter-related functions: (i) *Descriptive function* that provides for an easily accessible database, that is constantly updated; (ii) *Analytical function* that draws lessons from success and failures and that can assist policy makers in the formulation of strategies; (iii) *Prescriptive function* that brings forward recommendations to policy makers; (iv) *Monitoring function* that focuses on aspects that can be improved; and (v) *Capacity building function* that aims to develop partnerships and share knowledge across the region.

One of the principal instruments for achieving the above objective is the development of health system profile of each of the member states. The EMRO Health Systems Profiles are country-based reports that provide a description and analysis of the health system and of reform initiatives in the respective countries. The profiles seek to provide comparative information to support policy-makers and analysts in the development of health systems in EMR. The profiles can be used to learn about various approaches to the organization, financing and delivery of health services; describe the process, content, and implementation of health care reform programs; highlight challenges and areas that require more in-depth analysis; and provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries. These profiles have been produced by country public health experts in collaboration with the Division of Health Systems & Services Development, WHO, EMRO based on standardized templates, comprehensive guidelines and a glossary of terms developed to help compile the profiles.

A real challenge in the development of these health system profiles has been the wide variation in the availability of data on all aspects of health systems. The profiles are based on the most authentic sources of information available, which have been cited for ease of reference. For maintaining consistency and comparability in the sources of

information, efforts have been made to use as a first source, the information published and available from a national source such as Ministries of Health, Finance, Labor, Welfare; National Statistics Organizations or reports of national surveys. In case information is not available from these sources then unpublished information from official sources or information published in unofficial sources are used. As a last resort, country-specific information published by international agencies and research papers published in international and local journals are used. Since health systems are dynamic and ever changing, any additional information is welcome, which after proper verification, can be put up on the website of the Regional Observatory as this is an ongoing initiative and these profiles will be updated on regular intervals. The profiles along with summaries, template, guidelines and glossary of terms are available on the EMRO HSO website at www.who.int.healthobservatory

It is hoped the member states, international agencies, academia and other stakeholders would use the information available in these profiles and actively participate to make this initiative a success. I would like to acknowledge the efforts undertaken by the Division of Health Systems and Services Development in this regard that shall has the potential to improve the performance of health systems in the Eastern Mediterranean Region.

Regional Director

Eastern Mediterranean Region

World Health Organization

1 EXECUTIVE SUMMARY

Socio Economic Geopolitical Mapping

Palestinian People are living in two compartments (West Bank including East Jerusalem, and Gaza Strip) that form the Palestinian National Authority territories, with an estimated mid-year population of 3.6 million in 2004. Up to sixty percent of the population lives in approximately in 400 villages and nineteen refugee camps, and the reminder in urban refugee camps and cities. Gaza Strip is one of the highly dense population in the world where 1.3 million population are living in are of 365 km^2. Refugee camps contain two thirds of the population in Gaza Strip. The Literacy rate in Palestine is 85 percent among people above 15 years old. GDP/capita was 1,496 US$ in 2000 decreased to 865 US$ in 2004 after four years of the Intifada events.

Health status and demographics

63.2 percent of the Palestinian populations are living in the West bank, and 36.8 percent in the Gaza Strip. 42.6 percent of populations are refugees. 46.3 percent of populations are under 15 years, and two percent is above 65 years old. The percentage of female in the productive age is 44.8 percent of females in Palestine. The crude birth rate (CBR) in Palestine decreased from 45.4/1000 populations in 2000 to 33.6/1000 populations in 2004 with a population national growth of 2.6 percent. Life expectancy in 2004 is 72.6 (71.1 years for male and 74.1 years for female). Infant mortality rate is 27.8 percent/1000 live births, with a 7.1 percent of low birth weight.

Health System Organization

There are four major health service providers in Palestine: the MOH, United Nations Relief and Work Agency (UNRWA), non-governmental organisations (NGOs), and private for-profit providers. MOH provides primary, secondary and tertiary health services and purchase the unavailable tertiary health services from domestic and abroad providers. UNRWA provides primary care services, only for refugee and purchase secondary care services for the hardship cases. NGOs provide primary, secondary and some tertiary services. Private for-profit sector provides the three level of care though a variety of specialised hospitals and investigation centres.

Governance/Oversight

Public health services are directed and supervised by the Ministry of Health in a centralised manner, with a trend towards gradual decentralisation in the future. UNRWA is controlled by UN regulations. There is cooperation with public sector in immunisation programmes, with general health information despite having its own recording system. NGOs cooperate with MOH in recording system but with no role in Immunisation activities. There is no regulation controlling the private sector health activities apart from poor licensing for private clinics and health institutions.

Health Care Finance and Expenditure

The estimation of Public Health Expenditure (PHE) per capita in 2003 was 138.4US$. PHE represented 13.0 percent of the GDP in 2004 raised from 7.0 percent in 2003. Five percent of external donation is allocated for health sector. MOH expenditure was 38.9 US$ per capita in 2004. 56.0 percent of MOH expenditure was for salaries, 18.6 percent

covering Pharmaceuticals and medical needs, 15.0 percent for purchasing non-public medical services, and 10.4 for non-medical expenditures.

Governmental Health Insurance revenues form premium covered 24.2 percent and co-payment /fee revenues covered 6.9 percent of the total MOH running budget in 2004.

Human Resources

57 percent of health human resources in Palestine are employed by MOH. There are 9.73 physicians, 14.49 nurses, 1.43 pharmacists, 7.43 paramedics, and 17.5 administrators and workers per 10.000 populations in Palestine in 2004. There are 0.47 physicians, and 0.74 nurses per hospital bed in Palestine. There is one physician for 3.000 populations and one nurse for 2,265 populations in PHC clinics in Palestine.

Health Service Delivery

Ministry of Health operates 56.5 percent of total PHC clinics in Palestine in 2004, UNRWA operates 7.3 percent and NGOs operates 36.2 percent. Private PHC clinics are operated by physicians who are mainly working in the public or NGO sectors. There are 2.2 PHC centres per 10,000 populations.

Secondary care services are provided by 43 general hospitals with 3,539 beds. In addition to 10 specialised hospitals with total bed capacity of 813 beds, 20 maternity hospitals at a total bed capacity of 315 beds and finally four rehabilitation centres with a total bed capacity of 157 beds. MOH owns and operates 61.1 percent of the general hospital beds and 70.4 percent of the specialised hospital beds. All rehabilitation centres are owned and operated by NGOP sector. The total hospital bed/1000 population is 1.32 in 2004 in Palestine.

Health System Reforms

A National Strategic Health Plan was prepared in 1998 to cover five years 1999-2003. It was partially implemented and affected by the Intifada events from September 2000. There is a current evaluation to this plan for preparation for a Health system reform.

2 SOCIO ECONOMIC GEOPOLITICAL MAPPING

2.1 Socio-cultural Factors

Palestinian People are living in two compartments that form the Palestinian National Authority territories, with an estimated mid-year population of 3.6 million in 2004. These compartments called West Bank (of Jordan River) including East Jerusalem and Gaza Strip. West Bank with an estimated population of 2.3 million in 2004 contains nine big cities. Up to sixty percent of the population lives in approximately in 400 villages and nineteen refugee camps, and the reminder in urban refugee camps and cities. Many areas of West Bank have diversified communities. There are observable differences in life style and living conditions not only among classes and socio-economic levels and religious affiliations, but also among urban, rural and refugees camp communities with their respective subdivisions. On the other side, Gaza Strip is one of the highly dense population in the world where 1.3 million population are living in are of 365 km^2. Population is mainly concentrated in one city, six towns, twelve villages and eight refugee camps that contain two thirds of the population.

Table 2-1 Socio-cultural indicators

Indicators	1990	1995	2000	2003/2004
Human Development Index:	-	-	-	-
Literacy Total:	-	-	-	91*
Female Literacy:	-	-	-	86.4*
Women % of Workforce	-	-	-	-
Primary School enrolment	-	-	-	95.2
Primary education, pupils (% female)	-	-	-	90
Urban Population (%)	-	-	-	95

Source: PCBS, *: 2002

The population of the West Bank and Gaza Strip is young, with 46.5% under 15 years. The dependency ration is 99.6 (2003). About 80.2 of the Palestinian households live in houses that they own themselves. Eighty one percent of households have access to tap water. Public sewage is connected to 31.7% of the households. Electricity is nearly universal.

The literacy rate in the Palestinian territories is now among those aged 15 years and above, with 85%. Gross enrolment ratio is 91.4 % with 90.4% for males and 92.3 for females (2003/2004).

2.2 Economy

According to Palestinian Ministry of Finance (MOF) the Gross National Product (GNP) in Palestine has been subjected to high fluctuations during the last five years.

Gross National production (GNP) was 5,454 million US$ in 1999 and decreased to 3,720 million US$ in 2004. Gross Domestic Production (GDP) was 4,517 million US$ in 1999 and decreased to 3,286 million US$ in 2004. Gross National production per capita (GNP/capita) was 1,806 US$ in 1999 and decreased to 979 US$ in 2004. Gross Domestic Production per capita (GDP/capita) was 1,496 US$ in 1999 and decreased to 865 US$ in 2004.

Palestinian Central Bureau of Statistics (PCBS) reported that the unemployment rate was 26.8% (GS 35.4% and 22.9% in WB). This revealed sharply increase in unemployment rate from 11.8% in 1999 to 26.8% in 2004.

Using the national income data for the years 1995-2003 provided by the Palestinian Central Bureau of Statistics we observe the decline after the Intifada (2000). Income data classifies Palestine as a lower-middle income country, similar to Jordan according to World Bank classification (World Bank 1996a).

Table 2-2 Economic Indicators

Indicators	1990	1995	2000	2003
GNI per Capita (Atlas method) current US$	-	1,632	1,771	1,020
GNI per capita (PPP) Current International	-	-	-	-
GDP per Capita: (constant 1995 US$)	-	1,411	1,484	896
GDP per Capita annual growth %	-	-	-	-
Unemployment % (estimates)	-	18.2	14.1	27
Trade deficit	-	-	223.8M	400M (2004)

Source: PCBS

Table 2-3 Major Imports and Exports	1995	2000
Major Exports:	667.6M	933.1M
Major Imports	2602.6M	3866.5M

Source: Palestine Monetary Authority

Key economic trends, policies and reforms

The Palestinian Authority Territory is currently mired in a severe economic depression, mainly due to political and military actions. In Q2-2002, the Israel Defence Forces (IDF) re-occupied West Bank cities and towns. The combination of military incursions, widespread destruction and mobility restrictions severely diminished production and employment, leading to major increases in poverty.

The current dir situation reflects the deepening of an economic crises initiated by Israel's heightened closure policies implemented I October 2000, following the start of the Intifada. Before that, the Palestinian economy was embarking on the road of recovery. Between 1997 and 1999 real Gross Domestic Product (GDP) growth averaged 5 percent (UNSCO report, June 2002).

2.3 Geography and Climate

Palestine (Palestinian Authority) is formed of two regions. West Bank is in the north and Gaza Strip in the south. The previous nomination referred to the political situation of the rest of historical Palestine after 1948 (the date of establishing Israel).West Bank is a hilly region comprised of three ranges: the Nablus mountains in the north, the Jerusalem mountains in the centre and the Hebron mountains in the south. The West bank ranges fall between the costal plain in the west and the Jordan valley in the east with a width of 40-65 km and an average height of 2,400 feet. The land in the north and the south are good for cultivation with an average annual rainfall of 450-600 mm. West bank is separated from Gaza Strip which situated along the Mediterranean Sea in between Egypt and Israel with length of 45 km and width of 5-12 km. The annual average rainfall varies from 350 mm in the north to 150 mm in the south.

Map of Palestine

2.4 Political/ Administrative Structure

Basic political /administrative structure and any recent reforms

Palestinian Authority political system is a new system for the Palestine after Oslo Accord in 1993. It is built to be a Parliamentary system where there is an elected legislative council formed of eighty members elected from North and south provinces (West Bank and Gaza Strip). There is separation between the three powers (Executive, Legislative and Judiciary). The Legislative Council should adopt Law projects. The head of the state is elected directly from Palestinian population. The President with the agreement of the Legislative Council nominates the Prime Minister. Prime Minster is completely constrained by the parliament The Palestinian political system is still under expected changes according to the changes and development of the peace process in the Middle East.

Important laws related to health care are enacted in a mix way. Some laws are enacted mainly by primary legislation and other laws are enacted by presidential or ministerial decree. This situation comes as a result of absence of health care laws during the times before the Palestinian Authority had taken over the health sector.

3 HEALTH STATUS AND DEMOGRAPHICS

3.1 Health Status Indicators

Table 3-1 Indicators of Health status

Indicators	1990	1995	2000	2004
Life Expectancy at Birth:			M/F: 71.8/ 73.5	M/F: 71.1 / 74.1
HALE:	-	-	-	-
Infant Mortality Rate:		25	22	20.5
Probability of dying before 5th birthday/1000:	-	-	27.3	25.4
Maternal Mortality Rate:	-	-	37.3	10.0 *
Percent Normal birth weight babies:	-	-	95.9	98.8
Prevalence of stunting/wasting:	-	-	9%-2.5%(2002)	9.4%-1.9%

*: Underestimate.

Table 3-2 Indicators of Health status by Gender and by urban rural

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	-	-
HALE:	-	-	-	-
Infant Mortality Rate:	-	-	-	-
Probability of dying before 5th birthday/1000:	-	-	-	-
Maternal Mortality Rate:	-	-	-	-
Percent Normal birth weight babies:	-	-	-	-
Prevalence of stunting/wasting:	-	-	-	-

Table 3-3 Top 10 causes of Mortality/Morbidity

Rank	Mortality (2003)	Morbidity
1	Heart diseases	-
2	Cerebro-vascular	-
3	Peri-natal death	-
4	Malignancy	-
5	Accidents	-

Rank	Mortality (2003)	Morbidity
6	Senility	-
7	Hypertension	-
8	Pneumonia and other respiratory	-
9	Diabetes mellitus	-
10	Renal failure	-

Health indicators show an improvement in health status of the Palestinians. Life expectancy at birth increased mainly for women. Indicators show persistent decrease in Infant mortality rates in the last ten years, accompanies with a decrease in five-year mortality rates. Increasing in deliveries in health institutions and pre-natal care reflects on increasing rates of normal births. Ministry of Health directed more of resources and development projects towards supporting primary health care through extending PHC services in new areas mainly the deprived, and rural areas.

3.2 Demography

Demographic patterns and trends

The population in Palestine was estimated to 3.6 million at the end of 2004, thereof 2.3 million (63.2%) in the West Bank and 1.3 million (36.8%) in the Gaza Strip. 42.6%. According to the Palestinian Central Bureau of Statistics in 2004, 42.6% of the population in Palestine is refugees. According to the most recent estimation, 46.3% of the population in Palestine is under 15 years and 2% of the population in Palestine are above 65 years old. The median age for population in Palestine increased from 16.4 years in 1997 to 16.7 years in 2004. Male/Female ratio in Palestine at the end of 2004 is 102.6. 44.8% of females in Palestine aged 15-49 years.

Table 3-4 Demographic indicators

Indicators	1990	1995	2000	2004
Crude Birth Rate:	-	46.5	33.2	28.6
Crude Death Rate:	-	4.1	3.2	2.8
Population Growth Rate:	-	-	-	2.5
Dependency Ratio:	-	102.5	100.6	97.5
% Population <15 years	-	49.7	46.9	46.3
Total Fertility Rate:	-	6.7	4.31	4.1

Source: PCBS
MOH

It was found in census in 1997 in Palestine that the current population pyramid indicates the young Palestinian society. 47% of population was under the age of 15 years, 10.5 % of population was between 15 years and 19 years and 44.1% of population was between the age of 15 years and 65 years. 3.5% of population was above the age of 65 years. 41.4% of Palestinian population was refugee and 58.6% was non-refugee population. Male /female ratio was 1.03 with no difference between the two groups. 96% of Palestinian population was Moslems.

Israeli settlements are occupying 40 % of Gaza Strip land, which means that 1.3 millions (2003) are living on 60% of Gaza Strip land which makes Gaza Strip one of the most dense populated place in the world.

Table 3-5 Demographic indicators by Gender and Urban rural

Indicators	Urban	Rural	Male	Female
Crude Birth Rate:	-	-	-	-
Crude Death Rate:	-	-	-	-
Population Growth Rate:	-	-	-	-
Dependency Ratio:	-	-	-	-
% Population <15 years	-	-	-	-
Total Fertility Rate:	-	-	-	-

4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

On 13th September 1993, the Declaration of Principles was signed by the Palestinian Liberation Organisation (PLO) and the Israeli Government on limited self rule on the Gaza Strip and areas in the West Bank. In health, the responsibility of the Gaza Strip and West Bank had been taken over by the Palestinian Authority by November 1994.

Health care system was fragmented before November 1994. One health system catering for the needs for those with refugee status (UNRWA), another public system has been geared towards the rest of population in the occupied territories run and financed by the Israeli Civil Administration. In addition, NGOs (private not-for-profit organisations) offered health services often as 'gap fillers' and at times for political reasons, and finally, 'for profit' clinics have been offering health services to those who could afford it.

These four systems have developed independently without any overall plan, coordinated and regulation. The result has been costly health service, inefficient resource allocation with overlapping of services in some places while some areas are under-covered, great variation in quality of care, lack of standards and regulatory mechanisms, and unclear division of responsibility between the public and private providers.

The health financing system that has evolved since the handover reflects both the features inherited from the Israeli Civil Administration aspects introduced by the newly established MOH. Prior to the handover, the notable features of the health financing system included:

- A heavy reliance on external assistance for a significant part of health financing (over 40 percent in 1991, including UNRWA);
- Relatively limited contribution from the Israeli Civil Administration, deriver primarily from health insurance and accounting for less than a fifth of total health expenditure and covering only about a fifth of the Palestinian population;
- Direct household expenditures that accounted for about 40 percent of the total health expenditures (World Bank, 1988)

The Ministry of Health after passing the transition period in the second half of 1994, started to implement the recommendations of the National Health Plan, in establishing the Health Insurance Administration within the Ministry of Health. The main recommended principles for health insurance scheme where:

- Universal: to all people as far as possible.
- Comprehensive.
- Publicly administered.
- Promotion of efficient health care for the population.
- Financing resources should be collected from multiple resources, (private, public, and external). The percentage of GDP allocated to the health sector should be maintained at a reasonable level not exceeding 10 percent.

4.2 Public Health Care System

Organizational structure of public system

The organisational structure of the Ministry of Health in Palestine is a central structure depends on the three levels of commands:

1- The Minister: there are many central departments related directly to the minister. These departments are: Minister Office, Public Relations, International Cooperation, Legal Adviser, Health for Palestinian in Exile, Women Health, and Child Health. High policy decisions are the responsibility of the Planning and Policy Making Council, which is formed from the Minister, Deputy Minister and the General Director of the Ministry.

This organisational structure is under reforming in 2005, and not approved by the Cabinet till moment. The new reform considers more decentralisation within the Ministry structure and replacing the position of the Director General of the Ministry with Assistant Deputy of the Ministry.

2- The Deputy Minister: controls the following departments: Deputy Minister Office, Health Insurance, General Inspection, Private Medicine, Quality Improvement, Health Education, Coordination with Rehabilitation Centres, and Coordination with NGOs Department.

3- The Director General of the Ministry: There are two Director Generals for the Ministry, one in West Bank and another in Gaza Strip. Each Director General controls six General Administrations in his region. These General Administrations are: Financial and Administration affairs, Research, Planning and Development, Pharmaceutical, Primary Care, Hospitals, and Emergency. Primary Health care Administration only has decentralised offices in all provinces (10 provinces in the West bank and 5 provinces in Gaza Strip).

Planned organizational reforms in the public system

The different political situation between West Bank and Gaza Strip as a result of being historically ruled by two different political systems before 1967 (Jordanian system in the West Bank and Egyptian system in Gaza Strip), and absence of real changes during the Israeli occupation creates some differences in implementation of the health regulations in the two regions of Palestine. The geographical differences between the West Bank being containing many well defined provinces and Gaza Strip with small area and highly dense population with easy good communication creates a decentralised system in the West Bank and a Centralised system in the Gaza Strip.

The Ministry of Health started an intensive action towards unification of the health regulation and organisational structure for both West Bank and Gaza Strip. The new changes respond to the decentralised scheme in Palestine in the form of creating the province health service directorates in Palestine. The new trend is reflected in the new organisational chart, which is under discussion in the cabinet.

4.3 Private Health Care System

Modern, for-profit

Private health services (for-profit) are mainly offered by a network of individual clinics, mostly General Practitioners and specialists. An increasing numbers of private hospitals offering special types of curative care such as maternity, surgical and IVF services

started to work in many provinces in Palestine. There are many private health diagnosis facilities scattered all over Palestinian provinces. These diagnostic facilities include routine investigations and tertiary diagnostic facilities such as CT, MIR, and other tertiary diagnostic facilities. Most of the individual private health clinics are not registered, and are run by governmental employees in their outwork hours. Most of the private hospital or institutions are owned to persons or simple companies. The owners of these facilities run their activities or recruit human resources from the public health employees in their outwork hours. There is no clear line of cooperation between these private institutions. Ministry of health is encouraging the private health care activities.

Modern, not-for-profit

The main providers of non-profit services in Palestine are non-governmental organisation with political, charity or religious backgrounds. These institutions had an important role in providing health services to the Palestinian population during the Occupation era. All these institutions are registered and work with cooperation with public sector. Non-governmental health organisations provide their services all over Palestine with more primary care activities in the deprived and remote areas as well as in the big cities for secondary and tertiary care.

Most of the non-profit organisations are joined with unions according to their interests (political, charity or religious). The source of financing for the non-governmental organisation is coming mainly from international donations. The International donation is coming through UN agencies, foreign developmental agencies, and foreign private institutions. Local and foreign individual donations from Palestinian and Arab rich people play an important role in supporting the charity and religious organisation in Palestine.

Traditional

There is no significant role for the traditional healers in Palestine, except for some bone correction in the remote areas, which dates back to long time ago.

Key changes in private sector organization

There are no strict regulations controlling the activities of the private health sector in Palestine apart from their registration. There is no an accreditation committee, or inspection regulation except in rare events when mortality case happens. Ministry of Health is looking for setting regulations to control the private health sector in the future.

Public/private interactions (Institutional)

There is an institutional cooperation between the public sector and private and non-governmental organisations. Ministry of Health purchase the non-available secondary or tertiary care from both private and NGO sectors in Palestine through contracts. There is cooperation between Public sector and NGOs during the emergency situation where MOH provides NGOs with supplies, facilities and human resources. MOH strongly believes in the important role of the public/private cooperation role in building health system in Palestine.

Public/private interactions (Individual)

Non-governmental organisations can accept cooperation with public sector in the field of registration system, human resource development, and tertiary care providing. The only field for cooperation with private sector is only purchasing services mainly because the private system is not regulated in Palestine.

Public sector does not offer private health service within the public institution; despite there is some acceptance to this system waiting for a suitable time to implement this system. Private sector (for-profit and not-for-profit) depends mainly on the public human resources through work out hours. Private sector is completely financially independent from public sector.

4.4 Overall Health Care System

Brief description of current overall structure

There are four major health service providers in Palestine; The MOH, United Nations Relief and Work Agency (UNRWA), Non-governmental Organisations (NGOs), and private for-profit providers. The Ministry of Health provides primary, secondary and some tertiary health services and purchases some tertiary services from private providers domestically and abroad. Ministry of Health play the main role in providing and controlling immunisations scheme, public health activities, Licensing and registration of private clinics and non-public health institutions. Health care financing is mainly through MOH, apart from out-of-pocket health financing which is the first source of health financing in Palestine.

There are other limited public health providers beside MOH, mainly Police Health Services. There is a Governmental Health insurance scheme covering civil service employees, and voluntary individuals and groups in addition to the poor and vulnerable groups who are covered financially by the Ministry of Social Welfare. There is some private insurance activities but with a low percentage of population coverage (3%).

There is no change in the interrelations between MOH and other health service providers in Palestine since 1995.

5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy, and trends in stated priorities

The National Health Plan for the Palestinian People set the objectives and strategies for the Palestinian people in 1994. The National Health Plan 1994 served as an important baseline for the further development of the five-year plan by MOH. The National Strategic Health Plans (five year plan 1999-2003) considered the current changes in the health situation in Palestine after five years from establishing the Ministry of Health. This plan clearly stated the overall health system goals and objectives and reflects current intelligence on needs, resources and the feasibility of changes. Establishing the Health Management Information Centre with two branches in the West Bank and Gaza Strip helps in collecting information about health services provision, financing, human resources that are used in monitoring the health plan and following its implementation. Attention in public health services providing and health insurance has been taken to protect vulnerable and poor groups.

The current situation in Palestine including the political and security instability prevent setting a comprehensive plan including complementary role of public and private sectors in health service provision and financing.

Formal policy and planning structures, and scope of responsibilities

Ministry of Health has a Planning and Policy Making Council formed of the Minister, Deputy Minister and Director General of the Ministry, with the assistance of local experts. The General Administration for Research, Planning and Development is the responsible body for formulation of the plans with the donor bodies. The general situation of the Ministry of Health in Palestine is not highly developed to build a perfect and professional health planning body. The Department of Health Planning (DHP) serves the Palestinian people in meeting their needs and priorities and achieving the health for all strategy through peripheralization of health services, community participation in decision-making and intersectoral cooperation.

The DHP uses participatory and data-driven approaches to generate reliable plans for health development. The DHP serves as a gatekeeper to\link data to the decision-making process by verifying collected data and utilising research methods, so these planning decisions are proactive, scientifically based and cost-effective. Additionally, the DHP serves as a leading edge in monitoring, coordination and evaluation for the implementation of health plans. Subsequently, health goals and objectives are being sustained, and the state of health of the Palestinian people is improved.

Analysis of plans

Implementation of the national strategic health plan is the responsibility of the Ministry of health with cooperation with other health providers in Palestine. Implementation is severely influenced by the political and economic situation. Ministry of finance collects all revenues of the country including health insurance revenues and reallocate the budget of MOH. MOH budget control by the MOF affects implementation of any national health plan.

Key legal and other regulatory instruments and bodies: operation and any recent changes

Ministry of Health is the main statutory and legal body in Palestine that play the main role in building health system. UNRWA shares in planning for health status for the refugees, mainly in the PHC level. There is a small role for the Ministry of Higher Education, universities, and health training institutions in building the health human resource sin Palestine. Most of Doctors are trained outside the country but re-trained in the MOH institutions. Nurses and paramedical human resources are trained inside the country by MOH institutions and local universities.

5.2 Decentralization: Key characteristics of principal types

Within the MOH: e.g. to district teams, central or district boards

MOH runs health system in a highly centralised way, with some decentralised activities on the level of provinces mainly in primary health care level. PHC directorates in the provinces run clinics and all executive and community PHC activities. All financial, management, recruiting, planning and procurement are centralised. Local directorate government have a simple role in controlling and management their governorates. The political system depends on central control over all activities by the Cabinet.

Greater public hospital autonomy

Public hospitals are centrally organised through their directors who are controlled and supervised by the general directorate of hospitals in MOH. Their work is mainly administrative and technical through the head of the clinical departments. Public hospital directors have nothing to do with any financial job related to their hospitals. All budgeting and financial matters are controlled and run by the central financial department in MOH. Public hospital directors may participate in the planning, procurement and human resource development of their hospitals.

Private Service providers, through contracts

MOH purchase most of the tertiary and high-tech investigation services from private sector (for profit and NGOs), and non-technical services mainly the cleaning and transportation services. Contracting process is organised through bidding fro the non-clinical services and according to negotiation, speciality and geographical factors for the clinical services. There is a little observation policy of quality assurance supervision in the clinical and non-clinical services. Consumer satisfaction is the only used method to assure quality of the provided services.

5.3 Health Information Systems

Organization, reporting relationships, timeliness

Public and NGOs are subjected to the same requirements in reporting system. UNRWA has their own reporting system but it is compatible with the public system and there is full cooperation in this field. Private sector is obliged by law to report mortality, delivery and communicable diseases. All data are collected in the Health Management Information Centre in the Ministry of Health. The collected data is used in preparing the Annual Health Status Report in Palestine. The Annual Health status report covers data

about Population and Demography, Women's Health, Palestinian Health Care System including PHC, Communicable and non-communicable diseases, Environmental Health, Hospitals, Pharmaceuticals, Human Resources, Health Finance, Government Health insurance, Health management Information System.

All collected data is available through the annual report and through the Centre to all researchers. There is another channel for health data collection through national surveys by Palestine Central Bureau Centre, and some NGO institutions for researches in health field. All health information is available in the web site of MOH and other organisations.

Sources of information

The available information covers health provision, health financing, human resources, environmental health and health impact of the current political situation (Intifada causalities). It includes the public, UNRWA, and NGOs activities. The only existing gap is the lack and unreliable information from private sector.

The mortality, delivery and main health provision information is collected directly from site of services to the province directorate, regional (West Bank and Gaza Strip), then collected and recorded and interpreted on central level through the Central Information Centre in the Ministry. There is no specific legislation to govern freedom of information, but health information is available free for any researcher. PCBS have a press release after each survey activity and the information is available from the specific web site of the MOH or PCBS.

5.4 Health Systems Research

There is no statistic analysis for the health research in Palestine. Health researches are conducted through public health schools, health research institutions, universities and MOH.

5.5 Accountability Mechanisms

There are few existing standards for dealing with misconduct of health workers in the public or private sectors. There is a financial inspection and auditing system controlled by the Ministry of Finance regarding the budget and expenditure of the MOH, but there is no supervision or inspection system over the private for profit health institutions.

The Private health sector is less accountable in practice for their actions in relation to vulnerable groups and poor, where the public sector is responsible about covering the health needs of these groups.

Procurement / recruitment process in the public health sector is transparent to the public, cabinet and Parliament. All the process is done through the current regulations (biding, selection, financial coverage, inspection etc.). Personnel recruitment is running centrally through the Civil Service Council and controlled by the Cabinet and Ministry of Finance.

6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2004
Total health expenditure/capita,	-	122 $	-	138.4
Total health expenditure as % of GDP	-	8.6%	-	13%
Investment Expenditure on Health	-	-	-	-
Public sector % of total health expenditure	-	-	-	33.3%

Source; World Bank (1997)

Table 6-2 Sources of finance, by percent

Source	1990	1995	2000	2002
General Government				
Central				15%
State/Provincial				-
Local				-
Social Security			(Premium)	7%
Private				**-**
Private Social Insurance				2%
Other Private Insurance				-
Out of Pocket			**(Co-payment)**	**2%**
Non profit Institutions				11%
Private firms and corporations				15%
External sources				**48%**

Source: European commission, Health sector review in West Bank and Gaza Strip (2003)

Trends in financing sources:

The external source still has the upper share in supporting health sector in Palestine. This source is distributed among supporting the MOH recurrent budget (8%), MOH investments (16%), UNRWA (10%), and NGOs (14%). External donation is funding UNRWA and NGO as same as MOH due to the need of services outside the public sector, mainly primary care offered by UNRWA to refugees and supporting non-governmental

institutions to decrease the burden on public sector. There is no change in the pattern of external donation in supporting health sector in Palestine since 1994.

Health expenditures by category

Public expenditure is categorized by expenditure items and not by programmes in Palestine.

Table 6-3 Health Expenditures by Category

Expenditure	1990	1997	2000	2004
Total expenditure: (specify if only public)	-	-	95.72 $M	126.475 $ M
Capital expenditure	-	-	-	39$/Capita
% by type of service	-	-	-	-
Curative Care	-	-	-	-
Rehabilitative Care	-	-	-	-
Preventive Care	-	-	-	-
Primary/MCH	-	-	-	-
Family Planning	-	-	-	-
Administration	-	-	-	-
% by item	-	-	-	-
Staff costs	-	-	47.5%	56.1%
Drugs and supplies	-	-	20.9%	18.6%
Medical referral	-	-	6.5%	14.9%

Source: MOH annual report 2003

Trends in health expenditures by category: commentary

In reality the general situation after the second Intifada and the Israeli counteracts actions did not allow MOH to implement the National Strategic Health Plan (1999-2003). There is a difficult financial situation. Security and economic situation did not allow positive changes towards improving the quality or extension of services apart from the emergency health services and over employment.

6.2 Tax-based Financing

Levels of contribution, trends, population coverage, entitlement

Taxes are collected by Ministry of Finance. Responding to the difficult economic situation with high percentage of unemployment, collecting income tax is difficult except from the civil service employees. MOF set the taxes, 17% as VAT, and 10% for income tax and taxes on export and import.

Key issues and concerns

Tax system begins in 1995 in Palestine. Import taxes are still under the Israeli control according to the Paris Economic Agreement. There is no independent Palestinian tax system except for VAT, income and municipalities taxes.

6.3 Insurance

Table 6-4 Population coverage by source and families

Source of Coverage	1993	1995	2000	2004
Social Insurance	91,559	123,688	204,350	318,477*
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	-
Private firms and corporations	-	-	-	-
Government	-	-	-	-
Uninsured/Uncovered	-	-	-	-

Source: MOH (Health Insurance dep.).
* Including 150,253 families with a free emergency insurance.

Trends in insurance coverage

Governmental health insurance is a preliminary public insurance towards having a social health insurance. Insurance coverage increased in the years from 1995 to 2000. After the second Intifada (Sept.2000), thousands of families have free emergency insurance coverage to provide them with the public health services. This coverage was mandatory to support the Palestinian community against the hardship situation they received as a result of border closure, Israeli mass punishment procedures, re-occupation of the West Bank and deterioration of the economic status in the Palestinian Authority territories.

Private insurance is covering about 3 percent of population mainly workers in private firms in the West Bank. There is no enough studies about the private insurance activities in the Palestinian Authority territories. There is no supplementary insurance is offered by private sector.

Social insurance programs: trends, eligibility, benefits and contributions

The entire Palestinian population in the Gaza Strip and the West Bank is eligible for the GHI scheme, although there appear to be some questions regarding the eligibility of the Palestinians who are living outside the territories controlled by the Palestinian Authority. Enrolment in GHI grew from 20 percent of the total West Bank and Gaza Strip population in 1993 under Israeli Civil Administration to over 50 percent in 1998. After Intifada (Sept. 2000), and as a result of issuing the emergency free health insurance, the total coverage in the Palestinian Territories exceeds 90 percent of population (Dec. 2004).

Types of Participation:

1- Compulsory: for the government and municipality employees and retired government employees the premium equal, 5% of the basic salary, deducted from the

payroll by the civil service administration and paid on their behalf to the health insurance account. The compulsory premium has minimum limit of NIS 40 and maximum limit of NIS 75 per month.

2- Voluntary: for all self-employed people. They pay a fixed allocated premium which equals the upper limit of the premium (NIS 75), on a monthly basis, or in yearly basis with a 10% discount of the total bill, provided that they purchase the ticket in the period from January to March.

3- Workers in Israel: This is a compulsory insurance, with special allocated premium, paid by an authorised Israeli office, to the Palestinian Authority, on behalf of Palestinian workers. This is mainly for workers who work for more than two weeks every month, according to the Israeli Labour Regulations. The Israeli Labour Authority deducts NIS 93 monthly and pay NIS 75 for the Palestinian Ministry of Finance, the rest of the money is paid to the Israeli as administration cost (MOF, MOH and MOL, 1999, unpublished reports).

4- Contracts: this is a new type of contribution, started in the year 1995; it gives chance to the self-employed groups who are affiliated to occupational societies or associations to be covered by the governmental health insurance scheme. They are charged with a discount rate, this type of payment is negotiable every year and subject to change.

In addition to this regular type, there are few special groups who have special contract with the minimum premium of 40 NIS per month, such as poor people who have the premium paid on their behalf by charitable organisations. The Worker Union for the workers inside the Palestinian territories (because of their low wages and unstable work environment), pay 50 NIS per month.

5- Social Welfare: Hardship cases are defined by the regulations of the Ministry of Social Affairs according to their criteria regarding the income, the work power of the family, the housing and social status. They are covered by the supplement services of the Ministry of Social Welfare. The Ministry pays the minimum premium (NIS 40) on behalf of those cases, which is deducted centrally by the Ministry of Finance from the budget of Ministry of Social Welfare and added to the account of the Ministry of Health

The Insured Household:

Respecting the social values of Palestinian society. The insured household, considered an extended family, it includes:

- The head of household, and his wife or (wives), or her husband.
- Children below age of 18 years.
- Daughters until marriage.
- Sons and Daughters at the university until the age of 26 years.
- Parents of the household head over 60 years old.

The mentioned family members are eligible to be included in the same health insurance ticket without additional payment, which means that all the mentioned members are considered as one household.

The household head has the right to add other dependants, but with additional fees per head. These dependants are:

- Parents of the household head below age of sixty years provided that they did not have enough income are living under the household head under support. Added to

that the household head father's children from another wife (step- mother) if he has.

- Unmarried, divorced, or widowed sisters of the head of household, and their children if any of them have, provided that they dependent and are living under his support.
- Orphans, of the brother or sister head of household, with a legal sponsorship from the court denoting that he is responsible about their orphans.
- In cases of female household head, which is rare, the female household head can add her dependent parents to her insurance after proving that they did not have any support from brothers, because the society consider the male son is the first responsible person for the welfare of his parents.

Benefit Package:

The government health insurance offers primary health care services and secondary health care services that are available in the government institutions, plus diagnostic facilities. As regard the tertiary health services, the Ministry of Health purchases these services from neighbouring countries, Israel, Egypt, and Jordan, on a DRG-contract basis, according to the internal system of each country, and following the regulations of the Palestinian health insurance. The insured have to pay a co-payment from 5 percent to 25 percent of the cost. There are some services offered free regardless the insurance status, such as health services to the handicapped and mental retardation cases and to those with hereditary blood diseases such as Thalasaemia, and Haemophilia, health care to children aged from 0-3 years, vaccinations, plus high risk pregnancy and family planning services.

Methods of participation and payment

- There are no regulations regarding employer/employee contribution. The contribution rate is mainly set by the scheme administration. The deficit in general is covered by the MOF. There is no advanced tax system apart from the Export/Import tax, VAT, and income tax.
- The presence of ceiling premium makes the contribution more regressive, which appears in the premium of the compulsory group.
- Participants can pay their premiums through pay roll deduction for the compulsory and workers in Israel, through direct pay to the office in the West Bank and to the banks in Gaza Strip for the voluntary and contract groups, and by Ministry of Social Welfare through MOF.

Private insurance programs: trends, eligibility, benefits and contributions

There is no distinct private insurance activity. The existing private health insurance activates through general insurance companies as a part of their activities. Private health insurance is covering 3 percent of population only. Private health insurance commonly covers employees of the firms that deal with the same general insurance companies. They purchase their services through a medical network consists of hospitals, pharmacies, laboratories, diagnostic centres, and private doctors. They also purchase medical services from some NGO facilities.

The insured employees have free choices within the insurance medical network only. Private insurance commonly did not allow medical insurance for people with age more

than 65 years old. There is no relation with public sector, and so far there is no government regulation to check their activities.

6.4 Out-of-Pocket Payments

Palestinian people pay a large percentage as out of pocket for health services. Insured people pay cost sharing for drugs, lab, and investigations on the site of public services and co-payment for referral abroad cases. They pay also for unavailable drugs classified as out side the essential drug list. Non-insured people pay out of pocket for private clinics, drugs, and investigations in addition to secondary and tertiary care when they need.

(Direct Payments) Public sector formal user fees: scope, scale, issues and concerns

Insured patients are eligible to use public health services without fees apart from the cost sharing for the drugs and investigations. Hardship cases and chronic patients with blood diseases as well as cancer, renal failure are exempted from paying the cost sharing fees.

(Direct Payments) Private sector user fees: scope, scale, type of provider involved, issues and concerns

Private sector is financed through private investments. They charge their patients by fee-for-service, and the insured patients through contracts with the medical referral department in the MOH. All insured and the poor people (non-insured) can use the insurance regulations to receive private services. There are no regulations that can force the private sector to treat patients free of charge except in the emergency situation for saving life and referring cases to public sector to continue treatment.

Public sector informal payments: scope, scale, issues and concerns

Informal payment is illegal, but we cannot deny the existence of such payment sometimes, mainly to the specialists. Some of specialists such as surgeons or head of departments request such payment in their clinics for paying special attention to their patients or inform the patient that they well personally perform the intervention and not by the assistants. Some doctors for writing medical reports in their private clinics request informal payments. However, there is no data about informal payment. We can say that it is not a problem which affecting the health care quality but it affects the abuse of the system. Informal payment is practiced mainly to support the income of the medical professional.

Cost Sharing

The Ministry of Health charges insured people some type of co-payment, which are designed to prevent abuse of the health services, more than acting as income-generating procedures. But it plays a role in increasing revenue, containing costs and encouraging consumer responsibility. Co-payments are set centrally on national level.

The co-payments are:

- Drug co-payment per item.
- Laboratory and radiology co-payment per test.

- Referral System co-payment, the referred patient pays 5-25% from the total inpatient and outpatient cost of the service needed.

All poor households, who cannot pay the co-payment, can be exempted after having a social status research. In addition, cancer chemotherapy and radiotherapy services are completely exempted from co-payment, because the diagnosed cancer cases are defined to be treated completely, free without any type of payment

6.5 External Sources of Finance

Levels, forms, channels, use and trends

No-body can deny the role of external donors, international organisations (World Bank, EU, WHO) and international countries through their development agencies in supporting the Palestinian people and the Palestinian Authority after the Oslo Accord in 1993. The mentioned activities include only examples of the projects that were implemented in the West Bank and Gaza Strip.

Transient situation in mid-1994

After the Palestinian Authority took over the health services in June 1994, there was a great need to support the areas where the occupation had left the health department in a situation with which it was hard to cop without international support. The response to the Palestinian appeal for help was timely, where urgent medicaments and the vaccines arrived and covered the year of 1995.

The European Union built a modern 220-bedded hospital in the southern part of the Gaza strip, which started functioning in October 2000, and is now used for tertiary health services.

The World Health Organisation helped the health department by offering the vaccinations needed in the West Bank and Gaza Strip.

Rehabilitation and development of the health system

The international Donors formed a Sector Working Group Committee to coordinate the health projects in Palestine. This committee co-operated with the Palestinian Authority institutions. Palestinian Authority has received donation through international organizations, development agencies and through bilateral cooperation.

In 2003, 48 health projects still continue their activities in health sector with a total budget of 126.16 million US$. These projects are classified as follow:

- 12 ongoing soft projects with a total budget of 56 .14 million US$.
- 18 ongoing construction projects with a total budget of 42.83 million US$.
- 10 completed soft projects with a total budget of 22.9 million US$.
- 8 completed construction projects with a total budget of 4.34million US$.

External donations were distributed among a variety of health services. Primary health care was supported with 19 projects with a total budget of 69.53 million US$, and hospital sector was supported with 26 projects with a total budget of 52.9 million US$. Another three soft projects were conducted in other health sectors with a total budget of 3.7 million US$.

The international cooperation in helping the Palestinian People is a successful example of the role that the international community can offer for the people after crises all over the world.

6.6 Provider Payment Mechanisms

Hospital payment methods and recent changes; consequences and current key issues/concerns

Ministry of Finance allocates the year budget for MOH. Public hospitals received their needs by a centralized mechanism through the allocated MOH budget. MOH purchase medical services from outside public sector by case payments. UNRWA used to purchase the secondary care for refugee patients from NGO institutions through per diem fees.

The previous types of payments are complaining of many problems. There is a lack of regard for cost effectiveness. Low quality of services is manifested mainly in the public sector in addition to the low morale and low professional satisfaction.

Payment to health care personnel: methods and recent changes; consequences and current issues/concerns

All health personnel in public sector are paid by salary through Civil Service Commission regulations, added to incentives for overtime duties. NGOs and private pay most of their staff by salary, added to payment by case in few centres. There is no manifested payment concerned with specific activities as vaccination. Public sector practiced special incentives for surgeons and theatre staff doing high-skilled procedures in Public hospitals such as cardiac catheterization and open-heart interventions.

7 HUMAN RESOURCES

7.1 Human resources availability and creation

Table 7-1 Health care personnel

Personnel per 100,000 population	1990	1995	2000	2004
Physicians	-	-	75.2*	150.9*
Dentists	-	-	6.9**	9.2**
Pharmacists	-	-	7.4**	14.3**
Nurses	-	-	122.9	144.9
Paramedical staff	-	-	47.7	74.3
Midwives	-	-	12.3	14.9
Community Health Workers	-	-	22.2	7.4
Others	-	-	108.8	175.0

Source: MOH Annual Reports 2000, 2004
*: Includes physicians and specialists.
**: Underestimated, the private sector is not included

There is a general human resource policy in the public health sector where there is work towards increasing the human resources by type and number according to the extension of health services. Opening new clinics or hospitals depend on the needs and the priority is to the deprived areas according to the ministry strategic plan.

Civil Service is the main employer on behalf of the MOH. Political and economic current situation affects the procedures for hiring health staff where the Ministry of Health. MOH is overcrowded with not necessarily needed staff by type and numbers. There is a shortage of employed nurses and well qualified specialists meanwhile there is over auxiliary and low level administrative staff. There is a plan to cover the shortage of nurses and qualified specialists and hinder recruiting other staff.

Over-employment and staff retention is a real problem in the public health sector in Palestine. There is plan to reduce employment according to the real needs. There is a big demand for public sector employment, since public sector employees enjoy a good pension system. The hard economic and political situation gives more financial security to the pubic sector employees than the private sector. Staff are paid on time and salaries considered to be a 'living wage'.

Presence of other income generating activities for the public sector employees affects their productivity, mainly to the clinical and medical staff in the absence of strict work regulations. Medical and clinical staffs are appointed in their specialities and benefit from their original and in-service training. This is not exactly the case with the administrative and non-clinical staff. Productivity of health facilities depends on the situation of each facility regarding location, administration, and staff skills. The differences are limited and manifested as big phenomena. Assessment of staff performance is based mainly on supervision. Public sector does not follow other mechanisms. A yearly performance

report is needed for staff promotion, where all details of staff performance is recorded and approved by the direct senior supervisors.

Trends in skill mix, turnover and distribution and key current human resource issues and concerns

Total number of physicians (general practitioners and specialists) working in Palestine in 2004 was 5488 with a ratio of 150.9 per 100,000 populations. The number of nurses was 5270 with a ratio 144.9 per 100,000 populations. There are 336 dentists with a ration of 9.2 per 100,000 populations and 520 pharmacists with a ratio of 14.3 per 100,000 populations in Palestine. These figures are not included the dentists and pharmacists in the private sector. Dentists percentage is 9/100,000 populations and pharmacists is 14/100,000. The percentages of dentists and pharmacists are underestimated since the dentists and pharmacists who are working in the private sector are not included.

56 percent of total physicians are working in the secondary care while 35.8 percent of total doctors are working in the primary care in Palestine in 2004. 67.9 percent of nurses, 51.3 percent of midwifes and 44.6 of paramedical are working in the secondary level compared to 30.5 percent of nurses, 48.2 percent of midwives, and 51.1 percent of paramedical are working on the primary care level. The available data about the mix of different types of health workers compare the public sector with non-governmental organisations sector only. 57.0 percent of total physicians, 57.7 percent of nurses, 41.0 percent of midwives and 44.9 percent of paramedical in 2004 in Palestine are working in the public sector. The rest are working in the non-governmental organisations.

There is an increase in the numbers of total physicians in Palestine in the years from 2000 to 2004. The general practitioners ratio was 33.0 physicians per 100,000 populations in 2000 increased to 53.6 per 100,000 populations in 2004. Meanwhile the specialist ratio has decreased from 38.0 specialists per 100,000 populations in 2000 to 43.7 per 100,000 populations in 2004.

Table 7-2 Human Resource Training Institutions for Health

Type of Institution	Current		Planned		
	No of Institutions	*Capacity	Number of Institutions	Capacity	Target Year
Medical Schools	1	-	-	-	-
Postgraduate training Institutions	-	-	-	-	-
Schools of Dentistry	1	-	-	-	-
Schools of Pharmacy	2	-	-	-	-
Nursing Schools	-	-	-	-	-
Midwifery Schools	-	-	-	-	-
Paramedical Training Institutes	-	-	-	-	-
Schools of Public Health	3	-	-	-	-

*Capacity is the annual number of graduates from these institutions.

Accreditation, Registration Mechanisms for HR Institutions

Ministry of Education and Higher education is responsible for accreditation of the institution of the university level, while the Ministry of Health share in responsibility for accreditation of the vocational health institutions.

MOH face the problem of different medical schools graduates working in the MOH by doing compulsory courses fro internship before they apply to the fix-term posts in the Ministry of Health. MOH offer in-service training courses for all staff according to needs. The Human Resource Development Directorate runned 50 courses of total 4340 study hours for 1242 staff in 2003, and 30 courses of total 2787 hours for 929 staff in 2004.These in-service training courses included the subjects of emergency medicine for PHC doctors, emergency in cardiac and vascular diseases for doctors in the hospitals and PHC, intensive courses for general parishioners and specialists in new trends in their different specialities. Other in-services training courses were held for dentists, nurses, and psychiatric staff according to the real needs. All in-service training activities are coordinated through the Human Resource Development Administration with cooperation with other PHC, Hospitals, and Financial Administrations in the MOH.

7.2 Human resources policy and reforms over last 10 years

The National Strategic Health Plan (1999-2003) included a Human Resource Development Plan. The National Objectives of HRD plan emphasised the need for providing appropriate opportunities for in-service training and continuing education equality to staff, in all various health professional disciplines and providing proper infrastructure for training in the health field by establishing health science institution.

Training needs are calculating on bases of the local situations, future prospects and standards of developed and other neighbouring countries. The real current situation of training of the MOH staff showed orientation to the clinical side rather than the administrative and health systems planning side. There is a new trend to include community oriented training mainly in the mental health and health promotion activities.

7.3 Planned reforms

Information not available

8 HEALTH SERVICE DELIVERY

8.1 Service Delivery Data for Health services

Table 8-1 Service Delivery Data and Trends

TOTAL (percentages)	1990	1995	2000	2004
Population with access to health services	-	-	-	-
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	-	-	-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	100	100	92.2	100
Infants immunized with DPT3	78	100	93.3	97.6
Infants immunized with Hepatitis B3	-	97	95	97.9
Infants fully immunized (measles)	89	100	92.2	100
Population with access to safe drinking water	-	-	93.8*	-
Population with adequate excreta disposal facilities	-	-	99.2*	-

* In 2002

URBAN (percentages)	1990	1995	2000	2004
Population with access to health services	-	-	-	-
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	-	-	-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	-	-	-	-
Population with adequate excreta disposal facilities	-	-	-	-

RURAL (percentages)	1990	1995	2000	2004
Population with access to health services	-	-	-	-
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	-	-	-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	-	-	-	-
Population with adequate excreta disposal facilities	-	-	-	-

Source: MOH annual report (2004)

The planning of health infrastructure is the role of the MOH only for public institutions. Private sector and NGOs are planning their infrastructure according to their objectives, whether market status for private or political and organization objectives for NGO. Absence of over all planning in health sector did not prevent overlapping and waste of resources. MOH sometimes use special measures according to population distribution and needs in setting their priorities for infrastructure distribution.

MOH used to study the needs before asking for equipments and infrastructure and equipments distribution is based on field study and needs assessment. There are no estate surveys available at any level. But MOH give priority to replace old buildings or renovate them according to local study responding to the community needs.

In the stage of building Palestine state, and due to the financial constraint, Palestinian Authority mainly depends on external donation for capital investments. Capital investments are funded through central agreements with MOF and external donors.

All capital investments are negotiated with MOF and Ministry of Planning. Geographical distribution is determined according to real needs.There is no difference among investments in hospitals, primary care facilities or others. Primary care institutions are needed in the areas with low dens population, but respecting the existence of suitable and efficient secondary care facilities. Other services are selected and funded according to real need.

Access and coverage:

Patients have a direct access to specialists in PHC and outpatients of the hospitals in addition to the ambulatory services. Insured people have allocated clinics where they receive their primary care services. There are family files in these clinics. Any referral from PHC to hospitals or other secondary or tertiary services should be through internal referral system from the allocated PHC clinics to the hospitals. Tertiary care referral needs agreement from a special committee where specialists from secondary care level are needed to agree for this referral outside MOH facilities. Patients have no free of choice for hospitals or physicians.

The total number of registered PHC centres in Palestine is 731 centres (125 in the Gaza Strip and 606 in the West Bank). Distribution by provider shows that, 56.5% is owned and supervised by MOH, 7.3% is UNRWA clinics, and 36.3% are owned and supervised by NGOs. The geographical distribution is affected by population density in the West bank and Gaza. Number of PHC centres per 10,000 populations in 2004 was 2.6 clinics in the West Bank and 0.93 in Gaza Strip because of the small area and high dense population. Most of PHC in West bank are of second level, while most of PHC in Gaza Strip are from the fourth and third levels with more facilities and staff.

8.2 Package of Services for Health Care

Government health insurance offers a benefit package of services through its facilities in the PHC, secondary and tertiary levels to insured people. The Minister and Director Generals of PHC, Hospitals and Health Insurance defined this package. Decisions are based on explicit criteria and following health technology assessment. There are benefits that are available for whole population (insured and not insured). These services include vaccination, tuberculosis and epidemic diseases, MCH services, school health, chronic mental disorders, primary and secondary care for children below three years old, blood diseases, high risk pregnancy and family planning services.

Health system in Palestine is not covering plastic interventions, curative and constructive dental services, optics and lenses, artificial aids, hormonal therapy outside the essential drug list, organ transplantation except kidney transplant when the donor is available. Insured people pay co-payment for drugs, laboratory tests, and radiological investigations. Co-payment is mainly determined to control demand. Defined co-payment is based on local prices and ability to pay.

Most of the services are covered by main public source through the governmental health insurance system. There are some services that are covered mainly by NGO sector such as rehabilitation. NGO and private sectors share in providing primary and secondary care. UNRWA only provides PHC services to refugees, and purchase few secondary care services for the hardship cases. After 2000, public sector extends the emergency services in all areas responding to the Intifada causalities. Responding to the population demand, other services are added to the benefit package such as In-vitro fertilisation, and kidney transplant.

Foreigners have to pay for health services from private, NGO or public sectors. Governmental health insurance only covers Palestinians who are living on the Palestinian territories. Benefit package setting is a Ministerial decree approved by the cabinet. Benefit package can be modifies according to the population need. Current benefit coverage in the PHC is saturated. There is no extra benefit that is expected. Cost containment measures are expected in the future since there is an increase in health expenditure. Cost-containment measures may affect co-payment and restriction of some benefits. There is no regulation controlling deployment of new technologies in both private and public sectors.

8.3 Primary Health Care

PHC services are variable for all people with different ages. There are general practitioners clinics, specialists (paediatric, obstetric, internal medicine, skin and venereal, ENT), MCH, health education activities, and emergency services as well as the laboratory services in the clinics of level two and above. There are physiotherapy services in some of clinics of level four. Immunisation of Palestinian children is available,

accessible and affordable almost in all governmental and UNRWA PHC clinics. According to the Demographic and Health Survey (DHS) conducted by PCBS in 2004, the presence of married women reporting currently using family planning method was 47.9 percent in the year 2004 compared with 51.4 percent in the year 2000. Antenatal care is provided for pregnant women in 252 MCH clinics in MOH and 51 clinics in UNRWA. The number of visits paid per pregnant woman was 5.5 in Palestine and for each new client benefits from antenatal care, there are 4.5 repeated clients. In UNRWA, it was 6.6 repeated clients for each new client in Gaza Strip.. The percentage of newly pregnant women visits high risk pregnancy was 12.5 percent of total newly pregnant women in MOH clinics. The number of visits per high-risk pregnant woman was 4.9 visits. According to MOH and PCBS reports, about 96.9 percent of births took place in health institutions and 3.1 percent in homes.87.5 percent took place in hospitals.

There is no freedom of choice in the Governmental health insurance in Palestine. Insured population are registered in the PHC according to their location and play as gatekeeper.

Infrastructure for Primary Health Care

Settings and models of provision

MOH provide PHC on four levels according to geographical and population situation. These four levels are: Health Post covers less than 1,000 populations; Health Clinic covers 1000-3000 populations; Health centre covers 3000-1000 populations and Comprehensive Health Centre covers 10,000-25,000 populations. Primary health care providers are directly employed in public, private, UNRWA and NGO sectors Palestine.

There are 2.41 general practitioners per 10,000 populations working in PHC, 0.84 specialist, 0.77 Dentist, 0.70 pharmacist, 4.42 nurses, 0.72 midwives, 0.72 health workers, and 3.8 paramedics per 10,000 population in Palestine.

Public/private, modern/traditional balance of provision

Public-private ownership mix;

Governmental primary care is distributed according to population. More support for providing PHC services is to the rural areas, where urban areas are covered with primary care services by voluntary and NGO facilities in addition to the public sector.

Public Sector:

There are four types of public facilities providing PHC services.

1- Health post provides preventive health services (hygiene, sanitation, and MCH services) and keeps records. Health post provides curative services such as first aid.

2- Health Clinic provides preventive services such as MCH, vaccination, environmental health, safe water and sewage and safe food products. Health Clinic provides curative services in the form of general practitioner services.

3- Health Centre provides the same services as the Health Clinic plus the routine laboratory tests and preventive dentistry.

4- Comprehensive Health Centre offers the same preventive services as the Health Centre. Comprehensive Health Centre provides and extra curative services such as General medicine, specialised consultations, and emergency care.

Primary care delivery settings and principal providers of services; new models of provision over last 10 years

Last 10 years witnesses a change in the primary care delivery system. There is an increase in the total number of primary care centres with extension to the rural and deprived areas. Four levels of primary care centres is defined and distributed according to population.

Ministry of Health increase PHC centres. Total PHC centres increased from 595 centres in 200 to 619 centres in 2003 and 731 centres in 2004. In Palestine 4,273,820 visits were done to the MOH-PHC centres for general practitioners in 2004 compared with 4,039,479 visits in 2002. The annual ratio of visits per person was 1.17 in 2004 compared with 1.28 in 2002. The deterioration of using the PHC facilities might refer to insufficient drug supply by the clinics due to financial problems.

Public sector: Package of Services at PHC facilities

There are four levels of PHC providing services in all areas according to population. There is no difference of provided health services according to urban, rural areas in Palestine.

The first level, "**Health Post**", is staffed by a health guide and a registered nurse to serve population sites below 1,000 persons. Its function is to provide preventive health services such as health education (on MCH, safe water and sanitation, healthy nutrition, etc.), record keeping and follow-up, provision of first aid as well as MCH services. Curative services are provided by visiting physician once or twice a week.

The second level, "**Health Clinic**", is staffed by a general practitioner and nurses. It provides all preventive and general curative services throughout the week to sites populated by 1000 to 3000 persons.

The third level, "**Health Centr**e", provides a wider range of health services which includes preventive dentistry and basic laboratory services. Service provision is extended to cover mornings and evenings and is staffed accordingly. Health Centres are located in sites of 3000-10000 persons.

The fourth level, "**Comprehensive Health Centre**", is located in areas with more than 10,000 persons. It is supposed to provide full day preventive and curative services which include, in addition to what offered in the previous level, X-ray, physiotherapy, and consultations by a variety of specialists. Each Comprehensive Health Centre has 24 hours emergency services. There are no services excluded from package.

Private sector: range of services, trends

Private sector offers PHC service based on fee-for-services. Packages of services are set according to this principle with no control or regulation by government in this concern. Private sector selects area with over-population and with a high tendency for ability to pay. There is no regulation for governmental incentives in cases practicing in disadvantaged areas. There are no real and accurate studies for the private activities in the level of primary health care in Palestine.

Referral systems and their performance

Primary care centres are the first point for providing health service to the insured. An internal referral form is needed to receive service from hospitals except in the

emergency situation when the needed service is only available in hospitals. Referral committee agreement is needed in cases for tertiary care from outside public facilities.

This formal mechanism is functioning well when tertiary care is needed. Internal referral from primary to secondary levels is not functioning well, and patients use an emergency excuse in most cases. In cases of internal referral, patient receive medicaments and follow-up from the allocated primary care clinic and

Utilization: patterns and trends

There are 2.0 PHC centres per 10,000 populations in Palestine. There is total of 4,273,820 reported visits to the public PHC clinics in 2004 with average of 1.64 visits per person in Gaza Strip and 0.88 visits per person in the West bank per year in the Public sector. There are 1.17 visits seen by general practitioner per year, and 0.25 visits seen by nurses per person and 0.10 visits per person for specialist clinic.

The available data shows the differences among provinces and does not give details on urban-rural levels.

Current issues/concerns with primary care services

Primary care services cover all places in Palestine according to real needs. There is no restriction on any base.

8.4 Non personal Services: Preventive/Promotive Care

- **Availability and accessibility:**

93.8 of Palestinian populations have access to safe water in 2004. 92.9 percent is in the urban areas, 96.6 percent is in rural areas and 83.8 percent is located in the camps. There is 45.8 percent of households connected to public sewer and 53.2 percent is using cesspool.

- **Affordability:**

There is no significant financial barrier to an access to safe water.

- **Acceptability:**

Palestinian people are highly oriented about the importance of safe water drinking and good sanitation standards. MOH, Environment Protection Authority, and Municipalities are working together to satisfy the community for the healthy environmental status.

Organization of preventive care services for individuals

There is no existing preventive programmes have been developed for the early detection of pathology in Palestine.

Environmental health

There are many organisations responsible for environmental health, food safety, and sanitation. Environment Protection Authority is the main governmental body responsible for environmental health on national level. Activities for environment health, food safety and sanitation are included within the role of the municipalities, and environmental health department in MOH.

There is full cooperation on the licensing and control of food safety institutions and sanitation between MOH and Municipalities. Environment Protection Authority is responsible for planning and implementing of the Environmental projects on national level with good co-operation with the MOH and Municipalities. There is some formal mechanism in place for collaboration between the MOH and the municipalities.

Health education/promotion, and key current themes

Health Promotion Department is one of the departments that are directed and supervised by the minister. Physicians, nurses, specialised health educators and social workers run this department. Health promotion conducted many programmes such as adolescence programmes in the youth camps for reproductive health. Health promotion department staff conducted more than 12,000 site visits in 2004 to PHC clinics and hospitals and discussed the topics of breast feeding, nutritional issues, vaccination, personnel hygiene, heart diseases and blood pressure, stop smoking women health, mental health and oral health. The department issues many booklets, fliers, posters and video films covering health education and promotion subjects.

Current key issues and concerns

There is a priority for health education programmes for diabetes and hypertension since populations are presented late with the complications of these diseases. Also there is an interest in women health, family planning and antenatal care programmes. Health education staff and nurses working in PHC clinics and MCH centres carry out these programmes. 94.2 percent of pregnant women attended antenatal care out of total live birth, 96.9 percent of deliveries, and 95.6 percent of children received breast feeding in 2004 in Palestine. There are 47.9 percent of married women currently using family planning method.

Palestine is well known country of high coverage of vaccination of EPI. Vaccination coverage of **BCG** vaccination increased from 92.2 percent in 2000 to 100 percent in 2004, **DPT3** increased from 93.3 in 2000 to 97.6 percent in 2004, **HepB3** increased from 95.0 percent in 2000 to 97.9 percent in 2004, **MMR** increased from 87.5 percent in 2000 to 95.4 percent in 2004 and **OPV3** from 93.4 percent in 2000 to 98.3 percent in 2004, and **Measles** from 92.5 percent in 2000 to 98.3 in 2004.

It is reported that 94.2 percent of pregnant women had received antenatal care with an average of 5.5 visits paid per pregnant woman in 2004 compared with 95.4 percent of pregnant women had received antenatal care with an average of 2.9 visit paid per pregnant woman in 2000. 54.2 percent of newly pregnant women had received tetanus toxoid immunisation in 2004 compared with 27.5 percent in 2000. The Percentage of newly pregnant women visit at high risk pregnancy was12.5 percent in 2004 compared with 15.1 percent of all pregnant visits.

Delivery in Health Institutions had increased from 94.3 percent in the year 2000 to 96.9 percent in 2004. 87.5 percent of deliveries occurred in hospitals in 2004 compared with 77.5 percent of deliveries in 2000. Home deliveries at home decreased from 5.7 percent of total deliveries in 2000 to 3.1 in 2004.

Planned changes

It is planned to increase the level of antenatal care and improve the level of tetanus toxoid immunisation for pregnant women, and minimise home deliveries in Palestine in the next five years.

Secondary/Tertiary Care

Table 8-2 Inpatient use and performance

	1990	1995	2000	2004
Hospital Beds/1,000	-	-	1.4	1.3
Admissions/100	-	-	5.9	8.6
Average LOS (days)	-	3.2	2.8	2.6
Occupancy Rate (%)	-	68.5	72.4	81.1

Public secondary care services are organised through internal referral request from the primary care clinics to the insured people except the emergency situation where there is no need for internal referral request from primary level. Tertiary services need an approval from a special committee in the MOH before transferring the patient to domestic or outside non-public health centres. MOH purchase tertiary service on contract bases by case-management. UNRWA purchase secondary and tertiary care for the hardship cases among refugees. Specialists working in the primary clinics, hospital outpatient departments, provide specialised ambulatory medical services.

The secondary health care delivery system is a mix of governmental, NGOs, private and UNRWA providers. There are 4175 beds in acute hospitals in Palestine in 2004, 319 beds in psychiatric hospitals and 157 beds in the rehabilitations centres. Total beds /10,000 populations are 13.3 beds, and 11.5 beds/10,000 in acute hospitals in Palestine in 2004. MOH increased the total hospital beds in October 2000 to face the urgent demand because of increased causalities after the Intifada.

Admissions to the MOH hospitals were 76.7 admissions/1,000 populations compared with 26.2 admissions/1,000 to the non-MOH hospitals. Average length of stay was 2.6 days in MOH hospitals compared with 2.7 days in the non-MOH hospitals. Occupancy rate of the MOH hospitals was 81.1 percent compared with 47.9 percent in the non-MOH hospitals. Bed turnover in MOH hospitals was 116.3 patients/bed/day compared with 62.3 patients/bed/day in the non-MOH hospitals. Bed vacancy period was 0.53 day in the MOH hospitals compared with 2.96 days in the non-MOH hospitals.

Specialised ambulatory services under the public system are provided through directly employee specialist on salary basis. Hospitals in Palestine are not classified on geographical or capacity bases. Most of Hospitals in Palestine are general hospital distributed in the provinces in an average of one or two general hospital in each province. General hospitals contain most of secondary care departments. Some of departments in big capacity general hospitals have recognised as teaching departments. There are some special hospitals for paediatric, maternity, ophthalmic, and psychiatric care.

Public/private distribution of hospital beds

Ministry of Health owned and operates 22 hospitals, with total capacity of 2,735 beds. 17 hospitals provide general hospital services, two psychiatric hospitals with 319 beds, two paediatric hospitals in Gaza Strip with 222beds, and one ophthalmic hospital with 31 beds.

There are 31 hospitals with a capacity of 1,565 beds owned and operated by NGOs in Palestine in 2004. NGOs hospitals provide secondary, maternity, geriatric and

rehabilitation services. There are no geriatric or rehabilitation hospitals in public or private sectors.

Private sector has 23 hospitals with total capacity of 461 beds. Private hospitals provide special types of health service such as Intra Vitro Fertilisation (IVF), Ophthalmic, maternity, and surgical services.

Secondary and hospital care facilities are distributed equally in both regions (West Bank and Gaza Strip). There are 77 hospitals in the West bank including Jerusalem, where 60.0 percent of populations and most of the private hospitals in Palestine are working in the West Bank, and 22 hospitals in the Gaza Strip. There are 2,835 total hospital beds in the West bank with a ratio of 1.23 bed/1000 population, while there are 1,989 total hospital beds in Gaza Strip with a ratio of 1.33 beds/1000 populations.

Key issues and concerns in Secondary/Tertiary care

Primary care level is responsible for providing primary health care services in addition to selected services from secondary level, such as specialists' consultations. Patients with need for secondary care services receive an internal referral request to the proper place. There is a plan to provide some types of secondary level care to the PHC clinics of the fourth level, such as maternity, elective minor surgery that can be done in the hospital outpatient departments. This upgrading of PHC services can decrease the load in hospitals and minimise the need for adding new hospital beds.

There is a system of cooperation between both healthcare levels. The referred cases to the secondary level have to return back to their clinics for follow-up and for receiving their medicaments. Patient complaints are welcomed and directed to the hospital directors up to the minister, studied by the hospital administration or referred to special committees for their recommendations. Patient can go to the court in medical errors leading to mortality. Medical errors are not publicised or recorded. Cases of adverse drug reaction are reported by doctors, pharmacies and nurses to the hospital directors. Hospital directors stare special investigations to know the causes and their recommendation are respected. Direct-to-consumer advertising of drugs, medical devices or doctors' services permitted is not allowed.

Planned reforms

There is work in revising the previous National Strategic Health Plan (1999-2003), analysing the degree of implementation and the outcome of this plan. This revision is done in the MOH with the help of donors.

8.5 Long-Term Care

NGOs institutions in Palestine provide long-term care. Care for elderly provided is mainly institutional. There is a geriatric hospital in the Gaza Strip where MOH purchase the geriatric services. Physically disabled (e.g. Down's syndrome) is provided institutional and in-home care. Children with learning disability (speech and hearing problems) receive the care institutional; and through home visits by specialists. Mental Health Programmes provide their services both institutional and in community based activities.

Structure of provision, trends and reforms over last 10 years

There are community-based programmes mainly provided mental health services through specialised NGOs institutions or through the Mental Health Department in the MOH.

8.6 Pharmaceuticals

Public reimbursement of pharmaceuticals is only for the insured people and for the not available, outside the essential drug list according to a request from the specialist. Reimbursement is usually for cancer chemotherapy, endocrinal therapy and some important medicaments. The patient has to pay 50% of the price of the requested medicament except the poor who can be exempted by the agreement of the Minister, Deputy Minister or Assistant Deputy Minister.

Essential drugs list: by level of care

Ministry of Health has an essential drug list. It is arranged by drug category and products.

Manufacture of Medicines and Vaccines

There seven drug factories in Palestine. Drug factories produce 1,006 medical products. There are no possibilities to produce vaccines in Palestine. The wholesalers charge a profit of 8-10% on the ex-factory price, Pharmacy charge 30%, and the client pay VAT of 17% on the whole sale price.

Regulatory Authority: Systems for Registration, Licensing, Surveillance, quality control, pricing

There is no National Regulatory Authority for drugs. Local factories have to register their products in the Ministry of Health before selling to the market. All local medical products have a fix sale price from the factories. This is arranged between the factories and not related to MOH control. There is no price control for generics in Palestine. Control of OTC products is weak, mainly in the remote areas.

There are regulations controlling pharmacy working such as licensing and inspection from MOH. Direct-to-consumer advertising of prescription drugs is not permitted. Some advertising through newspaper is running after having registration and by the consent of MOH. Mail-order/internet pharmacies are not permitted, but there is no control for this activity.

Systems for procurement, supply, distribution

MOH purchased pharmaceuticals by national bidding following the regular bidding mechanisms. Agreement for purchasing is given by a special purchasing committee in the MOH. The drug committee in the ministry approves the requested types and amounts after studying all requests from PHC and Hospital departments. MOH gives the order for receiving samples from all to be tested and after the positive results of drug quality the Ministry of health receives medicaments from the bidding winner to central drug stores in West Bank and Gaza Strip. The purchased drugs distributed in quarterly bases to the PHC and Hospital headquarters, to be finally distributed to the hospitals and PHC clinics.

Current issues and concerns

All purchased medicaments are exposed for special laboratory examination for quality before accepting these medicaments. If any drug fails in quality testing it will not be accepted.

Chemotherapy drugs and vaccinations are not available. MOH can purchase the not available drugs from the main foreign producers through bilateral agreements. Narcotics and unregistered drugs are banned. There is a strict surveillance mechanism over the pharmacies in Palestine. Any spurious drug (if any) is a criminal offence and exposed to close the pharmacy and send to court.

8.7 Technology

Registration by computers is available in the central PHC and Hospital Departments, in addition to the Health Management Information Centre. There is a pilot study to implement a Clinic Information System in two clinics in both West bank and Gaza. There is a national strategy to extend this pilot study for more clinics in Palestine. There are computerised systems in all MOH departments. There is an intensive work to unify all these system to a national health system in Palestine.

Pilot study was conducted in two clinics of level four in both West bank and Gaza Strip. There is a plan to introduce the electronic medical records in all clinics and hospitals after managing the financial need. There are no regulations controlling technologies in the private sector in Palestine.

Trends in supply, and distribution of essential equipment

Process of purchasing medical aids and devices is same as purchasing medicaments in MOH. MOH has a maintenance department charged of maintenance and follow up for all high technology equipments. Most of these equipments are maintained in the warranty period by the seller agencies. MOH contracts special maintenance agencies or by MOH department during using these equipments.

Effectiveness of controls on new technology

There is no control regulation on the acquisition of costly technologies. Private sector is free to by and run advanced technology without consent from MOH or any public institution. There are only donated two CT scans in the MOH facilities.

9 HEALTH SYSTEM REFORMS

9.1 Summary of Recent and planned reforms

Information not available

10 REFERENCES

10.1 Source Documents

- The status of Health in Palestine, MoH. 2000-2004.
- National Strategic health plan1999-2003, MOH1998.

11 ANNEXES

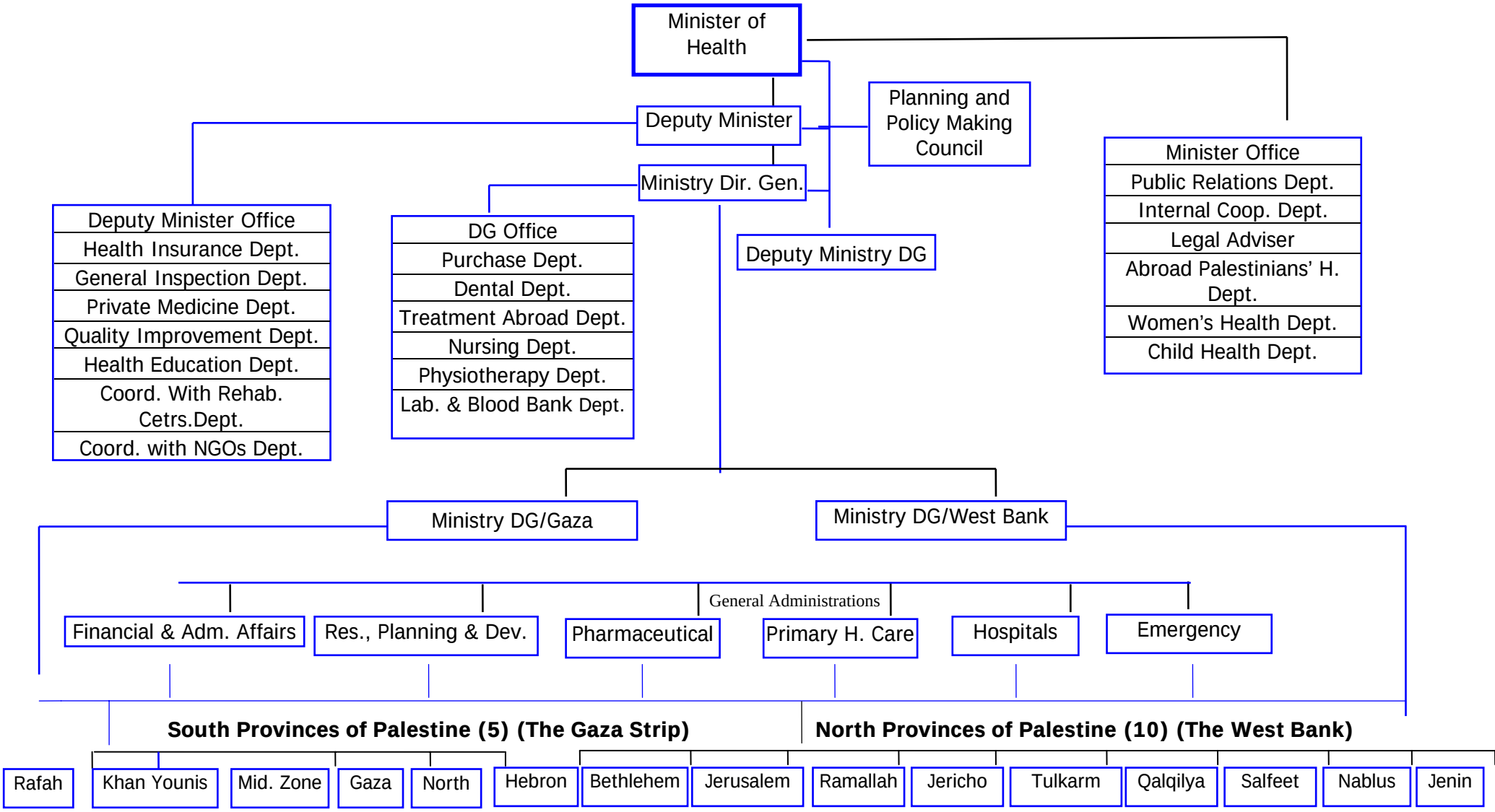
11.1 List of annex titles

1- Ministry of Health organization chart

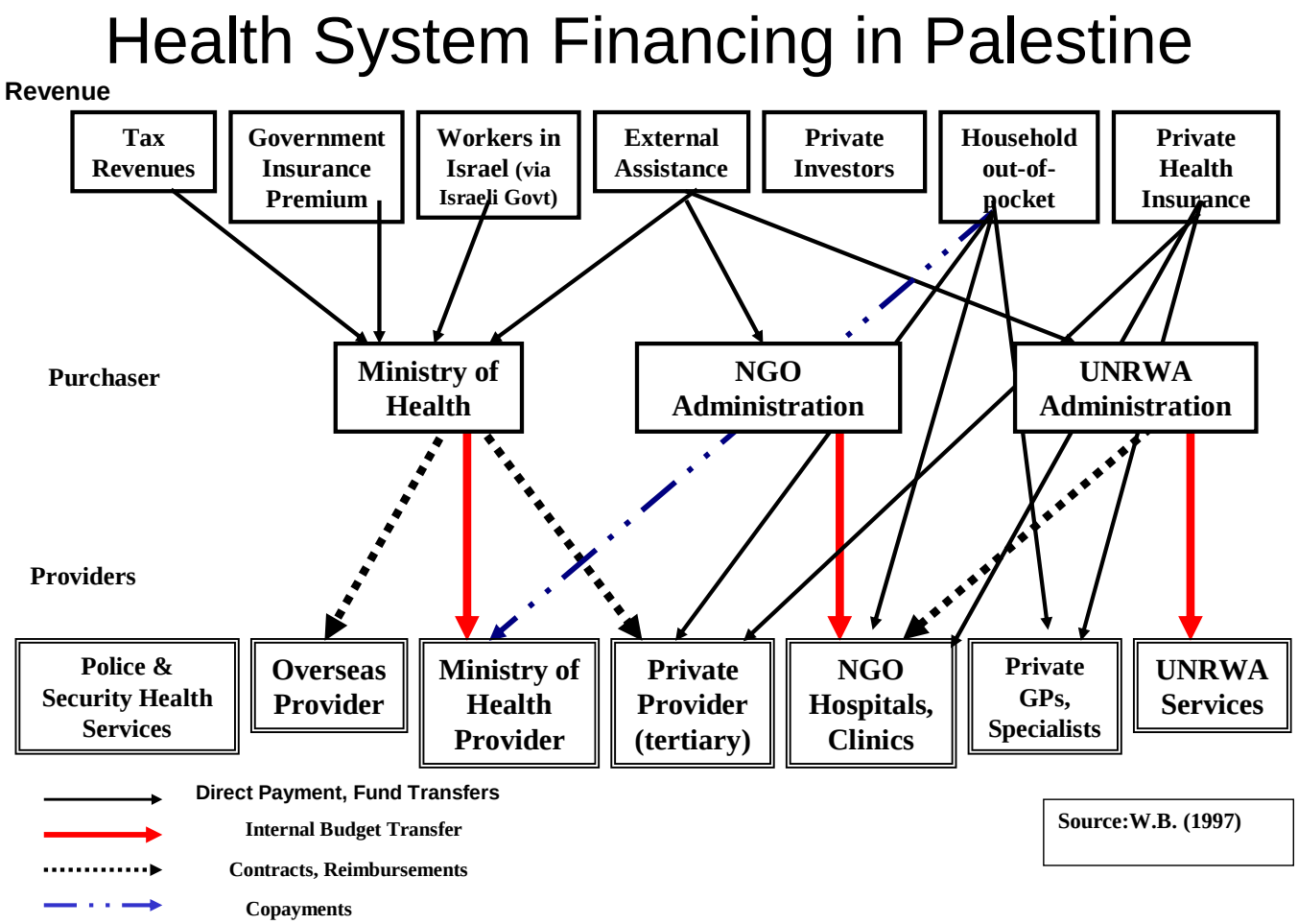
2- Fund Flow-Health System Financing in Palestine

Annex 1 Organisational Chart of MOH

PALESTINIAN NATIONAL AUTHORITY - MINISTRY OF HEALTH ORGANIZATION STRUCTURE, 1998



Annex 2: Fund Flow-Health System Financing in Palestine



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This document is part of a series of in-depth health systems profiles, produced and updated by the Observatory using standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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