

WEST BANK AND GAZA

HEALTH POLICY REPORT

REFORMING PRUDENTLY UNDER PRESSURE

**HEALTH FINANCING REFORM AND THE RATIONALIZATION OF
PUBLIC SECTOR HEALTH EXPENDITURES**



The World Bank
Human Development Sector
Middle East and North Africa Region

CURRENCY EQUIVALENTS

(As of December, 2008)

Currency Unit = NIS

\$1.00 = NIS 3.88

WBG FISCAL YEAR

January 1 – December 31

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LIST OF ACRONYMS

EDL	Essential Drug List
EMEA	European Medicines Evaluation Agency
FDA	Food and Drug Agency – United States
GDP	Gross Domestic Product
GHI	Government Health Insurance
GPC	General Personnel Council
GS	Gaza Strip
INTOSAI	International Organization of Supreme Audit Institutions
IPSAS	International Public Sector Accounting Standards
LPG	Lowest Priced Generic
MOF	Ministry of Finance
MOH	Ministry of Health
MONE	Ministry of National Economy
MOP	Ministry of Planning
MOSA	Ministry of Social Affairs
NGO	Non-Governmental Organization
NSHP	National Strategic Health Plan
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PHC	Primary Health Care
PRDP	Palestinian Reform and Development Plan
UNRWA	United Nations Relief and Works Agency
USD	United States Dollar
WB	West Bank
WHO	World Health Organization

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ACKNOWLEDGEMENTS

This health policy report was prepared by a World Bank team led by Firas Raad (Senior Health Policy Specialist and Task Team Leader) and consisting of Bruce Andrews (Financial Management Specialist), Alan Fairbank (Health Economist), Claudia Habl and Imad Dweik (Pharmaceutical Specialists), Adriana Tabisz (Human Resource Management Specialist), Manfred Zipperer (Health Insurance Specialist) and Maha Muhammed Bali (Program Assistant). The team also benefited from guidance and analytical inputs provided by Akiko Maeda (MNA Health, Nutrition and Population Sector Manager) and Awad Mataria (Health Economist, Birzeit University).

The team would like to acknowledge the valuable support of PA officials including H.E. Dr. Fathi Abu Mughli (Minister of Health), Dr. Anan Al Masri (Deputy Minister of Health), Dr. Hassan Al Khatib (Deputy Minister of Labor), Mr. Mazen Jadallah (Director General of International Relations, Ministry of Finance), Dr. Cairo Arafat (Director General of Aid Management and Coordination, Ministry of Planning), Dr. Nizar Masalmeh (Director General of General Health Insurance), Dr. Qassem Al Maani (Director of International Cooperation, Ministry of Health), Dr. Muhammed Itiyani (Director of Finance, Ministry of Health), Dr. Rania Shaheen (Director of Pharmacy Department), Mr. Rizq Othman (Director of Procurement), Dr. Fahd Al Sayed (Director of Human Resources, Ministry of Health), Mahmoud Abu Rub (State Audit and Administrative Control Bureau) and Aisha Mansour (Office of Minister of Health). The leadership and support of H.E. Dr. Fathi Abu Mughli, in particular, were critical to the policy workshops organized by the team and the preparation of this health policy report.

A debt of gratitude is also owed to a number of individuals from donor and local organizations who participated in the discussions of the policy workshops and provided comments on the draft policy notes prepared by the team. These individuals include Mr. Tony Laurence (Head of Office, World Health Organization), Dr. Ambrogio Manenti (former Head of Office, World Health Organization), Dr. Servio Pappagallo (former Health Program Coordinator, Italian Cooperation), Mr. Joel Toujas-Bernate (Resident Representative, International Monetary Fund), Ms. Fabienne Bessone (Director, European Union), Mr. Juan Tello, (Health Coordinator, European Union), Dr. Katja Schemionek (Public Health Officer, World Health Organization), Dr. Rana Khatib (Director, Institute of Community and Public Health, Bir Zeit University) and Rita Giacaman (Professor, Institute of Community and Public Health).

The team would also like to extend a special word of thanks to the West Bank and Gaza Country Management team and staff. David Craig (Country Director), Faris Hadad-Zervos (former Deputy Country Director), Dina Abu-Ghaida (Portfolio Manager and Deputy Country Director), Eileen Murray (Human Development Coordinator), Mark Ahern (Senior Public Sector Specialist), Elena Kastlerova (Country Program Coordinator), Hege Wage (Operations Officer) and Mary Koussa all provided very helpful support to the team during the preparation of the report. A final word of thanks are extended to the peer reviewers of the report: Andreas Seiter (Senior Pharmaceutical Specialist, World Bank), John Nasir (West Bank and Gaza Country Economist, World Bank), and Bjorn Ekman (Health Economics Professor, Lund University).

EXECUTIVE SUMMARY

Public sector health financing is at a critical crossroads in the West Bank and Gaza. The emergency environment in the Palestinian Territory since 2000 has engendered significant and unsustainable imbalances in the financing of public sector health services. While economic growth and fiscal revenues contracted during the post-2000 period due to continued Israeli-imposed economic closures, public sector health spending ballooned, particularly during 2003-2005. This expansion in expenditures was driven by an increase in MOH employment, an increase in average salary levels, greater spending on pharmaceuticals and specialty care referrals for treatment to private and overseas providers. Spending by MOH alone increased from US\$ 95 million to 157 million from 2000 to 2005 – a 65 percent increase. Other public sector expenditures included spending by the Humanitarian Aid Committee attached to the Office of the President. Part of the financial imbalance also stemmed from policy decisions related to the design of the Government Health Insurance Scheme (GHI). Since its establishment as an extra revenue-generating scheme for the MOH, there has been a significant financial gap between insurance revenues and the cost of benefits extended by the GHI. This financial disequilibrium grew with the adoption of the ‘free’ Al Aqsa program – a PA voluntary insurance program aimed at ameliorating the social conditions of the unemployed population after the beginning of the 2nd Intifadha.

This report aims to address and analyze these policy concerns with a focus on providing recommendations for medium-term reforms. The report builds on previous analytical work conducted by the World Bank on the Palestinian health sector and is aligned with the strategic objectives of the Palestinian Reform and Development Plan (PRDP) and the MOH National Strategic Health Plan (NSHP) for the years 2008-2010. The earlier reports by the World Bank consisted of a 1997 health sector report¹, a 2006 public expenditure review (PER), two 2008 reports prepared by World Bank consultants on pharmaceuticals and health equity issues. Between the years 2003-2007 the World Bank participated with several international donors (DFID, EC, Italian Cooperation, WHO) and the Palestinian Ministry of Health in the preparation of a health sector review document published in 2007. The health sector review document was the culmination of several years work by five task force committees focused on the areas of health status outcomes, health financing, health service delivery and health sector performance.

Key Sector Issues

- **Conflict conditions and closure policies** – The recent conflict between Israel and the Hamas government in Gaza and the continued Israeli security policies in the West Bank have had a profoundly negative impact on public health and access to basic health services. The conflict in December 2008-January 2009 resulted in hundreds of fatalities and thousand of injuries; and further undermined the already weakened state of the water, sanitation and power sectors in the Gaza Strip. Medical supplies were in very short supply and health facilities were often not able to treat the sick during the crisis. The checkpoints riddling the West Bank continue to hamper access to health services.

¹ The 1997 health sector report is entitled ‘A Medium Term Development Strategy and Public Financing Priorities for the Health Sector’ and consists of two separate volumes.

- **Fragmented institutional framework** – The governance of the sector is fragmented across two authorizing institutions in the West Bank and in the Gaza Strip. The division between the PA and the Hamas government has effectively created two Ministries of Health and fragmented the decision-making related to operational issues, investment planning and government initiated-reforms in the health sector.
- **Unpredictable health financing and donor dependency** - The unpredictability of budget revenues for the MOH hampers medium-term investment and recurrent expenditure planning. Due to the fiscal contraction in recent years, priority expenditures have focused on covering the wage bill and a share of the recurrent expenditures with fluctuating donor support making up the difference. This unpredictability will probably prevail over the short to medium term.
- **Efficiency of public sector health expenditures** - The efficiency of public sector health expenditures warrants continued attention by the Ministries of Finance and Health. Recurrent MOH spending on salaries almost doubled from 2000-2005 (\$48 million to \$83 million) and public sector expenditure on outside treatment referrals increased ten times during the same time period (\$6 million to \$60 million) taking into account the expenditures by the Humanitarian Aid Committee connected to the Office of the President.
- **Inadequate financial protection from illness** - Around 40 percent of total health expenditures in the West Bank and Gaza is in the form of out-of-pocket household expenditures. In 2004, the lowest income quintile of households spent an estimated 40 percent of their monthly income on health services while the richest quintile spent around 15 percent. When payments are catastrophic and beyond 40 percent of household incomes, families can sink into poverty. Between 1998 and 2006-2007, both the percentage of households making catastrophic health payments and the ‘intensity’ of the poverty gap attributable to health payments (extent to which household fall under the poverty line due to health payments), increased considerably.
- **MOH management capacity constraints** - The Ministry of Health is burdened with capacity constraints impacting its institutional effectiveness. The recent fiscal pressures leading to delayed salary payments, sometimes up to six to nine months, has weakened MOH capacity to motivate employees and attract new high-performing individuals. This environment of weakening incentives affects MOH management functions ranging from procurement of medical supplies and drugs to hospital claims processing to GHI enrollee management.
- **Increasing burden of chronic disease** – Chronic diseases and injuries are increasingly forming a larger part of disease burden in the West Bank and the Gaza Strip. Cardiovascular diseases, hypertension, diabetes mellitus are among the leading causes of adult mortality and morbidity among the Palestinian population. In 2004, heart diseases caused the highest number of adult deaths with a mortality rate of 60.5 per 100,000 in males and 48 per 100,000 in females.

Health Insurance Reforms

The PA and the MOH have already taken remedial measures to begin redressing the financial imbalances and administrative weaknesses of the GHI scheme. High-level decisions were taken to unify the decision process governing outside referrals for the insured under MOH authority and to consolidate the insurance and outside referral units under one administrative directorate in the MOH. Other decisions were taken to substantially reduce the volume of overseas

treatment referrals and to develop stricter criteria for outside referrals in general. Beyond the short-term options the PA is currently contemplating establishing a separate national health insurance agency under the chairmanship of the Ministry of Health. This policy direction signals an intention to by the PA to place health financing arrangements on a path towards achieving universal coverage through social health insurance.

This report examines the pre-requisites and enabling factors for an effective social health insurance system based on lessons from international experience. The report also reviews draft legislation prepared by the MOH for the establishment of an independent health insurance agency and provides recommendations for improving the legislation. In the report, three medium to longer term health financing reform options are examined including the option currently being considered by the MOH.

The three reform options are:

1. Consolidate MOH as an integrated national health service (NHS) that both pools resources and provides services
2. Maintain the MOH as the primary financing agency – but introduce broader purchasing reforms including contracting NGO and private providers
3. Move towards establishing a social health insurance system based on mandated contributions and administered by an independent national health insurance agency

The main features, advantages and disadvantages associated with each reform option are summarized in the Table below:

SUMMARY DESCRIPTION OF FEATURES, ADVANTAGES AND DISADVANTAGES OF OPTIONS

Policy Options	Features	Advantages	Disadvantages
Policy Option 1: Consolidate MOH as integrated national health service	Resource mobilization: Predominantly general tax revenues Fund management: Ministry of Health Purchasing: Potential reform in the internal budget process, including the introduction of global budget and performance-based payments within MOH	- Easy to implement - Provides universal access to health services	- Difficult to reform budget process and introduce performance payments - Services limited to MOH facilities
Policy Option 2: Maintain the MOH as the primary financing agency but strengthen the purchasing capacity of the MOH.	Resource mobilization: Predominantly general tax revenues, supplemented by co-payments, other fees Fund management: Ministry of Health Purchasing: Contracting providers, alternative payment methods	- Provides universal access to health services - More tools to introduce strategic purchasing - Expands choice of providers for patients (NGO, private)	- Technical expertise and capacity required to manage contracts
Policy Option 3: Move towards establishing a social health insurance system based on mandated contributions and	Resource mobilization: Contributory system (payroll tax, fees, copayments) with general revenues for targeted subsidies	- Establishes an independent financing agency with better defined	- Expanding coverage difficult if economy poor and informal sector is large

administered by an independent national health insurance agency	Fund management: National Health Insurance Agency Purchasing: Contracting providers, alternative provider payment methods	accountability - - Potential efficiency gains through better purchasing - Expands choice of providers for patients	- Potential access problems for non-contributing members - Significant technical capacity required and potentially high administrative costs - Exacerbates informality if contribution rates are high - Cost escalation could become problem if purchasing capacity is weak
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The policy approach currently being contemplated by the MOH (Option 3), given the current emergency conditions in May, 2009, is risky. The pre-requisites and enabling factors for successfully pursuing Option 3 at the present time are in very short supply. The PA and the MOH should alternatively give greater consideration to pursuing Options 1 or 2 over the medium-term. Ultimately, however, the decision to organize a health financing system in a given way (to mobilize resources for healthcare, pool and manage those resources, and use them for the purchase of health services) is, at its core, a social choice and governed by political, economic, and institutional factors prevailing in a country context.

Financial Management Reforms

In 2007-2008, the PA initiated broad-scale public financial management (PFM) reforms with the aim of improving public sector accountability and financial control. Under a restructured financial management system, the PA aims to increase the authority and accountability of specific ministries (including the MOH) through the allocation of funds to line ministries in accordance with an appropriation approved by the parliament. The Minister of Health will be authorized to disburse funds within the limitations imposed by the parliamentary appropriation and account for the performance of their responsibilities through the preparation of an annual financial statement. The current MOH financial management system needs to be redesigned and modernized so that the Minister of Health can properly discharge these new financial responsibilities. The existing system does not provide: (i) a reliable basis for preparing forward estimates; (ii) reasonable assurance about legislative regularity of all expenses; (iii) an efficient and timely mechanism for the payment of accounts payable; (iv) complete and accurate information about the real cost of health services.

There are five proposed reform options.

1. **Long-Term Transfer of Responsibility from the Ministry of Finance to the Ministry of Health** - In the medium term the Ministry of Health should concentrate on developing appropriate commitment controls before the MOH is authorized to assume responsibility for two important functions: (i) payment of salaries and wages and (ii) internal control and internal audit services.
2. **Reform the Budgetary Cycle** – As part of a whole of government approach to strengthening the budgetary cycle led by the Ministry of Finance, the Ministry of Health

should implement a performance monitoring program to support the introduction of a new program-based budgeting cycle. The Ministry of Finance should provide assistance and guidance to line ministries to assist the development of an agreed program structure, appropriate performance measurement tools and reporting requirements.

3. **Re-engineer the System of Internal Control** - The existing system of internal control is old-fashioned and labor intensive. The release of a new financial management system within the Ministry of Finance provides an opportunity for the Ministry of Health with the direct and specific support of the Ministry of Finance to: (i) implement control measures to detect and investigate fraud and over-servicing; (ii) re-engineer core financial management processes, i.e. collection of contributions, payment of accounts and procurement of services; (iii) expand the range of payment options available to contributors.
4. **Establish a New Chart of Accounts** - The existing chart of accounts does not support the accurate costing of specific services and/or service delivery outlets. As part of the general move to program budgeting the Ministry of Health (MOH) chart of accounts should be re-designed to facilitate the production of regular reports aligned to programs specified in the budget.
5. **Prepare Comprehensive Financial Statements** - The annual financial report prepared by the Ministry of Finance is not a complete record of all health portfolio assets and liabilities. In the short-term the Ministry of Health should focus on preparing a cash-based annual statement that accounts for all revenue and expenses assigned to the Minister of Health via the budget law.

In the longer term, the financial statements should be expanded to encompass all health related financial activity. This should include all non-current assets and liabilities such as plant and equipment and the accrued value of any depreciation of those assets. The Ministry of Health should develop accounting procedures for the valuation and depreciation of assets. These values should be included in the annual financial statements. The financial statements should comprise a balance sheet, a cash flow statement and an operating statement

MOH Human Resource Management Reforms

The political and macroeconomic environment in the West Bank and Gaza during 2000-2006 induced a rapid expansion in public sector employment particularly in the health, education, social development, and security sectors. The severe economic stagnation and growing unemployment in the private sector, particularly during the 2001-2003 period, prompted the PA to expand the scope of public employment. The total number of MOH employees during 2000-2006 increased from 7,500 to 13,057 and the MOH wage bill similarly rose from US\$ 48 million in 2000 to US\$ 83 million in 2005. This rapid increase in MOH employment, particularly among paramedical workers in the first six years after 2000, reversed course during the 2007-2008 due to employment retrenchment policies imposed by the PA.

As part of a reform agenda, a new Civil Service Law was passed in 2005 to bring greater uniformity and transparency to the recruitment practices of the public sector. This initiative helped rationalize the employment practices of the different PA Ministries including the MOH. Additional reforms by the MOH itself in the areas of human resource management and planning could further rationalize MOH employment policies and its overall wage bill. These reforms include the following five areas:

1. Consolidate disparate human resource management functions under a new MOH human resources department;
 2. Conduct a series of in-depth analyses on human resources in the MOH (mapping analysis, staff motivational survey) and preparing a comprehensive human resource development plan;
 3. Strengthen existing recruitment procedures and the development of a new MOH recruitment handbook;
 4. Prepare a training plan and calendar for the period 2010-2012;
 5. Adopt a new human resource management information system for the MOH.
- These reform measures could be implemented over the course of a year with the necessary technical and financial assistance of the donor community.

Pharmaceutical Cost Containment Strategies

Overall spending on pharmaceuticals in the West Bank and Gaza has expanded in recent years despite increasingly limited resources in the public and private sectors. This expansion has been fuelled by several factors including a growing number of publicly procured medicines, higher demand from a growing population and high pharmaceutical prices due to existing trade barriers and new expensive drugs entering the Palestinian market. The key pharmaceutical cost containment issues in the Palestinian Territories are as follows:

- **Current procurement policies in the public sector** - Aside from medicines donated in-kind by donors, all medicines available in the public sector are bought via government tenders. Drugs procurement guidelines follow PA general laws and regulations for general goods and services and do not take into account the specialized nature of pharmaceuticals (e.g. regarding their patent situation). Conditions of weak market competition, also, compel the MOH to buy from either Israeli companies, local manufacturers or the local providers at higher prices than those that could be achieved via more competitive tendering.
- **Current pricing policies in the private sector** - In the private market products are basically purchased by the pharmacists directly from agents or local manufacturers. Pharmacy retail prices are quite high. The reason for these high prices is that the list prices at the level of the manufacturers, importers or agents level are not effectively regulated but are usually suggested by the manufacturers, agents or importers. Agents usually have exclusivity contracts² for the branded medicines they import guaranteeing them a monopoly position with reported profits of 100 percent and more since the maximum allowed add-ons are not regulated. They are granted such contracts by both the Ministry of National Economy (MONE) and the MOH.
- **Existing Trade Agreements** – The ‘Paris Protocol’ Trade Agreement of 1993 between Israel and the PLO represents, according to many stakeholders one of the main barriers to trade and competition. Israeli authorities rely on certain stipulations (‘standard requirements’) in the Paris Protocol³ to require that all pharmaceutical goods (and raw materials needed for production) entering the Palestinian Territories need to comply with Israeli process standards. This requirement means that all medicines not produced

² Exclusivity contracts are a part of the market authorisation/registration process, to guarantee the availability of the medicine.

in Israel and not being donated in-kind by international organizations such as the UN are required to pre-register in Israel. The stated rationale of the Israeli authorities is that the medicines need to comply with Israeli public health standards and to avoid a potential backwash of medicines from Palestinian Territories into Israel. These expensive and time-consuming pre-registration requirements are a major barrier to competitive trade and discourage interest in the Palestinian pharmaceutical market.

The main pharmaceutical cost containment recommendations are:

RECOMMENDED PHARMACEUTICAL COST CONTAINMENT MEASURES

Recommendations	Proposed action	Feasibility	Fiscal Impact	Lead by
A) Preparing a National Drug Policy	- Prepare a new national drug policy	Possible	Intermediate	MOH
B) Promoting Rational Drug Use	- Develop an operational instrument to promote rational drug use, and the monitoring of prescription patterns	Possible	Intermediate	M MOH
C) Reducing the overall price level of pharmaceuticals	<ul style="list-style-type: none"> - Redraft the pricing ordinance after an evaluation of its objectives and impact. - Define that the procured price may not exceed the registered (approved) maximum price and try to cap the profit of agents. - Standardize the approval procedure for pricing requests by manufacturers/importers (in the long-term price increases shall only be possible after approval by the Technical Committee). - Improve strategic price negotiations. - Seek reliable information on price by enhancing data collection e. g. in cooperation with the Pharmacists Association. - Measures shall be directed at procurement and private market 	High	Immediate	MOH
D) Further encouragement of competition and enhancement of procurement system	<ul style="list-style-type: none"> - Increase number of bidders in procurement by addressing potential foreign bidders for multi-source products directly <u>and</u> guaranteeing them a timely payment. - Long-term: building up of electronic procurement - Customization of the standard bidding documents for goods to address any particular technical or legal requirement related to the purchase of medical equipment must be done through the Bid Data Sheet, the Special Conditions of Contract, and the Technical Specifications. - Not allow exclusivity contracts for agents - Try to promote “parallel imports” 	Possible	High	MOH MONE MOF

E) Minimize Trade Barriers	<ul style="list-style-type: none"> - Review Paris Protocol and accepted interpretation of its articles related to pharmaceutical supplies - Prepare a thorough dossier with a documentation of all unfavorable occurrences that impose non-tariff barriers (assisted by industry). - Start active discussions with the Israeli authorities on how to facilitate entry of medicines. - Improve efficiency of registration. 	Doable, but strong political support necessary	High	MONE together with Joint Economic Committee (JEC)
F) Modification of the Technical Committee and its subcommittee on Pricing	<ul style="list-style-type: none"> - Role and set-up of Committees should be redefined to avoid potential conflict of interest. - Voting process shall be made clear. - More weight for payers. - Involvement of independent experts in the field (one legal adviser already nominated). 	High	Linked to the draft pricing ordinance	MOH eventually jointly with MONE and MOF

Public Sector Expenditures on Contracted Specialty Care Services

The recent expansion of public sector expenditures on contracted specialty care services, as with human resources and pharmaceuticals, contributed significantly to the overall rise in public sector health spending in the West Bank and Gaza. In 2000, referrals for outside tertiary care services reported by the Ministry of Health slightly exceeded 5,000 cases. By 2005 this figure exceeded 30,000 – a 500 percent increase in five years. The factors driving this increase in outside referrals, according to the Ministry of Health officials, were several: (i) a general environment during the 2nd Intifadha which induced the Government to expand the number of outside referrals (deepening economic hardship; increased psycho-social stress on Palestinian households; higher incidence rate of conflict related injuries); (ii) an increase in the total number of beneficiaries under the Government Health Insurance (GHI) scheme as large numbers of non-contributing enrollees were brought under the scheme; and (iii) a loosening of the management and control mechanisms authorizing public sector referrals for specialized care services.

As part of its reform agenda, the PA and the MOH recently undertook several indirect and direct measures to contain and rationalize these public sector expenditures on specialty care services. The indirect measures involved efforts to design and implement new health promotion and prevention programs (smoking cessation, cancer screening). The direct measures involved the development of regulatory criteria for capital investments in specialty care services and facilities; and a move to strengthen the existing contracting mechanism with local providers through the development of a new model contract and the implementation of a competitive-based bidding approach. Due to technical capacity constraints in the MOH, implementation of this innovative approach suffered from long implementation delays and bottlenecks. Over the next two years, 2009-2010, it will be important for the MOH to evaluate, strengthen, consolidate and possibly expand (to include overseas referrals) this new contracting mechanism. External technical assistance would help facilitate and guides this process.

CHAPTER I – INTRODUCTION

Public sector health financing in the West Bank and the Gaza Strip has suffered from severe imbalances in recent years due to prolonged fiscal pressures and inefficiencies in government health spending. The fiscal pressures largely stem from a combination of economic closure policies and movement restrictions imposed by Israel beginning in 2000. Steep declines in general taxation revenue, health insurance premium contributions and co-payment fees have gravely impacted health service availability and induced a much greater dependence on external donor financing. The fiscal crisis shrank budgetary transfers for non-salary recurrent and investment expenditures and led to large accumulated Ministry of Health arrears to service providers. Although the Palestinian Ministry of Finance reduced its non-salary budgetary transfers to the Ministry of Health (MOH), it continued to cover the expanding MOH wage bill which grew by 70 percent during the period of 2002-2006. This growing imbalance between MOH non-salary and salary expenditures, as well as other MOH spending, particularly on pharmaceuticals and treatment referrals, has raised mounting policy concerns over the efficiency of public sector health spending.

This report aims to address and analyze these policy concerns with a focus on providing recommendations for medium-term reforms. The report builds on previous analytical work conducted by the World Bank on the Palestinian health sector and is aligned with the strategic objectives of the Palestinian Reform and Development Plan (PRDP) and the MOH National Strategic Health Plan (NSHP) for the years 2008-2010. The earlier reports by the World Bank consisted of a 1997 health sector report⁴, a 2006 public expenditure review (PER), two 2008 reports prepared by World Bank consultants on pharmaceuticals and health equity issues. Between the years 2003-2007 the World Bank participated with several international donors (DFID, EC, Italian Cooperation, WHO) and the Palestinian Ministry of Health in the preparation of a health sector review document published in 2007. The health sector review document was the culmination of several years work by five task force committees focused on the areas of health status outcomes, health financing, health service delivery and health sector performance.

The analytical work prepared by the donor community; as well as the work of international research organizations and local Palestinian and Israel health researchers in recent years all highlight several fundamental challenges facing the Palestinian health sector.⁵ These challenges can be summarized into the following categories: significant access and movement restrictions, a fragmented institutional framework, multiple MOH roles, unpredictable health financing and donor dependency, inefficiencies in public sector health spending, insufficient financial protection from ill-health, MOH management capacity constraints, and an increasing burden of chronic disease. These challenges are naturally buffeted and significantly shaped by factors outside the health sector namely the political, macro-economic and security conditions prevailing in the Palestinian National Authority. These conditions have ebbed and flowed since 2000 but

⁴ The 1997 health sector report is entitled 'A Medium Term Development Strategy and Public Financing Priorities for the Health Sector' and consists of two separate volumes.

⁵ Examples of health policy work by international organizations and local Palestinian and Israeli researchers include Schoenbaum M et al 2005, *Strengthening the Palestinian Health System*, RAND., Giacman R et al 2003, 'Health Sector Reform in the Occupied Palestinian Territories', *Health Policy and Planning*, March 18(1): 59-67., Barnea T and Hussein R 2002, *Separate and Cooperate, Cooperate and Separate: The Disengagement of the Palestinian Health Sector and its Emergence as an Independent System*, Greenwood Publishing Group.

the general trend has been one of marked decline given the political instability, conflict and breakdown of negotiations between the Palestinians and the Israelis.

In 2007, following the Hamas Takeover of Gaza, a reform minded PA Government, prepared the medium-term Palestinian Reform and Development Plan (PRDP) aimed at preparing the PA for eventual statehood and galvanizing the international donor community towards contributing greater amounts of aid for the Palestinians. The PRDP contained four main pillars focusing on governance, social development, economic and private sector development, and public sector infrastructure. In the area of social development, education reform, social safety nets, health reform and youth empowerment were highlighted as critical priority areas. The health section emphasized the urgent need to reform health financing and improve the quality and affordability of health services in the PA. As part of the PRDP preparation process, line Ministries were instructed to prepare a new medium-term development plan focused on vital sector-wide reforms

In the Fall of 2007, the Ministry of Health prepared its medium-term NSHP for the period 2008-2010 for the health sector. The plan focused on five core objectives: (i) improving health status outcomes; (ii) ensuring sustainable financing of the health care system; (iii) improving the infrastructure of health service delivery; (iv) ensuring adequate and appropriate workforce levels; and (v) improving national health policy, planning and management. The plan also presented two specific national programs: (i) the health quality improvement program and (ii) the health care affordability program. Aside from laying out the medium-term priority reform areas for the MOH and the sector, the plan provided updated information on donor commitments towards supporting different reform areas outlined in the plan. These commitments focused heavily on investments in health service infrastructure, public health programs to improve health status outcomes and national health planning efforts; and to a lesser degree on health financing reforms and human resource development. After careful review of the plan and following discussions with the MOH and other donors active in the sector, it was proposed that the World Bank focus its efforts in area of health financing.

This particular area received special attention in the Public Expenditure Review (PER) exercise undertaken by a World Bank team in 2006. The PER underscored two particular issues: (i) the weak design and organization of the Government Health Insurance (GHI) administered by the Ministry of Health and previous policy decisions which adversely affected the revenue base of the GHI; and (ii) an increasing imbalance in public sector health financing after 2000 due to a significant drop in GDP growth and a simultaneous expansion in government health spending, particularly on salaries, outside treatment referrals and pharmaceuticals. These two issues affecting the overall financial sustainability of public sector health financing were the prime factors motivating the preparation of this policy report. The goal was to provide an in-depth analysis of these two issues and provide feasible and forward-looking options for reform.

The chapters of the policy report are organized as follows. Chapter II provides an overview of the Palestinian health sector and reviews the key policy issues facing the sector. The chapter also presents the underlying demographic, epidemiological and macroeconomic trends affecting the financing and provision of health services in the West Bank and Gaza. Chapter III analyzes the origins, design and current problems of the Government Health Insurance system and provides short- and medium-term options for reform. In discussing possible pathways to reform, the chapter also highlights the financial, social and institutional pre-requisites of an effective social health insurance system. Chapter IV examines the current financial management system of the PA and the MOH and provides a road map for developing more effective tools for financial

management and control. The focus of the chapter is on MOH internal control, financial reporting and budgeting policies and procedures.

The remaining three chapters examine MOH expenditures trends across three large recurrent budgetary items. Chapter V reviews the evolving MOH human resource profile and its impact of the overall wage bill of the Palestinian National Authority. The chapter also provides recommendations for improving the effectiveness of the recruitment, development and management of human resources by the Ministry of Health. Chapter VI analyzes MOH pharmaceutical expenditures and discusses different cost containment strategies the PA and the MOH may choose to pursue. Chapter VII reviews public sector expenditure trends on outside treatment referrals to the private sector and neighboring countries and discusses ways to strengthen the current MOH contracting mechanism.

CHAPTER II – HEALTH SECTOR OVERVIEW

BACKGROUND

The evolution and performance of the Palestinian health sector have been profoundly impacted by the unique national circumstances governing the West Bank and Gaza Strip. Over nine decades, these territories and their Palestinian inhabitants experienced four different systems of governance and have been constantly buffeted by recurring wars, violence and unanticipated refugee movements. The West Bank experienced a British Mandate (1917-1947), Jordanian control (1951-1967), Israeli occupation (1967-1994) and partial autonomy under the Palestinian National Authority (PA) since 1994. The Gaza Strip, disconnected geographically from the West Bank, followed a similar yet separate historical trajectory. During the period 1947-1967, Gaza came under Egyptian control followed by Israeli occupation to 2006; and then in 2007, it split away from the Palestinian National Authority under the de facto control of the Hamas government.

In 1993, the newly established PA established the Ministry of Health (MOH) and mandated it with overseeing the financing and provision of health services for Palestinians in the West Bank and Gaza – in coordination with the existing sector stakeholders namely the United Nations Relief and Works Agency (UNRWA) responsible for the displaced refugee population, NGOs and private health service providers. The MOH established the Government Health Insurance (GHI) system to cover public and certain private sector employees and made substantial investments in health service infrastructure, essential health services and public health programs to promote the health status of the population. By 2000, PA spending on health reached around 13 percent of Gross Domestic Product (GDP) – a spending level almost on par with countries in the region spending the most on health as a percentage of GDP, Lebanon and Jordan.

The health gains during 1994-1999, both in terms of service infrastructure and health status outcomes, came under significant strain following the outbreak of the 2nd Palestinian Intifadha in 2000. The ensuing political instability and conflict resulted in a return of Israeli control in major parts of the West Bank and Gaza and a steep deterioration in overall economic conditions. While household incomes and fiscal revenues declined sharply from 2000-2003, donor funds provided a temporary cushion -- representing an estimated 30 percent of Palestinian GDP from 2000-2003. The emergency circumstances enveloping the West Bank and Gaza thereafter induced an expansion in government health sector spending to help alleviate the social and economic pressures on the Palestinian population. The Ministry of Health significantly augmented the volume of its workforce and increased its spending on pharmaceuticals and overseas treatment (to Jordan, Egypt and Israel). Another policy response to the emergency circumstances was a decision to allow unemployed workers to freely enroll into the GHI system and utilize its generous health benefits, thus further compromising the financial sustainability of the health financing system.

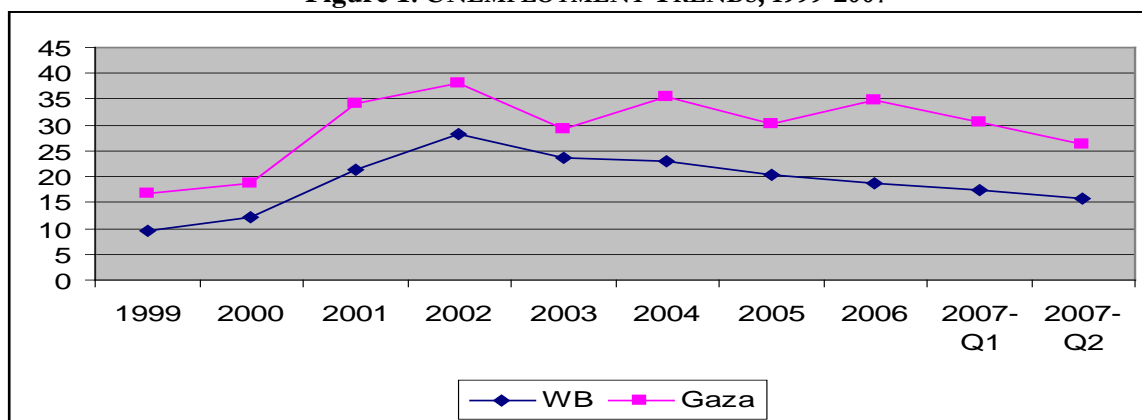
MACROECONOMIC-FISCAL CONTEXT AND DEMOGRAPHIC TRENDS

Health sectors are greatly influenced by the underlying macro-economic context and demographic trends in a country. Overall per capita income and donor aid determine the level of financing flowing through a health sector and the type and scope of health benefits the country

can afford. Labor market conditions (unemployment levels and the size of the informal sector) can affect the overall effectiveness and sustainability of social health insurance schemes financed through payroll taxes. Changing fertility and mortality trends can significantly affect overall demographic growth and the age structure of a population. Higher population growth can increase fiscal pressures to finance health services and the phenomenon of population aging (a growing number of elderly as a percentage of the population) heightens these pressures given the propensity of the elderly to use more health services than the non-elderly.

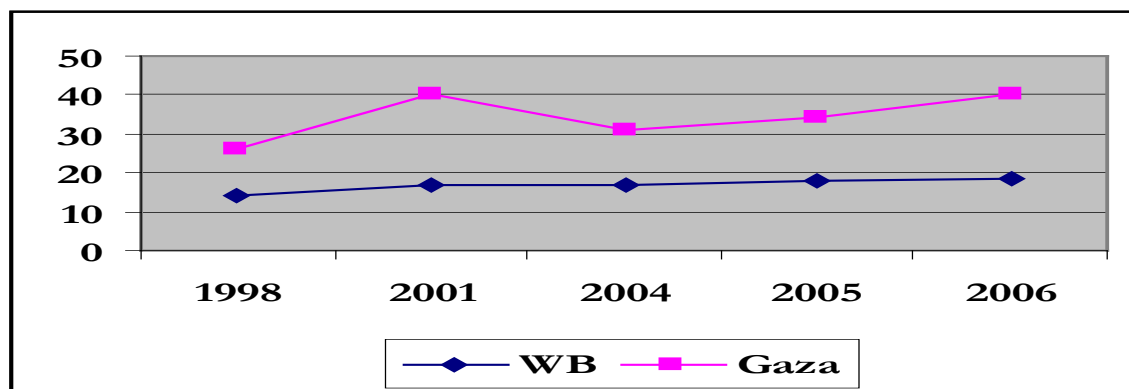
In the West Bank and Gaza, macroeconomic conditions gradually weakened after 2000 punctuated by a brief economic upturn during the 2003-2005 period. After the Hamas electoral victory in January, 2006, government revenues declined dramatically as Israel suspended clearance revenue and external donors held back donor funds. Total revenues for government recurrent spending fell by one-third and almost \$US 1 billion in expenditure arrears had been accumulated by the end of 2006. With unemployment increasing, as shown in Figure 1 below, household incomes dropped raising the proportion of people living in deep poverty close to 12 percent in the West Bank and 35 percent in Gaza. Unemployment peaked in 2002 at almost 30 percent in the West Bank and almost 40 percent in Gaza.

Figure 1: UNEMPLOYMENT TRENDS, 1999-2007



Source: Expenditure and Consumption Survey, PCBS, 2007

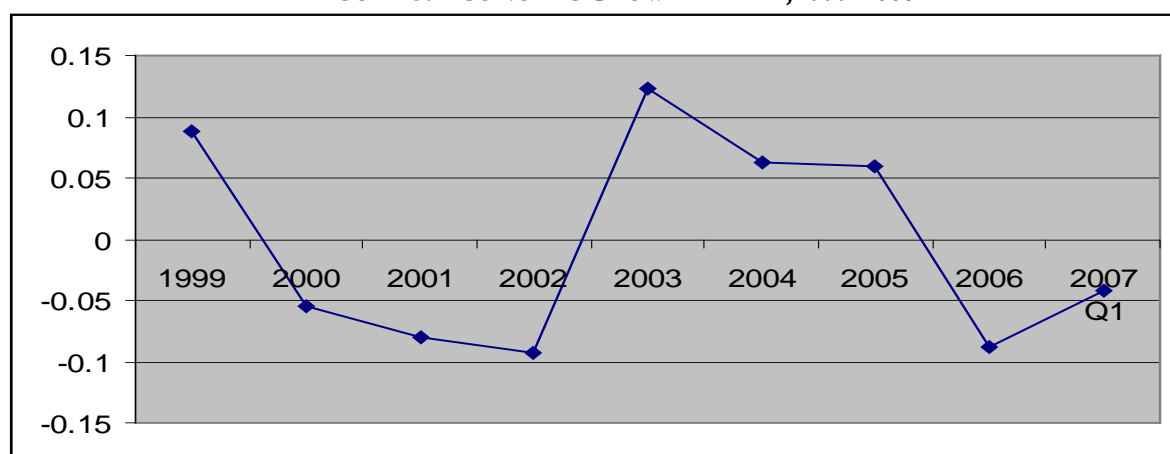
Figure 2: DEEP POVERTY IN THE WBG, 1998-2006



Source: Expenditure and Consumption Survey, PCBS, 2007

While general economic growth returned in 2005 to the level it was in 1999 (refer to Figure 3 below), it declined again by almost 11 percent in 2006. In 2007, there was a resumption of external aid as well as some release of clearance revenues by the Israeli government. Towards the end of 2007 the PA prepared its 2008-2010 Palestinian Reform and Development Plan (PRDP) to jumpstart economic recovery and initiate significant policy and institutional reforms. The baseline projection in the PRDP for economic growth was an average 4.8 annual percent change in real GDP from 2008-2010. By September, 2008, overall economic and political conditions fell short of the scenario envisaged in the PRDP. Continued restrictions on access and movement, inflationary pressures, exchange rate changes and a general slowdown in the Israeli economy has hindered private sector growth in the West Bank and Gaza. Unemployment in the beginning of 2008 was around 19 percent in the WB and around 30 percent in Gaza, higher than the average unemployment figures during the previous year. Despite substantial donor support flowing to the PA after adoption of the PRDP, the general fiscal position remains tenuous. Out of a projected \$US 1.3 billion required in external donor assistance for recurrent budget support in 2009, as of the end of 2008, only around 35 percent has been pledged by the donors.⁶

FIGURE 3: ECONOMIC GROWTH RATE, 1999-2007



Source: Expenditure and Consumption Survey, PCBS, 2007 cited in 'West Bank and Gaza Update: The Preconditions for Palestinian Economic Recovery', Washington, DC: November, 2007.

The general economic outlook for the West Bank and Gaza hinges critically on the triad of reform, donor support and access. The reforms initiated by the PA to consolidate its fiscal position and implement institutional reforms under the PRDP are crucial for continued donor support. Greater amounts of donor funds are needed for recurrent budget support as opposed to development assistance support. In 2008, more than \$1.7 billion in donor funds was received by the PA. While a similar level of assistance will be needed in 2009, it is unclear whether donors will maintain such high levels of support, particularly in view of the forecasted global economic slowdown in 2009. Economic recovery will also be contingent in a critical way upon the removal of access barriers, not only in the physical sense of roadblocks and checkpoints – but in the full economic sense of access to economies of scale, natural resources and private investment. Without expanded opportunities for Palestinians to scale up economic production, utilize natural

⁶ Macroeconomic and Fiscal Framework for the West Bank and Gaza, AHLC Report, September, 2008.

resources and attract private investment, full economic revival is enormously difficult to realize. This overall macro-economic and fiscal context will undoubtedly influence the pace and options for reforming the General Health Insurance scheme administered by the Ministry of Health and the efforts to rationalize MOH expenditures. A summary snapshot of the macro-fiscal outlook is provided below in Table 1.

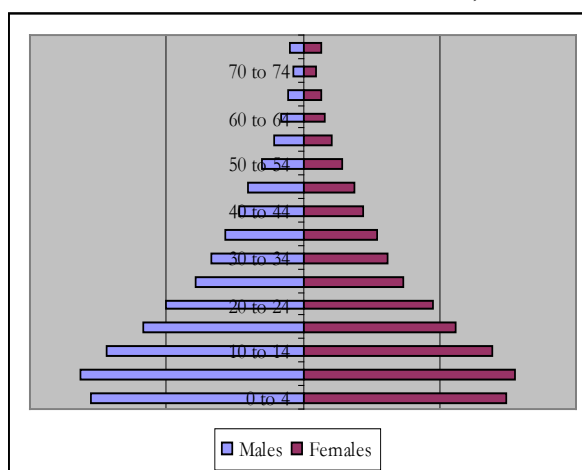
TABLE 1: MACROECONOMIC-FISCAL FRAMEWORK (2006-2011)

	2006	2007	2008	2009	2010	2011
<i>Indicators</i>		Est.	Projection			
Real GDP 1997 Market Prices (annual % change)	-4.8	-1.2	2	5	6.5	7.5
Nominal Per Capita GDP (millions of US dollars)	1,166	1,257	1,552	1,473	1,561	1,647
Unemployment Rate (average in % of labor force)	23.6	21.3	21.3	19.4	17.9	14.4
	2007	2008	2009	2010	2011	
		Act.	Proj.	Projection		
Recurrent balance in millions of USD (before external support and as a % of GDP)	-24.9	-26.7	-20.5	-16.9	-12.7	-9.5
Overall balance in millions in USD (including development expenditures and before external support and as a % of GDP)	-31.1	-28.7	-23.6	-25.7	-22.3	-19.7

Source: Macroeconomic and Fiscal Framework for the West Bank and Gaza, AHLC Report, IMF, January, 2009

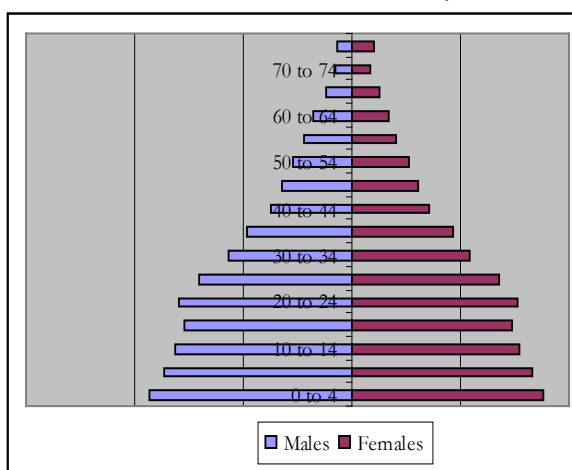
Demographic Trends: Population dynamics in the West Bank and Gaza point to three evolving demographic trends: (i) a rapidly growing Palestinian population; (ii) a growing labor force bulge and (iii) the phenomenon of population aging. The Palestinian population in 2008 in the West Bank equals 2.4 million persons and in Gaza, it equals to 1.5 million persons. This total population of 3.9 million in 2008, with a current total fertility rate of around 4.5 births per woman, is projected to grow to 5.94 million by 2025 -- a 52 percent increase in 17 years. The average annual population growth rate during the period is estimated to be 2.5 percent. The proportion of working-age Palestinians is also expected to grow considerably. It is projected this proportion will increase from 43 percent in 2010 to 52 percent in 2025. As to population aging, the number of elderly (over 65 years) as a percentage of the population is expected to increase by only 1 percent between 2010 and 2025 – from 3 percent to 4 percent of the population. The changes in population age structure can be gleaned from Figures 4 and 5 below.

FIGURE 4: WBG POPULATION PYRAMID, 2010



Source: World Bank demographic projections, 2008

FIGURE 5: WBG POPULATION PYRAMID, 2025



Source: World Bank demographic projections, 2008

An average annual population growth rate of 2.5 percent will require a higher economic growth rate for per capita growth to be positive in real terms. This projected change in demographics, both in terms of absolute growth and population aging, will place substantial demands on the Palestinian economy and similar pressures on the fiscal budget of the PA to finance needed health services. The growing proportion of elderly Palestinians will also necessitate a greater focus by the healthcare delivery system on providing integrated care services for patients with chronic disease. Another significant challenge will be employment generation for the large bulk of young Palestinians entering the workforce. Private sector markets will have to grow significantly enough to absorb the increasing number of labor force entrants. This change in population age structure, in the absence of strong economic growth, could substantially increase unemployment levels in the West Bank and Gaza and could further undermine the financial sustainability of health insurance coverage provided by the PA.

MACRO-ORGANIZATION OF HEALTH SECTOR

At a general level, the health sector in the West Bank and Gaza Strip can be characterized as a hybrid system incorporating aspects of both a 'national health service' model and a 'social health insurance' model. The Ministry of Finance finances the MOH through donor assistance and general tax revenues; and the MOH delivers health services in government facilities to the general population with some level of cost-sharing. The MOH also administers a government insurance scheme for public sector employees and other categories of workers financed partially through payroll and co-payment contributions. Enrollees under this government scheme contribute monthly premiums from their salaries and enjoy MOH benefits paying lower co-payment levels than the general population. The MOH also purchases tertiary care services from local and overseas providers (in Egypt, Jordan and Israel) for patients needing care not available in the West Bank and Gaza. Individuals who choose not to access MOH services, whether insured or not insured, and are not registered with the United Nations Relief and Works Agency (UNRWA) agency can purchase health services from the NGO and private sectors.

The legal-institutional framework governing the health sector is embodied in the Palestinian Constitution (2003) and the Public Health Law No. 20 (2004). The Constitution affirms that the PA shall guarantee 'health services' to particular population subgroups (families of martyrs, prisoners of war, the injured and the disabled) and states that health insurance will be regulated by law. The Public Health Law mandates the provision of government health services including preventive, diagnostic, curative and rehabilitative care and enumerates 16 functions of the MOH covering the areas of infrastructure development (public health facilities), health insurance, licensing (private providers, pharmaceutical companies, drugs), public health regulation (food safety, environmental health). While the Public Health Law mandates the provision of health services, it does not explicitly define the key parameters governing those services in terms of scope. The Law also states that the MOH will provide health insurance coverage to the population based on resource availability. The key articles of the Constitution and the Public Health Law are cited below in Box 1.

Box 1: LEGAL-INSTITUTIONAL FRAMEWORK GOVERNING SECTOR

Palestinian Constitution (2003)

Article 22: (1) *Social, health, disability and retirement insurance shall be regulated by law*

(2) *The welfare of the families of martyrs, prisoners of war, the injured, and the disabled shall be regulated by law. The PA shall guarantee them education services, health and social insurance*

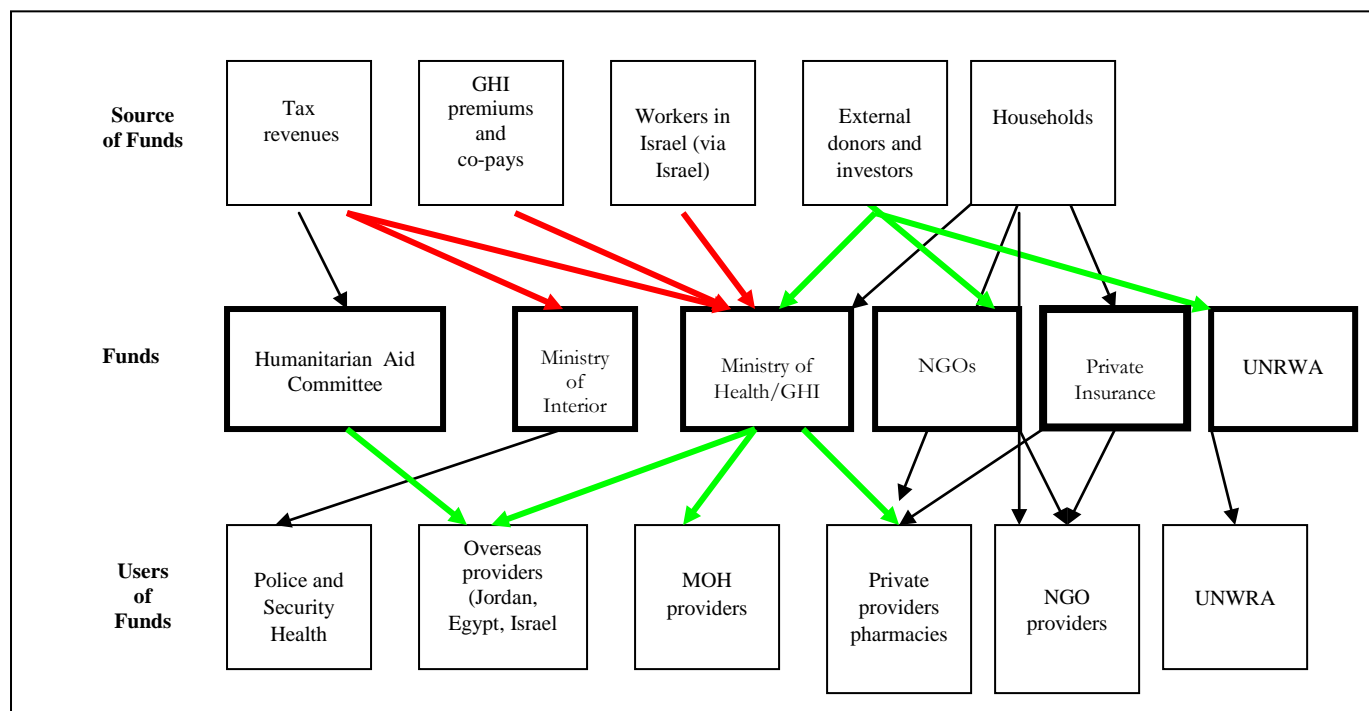
Public Health Law No. 20 (2004)

Article 2: *In accordance with this law and in coordination with relevant agencies the MOH has to:*

- (1) *provide government preventive, diagnostics, curative, and rehabilitative health services and establish the required facilities*
- (2) *license and regulate the private health facilities*
- (3) *license and regulate the medical and ancillary medical providers*
- (4) *license and regulate of food products and industries and location of sale*

The macro-organization of the health sector and the financial flows flowing through the sector are depicted below in Figure 6. Funds are mobilized from different sources and channeled via different funds/purchasers to the service providers through internal budget transfers, copayments, direct payments and reimbursements. The largest sources of funds injecting finances into the system are donor assistance, tax revenues and private out-of-pocket household spending. The colored arrows in the diagram reflect the general public funding and expenditure trends in the West Bank and Gaza since 2000. The red arrows indicate shrinking sources of funds flowing through the Ministry of Finance while the green arrows indicate either increases in external financing or increased public spending. Two areas in the diagram requiring further clarification are the level of expenditures by the Humanitarian Aid Committee and the Ministry of Interior on local and overseas treatment. Precise data are not available on the scope of these financial transfers and accumulated liabilities.

FIGURE 6: MACRO-ORGANIZATION OF SECTOR AND FINANCIAL FLOWS



Source: Adapted from Medium Term Development Strategy and Public Financing Priorities for the Health Sector, World Bank, 1997.

HEALTH STATUS OUTCOMES

The health status outcomes related to general life expectancy at birth and under-five and infant mortality rates⁷ in the West Bank and Gaza compare very well with countries of similar income levels despite the difficult social and economic circumstances of the Palestinians. Table 2 below provides data on these population-level health indicators for the West Bank and Gaza, three neighboring countries, the MENA region and lower-middle income countries worldwide. The life expectancy at birth of a Palestinian infant in 2006 was 73 years while the same indicator for all MENA countries was 70 years. Similarly the infant mortality and under-5 mortality rates were 20 and 22 deaths per 1,000 live births and in the West Bank and Gaza. These mortality rates are lower than those for the neighboring countries of Jordan, Lebanon and Egypt as well as for the region and all lower-middle income countries. One of the factors contributing to the relatively good mortality indicators is the high immunization coverage rate achieved by the Palestinian health sector. The vaccination coverage rates for measles, polio and other infectious diseases are all over 95 percent. These outcomes generally reflect the resiliency of the health sector and human development gains in the West Bank and Gaza in the face of considerable socio-economic pressures and strain. The one area of mortality, however, which is relatively high is connected to maternal health. The maternal mortality ratio defined as the number of maternal deaths per 100,000 live births increased in the West Bank and Gaza from 70 in 1995 to 100 in 2000.⁸ This increase in maternal deaths reflects, inter alia, a deterioration in the quality and accessibility of reproductive health services over a period of ten years.

TABLE 2: COMPARATIVE HEALTH STATUS OUTCOMES (2006)

Countries Outcomes	Life Expectancy	Infant Mortality	Under 5 Mortality
Jordan	72	21	25
Lebanon	72	26	30
Egypt	71	29	35
WBG	73	20	22
MENA	70	42	34
Lower Middle Income	71	36	25

Source: World Bank HNP Database (2008)

The generally good mortality outcomes aside from maternal mortality, however, do not fully reflect underlying health status inequalities, and do not reflect the underlying trends in morbidity. Although average infant mortality was 20 deaths per 1,000 live births in 2006, significant differences exist in health status between the West Bank and Gaza. Data from earlier years (2001-2004) indicate an infant mortality rate in the West Bank of 17 deaths per 1,000 live births while in Gaza, it was 32 deaths per 1,000 live births – almost double. Other data indicates that a Palestinian infant born into the poorest income quintile in Gaza is twice as likely to die as an infant born into richest income quintile in Gaza. These income and geographic inequalities in

⁷ The under-five and infant mortality rates are defined as the number of deaths of children under 5 years and infant deaths per 1,000 live births respectively.

⁸ Halabi H et al 2008, 'Challenges to Maternal and Child Health in the Occupied Palestinian Territory', The Lancet, Forthcoming

mortality-related health status warrant substantial policy concern by the Palestinian Authority, the Ministry of Health and international donors.

Although average mortality rates except for maternal mortality have defied the deteriorating socioeconomic conditions and access restrictions paralyzing large segments of the Palestinian health sector and have continued to decrease, other indicators related to childhood malnutrition, chronic diseases and conflict-related injuries have tended to worsen over time. The percent of Palestinian children suffering from stunting increased from 7.2 percent to 9.4 percent over the period 1996-2004. Hypertension and diabetes, two common chronic diseases, increased in prevalence from 24.2 percent and 18.5 percent respectively to 33.7 percent and 21.1 percent from 2000 to 2004.⁹ As to injuries, 32,744 Palestinians have been injured since 2000 from acts of violence and conflict.¹⁰

HEALTH SERVICE PROVISION

Health service provision in the West Bank and Gaza is divided among five types of health service providers: two public providers (the Ministry of Health and the Ministry of Interior), multiple private providers (hospitals, clinics) and numerous NGO providers (the United Nations Relief and Works Agency and other non-profit institutions). Traditionally the NGO sector played an important role in the West Bank and Gaza, particularly by prominent East Jerusalem hospitals and other charitable organizations. Similarly, UNWRA operated an extensive network of outpatient services for the registered refugee population following 1948. Over the last six decades, UNRWA has provided extensive and critical social assistance to this population covering a range of health, education and social services. After 1994, under the Palestinian National Authority, the composition of health service provision changed appreciably with the public sector playing an increasingly larger role in the provision of primary and hospital care services. The number of MOH hospital beds, for example, increased by 53 percent from 1994-2006 while NGO beds and private sector beds increased by 26 percent and 19 percent respectively.¹¹

Ministry of Health - The Ministry of Health currently owns and operates 24 hospitals in the WBG with a total stock of 2,864 hospital beds. It provides services to insured enrollees under the Government Health Insurance (GHI) scheme and serves as the insurer of last resort for uninsured Palestinians according to a higher fee schedule. 57 percent of all hospitals beds in the WBG (equaling 5,024) are owned by the MOH. 45 percent of these hospital beds are in the West Bank and the remaining 55 percent of the beds are located in Gaza. The number of MOH beds per 1,000 capita in the WB is 1.2 while the rate in the GS is 1.4 per 1,000 per capita. The average occupancy rates in MOH hospitals are estimated at 85 percent in the WB and 78 percent in the GS; a rate similar to the bed occupancy rates in most OECD countries. This distribution of MOH hospital beds indicates a geographic imbalance between the more populous WB and the GS and the need to potentially rationalize further investment planning by the MOH over the medium-term (depending on hospital investment trends in the private sector). The average occupancy rate in MOH hospitals indicates an overall efficient use of MOH service capacity.

⁹ The State of Nutrition in the West Bank and Gaza 2005, Palestinian Ministry of Health, UNICEF and WHO.

¹⁰ The sources of these figures are the Palestinian Red Crescent Society (PRCS) website and the Israeli Foreign Ministry websites. October, 2008.

¹¹ The National Strategic Health Plan 2008-2010, Ministry of Health, Palestinian National Authority

The occupancy rate for all Palestinian hospitals, however, is estimated at 65 percent; indicating that there is under-utilized service capacity in the private and NGO sectors.¹²

At the primary care level, the MOH manages 416 centers constituting about 64 percent of the total number of PCH facilities in the WBG. 360 of those centers are in the WB while 56 facilities are located in the GS indicating a contrasting regional imbalance to the one in the hospital sector. The number of MOH primary care facilities per 10,000 population in the West Bank is 1.5 while in the GS the number is .4. The remaining 36 percent of PHC centers are operated by the NGO sector including those of UNRWA and the Palestinian Red Crescent Society. In terms of the health workforce, the MOH employs around 13,057 employees representing around 33 percent of the total number of human resources in the health sector. The majority of MOH employees work in administrative positions and in hospital settings. The current stock of human resources in the WBG points to a shortage in medical specialties particularly in preventive medicine, psychiatry and family medicine.¹³

The second largest provider of hospital beds is the NGO sector with 1,246 beds in the WB and 399 beds in the GS jointly representing 31.6 percent of the total stock of hospital beds. The NGO sector with respect to hospital services is dominated by 6 East Jerusalem hospitals (Augusta Victoria, Al Makased, St. John, St. Joseph, Palestinian Red Crescent Hospital and the Princess Basma Rehabilitation Centre) operating approximately 592 beds and employing around 1170 health professionals. As to outpatient and primary care services, NGOs operate 165 centers in the WB and 73 in the GS. 35 of the 165 centers in the WB and 18 of the 73 of the centers in the GS are owned and administered by UNRWA. The third and fourth largest hospital providers are private hospitals and the military services. The private hospitals equal 23 in number, manage 433 beds in total and specialize mainly in maternity services located in urban centers. The military services consist of two small hospitals under the Ministry of Interior with a total bed capacity of 73 beds.¹⁴

HEALTH FINANCING

The overall flows of health financing in the West Bank and Gaza, as depicted in Figure 7 below, emanate from four sources. The largest source, donor assistance contributes up to 42 percent in the form of budget support and project financing, supporting both the PA and NGOs. An estimated 25 percent of this external funding flows to UNRWA. A certain proportion of donor funds are also given as in-kind contributions and are often not included in the reporting of donor assistance. The next largest source, private households, is responsible for 40 percent of total health financing. Households spend money directly on health insurance premiums, co-payments, pharmaceuticals and health services. The last source, government tax receipts and fees, provides 20 percent of health financing. These figures are 2004 estimates based on data collected from government sources, donors and household surveys. The composition of this financing has fluctuated considerably since 2000, particularly during 2002-2005.¹⁵

Total expenditures on health services in the West Bank and Gaza, by health financing intermediaries, were estimated to be around USD 220 million in 2004. Spending by the MOH

¹² Data collected from the Ministry of Health, 2008 Palestinian National Authority

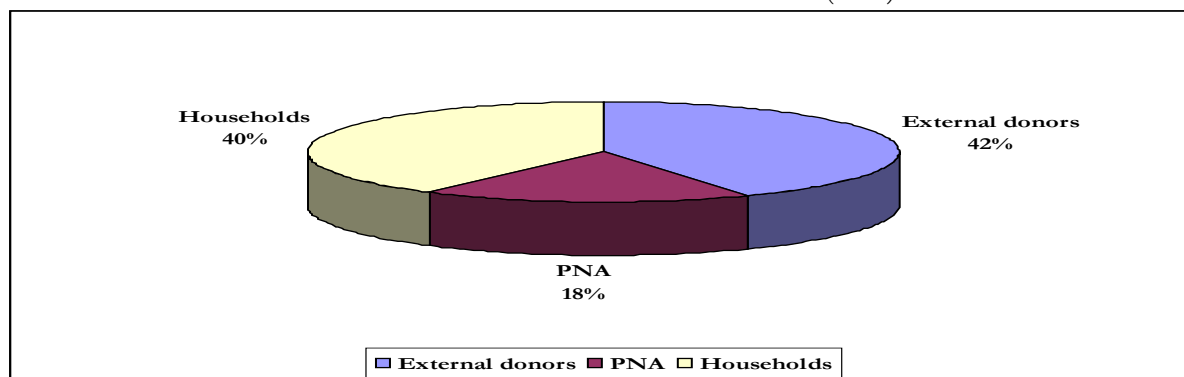
¹³ Ibid

¹⁴ The National Strategic Health Plan 2008-2010, Ministry of Health, Palestinian National Authority

¹⁵ Source: World Bank Public Expenditure Review, 2007.

represented about 35.2 percent of all health expenditures. Household health expenditures were slightly greater representing 40.5 percent of all health expenditures, while NGOs represented 14.5 percent of spending and UNRWA spent 9.8 percent of all health resources. There was no data readily available on the health expenditures by the Humanitarian Aid Committee in the Office of the President and by the Ministry of Interior.¹⁶

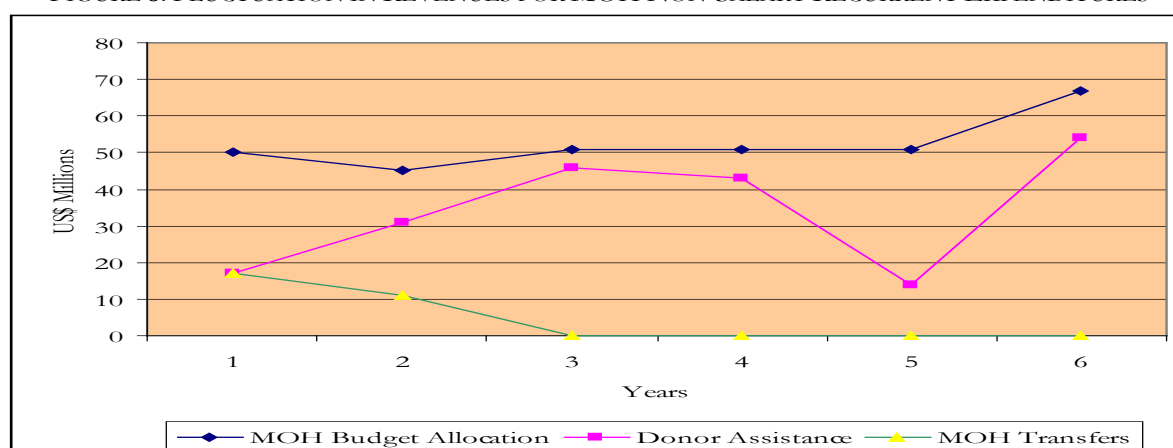
FIGURE 7: HEALTH FINANCING BY SOURCE (2004)



Source: World Bank Public Expenditure Review, 2007.

In the first years of the 2nd Intifadha from 2001-2002, donor financing comprised about 50 percent of the budget allocated by the Ministry of Finance to cover MOH non-salary recurrent expenditures – USD 47.3 million out of USD 95.3 million. This percentage of donor support increased to around 87 percent during 2003-2004 as MOF transfers dropped to zero. By 2005, donor assistance itself decreased to 29 percent of the approved MOH budget increasing the financing gap and leading to large accumulated MOH arrears with local and overseas suppliers of drugs, medical supplies and health services. One year later, in 2006, donor assistance to cover this non-salary spending rebounded to 80 percent, similar to levels in earlier years. Figure 8 below reflects these changes in revenues relative to the MOH budget for non-salary expenditures.

FIGURE 8: FLUCTUATION IN REVENUES FOR MOH NON-SALARY RECURRENT EXPENDITURES

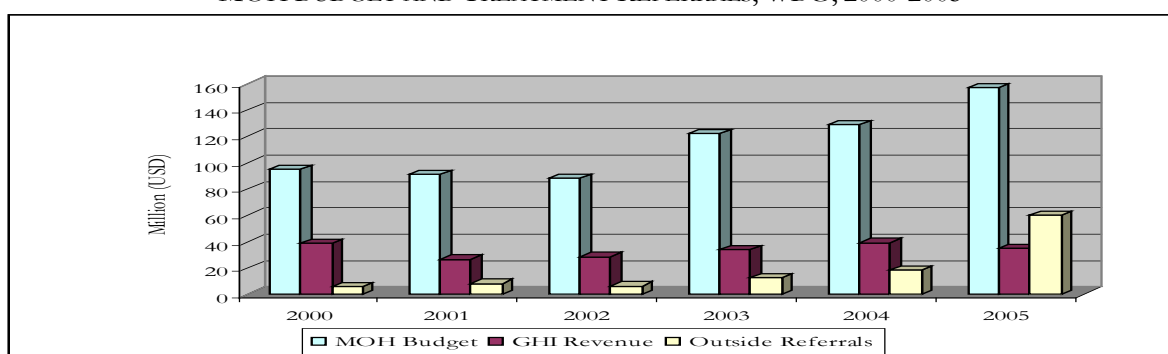


Source: MOH budget data, 2008, World Bank Public Expenditure Review, 2007.

¹⁶ Palestinian Central Bureau of Statistics (2005), Healthcare Providers and Beneficiaries Survey

Another factor impacting revenues for overall public sector health spending (recurrent and investment expenditures) during the period 2000-2006 was the drop in premium and co-payment revenues under the Government Health Insurance (GHI) scheme. These revenues decreased by USD 10 million during 2000-2002 primarily because of job losses suffered by Palestinians working in Israel who had been obliged to pay premium contributions to the GHI. By mid-2002, around 7,532 Palestinians had been working in Israel compared to 125,000 in year 2000 – a drop of 118,000 workers.¹⁷ After 2002, GHI revenues actually increased due to the expansion of the public wage bill and the mandatory premium contributions flowing from government employees. Another issue impacting the financial sustainability of GHI was the emergency decision by Palestinian President Arafat in 2000 to exempt families affected by the 2nd Intifadha from having to pay insurance premiums and co-payments. As a consequence, large numbers of non-paying households enrolled in GHI. In, 2001, there were 191,000 non-paying households compared to 153,000 paying households – a trend that continued to 2004.

FIGURE 9: TRENDS IN GHI REVENUE RELATIVE TO MOH BUDGET AND TREATMENT REFERRALS, WBG, 2000-2005*



Source: MOH Strategic Health Report, 2008-2010, World Bank Public Expenditure Review, 2007. * Note: expenditures on outside referrals in 2005 reflect MOH spending and expenditures by the Humanitarian Aid Committee.

As public revenues contracted after 2000, public sector expenditures on health trended in the opposite direction. The overall MOH budget soared from USD 95 million in 2000 to USD 157 million in 2005 – an increase of 66 percent. The largest expenditure item, salaries, increased from USD 48 million to USD 83 million from 2000-2005 in five years almost doubling. Pharmaceuticals, medical supplies and outside referrals similarly increased. MOH spending on outside tertiary care referrals to Palestinian and overseas hospitals (Jordan, Egypt and Israel) increased from USD 6 million in 2000 to USD 22 million in 2005. MOH spending on outside referrals, however, was also accompanied by treatment referrals organized by the Humanitarian Aid Committee (HAC) connected to the Office of the President. In 2005, commitments by HAC to pay for outside overseas referrals equaled USD 40 million; almost twice the amount committed by the MOH. The column in Figure 8 above reflecting spending on outside referrals in 2005 incorporates both MOH and HAC expenditures. Data on HAC spending for earlier years were not available. With HAC expenditures taken into account, the financial imbalance between GHI revenues and treatment referrals becomes readily apparent. Figure 9 above and Table 3 below reflect these trends in spending.

¹⁷ Source: 'Palestinians Working in Israel', report by MEDEA, European Institute for Research on Mediterranean and Euro-Arab Cooperation, June, 2004.

TABLE 3: MOH EXPENDITURE DATA (2000-2015)

	2000	2001	2002	2003	2004	2005
Recurrent Salary Expenditures	48	55	49	57	77	83
Recurrent Non-Salary Expenditures	46	35	38	65	51	71
Capital Investment Expenditure	6	1	1	0	0	1
Total MOH Expenditures	95	91	88	122	129	157
MOH expenditure as % of Public Expenditure	8	8	9	11	9	10
MOH expenditure as % of GDP	2	2	3	3	3	4
CPI	2.7	1.2	5.7	4.4	3	3.5
Exchange Rate	4.08	4.21	4.74	4.54	4.47	4.53
GDP (USD)	4636	4034	3396	3454	3765	4044
Total Public Spending	1212	1120	984	1140	1512	1496

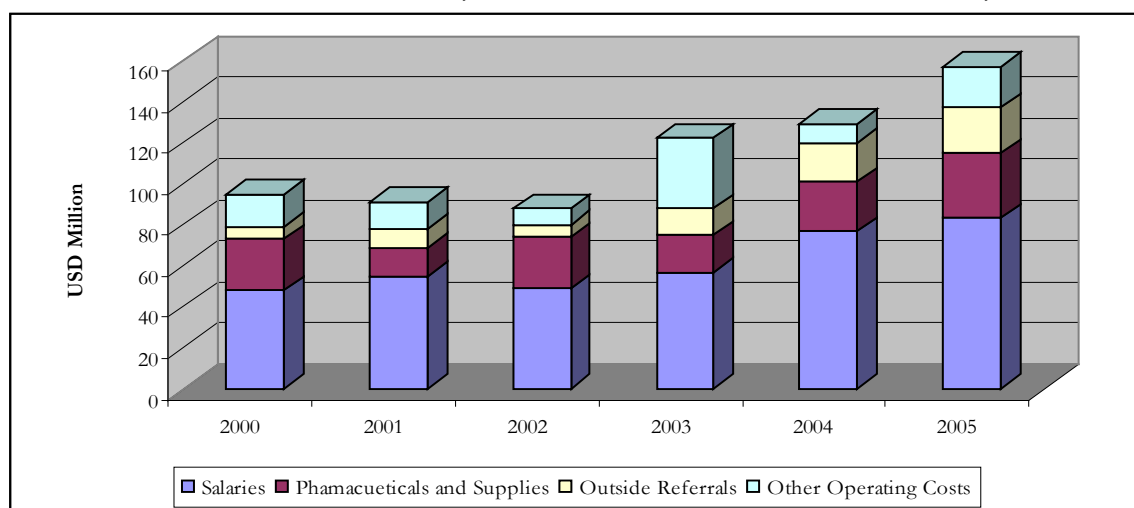
Source: World Bank Public Expenditure Review, 2007. IMF Macroeconomic and Fiscal Framework for the WBG, Sept, 2008.

Health Insurance Coverage –According to a recent household survey study conducted in 2005, 77.6 percent of those surveyed reported to be covered by at least one type of health insurance scheme. 62.5 percent were covered through the GHI of the MOH, 24.4 percent were covered by UNRWA and the remainder was covered by military, private and Israeli insurance schemes. Broken down geographically, overall GHI coverage in Gaza was 81.5 percent of the population while in the West Bank, it only covered 54.9 percent of the population. What is remarkable about the survey study is the discrepancy between the coverage ‘owned’ and the coverage ‘utilized’ by the population. Although 54.9 percent of the respondents in the West Bank said that they had GHI coverage, only 24.4 percent reported that they actually used that coverage. In the Gaza Strip, the discrepancy was even wider, with only 9.5 percent of respondents reporting using GHI coverage. These discrepancies point to an absence of confidence by the general population in the services covered by the GHI scheme.¹⁸

Analysis of Health Equity. Despite the increased financial protection extended by the MOH to Palestinian families, households generally experienced an increase in out-of-pocket payments on catastrophic health expenses after 2000. Household survey data provided by the Palestinian Central Bureau of Statistics (PCBS) reveal an almost 100 percent increase in the percentage of households experiencing catastrophic health care costs between 1998 and 2007. These households allocate more than 40 percent of their non-food expenditures towards purchasing health care services. In addition to an increase in the actual number of families paying almost prohibitive amounts of money for health care, the actual magnitude of the catastrophic amounts paid increased by almost three times between 1998 and 2007. This finding suggests several things: (i) a rise in catastrophic health cases (e.g. injuries from conflict, stress-induced conditions) stemming from the increased political and economic instability since 2000; (ii) an insufficient capacity to extend adequate financial protection from illness despite the overall increase in public sector health expenditures; and possibly (iii) insufficient confidence by Palestinian households in the quality of health care coverage provided by the MOH.

¹⁸ Palestinian Central Bureau of Statistics (2005), Healthcare Providers and Beneficiaries Survey, 2005.

FIGURE 10: MOH BUDGET: SALARY, DRUGS AND TREATMENT REFERRAL COSTS, 2000-2005



Source: MOH Strategic Health Report, 2008-2010, World Bank Public Expenditure Review, 2007

The same survey data also indicate an increase in the poverty gap connected to out-of-pocket household expenditures on health care between 1998 and 2006. The poverty gap is an equity indicator measuring the ‘depth’ or ‘intensity’ of poverty, or the degree by which individuals fall below a given poverty line. The average poverty gap in 1998, according to these data, was around \$US 11 using a \$US 64.5 per capita per month poverty line (or \$US 2.15 per capita per day used by the World Bank). In other words, on average, poor people in the West Bank and Gaza in 1998 had monthly incomes \$US 11 less than the adopted monthly poverty line. In 2006 the poverty gap increased to slightly more than \$US 12 – using the same World Bank poverty level. Similar trends using other poverty lines (e.g. World Bank ‘deep poverty’ level of \$US 1.08 per capita per day and the Palestinian poverty level of \$US 2.13) are observed during the same time period. In fact the poverty gap using the Palestinian poverty level of \$US 2.13 increases from \$US 11 dollars in 1998 to around \$US 15 dollars in 2006. These findings point to the impoverishing effect health payments have had on those already impoverished in the West Bank and Gaza.

KEY ISSUES FACING THE HEALTH SECTOR

The Palestinian health sector faces two central challenges over the near and medium-term: (i) continuing to provide adequate health services in the face of unpredictable financing in geographic areas replete with movement and access barriers (continuing to manage under emergency conditions); and (ii) implementing reforms to effectively expand health insurance coverage and improve the efficiency of public sector health spending (initiating an action oriented reform agenda). The ability of the PA and the MOH to respond to these challenges will necessarily be shaped by the following key issues facing the sector.

Significant access and movement restrictions – The continued Israeli occupation in the West Bank and the imposed closure policy on Gaza negatively impacts access by Palestinian patients to required health services. From September, 2006 -- August, 2007, 171 ambulances were denied access at West Bank check points and within the same time period, five patients died while waiting for permission to cross those checkpoints. Access by Gaza residents to treatment in Israeli hospitals has also been restricted at the Erez border crossing. Around 10 percent of those

requesting access to cross Erez for medical reasons were denied access by Israeli authorities.¹⁹ During the period July-November, 2008, access to East Jerusalem hospitals was restricted to only two crossings causing serious delays in the movement of medical works and patients.²⁰ Beyond the movement of patients, general economic closure policies have affected the infrastructure for water, sanitation and power. The lack of access to spare parts has undercut the efficiency of sewage treatment plants in Gaza prompting the authorities to unload large amounts of untreated sewage into the sea.²¹ These general access and movement restrictions affecting all sectors have an important impact on health service delivery and can carry substantial risks for human health status in the West Bank and Gaza.

Fragmented institutional framework – The governance of the sector is fragmented across two authorizing institutions in the West Bank and in the Gaza Strip. The division between the PA and the Hamas government has effectively created two Ministries of Health and fragmented the decision-making related to operational issues, investment planning and government initiated-reforms in the health sector. Two authorizing institutions governing the delivery of health services and the practice of medicine creates uncertainty and negatively impacts the effectiveness of health service provision. Over the last two years during the months of August-September, general strikes by the Union of Medical Professions in Gaza, protesting decisions by the Hamas government, disrupted hospital services for extended periods of time and prompted retaliatory measures by health officials in Gaza.²² This institutional schism, as with other sectors, continues to adversely affect the governance and development of the sector, and undercuts the capacity to implement national reforms.

Unpredictable health financing and donor dependency - The unpredictability of budget revenues for the MOH hampers medium-term investment and recurrent expenditure planning. Due to the fiscal contraction in recent years, priority expenditures have focused on covering the wage bill and a share of the recurrent expenditures with fluctuating donor support making up the difference. Due to this unpredictability of fiscal revenues and donor assistance, wage and payment arrears tend to accumulate at times affecting the performance of staff and the institutional relations between the MOH and its network of contracted service providers (hospitals) and medical suppliers (drugs and disposables). Another area affecting premium and co-payment revenues from the health sector are the large segment of insurees enrolled under the free Al-Aqsa scheme administered by the GHI. These enrollees exempt from any cost-sharing actually exceeded the number of contributing enrollees during the period 2001-2004.

Efficiency of public sector health expenditures - The efficiency of public sector health expenditures warrants continued attention by the Ministries of Finance and Health. Recurrent MOH spending on salaries almost doubled from 2000-2005 (\$48 million to \$83 million) and public sector expenditure on outside treatment referrals increased ten times during the same time period (\$6 million to \$60 million) taking into account the expenditures by the Humanitarian Aid Committee connected to the Office of the President. During the 2007-2008 period, reform measures by the MOH tightened the criteria governing the outside referral process and successfully reduced the volume of overseas referrals to Egypt, Jordan and Israel. Public sector

¹⁹ UN Office for the Coordination of Humanitarian Affairs (OCHA) 2007, 'The Humanitarian Monitor', Number 16, August.

²⁰ Humanitarian Coordinator Donor Briefing, Humanitarian Issues, November 13 2008.

²¹ World Bank 2008, 'Palestinian Economic Prospects: Aid, Access and Reform', Economic Monitoring Report to the Ad Hoc Liaison Committee, September 22.

²² BBC News Website 2008, 'Splits behind Gaza Medic Strikes, 12 September (www.bbc.news).

expenditures on pharmaceuticals also increased significantly in recent years owing in part to the high procurement prices paid by the Ministry of Health. On average, MOH procurement prices for pharmaceuticals are 4.4 times higher than the UNRWA prices and 7 times higher than international procurement prices. A major reason for the inefficiency in public spending on pharmaceuticals is the lack of real competition in the Palestinian pharmaceutical market.²³

Inadequate financial protection from illness - Around 40 percent of total health expenditures in the West Bank and Gaza are in the form of out-of-pocket household expenditures. Given the unpredictable nature of health care expenses, health insurance allows individuals and communities to protect themselves from financial risk by pre-paying into risk-pooling contributory schemes. Out-of-pocket health spending, however, can place a disproportionate amount of financial risk on lower income households. In 2004, the lowest income quintile of households spent an estimated 40 percent of their monthly income on health services while the richest quintile spent around 15 percent. When payments are catastrophic and beyond 40 percent of household incomes, families can sink into poverty. Between 1998 and 2006-2007, both the percentage of households making catastrophic health payments and the 'intensity' of the poverty gap, (extent to which household fall under the poverty line due to health payments) increased considerably.

MOH management capacity constraints --The Ministry of Health is burdened with capacity constraints impacting its institutional effectiveness. The recent fiscal pressures leading to delayed salary payments, sometimes up to six to nine months, has weakened MOH capacity to motivate employees and attract new high-performing individuals. This environment of weakening incentives affects MOH management functions ranging from procurement of medical supplies and drugs to hospital claims processing to GHI enrollee management. The current MOH organizational structure separates the functions of personnel management and human resource development. An important reform measure would be the integration of both functions under one new human resource management unit. Such a unit, supported by a modern information system, would be better placed to identify gaps in staff skills mix and to recruit, manage, train and continuously educate MOH human resources. This reform measure, among others, could contribute to improving the management capacity of the MOH.

Increasing burden of chronic disease – Chronic diseases and injuries are increasingly forming a larger part of disease burden in the West Bank and the Gaza Strip. Cardiovascular diseases, hypertension, diabetes mellitus are among the leading causes of adult mortality and morbidity among the Palestinian population. In 2004, heart diseases caused the highest number of adult deaths with a mortality rate of 60.5 per 100,000 in males and 48 per 100,000 in females. In 2000, study initiated by the Ministry of Health and Al Quds University indicated a prevalence rate of diabetes mellitus at around 9 percent of the population. In another epidemiological study focused more urban populations the prevalence rate of diabetes reached 12 percent. The growing incidence of these chronic diseases including injuries will contribute to cost escalation in the health sector and will necessitate a greater focus on health prevention and integrated disease management by the Palestinian health sector.²⁴

²³ Dweik, I 2007, 'Assessment of the Pharmaceutical Sector in the West Bank and Gaza'

²⁴ Abdeen H 2006, 'Chronic Diseases in Palestine: The Rising Tide', Israeli-Palestinian Public Health Magazine (Bridges), Volume 2, Issue 3, April-May.

SUMMARY

The Palestinian health sector is confronted with a unique set of obstacles and challenges compared to the health sectors in other MENA countries. The impact of occupation, conflict and violence, economic closure policies, and access and restriction movements have stifled the capacity of the health sector in the West Bank and Gaza to grow systematically; and to adequately respond to the health needs of the population. Apart from the constricting economic environment, underlying demographic trends (a rapidly growing population with an increasingly largely proportion of elderly) and a changing epidemiological profile (a greater burden of chronic diseases), inter alia, will continue to place upward pressure on the public financing of health sector spending priorities.

The scarceness and unpredictability of public resources, both from local revenues and donor funds, will place a higher premium on raising the efficiency of public sector spending in the health sector. During 2000-2005, government spending on health expenditures increased by more than 60 percent with the largest proportion of increased spending being allocated towards recurrent salary expenditures. As economic growth in the West Bank and Gaza faltered in the years after 2000 and unemployment levels swelled, government Ministries attempted to partially offset these conditions by boosting the number of employees on public payroll. Another issue affecting the financial sustainability of health expenditures was the policy decision to include Palestinian households affected by the 2nd Intifadha in the GHI scheme with no cost-sharing. Introducing changes in health insurance and raising the efficiency of public sector spending (both spending by the MOH and other government agencies) are a current health reform priority of the MOH as spelled out in the 2008-2010 Strategic Action Plan.

CHAPTER III – HEALTH FINANCING AND INSURANCE REFORMS

INTRODUCTION

Countries worldwide are engaged in resource mobilization and the pooling of risk to finance health care services for their populations. In some countries, resources are mobilized through general taxation and managed directly by governments to fund public sector health services – pooling risk across the general population. In other countries, revenues for health services are generated mainly through taxes on wages and salaries; and managed by one or more public insurance funds to cover a specific risk pool of insured enrollees. Yet in other countries with vast and under-developed regions, local governments are engaged in resource generation and risk pooling at the community level. In most countries, overall sources of health financing are a combination of general tax revenues, payroll taxes, private insurance premiums, and out-of-pocket household spending. External donor financing is another important source of funds in low-income and conflict affected countries.

One health financing approach, social health insurance, has been adopted and implemented in varying degrees by different countries around the world. The approach has been viewed by health officials as a way to generate additional resources for the health sector and a means to improve the quality of health care through more effective purchasing of health services. Under social health insurance, a major portion of the funds are generated through payroll tax contributions paid by working individuals and their employers, and these covered individuals and their dependents are given access to a set of health care benefits provided by approved health service providers. Other mandated contributions paid from general revenues are typically required to equalize access across different sub-groups of the population. In 1994, the Palestinian National Authority established the Government Health Insurance (GHI) scheme under the administration of the Ministry of Health. The adoption of the GHI signaled the intention of the PA to work towards universal health insurance coverage via a social health insurance model of health financing. Under such a model, it was expected over the long-term that GHI premium and co-payment revenues would become the predominant source of health financing for the population.

A HEALTH FINANCING ANALYTICAL FRAMEWORK AND PRE-REQUISITES FOR REFORM

This chapter on insurance reform adopts an analytical framework centered on the main functions of a health financing system: (i) revenue generation; (ii) fund management; and (iii) the strategic purchasing of health services. Revenue generation refers to the mobilization of financial resources to cover the costs of health services (either through direct or indirect taxes, insurance premiums, direct household spending). Fund management refers to how these resources are collected, channeled and generally allocated across one or more institutions providing health insurance coverage. Strategic purchasing of services refers to ways in which funding institutions buy health services from health service providers. This analytical framework is used to examine different health financing reform options focused on improving the efficiency and financial sustainability of the Palestinian health system. The chapter also reviews the prerequisites for effective health financing in a country and the enabling factors critical for successful social health insurance. Governance, design and implementation-related topics relevant to social insurance are discussed as well. These prerequisites, enabling factors and other issues are discussed based on international experiences examined in the health financing and health economics literature.

DESIGN OF GOVERNMENT HEALTH INSURANCE (GHI) SCHEME

The design of the GHI scheme is akin to the insurance program implemented by the Israeli Civil Administration during the pre-Oslo period. Under the Civil Administration imposed by Israel, insurance coverage was compulsory for all public sector and municipal employees in the West Bank and Gaza Strip. Voluntary coverage was also provided to private individuals and households. With the establishment of the PA in 1994, health insurance coverage administered by the Palestinian MOH was eventually extended to six categories of population subgroups: (i) public sector workers on a compulsory basis; (ii) individuals and households on a voluntary basis; (iii) Palestinian workers in Israel on a compulsory basis; (iv) businesses and employer groups; (v) special hardship cases (those on social assistance) and (vi) unemployed individuals (those exempted from paying premiums and co-payments under the Al-Aqsa scheme). Each membership category has different monthly premiums and a varying set of requirements for collection (as shown below in Table 4). Except where otherwise specified, the monthly premium covers the enrollee, spouse, and children. Additional ‘escorts’, defined as members of the extended family, cost an additional US\$ 1.39 per month (or 5 New Israeli Shekels per month).

TABLE 4: GHI BENEFICIARY GROUPS, PREMIUMS AND COLLECTION SYSTEM

Beneficiary category	Monthly Premium	Collection System
Compulsory	5 percent of the basic salary Minimum amount of NIS 50 & maximum of NIS 100. For civil service pensioners, 5 percent of basic payment, no minimum & NIS 100 maximum.	Automatically deducted from the salary and transferred from MOF to the GHI account.
Voluntary	NIS 80 per family; NIS 50 for any individual; NIS 20 for any student; NIS 80 for any member of a professional union; NIS 50 for members of workers’ unions	To be paid to one of the health directorates in the West Bank or to the post offices in Gaza monthly, every six months or yearly.
Workers in Israel	NIS 75 per month—the Israeli Authorities deduct NIS 93 and reimburse only NIS 75 for GHI. Workers in Israel should have to pay NIS 93 Most have not paid since 2000	The Israeli Authority pays the premiums (NIS 75) to the Palestinian MOF on a monthly basis (i.e., it is among the amounts owed by and owed to Israel that are reconciled every month.
Contracts ¹	5 percent of employer’s collective wage bill with an individual minimum amount of NIS 50 and a maximum amount of NIS 100.	Payments are made collectively through the employers on a monthly or yearly basis.
Special Hardship Cases	NIS 45 per month per family.	The MOF is making transfer payments from the MOSA budget to the MOH account for all beneficiaries once a year.
Registered as unemployed (‘Al-Aqsa Scheme)	Anyone registered with a union that certifies them to be unemployed is eligible for benefits without paying a contribution .	According to recent Cabinet decision, all “free” BHI enrollees must be certified as unemployed by the Ministry of Labor.
For all categories	Premiums for additional dependants: NIS 5 per month for each additional dependant.	Amount is included in the monthly premiums.

Source: Data from MOH 2006, Health Insurance and Overseas Treatment Law No. 11 for 2006. Note: Effective Exchange Rate 1 NIS = US\$.278 - October 8, 2008.

Co-payments – On top of premium contributions, GHI enrollees, except for those receiving free services under the Al Aqsa scheme, are required to make co-payments for services rendered. The co-payments represent, on average, 12 -15 percent of total GHI revenue. Co-payments are required for treatment both at MOH facilities and at referral providers inside and outside WBG. The fees include drug co-payments, laboratory co-payments and co-payments for services in referral facilities (non-governmental services and services abroad).

Management of GHI – Since its inception the GHI was administered by the Health Insurance Directorate of the Ministry of Health. The primary function of the Directorate was the maintenance of beneficiary enrolment records and monitoring the collection of co-payment and premium revenues transferred directly to the Ministry of Finance. Traditionally the Directorate had limited authority in redesigning benefits and purchasing health services from outside health providers. This referral and contracting function fell under the authority of a separate administrative directorate in the MOH. In 2008, as part of a reform process, the MOH consolidated these two directorates under a new General Director for Health Insurance effectively integrating the two key functions of collection and contracting within one administrative unit. A further reform measure the MOH is currently contemplating is the establishment of a national health insurance agency independent from the MOH.

Benefits Package - All GHI enrollees are entitled to a wide set of benefits including maternal and child health services, primary health care, prescription drugs as well as school health services. These services are provided in MOH health facilities (primary health care centers and secondary level hospitals) throughout the West Bank and Gaza Strip. Inpatient services are not explicitly included in the GHI law, but the law does stipulate that the GHI benefits package includes all health services purchased from non-MOH health service providers, namely hospitals located in East Jerusalem and abroad in Egypt, Jordan and Israel. The explicit exclusions listed in the GHI law include expensive transplant operations (except for kidneys and corneas), invitro fertilization services, prosthetics, eye glasses and cosmetic surgery.

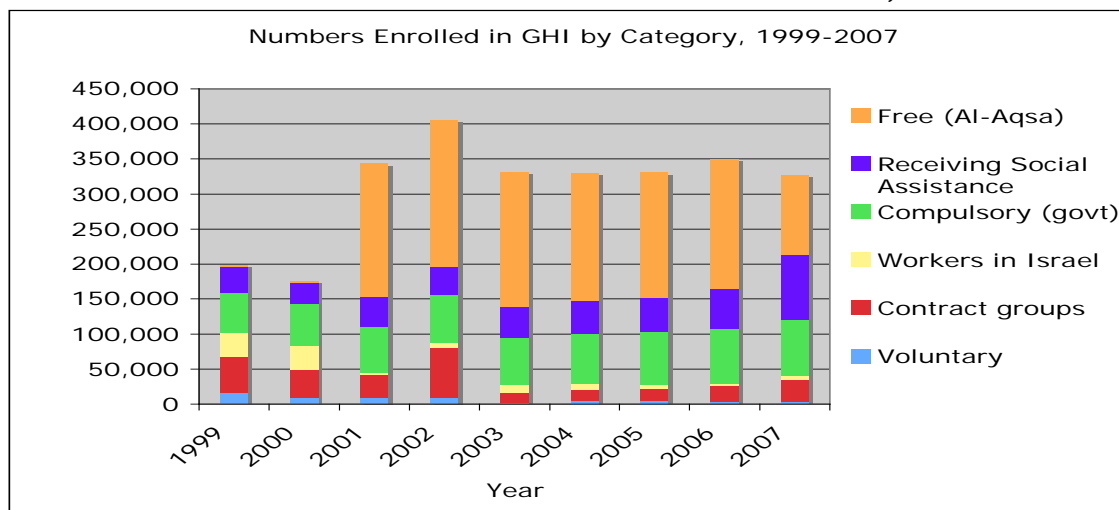
Contracting and Purchasing of Services – The MOH has traditionally purchased tertiary health care services from contracted providers on a fee-for-service basis. The MOH approves annual contracts with local and overseas hospitals and has not yet developed a performance-based contracting capacity. In 2008 the MOH made important improvements to the contracting process by introducing an element of competition (issuing a tender for specialty care services and inviting Palestinian hospitals to submit bids) and focusing more on assuring higher quality standards (requiring bidding hospitals to submit quality-related information). This process is still underway and requires substantial capacity-building to improve its overall effectiveness. Policy reform measures worth considering over the medium-term are developing a special MOH contracting unit independent from the general procurement directorate of the MOH.

TRENDS IN GHI ENROLMENT AND CONTRIBUTIONS

Since 2000, GHI enrolment witnessed significant volatility: (i) a dramatic drop in the number of insured Palestinians working in Israel; (ii) a sudden and sizable increase in the number of free ‘Al Aqsa’ enrollees and (iii) a rise in the number of social assistance cases toward 2006-2007 -- as shown below in Figure 11. The number of insured workers in Israel decreased from 34,000 in 2000 to only 5,000 in 2007 due to the economic closure policies imposed by Israel. At the same time in 2001, almost 200,000 not-contributing enrollees were included in the GHI and thereafter constituted the majority of enrollees till 2005. As to the enrollees receiving social assistance from

the government, their numbers almost doubled from 2005-2007. Another discernable trend is the one year rise in business 'contract' enrollees in 2002. These trends have seriously undermined the capacity of the MOH to generate revenues commensurate with the obligation to pay for GHI benefits.

FIGURE 11: NUMBERS ENROLLED IN GHI BY CATEGORY, 1999-2007

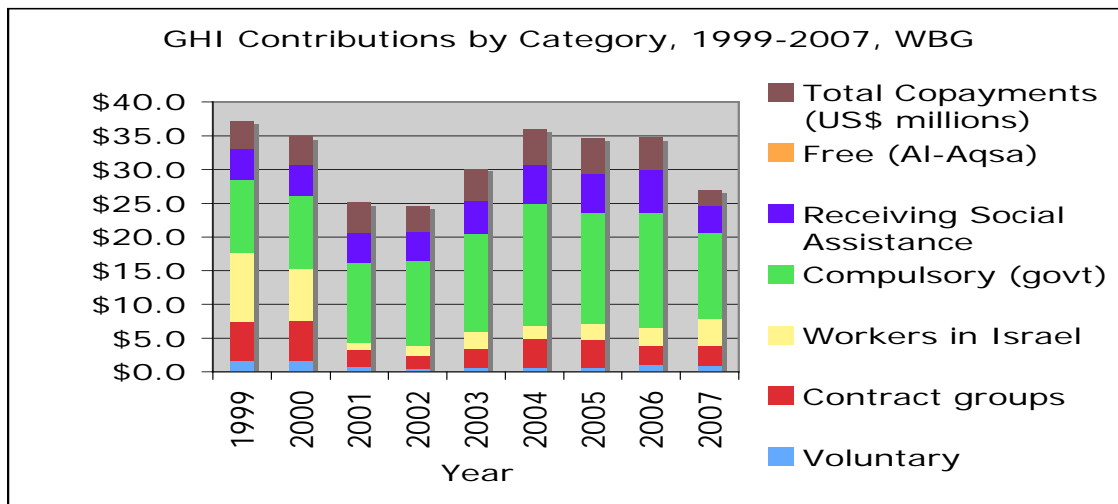


Source: Health Insurance Administration, MOH/PA, WBG [Data for 2003, 2004, 2007 include estimates for Gaza]

As to overall GHI contributions, they decreased by \$US 10 million from 2000 to 2001 and later increased to previous contribution levels during the 2004 -2006 time period. Contributions from government workers, in particular, grew as their numbers expanded from 60,000 in 2000 to around 80,000 in 2007, as shown below in Figure 12. By contrast, contributions from enrollees in the voluntary category of insured represented a small portion of total GHI revenues. Since 2000 the GHI has become less like a traditional health insurance program (in which enrollee contributions largely cover the cost of benefits) and more like an under-funded entitlement scheme relying heavily on contributions from only one category of enrollees (government workers) and government subsidies.

While a gap between GHI revenues and MOH expenditures on insured benefits has existed since 1994 the gap has widened substantially in recent years. Expenditures, particularly for outside referrals, as mentioned above, have risen significantly as a portion of MOH spending; while GHI contributions have declined as a percentage of MOH spending. Figure 12 below shows how GHI contributions and co-payments decreased from US\$ 35 million in 2000 (35 percent of MOH spending) to US\$ 25 million in 2002 (25 percent of MOH spending), and then increased to US\$ 35 million in 2005 (again 25 percent of MOH spending). Over the same period, however, GHI beneficiaries doubled in number. This continued imbalance between revenues and contributions erodes the financial sustainability of the GHI scheme and ought to prompt the MOH to implement short to medium-term reforms to reduce the degree of financial disequilibrium over time.

FIGURE 12: GHI CONTRIBUTIONS BY CATEGORY, 1999-2007



Source: Health Insurance Administration, MHO, WBG (2007 excludes Gaza data)

KEY HEALTH FINANCING AND HEALTH INSURANCE ISSUES

Limited fiscal space - The decline in tax revenues experienced by the PA provides limited fiscal space to offset the financial imbalance of the GHI. External donors, in large measure, have assisted in closing the gap, but donor assistance to finance the recurrent cost obligations of new MOH service infrastructure is not guaranteed over the short and medium-terms. After MOF transfers for non-salary expenditures were suspended in 2003, donors covered 89 percent of the non-salary budget allocation in the same year and 84 percent of the recurrent budget in the next year. Yet in 2005, donor funding dropped to less than 30 percent of the budget allocation, as the MOF again was unable to provide funds. The ability of the MOF to continue subsidizing MOH service infrastructure and GHI benefits hinges crucially on the prospects of economic recovery in the West Bank and Gaza and the fiscal space it provides.

Unclear path to universal coverage – The path to achieving health insurance coverage, a long-term objective of the PA, remains uncertain. On the one hand, GHI is a ‘third party’²⁵ insurance scheme dedicated to financing coverage through payroll taxes; and a system that explicitly incorporates the separation of purchasing from service provision. On the other hand the MOH continues to expand its own health service infrastructure financing it through traditionally input-based line-item budgeting. Pursuing the first path to universal coverage, under a social health insurance model, would require much larger investments in upgrading the administrative and purchasing capacity of the GHI; and in preparing MOH hospitals for new contracting and billing procedures. The second path would be akin to an integrated health services model of financing under which the MOH would own and finances its own health services effectively combining the functions of the ‘second party’ (provision) and the ‘third party’ (financing). Clarifying and reaching consensus on the path forward towards universal coverage would better guide the resource allocation decisions of Palestinian health policy makers.

²⁵ Note: In a third party scheme, patients are the ‘first party’, providers are the ‘second party’ and the insurance entity is the ‘third party’.

Fragmentation of GHI functions – The GHI revenue collection and contracting functions until 2008 operated independently inside the MOH. The responsibility for contracting health service providers and processing benefit payments was performed separately from the responsibility for collecting contributions to help pay the service providers. Even though the GHI had successfully established the principle of cost-sharing (attempting to tie contributions to the cost of services), the fragmented administrative operation tended to reinforce the disconnect between the two, and the initial gap between revenue and benefit outlays became wider over the years. This fragmentation in management functions, again, was recently addressed through the consolidation of both activities under a new directorate of health insurance.

Inadequate design of health insurance scheme and ad-hoc decision-making – There is no actuarial link between contributions, covered risks and the cost of the health benefits package provided by the GHI. Contribution rates are set without reference to the expected costs of providing the promised benefits to those contributing (or enrolling without contributing) and thus causing diverging trends between enrollment and revenues. The decision to offer free ‘al-Aqsa’ and voluntary coverage to certain enrollees exacerbated this discrepancy between revenues and outlays. The voluntary coverage scheme exposes the GHI to the problem of ‘adverse selection’ when high-risk individuals only seek insurance coverage after falling ill and needing health care services.

Limited data availability and analytical capacity - The MOH at present has neither the data nor the analytical capacity to determine the total or average costs of the benefits it finances for GHI enrollees. For the benefits it purchases from private providers, it does not have the capacity to know whether the negotiated prices are a reasonable reflection of costs, and whether the costs of one provider are more or less than the costs of another provider for the same diagnosis or episode of care. Without such cost data, it is difficult to design and implement measures to restore the GHI to greater degrees of financial balance.

Weak governance and administrative systems – The GHI scheme is still operating under the administration and financial management of the MOH. This governance arrangement creates internal tension between the purchasing function of the MOH and its role in providing healthcare services. Splitting the functions under separate organizations can improve the purchasing capacity of the GHI and create clearer lines of accountability. The MOH is currently performing multiple functions (service provision, regulator of service provision, insurer, purchaser of health services) which can create conflicting policy agendas and diminish its capacity to effectively administer the GHI scheme. The administrative and health management information systems of GHI related to beneficiary management, provider relations, contracting and purchasing of services are also outdated and need significant strengthening and modernization.

Impact of GHI on MOH budget - Even though the MOH owns and operates an extensive network of medical care facilities, it does not have full control over its budget for operating the service network and for administering GHI insurance benefits. Non-salary recurrent items in the budget important for service delivery (drugs, disposables) are usually the first to witness cuts in response to fiscal pressures. Non-salary operating costs dropped from 24 percent to 9 percent of total MOH expenditures from 2000 to 2005. This reduction in spending on ‘other operating costs’ reflects the pressure on the MOH budget due in part to its inability to control other expenditures such as spending on GHI tertiary care benefits. Uncontrolled spending on outside tertiary care referrals for GHI enrollees compels the MOH to cap its budget for non-salary expenditures on its facilities. Between 2000-2005, nominal GHI revenues remained virtually the

same (at around US\$ 35 million despite a dip in 2001-2002) and their share of the MOH budget declined from 35 percent in 2000 to 25 percent in 2005. During the same period, the costs of outside referrals, as a percent of GHI total revenues, rose from 17 percent to 61 percent.²⁶

PREREQUISITES FOR EFFECTIVE HEALTH FINANCING AND ENABLING FACTORS FOR SOCIAL HEALTH INSURANCE (SHI)

Prior to considering short and medium-term options to reform health financing in the West Bank and Gaza, it is appropriate for Palestinian health policymakers to revisit the prerequisites for sustainable health financing and the enabling factors for effective social health insurance. Fourteen years of administering the General Health Insurance (GHI) scheme from 1994-2008, as a national attempt to reach universal coverage through a social health insurance approach, have revealed the difficulties of implementation under a uniquely difficult development context. The decisions of how to reform the current health financing system ought to be predicated on future economic development scenarios for the West Bank and Gaza and whether these scenarios include in themselves the enabling factors necessary for effective social health insurance. The reform process should also benefit from the lessons of international experiences related to the governance, design and implementation of social health insurance.

As a general proposition, the main functions of a health financing system — however organized and financed -- are to collect, manage, and channel funds allocated by society for health to providers of health services. Due to the unpredictable nature of ill-health and the costliness of its treatment, societies have attempted to protect individuals from the financial risk of ill-health through the organization of health insurance. This health insurance function makes coverage affordable through its pre-payment feature (accumulating contributions during periods of healthy living for low-cost, high probability cases of illness) and through its risk pooling feature for groups (pooling risks across different types of individuals for high-cost, low probability cases of illness). The different types of health insurance schemes can be broadly divided into two categories: mandatory and voluntary. The mandatory ones are overseen by the public sector and largely consist of three different types of insurance schemes: (i) schemes funded through general taxation with an implicit insurance function (United Kingdom, Sweden, Canada); (ii) schemes funded largely through publicly mandated contributions with an explicit insurance function (Germany, France, Thailand) and (iii) schemes funded through private sector contributions (Netherlands). The voluntary schemes are administered by the private sector and can be grouped into schemes that are: (i) employer-based (companies purchasing insurance coverage for their employees); (ii) community-rated (civil organizations paying insurance premiums defined by the community); and (iii) risk-rated (individuals or groups purchasing insurance policies rated on the basis of actuarial risk).

The prerequisites for effective health financing under the mandatory insurance schemes - irrespective of how financing and services are arranged - can be categorized into economic, financial, social, and institutional categories. These pre-requisites are summarized below:

²⁵ Ministry of Health, 2008.

Economic Prerequisites

- A macro-economy able to generate sufficient tax revenues (whether through income, payroll or sales taxes) to finance a risk-pooling health insurance scheme for the population. While this prerequisite may be met in a growing economy, it is not easily met in a stagnant or depressed economy.

Financial Prerequisites

- Financial contributions sufficient to finance current health care benefits, administrative costs and reserves for unexpected liabilities;
- Financial contributions sufficient to also pay for the future benefits of existing enrollees as their health care needs and associated financial liabilities rise with age.

Social Prerequisites

- A social commitment to cover the costs of medical care —especially in catastrophic cases— and that these costs not be borne primarily by those who are sick or injured;
- A sufficient sense of social solidarity to allow the transfer of cross-subsidies from low-risk individuals to high-risk individuals (from the rich to the poor, from the young to the old, from the healthy to the sick);

Institutional Prerequisites

- Sufficient administrative capacity to effectively collect and manage revenues; and allocate those revenues to finance health services in ways that minimize administrative costs and the cost of delivering those health services;
- Under a purchasing-provider split arrangement, enough institutional capacity to administer cost-based purchasing systems (and eventually performance-based contracting systems) with service providers; and an ability to monitor and manage the utilization of health services.

ENABLING FACTORS FOR SOCIAL HEALTH INSURANCE

Social health insurance (SHI), as a particular health financing approach, has generated increased interest among transition and low to middle income countries seeking to move away from general taxation models of health financing. These countries include nations from Eastern Europe (Slovenia), Africa (Kenya, Ghana), Asia (Philippines, Thailand), South America (Columbia) and the Middle East (West Bank and Gaza, Egypt, Jordan). Although different definitions exist, SHI at its core, is essentially a revenue raising mechanism; and it has broadly four distinctive features: (i) a government-imposed mandate; (ii) financing relying predominantly on an explicit payroll tax plus mandated contributions from other sub-categories of the population; (iii) an explicit benefits package and (iv) a purchaser-provider split (in which the purchasing function of health services is placed outside the administrative responsibility of the Ministry of Health). The recent interest in SHI by different countries comes at a time when other more developed countries with long-standing historical SHI traditions (Germany, France and Spain) are relying increasingly more on general revenues for health financing. These differing trends have prompted a debate about the merits of SHI as a general health financing approach, particularly in developing countries.²⁷

²⁷ Wagstaff A 2007, 'Social Health Insurance Revisited', World Bank, Working Paper

The arguments presented by health officials in favor of SHI approaches include the following contentions. SHI offers an attractive source of new revenue for health financing as it relies on an explicit tax for health insurance. According to this view, there would be greater willingness to pay an explicit tax for health, rather than a hidden one under general taxation; especially if the tax payment is associated with improvements in the quality of the benefits package and services delivered. The purchaser-provider split is also viewed as a way to improve the quality of services by creating a separate purchasing function with new tools to demand better services from contracted public and private health providers. Often this purchaser-provider split is accompanied with a move towards public hospital autonomy and preparing them for new contracting and billing arrangements. Another contention is that the specific tax payments earmarked for health under SHI protects the revenues from the political debates governing the annual budget process of the government.

The skeptics arguing against SHI base their views on recent evidence from national experiences with SHI.²⁸ Several issues are highlighted as important factors. First, SHI does not necessarily lead to significant additional revenues for health care (as in the cases of Lithuania and Moldova). The revenue enhancements depend critically on the pace of economic growth. Second, there is no conclusive evidence indicating that SHI schemes perform better than general taxation schemes in terms of improving the quality of health services. Third, implementing SHI and the purchaser-provider split is a highly complex and technical exercise; and without enough capacity to manage the process, cost escalation can rapidly become an issue. Fourth, using SHI to reach universal coverage depends on the size of the informal labor market. The larger the informal sector (which is growing in many developing countries) the greater the difficulty in extending insurance coverage to all individuals. Fifth, SHI schemes often do not give enough attention to preventive and promotive health services. Lastly, SHI can encourage greater informality in the labor market if the payroll tax is set too high.

Notwithstanding the diverging points of view related to SHI, there are several enabling factors which are deemed critical for the success of a SHI scheme based on international experience.

These enabling factors are enumerated and explained below:

- **Good economic growth** - countries adopting SHI need strong and consistent economic growth over time to generate significant revenues and reach universal coverage. The prospects of high economic growth in the West Bank and Gaza in the short-term are doubtful given current political and economic trends.
- **Small informal sector** - countries with large informal sectors find it very difficult to reach universal coverage through a SHI mandated contribution scheme. For SHI to succeed the size of the informal sector needs to be relatively small. The problem in the West Bank and Gaza is that the informal sector is indeed large and growing over time.
- **Modest impact on labor costs** - SHI schemes can have a negative impact on job creation in the formal sector if the additional costs imposed on labor by the payroll tax are excessive. Companies and workers, in such cases, maybe incentivized towards joining the informal sector which compromises the path towards universality.
- **Management and analytic capacity** – countries seeking to adopt SHI and the implementing a purchaser-provider split will need to learn a new set of management and analytical skills. These skills include actuarial modeling, benefit cost analysis, beneficiary management, contracting, purchasing of services, and utilization review and

²⁸ Ibid

management. These skills are complex and not easily mastered; and are currently in short supply in the West Bank and Gaza.

- **Good quality health services** – inducing individuals to pay an extra-tax for health insurance needs to be supported by the availability of good quality health services. There would be greater willingness to pay and enroll the higher the quality of health services. Maintaining the quality of public sector health services and those contracted services is a challenge in the West Bank and Gaza given the fiscal constraints and geographic restrictions on access and movement.
- **Social solidarity** – countries seeking to implement SHI with a benefits package for all individuals will fare much better if there exists ample solidarity within different parts of society. Pressing forward with providing a single benefits package for all individuals may entail resource redistribution which has to be supported by higher income groups. Among Palestinians, there is evidence of social solidarity within the broader segments of society despite the current geographic and political fragmentation between the West Bank and the Gaza Strip.

SHI GOVERNANCE, DESIGN AND IMPLEMENTATION ISSUES

The Palestinian Ministry of Health is currently moving towards altering the governance of the Government Health Insurance (GHI) system. The MOH is preparing new legislation for a separate health insurance agency to administer the GHI independent of the budget and financial management procedures of the MOH. The new agency will be governed by an independent board and will be responsible for collecting, managing and using its insurance revenues to provide coverage for eligible enrollees. The new legislation, in addition to defining the role of the new agency, will potentially redesign the insurance program implemented under the GHI to ensure greater degrees of financial sustainability. If the PA does decide to establish this new agency moving further along the path of social health insurance, it will need substantial technical support to build up its analytical capacity and to develop an effective administrative system.

The governance structure of the new agency could also take several forms. It can become a semi-public agency with a national board under the supervision of the Ministries of Health or Labor; or even Social Security. Prior experience from other countries indicates that new social health insurance agencies placed under Ministries of Health run the risk of catering excessively to the demands of physicians and not effectively exercising their purchasing function. In some countries, newly established agencies under the authority of physicians have led to significant increases in salaries for fellow physicians providing contracted health services (Colombia, Philippines). In other countries in which the Ministries of Labor or Social Security become the governing umbrella, the risk is that these organizations only become payment mechanisms with no due attention to organizing the purchasing of health services for the benefit of the enrollees. The new agency can also become a semi-private non-profit organization which may protect it from political influence but could also raise serious questions of accountability.²⁹

In addition to the types of ownership, there are different ways to structure the management of the new agency. The executive management of the agency can be given significant authority over decision-making related to human resources and financial management practices or it can be granted less authority with more direct oversight by the board of the agency. The former option

²⁹ Hsiao WC and Shaw RP 2007. *Social Health Insurance for Developing Nations*, World Bank Development Series, pgs. 27-31.

requires enabling legislation and highly competent management choices from the very beginning. The down-side risks are abuses or mismanagement of authority to the detriment of the reputation of the new agency, especially if there is no public auditing of the new agency. The latter option necessitates an active board but can stifle independent managerial initiative and innovation to improve the performance of the new agency, particularly in relation the recruitment and management of human resources.

Irrespective of the exact arrangements, certain dimensions or principles of governance ought to be kept in mind by Palestinian health policymakers and legislators to assure effective accountability. The arrangements should be structured to allow for the following dimensions of governance: effective decision-making, stakeholder participation, transparency, regulation, and stability. The agency needs to have clear lines of authority and accountability between the board and management and across different parts of management. There should be adequate stakeholder representation on the board including a mix of employees, employers, and shareholders –with some perhaps indirect representation from other affected groups (e.g. health service providers). Such representation can improve overall accountability flows. Ensuring transparency of governing legislation and executive rules is another important dimension of governance. Agencies that create ‘this culture of transparency’ by repeatedly placing important information in the public domain do better at maintaining accountability standards. The last two dimensions of effective governance are regulation and stability. These two dimensions refer to the regulatory framework to monitor the exercise of fiduciary responsibilities by the agency and to the overall consistency of policies implemented by the agency.

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Design Issues - The design of a new social health insurance scheme in a country involves tackling and resolving several critical questions: Who to cover under the contributory scheme? How to cover the unemployed and non-poor in the informal sector? How to target the poor? How to decide the level of public subsidy for different groups? What to include in the benefits package and deciding whether to have several different benefits packages? How to estimate the cost of each of the benefit packages?

In view of the current Ministry of Health proposal to establish an independent social health insurance agency under new legislation, these questions about design ought to be carefully considered by the Palestinian health planners. Specifically:

- **Who to cover in the formal contributory system?** - Currently the GHI includes all public sector employees (excluding the military), Palestinians working in Israel, employees of private sector companies and individuals who would like to voluntarily contribute to the system). Under a revised scheme, consideration ought to be given to phasing out or removing the voluntary program as it allows healthy individuals to avoid making contributions until the time of ill-health. Voluntary enrolment runs against the principle of solidarity embedded in a social health insurance and can pose financial risks to the scheme. Collecting premium and co-payment contributions can still remain the responsibilities of the Ministries of Finance and Health which will in turn transfer the insurance revenues to the new health insurance agency.
- **How to cover the unemployed and the non-poor in the informal sector?** - The existing Al Aqsa program under the GHI scheme had allowed all those certified by the labor unions as ‘unemployed’ to eligible for free insurance

³⁰ Savedoff, W. and Gottret P, (eds) 2008., *Governing Mandatory Health Insurance*, The World Bank

coverage with the same level of benefits. A policy decision by the PA recently transferred this verification responsibility over to the Ministry of Labor. Without appropriate monitoring and verification procedures, such a program can compromise the contributory scheme as private sector companies may be incentivized to encourage their employees to falsely claim unemployment status. Covering the unemployed effectively requires stringent verification procedures and an available source of finance. With the high-levels of unemployment in the West Bank and Gaza, decisions will have to be made regarding eligibility rules, the benefits package and the level of public subsidy for the unemployed given the projected fiscal space of the PA. Covering the non-poor in the informal sector will be difficult given the unavailability of a mechanism to enroll them and collect contributions. One mechanism for some self-employed individuals (e.g. taxi drivers) is to encourage the formation of an association and their enrolment as a group on that basis.

- **How to cover the poor?** As with the unemployed, covering the poor with health insurance requires an appropriate identification mechanism and a source of finance to subsidize their coverage. Currently, the Ministry of Social Affairs (MOISA) identifies special 'hardship cases' and the Ministry of Finance transfers an allocated amount of the MOISA budget to the MOH to finance their coverage. The Government, in parallel, has also identified with the support of the World Bank Social Safety Net Reform project, over 40,000 poor households using a national poverty targeting database. This database, once well-established and consolidated, could be used in the future to help allocate public subsidies to cover the poor. Fully subsidizing the coverage would also require careful analysis of the benefits package and the costs of the subsidy, especially in light of the projected fiscal constraints.
- **What to cover?** Does the new benefit design cover the wide range of services as currently included in the GHI benefits (outpatient, inpatient, drugs and overseas coverage) or should it be reduced to a more modest package of essential benefits? Should there be one benefits package for all groups and to what extent should these benefits include overseas coverage? The new design of the GHI insurance system should consider different options related to insurance coverage (covering only basic health care services or covering catastrophic health care services) or some combination of both. Other design issues include the desirability of having different benefit packages for population sub-groups (over 65 population could be a separate group of beneficiaries) and to what extent would any overseas services be included in the benefits package and under what circumstances.
- **What will it cost?** The basic benefits package and other possible packages ought to be properly costed to determine the right levels of premium contributions and co-payments to assure the financial soundness of the new GHI scheme. Such costing is usually done through actuarial analysis examining previous medical claims and making projections about future costs based on different risk factors (age, sex) associated with the insured beneficiaries. Actuarial modeling is critical to assure financial solvency of an insurance plan and it ought to take into account behavioral changes (moral hazard, induced demand) that may accompany the introduction of a new health insurance plan. In the West Bank and Gaza, there has been no actuarial valuation of the GHI. Such analysis should be a critical part of designing a new health insurance scheme.

Implementation Issues – There are positive effects associated with implementing reforms related to social health insurance as well as important challenges. Some of these positive effects and challenges are enumerated below in Box 2:

**Box 2: POSITIVE AFFECTS AND IMPLEMENTATION CHALLENGES
ASSOCIATED WITH SOCIAL HEALTH INSURANCE**

Positives effects

- Introducing social health insurance generates a public discussion of the costs of providing health insurance coverage particularly for those eligible groups who will be receiving public subsidies. Under a tax-financed state-run health system, subsidies are often implicit and do not get exposed to public scrutiny.
- A social health insurance scheme often incorporates a provider-purchaser split function under which the purchasing function is separated from the service provision responsibilities of the MOH. This separation can help re-identify institutional roles and strengthen the planning, regulatory and core public health functions of the MOH.
- Due to its complexity and the associated financial risks, introducing or reforming SHI requires careful analysis by both health and finance officials which strengthens inter-sectoral planning.
- With a new purchasing function, a social health insurance agency can be empowered to seek greater 'value for money' which helps generate a greater focus on achieving efficiency gains.

Implementation challenges

- Reforming social health insurance schemes may involve the curtailing of benefits for some groups or an increase in contributions by others which will require strong political support by top policy-makers.
- Implementing social health insurance may actually increase inequity if the informal sector remains outside the scheme and continuous to rely on a lower-quality benefits package.
- Controlling costs can pose a significant challenge under a new social health insurance scheme given the difficulties inherent in contracting and purchasing of health services; and establishing utilization management and review functions to reduce inappropriate care.
- Reaching universal coverage depends critically on overall economic growth and may take decades to

OPTIONS FOR REFORM UNDER THE CURRENT DEVELOPMENT CONTEXT

Prior to considering the redesign and implementation of health financing and health insurance reforms in the Palestinian Territories, there are several important points that ought to be continuously kept in mind by Palestinian policymakers. The first point concerns the feasibility of pursuing and implementing far reaching reforms under a seemingly chronic Israeli-imposed occupation regime in the West Bank and Gaza. Implementing fundamental health reforms even in normal non-emergency environments is a complex and exceedingly difficult undertaking. Doing so in an emergency environment is all the more complex and difficult. Expectations, therefore, ought to be tempered about what reforms are achievable over a given period of time. Reaching genuine universal health insurance coverage which affords adequate financial protection to all Palestinians from the risks of ill-health may take decades to achieve.

The second point is that health financing reforms often involve trade-offs and policymaker having to make difficult choices. Some of these choices could involve cutting back on health benefits or raising contribution levels for health insurance. These kinds of choices usually need a relatively wide political consensus for implementation to succeed. The current political climate internal to the Palestinians, on top of the emergency environment brought on by Israeli closure policies, will naturally constrain their ability to reach consensus on different sector reforms

including ones related to health financing. This second point adds another layer of complexity in the face of Palestinian policymakers.

The third point is the short and medium terms prospects for economic growth in the West Bank and Gaza. The baseline macro-fiscal framework of the Palestinian Reform and Development Plan (PRDP) projected an average annual change of 4.8 percent in GDP from 2008-2010 assuming an easing of economic restrictions and forthcoming donor assistance of \$ 1.6 billion for recurrent expenditures over 2009-2010. This more optimistic economic outlook combined with possible efficiency gains achieved by the MOH could provide the fiscal space to support the implementation of needed insurance reforms. This scenario, however, may prove overly optimistic in view of the continuing Israeli closure policies in the West Bank; the current hostilities between Israel and Hamas in the Gaza Strip, and the global economic slowdown forecasted for 2009 which may reduce overall donor support extended to the PA. The fiscal unpredictability over the medium-term will naturally constrain the health insurance reform plans of the PA.

The fourth consideration is the type of health insurance reform option chosen by the PA. There is no gold standard or best-practice normative approach to financing and organizing health insurance coverage. The road taken ultimately reflects a social choice influenced by values, institutions, economics and political considerations.

SHORT-TERM REMEDIAL OPTIONS FOR GHI

There are short-term remedial measures the MOH can implement to begin redressing the financial imbalances of the GHI. These measures could be considered by the PA and the MOH as stopgap options to bring greater efficiency and financial balance to the GHI scheme. They would require parametric changes in the Health and Overseas Treatment Law No. 11 (2006) and are divided into two categories: options to increase revenue and expand enrollment and options to contain the costs of providing benefits to enrollees. These measures, summarized below in Table 5, would not necessarily be important steps towards reform unless they are undertaken in the context of one or more of the proposed medium to longer-term reform options.

Some of these prescribed measures have already been adopted by the Ministry of Health such as restricting the number of enrollees entering the free Al Aqsa scheme and limiting the number of overseas referrals, as well as introducing a form of competitive contracting for tertiary care services. These options in general are not easy to implement given the economic distress prevailing in the Palestinian territories. Many of them require GHI enrollees to either pay for more coverage, pay more at the point of service, or face restrictions on accessing currently provided benefits. While these measures could be difficult to put in place, they are not excessively burdensome and will help improve the short-term financial sustainability of the GHI. Over the medium and longer term, more substantive options need to be considered.

TABLE 5: SHORT-TERM REMEDIAL OPTIONS FOR ADDRESSING GHI FINANCIAL IMBALANCES

Expanding Revenues	Measures	Possible Impact
Eligibility Rules	<p>Restrict enrolment under the free Al-Aqsa scheme through stronger verification of unemployment status</p> <p>Restrict access to the voluntary scheme by stronger enforcement of the six month waiting period from first payment before accessing benefits</p> <p>Restrict any new enrolment under the voluntary scheme</p>	<p>Increased contributions by those re-enrolling under the 'contracts' scheme</p> <p>Reduced benefit expenditures by those choosing not to re-enroll through the 'contracts' scheme</p> <p>Increased contribution level relative to expenses incurred</p> <p>Reduced net expenditures on 'voluntary' enrollees</p>
Premiums & Copayments	<p>Raising the maximum wages subject to the 5 percent contribution rate above the NIS 100 per month cap</p> <p>Raise contribution rate to 6 percent of salary wages</p> <p>Increase the copayments on prescription drugs from the current NIS 1-3 range to a higher percentage of the actual costs of the drugs.</p>	<p>Increased revenue from those with higher salary incomes</p> <p>Increased premium revenue</p> <p>Increased co-payment revenue and decreased benefit costs</p>
Controlling Benefit Costs		
Benefit Package	Phase out overseas benefits to limited number of referrals	Lower number of referred GHI patients and decreased benefit costs
Referrals and Contracting	<p>Tightening the overseas referral process through more stringent evaluation criteria and impose restrictions on the number of overseas referrals per insure per year</p> <p>Contract with private hospitals receiving referrals on a more competitive basis</p>	<p>Lower number of referred GHI patients and reduced benefit costs</p> <p>More competitive prices and reduced outlays per referred patient</p>

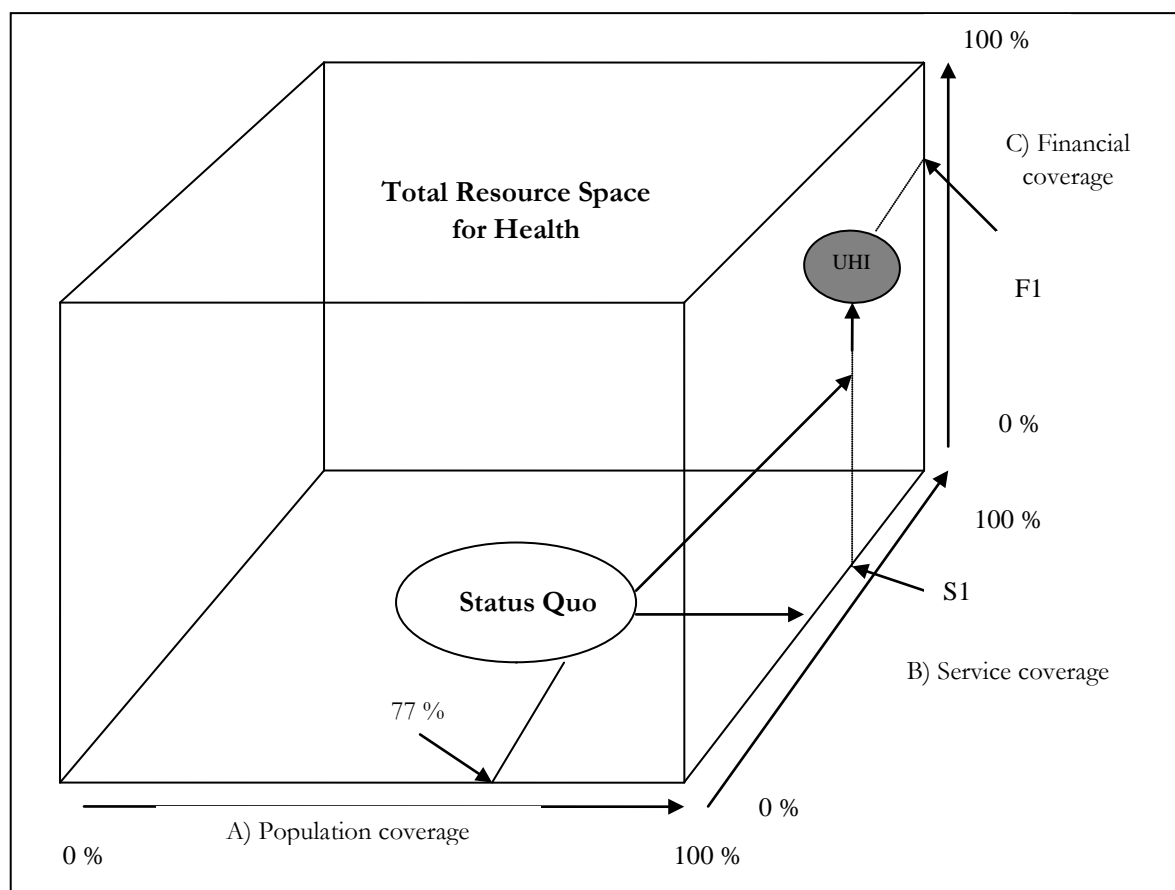
MEDIUM TO LONGER TERM REFORM OPTIONS

Implementing medium to longer-term health financing and health insurance reforms will be highly contingent upon the future scenarios for economic growth and donor assistance in the West Bank and Gaza. The current health financing system is exceedingly donor-dependent and embedded within the larger development context still affected by occupation, conflict and severe access and movement restrictions. This development context will determine overall job creation, income levels and the taxation based needed to support expanded health insurance coverage for the Palestinian population. At the moment prospects for a modest economic recovery and an easing of general access restrictions, as envisaged by the Palestinian Reform and Development Plan (PRDP), are tenuous and rest upon achieving greater progress on the political and security fronts.

The fiscal space needed to support health financing and health insurance reforms depends on the ability of the PA to collect tax revenue, borrow money, obtain grant assistance and generate greater efficiencies in public spending. Collecting tax revenue, securing loans, and receiving donor support cannot in the current climate yield a fully predictable fiscal position for the PA. The ability to improve the efficiency of government spending is also dependent on structural and institutional reforms in the different economic and social sectors. The available fiscal space for health will ultimately determine the comprehensiveness of universal health insurance coverage for Palestinian citizens in the future. This coverage or total resource space, as depicted by Figure 12 below, has three critical dimensions: (i) the extent to which the population is covered; (ii) the degree to which all services are covered in the benefits package and (iii) the financial coverage afforded to all insured individuals via health insurance. The current situation of the coverage in the West Bank and Gaza is illustrated below by the 'status quo' oval reflecting varying degrees of population, service and financial coverage. Population coverage is estimated at around 77 percent based on recent household survey results.³¹ The challenge facing health policymakers is to decide how to organize and finance the transition from 'status quo' to the 'universal health insurance' (UHI) oval on the B axis below and under which health insurance reform option. Ultimately the policy objective of the PA would be to reach 100 percent population coverage with a fairly substantial benefits package and some level of cost sharing with individual citizens. Such levels of service and financial coverage could be represented by points S1 and F1 below. To what degree these coverage levels could be increased hinges on the future fiscal position of the PA.

³¹ PCBS Health Providers and Insurance Beneficiaries Survey, 2005

FIGURE 13: TOTAL RESOURCE SPACE FOR HEALTH INSURANCE COVERAGE



Source: Adapted from Busse et al, 2007 and used in World Bank Policy Note on Social Insurance in Jordan, 2008

In terms of the health financing functions framework introduced earlier, the Palestinian health financing system, again, is a hybrid arrangement incorporating features of a tax-financed system (relying predominantly on general revenues) and a social health insurance system (relying predominantly on payroll taxes); as well as a heavy dependence on donor assistance.

Revenue Generation: Under the current system, overall resources for health are mobilized primarily through direct household spending, donor support and general taxation. Household spending is a combination of direct out-of-pocket spending for health services and pharmaceuticals, contributions to the GHI scheme through premiums and co-payments and premium payments for private health insurance. The distinctive feature of the Palestinian health financing system, akin to other conflict affected countries, is the heavy reliance on direct and indirect donor support (representing around 42 percent of all resources devoted to health).

Fund Management: As to the *fund management function*, and was indicated earlier in Figure 6 (page 9) depicting the macro-organization of the health sector, there are a number of institutions currently performing this function. These institutions are the Ministry of Health, UNRWA, the Ministry of Interior, NGOs and the Humanitarian Aid Committee in the Office of the President. The predominant institution is the MOH which pools and manages about 35 percent of all resources mobilized for the health sector followed by NGOs and UNRWA. There is also a very small Palestinian private health insurance sector that covers an estimated 3 percent of the

population in the West Bank and Gaza.³² While the Humanitarian Aid Committee has authorized significant health expenditures, particularly for overseas treatment, there are no readily available trend data on these expenditures.

Strategic Purchasing: With respect to the *strategic purchasing* function, there exists the traditional line-item budgeting within health service organizations such as the Ministry of Health, UNRWA and the Ministry of Interior. These organizations, through line-items, cover recurrent expenditures on salaries and non-salary expenditures (medical supplies, drugs). Aside from this type of passive resource allocation, there exists contracting and purchasing arrangements in place to purchase hospital services from the private sector by the MOH. The Humanitarian Aid Committee does not have formal contracts per se, but a process to refer patients to private and overseas providers on a fee for service basis. More recently the MOH has moved towards improving its contracting mechanism with private hospitals by moving towards a competitive bidding process based on price, quality standards and general service availability.

Three medium to longer term options for implementing health financing and health insurance reforms in the West Bank and Gaza could be considered and are listed below:

1. Consolidate MOH as an integrated national health service (NHS) that both pools resources and provides services
2. Maintain the MOH as the primary financing agency but strengthen purchasing capacity of MOH.
3. Move towards establishing a social health insurance system based on mandated contributions and administered by an independent national health insurance agency

Option 1: *Consolidate MOH as an integrated national health service (NHS) that both pools risks and provides services.* - Under this option the PA continues to finance MOH services through general taxation revenues and works to consolidate this model of healthcare financing over the medium and long-term. *Revenues* would be mobilized as part of the general taxation system relying on broad-based taxes (sales) rather than a specific payroll tax. The PA and MOH would pool and *manage* these fiscal revenues to ‘prepay’ for MOH services provided to the general population. The MOH would continue to own and operate an integrated network of health facilities; and scale up public sector investments in tertiary care. The *purchasing* of health services would continue to be through the existing line-item budgeting system with possible adaptation to allow for greater financial incentives to be given to MOH employees. Some strategic purchasing of tertiary-care services from providers outside the MOH network would continue to exist and some would gradually be phased-out as the public sector scaled up its own investments in tertiary care treatment services. Choosing this option would lead back to a United Kingdom-style national health service system in which universal coverage is extended implicitly to tax-paying citizens. Option 1 as well as Options 2 and 3 are depicted below schematically in Figure 14.

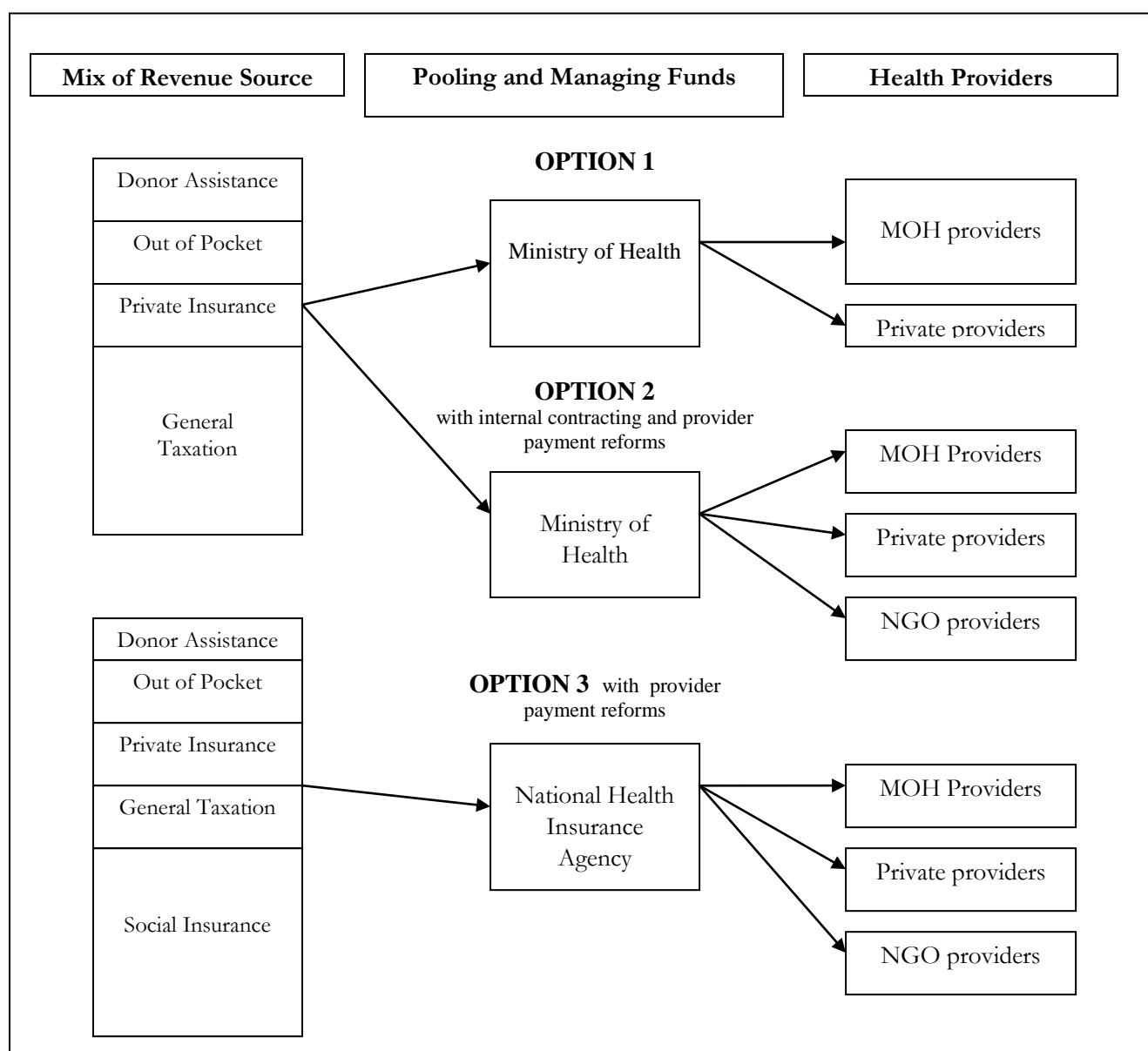
The vision underlying this option is one of a relatively strong public sector with enough administrative efficiency and organizational capacity to operate a good quality national health services network. Pursuing this option requires fiscal space and expanded government commitment towards revitalizing MOH services. In the West Bank and Gaza, investments

³² PCBS Health Providers and Insurance Beneficiaries Survey, 2005

would be needed over the medium and long-term to strengthen administrative effectiveness, incentivize human resources, upgrade information technology and develop higher quality and service standards. The Palestinian population will need to have sufficient confidence in the MOH services to reduce their sizable out-of-pocket payments to the private healthcare sector. Embedded in this vision is the eventual phasing out of GHI payroll revenues and MOH reliance on donor funds. The majority of financing for MOH services would flow from general taxation. The private sector, in both the financing and provision of health services, would play a supplementary role. Some private providers could be contracted or admit self-paying patients and health insurers could provide supplementary insurance.

There are several advantages associated with this option as there are disadvantages. One of its major advantages is its relatively simple health financing and governance arrangements. Resources are pooled through general taxes and allocated centrally towards funding government-owned health services. A second advantage is the comprehensive coverage provided to all citizens on an equal basis – one system in which all citizens become vested in. A third advantage is the potential for broad resource allocation to the health sector through numerous indirect taxes and fees providing general tax revenues. As to disadvantages, a prominent one is the difficulty of incentivizing human resources towards more efficient performance in a job environment governed by civil service regulations. Relatively low salary-based remuneration coupled with rigid seniority rules does not tend to promote productive behavior on the part of the health workforce. Another associated disadvantage is the unpredictable flow of funding since tax-financed health sectors have to compete with other sectors financed from the general budget – and approved budgets can differ from one year to another. This unpredictability can harm the ability of the MOH to maintain the quality of its infrastructure. A last disadvantage associated with national health services is the potential for better-off individuals to benefit proportionately more from the system than the poor. This overall trend has been confirmed in a large number of low and middle income countries revealing that the poorest 20 percent of the population in each country benefits the least from government-subsidized services.

FIGURE 14: MEDIUM TO LONGER TERMS HEALTH FINANCING AND HEALTH INSURANCE OPTIONS



Option 2: Maintain the MOH as the primary financing agency but strengthen the purchasing capacity within MOH. Under this medium and long term option, policymakers would move to maintain and consolidate the Palestinian MOH as the primary financing agency - but strengthen its capacity for both internal and external contracting. *Revenues would be generated* via broad-based general taxes and they would be pooled and allocated for health services under the *management* authority of the Ministry of Health. The difference under this option would be the way in which the MOH uses its resources to incentivize and *purchase* health services from its own health care facilities, particularly its hospitals. The MOH could develop ‘internal contracts’ with its own hospitals based on agreed upon performance indicators and it could move away from traditional-line item budgeting to more modern forms of provider payment such as global budgets or capitation. Such innovations in budgeting or purchasing of health services would probably require changes in the governing financial management and civil service regulations of the

Palestinian MOH. The MOH would also continue to contract with private and overseas providers to specialty care services.

The vision of the health sector under this option is the same one under Option 1 – but more progressive in its assumptions about the quality of public sector capacity. The public sector will play the predominant role in healthcare financing and health service delivery with the MOH taking the lead in administering all levels of health services. Such a vision, again, would require investments in upgrading the quality of human resources, physical infrastructure, service and quality standards and information technology of the MOH. The MOH may continue to contract selectively for certain tertiary care services from outside providers but it would invest more heavily in developing its own internal contracting and purchasing capacity. These innovations focused on boosting the performance of MOH facilities and services will place a higher premium on data-collection and using the collected data for purposes of financial reward and accountability. Managing and implementing these innovations do require a substantial degree of management capacity and technical expertise.

The advantages and disadvantages of this option are similar of this option are similar to those of Option 1. One difference among the listed advantages is the issue of simplification. Line item budgeting for salaries, recurrent expenditures and investment spending has been in place for over fourteen years in the West Bank and Gaza and it is relatively easy to implement. Developing and implementing contracting and provider payment reforms will require, as discussed above, substantial investments in building up this technical capacity. As to other advantages under Option 2, contracting and provider payment reforms can improve efficiency and quality standards relative to the line-item budgeting system envisaged under the previous option. The disadvantages under this option are the same as those under the previous one except perhaps for the issue of incentivizing human resources. With pay-for-performance type schemes, staff can become more motivated to increase their own productivity.

Option 3: *Move towards establishing a social health insurance system based on mandated contributions and administered by an independent national health insurance agency.* Under this option which represents the current policy approach of the Ministry of Health, the PA would move towards establishing over the medium to long-term a health financing system in which the predominant *source of finance* would be revenues from collected payroll taxes. Other revenues from general taxation and donor assistance would help subsidize health services and there would also be a percentage of health financing emanating from private households (see Figure 13 above). The collected payroll tax revenues would be pooled and *managed* by the new health insurance agency and used to cover the healthcare treatment costs of the enrolled beneficiaries based on an agreed upon and explicit package of benefits. This new agency, acting as a single payor, would *purchase* health services from contracted providers in both the public and provider sectors. Insured beneficiaries could access their provider of choice and the money from the national health insurance agency would ‘follow the patient’ to the provider.

Moving towards Option 3 over the medium to long-term will affect significant change to the status quo. The first change will be the explicit transfer of the purchasing function from the MOH to the new health insurance agency. The new role of the MOH would focus on sector planning, regulatory functions, and overall service provision. Service provision, particularly hospital services, could also be ‘de-linked’ from the MOH and placed under the authority of a new public corporation. These new corporatized hospitals, operating under a non-civil service environment, could compete for patients with the private sector hospitals under contract with

the health insurance agency. Under such a scenario, the MOH would probably retain a health financing role in the core areas of public health and primary health care. The second major change relates to the establishment of an independent insurance agency to provide coverage for all Palestinians. In establishing the agency, there are three critical issues that need to be determined: (i) its governance structure; (ii) the design of its health insurance plan and (iii) a plan to build up the core business functions of the agency. The governance structure, as discussed earlier in the chapter, refers to questions of ownership, oversight and management functions as defined by authorizing legislation. The Palestinian MOH has already prepared draft legislation for the new agency. Highlights of this draft legislation are provided below in Box 3. A detailed review of the law is attached as Annex I to the report.

The design of the insurance plan refers to eligibility rules, covered health benefits, contribution rates, and targeted subsidies to benefit certain beneficiary groups. The financial solvency of the new agency needs to be maintained using sound actuarial analysis. The core business functions of the agency refers to contribution collection, beneficiary enrolment and management, benefit design and costing (using actuarial techniques), contracting and purchasing of health services. These core business functions need to be underpinned by strong supportive human resource management, financial management and health management information systems.

Box 3: HIGHLIGHTS OF DRAFT HEALTH INSURANCE LAW

Draft Health Insurance Law

- *The objective of the law is to introduce a new national health insurance program administered by an independent health insurance agency for all Palestinian citizens based on the principle of social solidarity*
- *The proposed national health insurance program would be comprehensive, mandatory and contributive by design – not allowing for any voluntary insurance coverage and opt outs by particular sub-groups of the population*
- *The basic benefits package provided by the national health insurance program would cover primary and specialty outpatient care, lab tests and radiology, surgeries except for cosmetic surgery, inpatient care, routine dental care, prescription drugs based on the essential drug list, and a preventive health consultation*
- *The agency would be governed by the Board chaired by the Minister of Health and managed by an appointed executive director*
- *The proposed national health insurance program would be funded through contributions from wages and salaries, subsidies from general revenues for certain sub-categories of populations (Ministry of Social Development would pay the contributions of the poor, Ministry of Labor would pay the contributions of the unemployed), co-payments and investment revenue.*

Some of the advantages and disadvantages of pursuing Option 3 have already been discussed earlier in the chapter. To summarize, again, the main positive aspects of the social health insurance model, as argued by its proponents, are as follows: (i) it can provide an extra source of health financing revenue as individuals would be more willing to pay for an explicit 'health insurance' tax than they would for regular taxes; (ii) it can also provide a stable source of funding protected from political interference and inter-sectoral competition; and (iii) it can generate greater efficiency and accountability through demand-side improvements in the purchasing of health services. The potential drawbacks of the social health insurance model on the other hand are put forth by the following observations: (i) it is very difficult to reach universal coverage under social health insurance if the informal sector is large; (ii) it requires strong technical capacity to control utilization and effectively use the purchasing function to generate greater efficiencies; and (iii) it can increase inequalities in the use of health services if the informal sector

remains outside the health insurance network and continues to use lower quality health care services.

The main features, advantages and disadvantages of the three options are presented and summarized below in Table 6.

TABLE 6: SUMMARY DESCRIPTION OF FEATURES, ADVANTAGES AND DISADVANTAGES OF OPTIONS

Policy Options	Features	Advantages	Disadvantages
Policy Option 1: Consolidate MOH as integrated national health service	Resource mobilization: Predominantly general tax revenues Fund management: Ministry of Health Purchasing: Potential reform in the internal budget process, including the introduction of global budget and performance-based payments within MOH	- Easy to implement - Provides universal access to health services	- Difficult to reform budget process and introduce performance payments - Services limited to MOH facilities
Policy Option 2: Maintain the MOH as the primary financing agency but strengthen purchasing capacity of MOH.	Resource mobilization: Predominantly general tax revenues, supplemented by copayments, other fees Fund management: Ministry of Health Purchasing: Contracting providers, alternative payment methods	- Provides universal access to health services - Broader potential for revenue raising - More tools to introduce strategic purchasing - Expands choice of providers for patients (NGO, private)	- Technical expertise and capacity required to manage contracts
Policy Option 3: Move towards establishing a social health insurance system based on mandated contributions and administered by an independent national health insurance agency	Resource mobilization: Contributory system (payroll tax, fees, copayments) with general revenues for targeted subsidies Fund management: National Health Insurance Agency Purchasing: Contracting providers, alternative provider payment methods	- Establishes an independent financing agency with better defined accountability - - Potential efficiency gains through better purchasing - Expands choice of providers for patients	- Expanding coverage difficult if economy poor and informal sector is large - Potential access problems for non-contributing members - Significant technical capacity required and potentially high administrative costs - Exacerbates informality if contribution rates are high - Cost escalation could become problem if purchasing capacity is weak

SCOPE OF TECHNICAL ASSISTANCE

There are a critical number of areas in which technical assistance ought to be provided to the PA and the Ministry of Health. These areas are as follows: (i) health financing policy development,

tracking the flow of funds through the institutionalization of National Health Accounts and internal contracting and payment arrangements, (ii) health insurance legal and governance arrangements; (iii) actuarial modeling and health insurance design options; (iv) core business functions of health insurance and (v) health management information systems (HMIS). The first area relates to health financing in general whereas the latter four areas are concerned more directly with the social health insurance model. Table 7 provides a summary description and time frame for each of the mentioned areas. In providing the technical assistance and building-up the institutional capacity of the MOH, it is recommended that any international expertise in these areas be teamed up with local specialists or institutions in the West Bank and Gaza. Such partnerships would strengthen the work and provide greater perspective on the issues being addressed by the MOH.

TABLE 7: SUGGESTED AREAS OF TECHNICAL ASSISTANCE

	Health Financing Policy Development, NHA and New Purchasing Arrangements	Timeframe	Estimated cost (US\$)
1	Set Up High-Level Health Financing Commission. Provide international expertise and organize structured seminars for a high-level health financing commission (HFC) established by the PA. The mandate of the HFC would be to provide strategic recommendations on the most appropriate medium-term health financing reform option	2009	\$200,000 for two structured seminars with a panel of international experts
2	Institutionalize National Health Accounts. Help set up a NHA unit in a government agency (either MOH or PCBS) and organize training to track the flow of funds in the health sector. This unit would be responsible for generating and updating the National Health Accounts on an annual or bi-annual basis.	2009	An NHA expert for 45 days to help set-up unit and train at \$ 150,000.
3	Develop internal contracts with MOH facilities. These internal contracts could be piloted with MOH facilities for the first 1-2 years to measure performance and provide feedback. MOH hospitals with relatively good costing and information systems would be selected, performance indicators would be agreed upon upfront. These internal contracts would be the vehicle to collect good performance indicators and could be linked to provider payment schemes.	2009	\$200,000 for one or two experts in performance-based contracts for a period of 3 months
4	Initiate new payment pilot schemes: The MOH would initiate payment pilot schemes with the hospitals and PHC facilities. Standardized utilization and costing information would be developed and included as part of the requirements of the internal contracts. The MOH would then phase in global budgets (one item line budgets) for the hospitals based on business plans; and phase-in a capitation and physician pay for performance scheme to pay PHC facilities.	2009-2010	\$150,000 for 3-4 trips by health economist/ payment specialist
	Legal Review, Insurance Design and Core Business Functions		
1	Legal Review and Governance of Social Health Insurance. Provide legal review of draft social health insurance by-laws which further develop the governance arrangements for a new social	2009	\$60,000 for 30 days of time of legal expert in

	health insurance scheme. The Bank is currently reviewing the draft legislation for the new National Health Insurance Agency. Additional technical assistance in this areas can help develop and review the necessary by-laws for the proposed agency.		social health insurance
2	Insurance Design. Provide assistance in the design of the new health insurance scheme governing eligibility rules, contribution rates (premiums and co-payments) and covered benefits. The design of the new insurance scheme would be based on actuarial modeling and impact analyses. A unit could also be created to regularly review and update the benefits package based on technology assessments.	2009	1-2 experts in designing insurance schemes for a cost of \$ 200,000
3	Actuarial Modeling and Impact Analyses. Expertise would be provided to build an actuarial model to simulate the impact of different health insurance expansion options. The model would help ensure the financial solvency of the new insurance scheme by providing an actuarial link between contributions, risks and benefits. Building the model would also require the collection of a certain amount of data (see Annex I).	2009	\$150,000 for a health actuary for 3 trips
4	Core Business Functions. Provide support to the new National Health Insurance Agency in establishing its core business functions of collection, beneficiary enrolment and management, contracting and purchasing, claims processing and utilization review. Financial management and human resource expertise could also be provided for administrative strengthening.	2009-2010	\$500,000 for 3-4 trips by a business functions specialist, a contracting specialist, a claims processing/IT/utilization review specialist, a financial management specialist and an hr specialist.
	Health Management Information Systems (HMIS)		
1	Review Palestinian Data Health Dictionary and prepare HMIS master plan. Support the review of the established data health dictionary and prepare a new HMIS master-plan in close coordination between the health insurance agency and health providers.	2009	\$100,000 for an HMIS specialist for two visits
2	Define Business Requirements and Technical Specifications for new HMIS. Expertise would be provided to define the business requirements and technical specifications of the new HMIS for health insurance.	2009	\$ 60,000 for two trips by a HMIS specialist.
3	Examine the process for generating insurance claims electronically. This study will be examine and define the business processes between the insurance agency and providers.	2010	\$ 30,000 for an HMIS specialist for one visit.

SUMMARY CONCLUSIONS

Public sector health financing is at a critical crossroads in the West Bank and Gaza. The emergency environment in the Palestinian Territory since 2000 has engendered significant and unsustainable imbalances in the financing of public sector health services. While economic growth and fiscal revenues contracted during the post-2000 period due to continued Israeli-imposed economic closures, public sector health spending ballooned, particularly during the 2003-2005 period. This expansion in expenditures was driven by an increase in MOH employment, an increase in average salary levels, greater spending on pharmaceuticals and referrals for treatment to private and overseas providers. Spending by MOH alone increased from USD 95 to 157 million from 2000 to 2005 – a 65 percent increase. Other public sector expenditures included spending by the Humanitarian Aid Committee in the Office of the President. A substantial part of this spending relied on international donor assistance. Part of the financial imbalance also stemmed from policy decisions related to the design of the Government Health Insurance Scheme (GHI). Since its establishment as an extra revenue-generating scheme for the MOH, there has been a significant financial gap between contribution levels and risks covered on the one hand; and the cost of benefits extended by the GHI on the other. This financial disequilibrium grew with the adoption of the ‘free’ Al Aqsa program – a PA initiative aimed at ameliorating the social conditions of the Palestinian population after the beginning of the 2nd Intifadha.

The PA and the MOH have already taken remedial measures to begin redressing the financial imbalances and administrative weaknesses of the GHI scheme. High-level decisions were taken to unify the decision process governing outside referrals for the insured under MOH authority and to consolidate the insurance and outside referral units under one administrative directorate in the MOH. Other decisions were taken to substantially reduce the volume of overseas treatment referrals and to develop stricter criteria for outside referrals in general. Beyond the short-term options the PA is currently contemplating establishing a separate national health insurance agency under the chairmanship of the Ministry of Health. This policy direction signals an intention to by the PA to place health financing arrangements on a path towards achieving universal coverage through social health insurance. This chapter reviewed the pre-conditions for effective social health insurances based on international experience as well as the draft legislation for establishing an independent health insurance agency (see Box 3 and Annex I). The chapter also provided three medium-term health financing options (one of which included the current policy direction toward establishing social health insurance), discussed the advantages and disadvantages associated with each option, and provided a menu of possible technical assistance. The policy approach currently contemplated by the MOH (Option 3), given the current context, is risky. The pre-requisites and enabling factors outlined in this chapter for effectively pursuing Option 3 are in very short supply. The PA and the MOH could alternatively, in the interim and as a transitional step, give greater consideration to pursuing Options 2 over the medium-term. Ultimately, however, the decision to organize a health financing system in a given way (to mobilize resources for healthcare, pool and manage those resources, and use them for the purchase of health services) is, at its core, a social choice and governed by political, economic, and institutional factors prevailing in a country context.

CHAPTER IV- MOH FINANCIAL MANAGEMENT AND CONTROL

BACKGROUND

Over recent years the Palestinian National Authority (PA) initiated broad-scale public financial management (PFM) reforms with the aim of improving public sector accountability and financial control at the ministerial level. Under a modernized financial management system, the PA aims to increase allocated funds to specific ministries in accordance with an appropriation approved by the parliament. Ministers will be authorized to disburse funds within the limitations imposed by the parliamentary appropriation and account for the performance of their responsibilities through the preparation of an annual financial statement.

The current government operates in a very demanding financial environment. In 2006, the government experienced significant cash flow problems arising from a raft of sanctions and restrictions imposed on citizens and the PA as a whole. While this situation has improved through 2008, cash resources are still limited and continue to restrict the capacity of the government to meet payment liabilities as they occur. Efforts have been made to successfully reduce the total outlay on salaries and other regular items of expenditure. Other initiatives have been implemented to improve the regularity of the revenue stream of the public sector. These initiatives have contributed to an improving cash position but cash management remains a priority for public financial management.

Current PFM reform efforts are focused on improving the cash position of the PA and managing the difficulties associated with cash-flow shortfalls. These reform efforts have taken two forms:

1. The introduction of commitment guidelines on monthly expenditures that give a degree of certainty to line ministries on the level of expenditure that can be processed within a specified period;
2. The development of a more rigorous budget estimating process that includes providing line ministries with budget ceiling estimates to prevent work on items unlikely to receive budget support

The international donor community has established a trust fund administered by the World Bank to help ensure that payment for health services is not unreasonably constrained by the cash position of the Government. The purpose of the fund is to cover up to 50 percent of non-salary recurrent health expenditures. Consequently, the Ministry of Health has been insulated from the more severe impacts of cash shortfalls experienced in other budget sectors. This situation places the Ministry of Health in a stronger position to lead the next level of PFM reform, namely, improving the system of internal control and developing financial management practices to support the incremental distribution of financial accountability and authority to line Ministries.

The Ministry of Finance is considering transferring financial responsibility for a proportion of health related expenditures to the Ministry of Health. A new financial management information system is under development by the Ministry of Finance which will allow line ministries to control funds appropriated under the budget act. The first release of this application will be implemented on a limited basis in the Ministry of Health and the Ministry of Education. The new application will provide the Ministry of Health with the capability to make health related payments for specific expenditure types without the direct approval of the Ministry of Finance.

This initiative provides a singular opportunity to ensure that ministerial accountability for financial performance is commensurate with their level of financial authority. Distributing financial authority to line ministries must necessarily be accompanied by corresponding changes and enhancements to the system of internal control operating within each line ministry. To support the distribution of financial authority to line ministries, the government has moved to strengthen the key organizations that provide the parliament, the executive and the Ministry of Finance with assurances about the regularity, accuracy and completeness of financial records.

The government is in the process of re-building the State Audit & Administrative Control Bureau in preparation for the move to a more distributed financial management system. The Bureau has recently acquired new accommodation in Ramallah, is in the process of recruiting new staff and is now a full member of the ARABOSAI (a representative organization of the supreme audit institutions in the Arab region), although lack of national sovereignty has prevented them from gaining membership in the INTOSAI, the International Organization of Supreme Audit Institutions. Considerable scope still exists to establish a strong legislative framework to govern the work of the bureau and protect its independence. Further work is also necessary to develop the standardized work practices and professional competencies needed to deliver the services required of a modern public sector audit institution.

The Ministry of Finance has also moved to strengthen the internal control and assurance mechanisms of the Government. The Ministry has invested in improving the standard of financial control by creating a government-wide Internal Audit Group within the Ministry of Finance and an Internal Control Group also administered by the Ministry of Finance with staff embedded within accounting departments across line ministries. The Internal Audit Group is currently in the process of preparing an Internal Audit Practice Manual and they have elected to adopt the 'International Standards for the Professional Practice of Internal Auditing' prepared by the International Institute of Internal Auditors. They are being assisted in this process by an external consultant.

There has also been a considerable amount of research and preparatory work done on modernizing government accounting standards and policies. The government has indicated a long-term desire to operate in compliance with the International Public Sector Accounting Standards (IPSAS) in the future. The inclusion of the Ministry of Health in the first implementation stage of the new financial management information system stage creates a need to reform the system of financial control operating within the Ministry of Health. The availability of budgetary support provided through the Emergency Social Support Project (ESSP) provides an opportunity for the Ministry of Health to reform core financial management processes. Together, these reforms should be aimed towards the achievement of three key objectives:

1. Develop a system of internal control that will provide the Minister of Finance with sufficient confidence to gradually transfer greater levels of financial responsibility to the Ministry of Health and have confidence in the accuracy and reliability of financial information provided by the Ministry of Health.
2. Develop a payment system that reduces the administrative burden on suppliers currently passed on to the Ministry of Health
3. Assemble comprehensive financial data to support long term sustainability planning and performance measurement.

Reforming the Ministry of Health financial management system might reasonably be expected to deliver the following tangible benefits:

- A comprehensive and consolidated record of all financial transactions (and commitments) relating to the delivery of health services – that builds financial management capacity within the Ministry of Health and, ultimately, focuses accountability for health services within the Ministry of Health and allows the government, the parliament and citizens to assess the financial performance of the Ministry of Health and the extent to which health services are delivered according to relevant laws, policies and plans;
- Complete and accurate base-level financial information that can be used to accurately measure the cost of services and the real level of revenue required to meet the health care needs of Palestinian citizens;
- More prompt and accurate payments to health service providers – that minimize the cost of health services and treat all approved health service suppliers in a consistent and equitable manner ;
- Improved compliance with legislation relating to health insurance contributions and payments – that ensures contributions are made as directed by law, eligible patients receive services to which they are entitled and service providers operate in accordance with the law; and
- Comprehensive financial statements – that supports the development of accurate revenue and expenditure estimates, year-on-year performance comparisons and personal accountability at the ministerial level.

KEY ISSUES AND CHALLENGES

The Ministry of Health financial management system needs to be redesigned and modernized. The existing system does not provide: (i) reliable basis for preparing forward estimates; (ii) reasonable assurance about legislative regularity of all expenses; (iii) an efficient and timely mechanism for the payment of accounts payable; (iv) complete and accurate information about the real cost of health services.

Budgeting and Estimating - There are two key factors impacting the capacity of the Ministry of Health to prepare and defend reliable budget estimates. These factors are:

1. The accuracy and completeness of historical data used to prepare budget estimates, given that these figures are drawn from a variety of independent financial systems; and
2. The lack of performance evaluation data (and the absence of key performance indicators) from previous financial years that necessarily limit the ability of the Ministry of Health to identify areas where previous funding levels may not have been appropriate to need.

The Ministry of Finance is in the process of strengthening the budget estimating process. Officials within the MOF are working in conjunction with line Ministries to implement a consistent approach to the task of preparing annual estimates. The Government is planning to introduce program budgeting in 2009. The proposed program structure for health related expenditures includes items related to both development (as defined in the 2007 Palestinian Reform and Development Plan (PRDP) and recurrent expenditures. The Ministry of Finance

has clearly acknowledged the inherent risks associated with defining the medium term macro-economic framework. A number of external agencies, including the IMF and the World Bank, are assisting the Ministry of Finance to improve the annual budgeting process.

At this stage, the Government intends to roll development and recurrent expenditure into the program structure defined within the Palestinian Reform and Development Plan (PDRP). This decision implies that forward estimates for health expenditures will be classified under one of the following two programs (defined in the PRDP): (i) health quality improvement and (ii) health care affordability). This proposed program structure will need to be reviewed. The two items noted above are suitable for the classification of development expenditures. The program structure, however, will need to be enhanced to encompass health related recurrent expenditure before it can become a useful tool for presenting and analyzing the financial performance of the health portfolio.

Notwithstanding the value of the work done to improve the reliability of forward estimates, the financial records held within the Ministry of Health do not support the preparation of a forward estimate based on the program structure defined above. Clearly, it will be difficult to attribute expenses incurred in delivering primary and secondary health care in previous financial years to one of these two programs. As a result, the subsequent budget proposal is at risk of being based on the arbitrary allocation of recurrent expenses to one or either of the budget program items.

Given the arbitrary nature of the allocation of planned expenditures to individual program items, confidence in the accuracy of the forward estimates is, justifiably, questionable. Questions over the accuracy of the budget estimate will erode the capacity of the Minister of Health to protect the annual budget estimate during negotiations with the Ministry of Finance and the Legislative Council. Financial data from previous financial years is drawn from a variety of sources. Information relating to health services is held in the Ministry of Health, the Ministry of Finance and the World Bank (steward of the ESSP trust funds). Since 2006, there has been no information regarding the breakdown of expenditure regarding funds forwarded to Gaza. At the time of writing (July 2008) basic government finance data on revenues and expenditures for the financial years 2006 and 2007 are presented as estimates rather than actual amounts.

Leaving aside the problems associated with extracting data from Gaza, only the Ministry of Finance are in possession of comprehensive data, regarding health related financial activity. The transactions not made in the Ministry of Health are not reported to the Ministry of Health and, consequently, the ministry is not in a position to prepare a budget estimate that encompasses the full range of portfolio financial activity.

Current financial reports regarding health related financial activities do not include performance indicators. Consequently, there is no mechanism to evaluate the quality of financial activities. Performance, to date, is assessed on the extent to which actual financial outcomes correspond with budgeted financial outcomes. As a result, budget estimates, that are prepared on the basis of historical data, are likely to perpetuate problems associated with under and over-resourcing. The budget process currently being undertaken with respect to 2009 will include development of key performance indicators (KPIs) for each of the health related program items. This will allow for an assessment of spending quality to be included in the budget estimate process for the financial year 2011.

System of Internal Control - The Ministry of Health is supported by a reliable accounting system. Accounts receivable and payable, which are accepted within the Ministry, are brought to account. The Ministry of Finance has introduced a commitment recording mechanism within

the Ministry of Health that supplements the cash accounting process. The commitment register process allows the Ministry to quantify the cost of services received and not yet paid. The accounting system includes a financial control facility operating under the supervision of the Ministry of Finance and is also subject to regular compliance-based audit inspections by the Internal Audit Group (also operating under the supervision of the Minister of Finance).

In general terms, however, the accounting system is traditional and old-fashioned. There are areas where the level of internal control could be improved and other areas where there is considerable scope to increase the efficiency of operations. These are: (i) validation of entitlement to health insurance benefits under the Al Aqsa policy; (ii) processing of hospital accounts; (iii) receipt of cash and cash values; and (iv) accounting for expenditure of funds allocated to Gaza.

Validation of Entitlement - An increasing level of unemployment has reduced the number of people voluntarily contributing to the General Health Insurance Scheme. Many of the families previously making voluntary contributions to the scheme are now claiming entitlement to medical services under the Al Aqsa Intifada insurance policy. The internal controls used to establish unemployment are weak and it seems very likely that many of the families receiving services under the Al Aqsa policy may not be legally entitled. The policy was originally introduced to help individuals who had previously been employed in Israel. Prior to 2006 approximately 120,000 families were supported by income earned in Israel. By mid-2008 the number of families registered as eligible to receive health services under the Al Aqsa policy was approximately 330,000.

The Al Aqsa policy allows unemployed persons and their dependents to claim health benefits on the basis of a nominal contribution payment and co-payment determined by the period of time they have been contributing to the health insurance scheme. Unemployment status is established by producing a card issued by a registered professional union certifying that the nominated bearer is unemployed. The cards are valid for a period of 12 months. Card holders pay a nominal service fee to the professional union when applying for the card. Thus, the union has a positive financial incentive to issue cards with no corresponding penalty for false certificates. In addition, Trade Unions are not obliged to verify that holders of the card remain unemployed for the full 12 months of the validity of the card.

The status of the certificate and the legal obligations incumbent on the issuing union do not appear to be a sufficiently rigorous control to justify the cost of health services supplied on the basis of the certificate and charged to the Ministry of Health. The Ministry of Health has transferred responsibility for the certification of employment status to the Ministry of Labor. The Ministry of Labor will be obliged to validate the employment status of all individuals claiming to be unemployed. In addition, having certified an individual as unemployed, the Ministry of Labor will be obligated to make health insurance contributions (at a reduced rate) on behalf of unemployed persons.

Hospital Accounts - In cases where the required service cannot be delivered through a Ministry of Health hospital, patients may be referred to private medical institutions in the West Bank and Gaza or to a variety of hospitals abroad. The Ministry has negotiated an agreed schedule of fees with each of the private and/or foreign institutions authorized to deliver certain services on behalf of the Ministry of Health. These purchased external services are the most rapidly growing item of expenditure on the Ministry of Health balance sheet.

Hospitals render aggregated accounts on a regular basis. These accounts may cover thousands of chargeable service delivered to hundreds of individual patients. Each charge on the account is supported by an invoice, medical report and various authorization forms and registrations. A large hospital account may total many millions of Israeli Shekel. Administrative staff, within the Ministry of Health, are obliged to check and verify the accuracy of all the supporting documentation supplied in support of each charge appearing on the account prior to payment. This can be a labor intensive and time consuming task. As a result, there can be extensive delays (in excess of six months) between receipt of invoice and payment of the account. This delay has a direct impact on the service fee charged by the treating institution. During an interview with staff from the Al-Maqassed Islamic Charitable Society Hospital in Jerusalem, the Chief Financial Officer explained that the current level of delay in payment added an additional 9 – 16 percent to institutional costs through opportunity costs and financing fees.

The financial impact of delay on suppliers is further aggravated by a level of uncertainty surrounding when an account will be paid. While accounts are paid when they are deemed fit for payment and as soon as funding restrictions permit, the time between receipt and payment can vary dramatically. Consequently, suppliers commonly calculate a fee on a worst case basis. Streamlining the payment process and operating within a guaranteed payment period will help reduce the pressure on hospitals to increase fees in the future and may even encourage some institutions to reduce the fees they currently charge.

Receipt of Cash and Cash Values - The Ministry of Finance encourages all payments to be made in cash. Staff from the Ministry of Health are discouraged from accepting payment by check. This measure has been introduced to reduce the delay between receipt of payment and availability of funds to Treasury. Cash is available for dispersal within forty-eight hours of being banked. Checks may take up to 5 days to clear. While there are clear advantages for the Treasury in accepting cash in preference to check payments there are also considerable costs associated with handling, transporting, securing and accounting for cash. In cases where the payment is quite large, for example, contract contributions from a large employer, the need for cash also adds to the cost and inconvenience of the payer. The Ministry of Health needs to consider other methods of payment that are cheap to process, easy to handle, quick to clear and convenient for the payer.

Funds Allocated to Gaza - The sum total of funds transferred to Gaza appears as a single line entry on the 2006 & 2007 Balance Sheets. This figure is not supported by any corresponding documents to demonstrate that the moneys have been dispersed in accordance with the budget. Clearly the situation between the West Bank and Gaza administrations is complex and delicate. An agreement, however, needs to be reached as soon as possible about how moneys appropriated in the budget can be properly accounted for.

Statutory Financial Reporting - The annual Balance Sheet is prepared in accordance with the Financial By-Laws for Ministries and Public Organizations, Number 43, 2005. The accounts are presented in a Balance Sheet format on a cash-basis. The Balance Sheet is not supported by a Cash Flow Statement or an Income Statement. The information in the report is derived from financial transactions processed within the Ministry of Health. The report does not include any information about health related items that are processed within other Ministries, including the Ministry of Finance.

As a result of the above, the financial statement has limited use as an aid to financial planning. In addition, the financial data held within the accounting system does not support detailed

analysis nor does it serve as the basis for measuring the financial performance of the Ministry of Health and the Health Insurance Scheme in particular. In the long-term, there are three key issues that need to be addressed in order to produce financial information that better supports the management of the Health Insurance Scheme. These are:

1. Consolidation of all health related transactions within the Financial Statement of the Ministry of Health;
2. Reporting of all non-current assets and depreciation costs; and
3. Attribution of revenue and expenses to specific programs and/or services.

Consolidation of Transactions - A large number of health related transactions are not processed within the Ministry of Health. The main two groups of these are the salary costs for all Ministry of Health employees and the cost of hospital services approved by the Office of the President and paid directly by the Ministry of Finance. A third type of case exists where medical cases are referred to medical facilities abroad by NGOs without the approval, or knowledge, of any arm of the government. As a result, health expenses are incurred by individuals and organizations outside the control of the Minister of Health and the cost of those services is not recorded within the Ministry of Health.

The current system makes it very difficult for the Minister of Health to assemble a complete view of the financial cost of health services. Information, recorded in various systems, needs to be manually assembled before total revenue and expenses can be compared and analysed. This information should reside within one system, it should be regularly available to support performance management and responsibility for financial performance should rest with one authority, namely the Ministry of Health.

Recording of Non-Current Assets - The Ministry of Health currently maintains an asset register but does not record the value of those assets. As a result, the value of assets is not depreciated and there is no capacity to ensure that adequate financial provision is made to maintain or replace business critical plant and equipment.

Health services in particular are very dependent on expensive and complex machines and facilities. In order to ensure the continuity of services it is vital that the Ministry of Health has a financial plan that ensures these machines and facilities are maintained in accordance with manufacturer's instructions and that there is sufficient funds available to replace these machines as they become obsolete. In order to achieve this, the accounting system should record the value of all assets and depreciate the value of those assets over time in order to reflect the accrued liability to the organization of replacing business critical assets.

Allocation of Costs - The current accounting system does not allow the Ministry of Health to calculate the cost of services. As a result, the fees charged to non-insured patients and the value of co-payments paid by insured individuals is based on an estimated cost that might not be accurate. In addition, the lack of accurate costing information makes it very difficult for the Ministry to evaluate the comparative cost benefit of various treatment programs. In order to properly fix a price for services, compare the cost of various service options and identify potential savings and efficiencies the chart of accounts must be re-developed to allow for the accurate allocation of costs to a line of service.

OPTIONS FOR REFORM

The following options for reform each seek to address discrete situations. None are dependent upon another. Collectively, the starting points of a program of specific reform activities designed to:

- assist the organisation to implement international accounting standards, specifically the International Public Sector Reporting Standards (IPSAS);
- improve the level of internal control;
- promote accountability;
- improve financial planning and strategic decision making; and
- reduce administrative costs associated with processing accounts.

As a program the following reforms address each of the issues raised in the preceding section but there is not necessarily a one-to-one relationship between the issues noted above and the suggested option for reform.

Long-Term Transfer of Responsibility from the Ministry of Finance to the Ministry of Health - The division of responsibility and, therefore, accountability between the Ministry and Health and the Ministry of Finance should be clarified. At the moment, it is not clear whether the Minister of Finance or the Minister of Health is responsible for the standard of internal control within the Ministry of Health. Given this uncertainty, it is also not clear who is ultimately responsible for the completeness and accuracy of financial information. Clear accountability is dependent upon the appropriate allocation of authority and responsibility.

FIGURE 15 – ACCOUNTABILITY MODEL



The Minister of Health is accountable for the standard of internal control within the Ministry of Health but the Minister of Finance has authority over the processing of accounts (via the Internal Control Group) and there are a number of significant account areas where the Ministry of Finance is responsible for the approval and payment of accounts.

The following options would help to regularize the current arrangements.

Payment of Salaries - Once appropriate commitment controls are established the Ministry of Health should assume responsibility for the payment of salaries and wages. This will involve preparation of an annual estimate of salary costs based on the planned staff resource allocation to individual service delivery outlets (cost centers). Planned salary costs should be appropriated to the Ministry of Health via the annual budget appropriation process and the Minister of Health should be responsible for managing salary costs and providing regular (perhaps quarterly) reports to the Minister of Finance regarding planned and actual wage expenditure. In the interim, the Ministry of Finance should supply the Ministry of Health with regular statements of salary and wages paid. This information should come in the form of a payroll statement and should be sufficiently detailed for the Ministry of Health to attribute salary costs to individual employees and cost centers. This information should be used to determine the size of any unpaid liability and the extent to which actual salary expenditure is in line with planned salary costs.

Internal Control and Internal Audit Services - Responsibility for the operations of the Internal Control and Internal Audit Groups should be transferred to the various line ministries. This will require line ministries to create a Ministry Audit Committee. That committee will comprise senior managers and include an independent representative. The committee will be responsible for:

- approving the charter of the internal control and internal audit groups within the ministry;
- responding to defined internal control weaknesses and audit reports;
- approving strategic and tactical internal audit plans;
- certifying the adequacy of internal control; and
- managing the investigation and prosecution of reported financial improprieties.

The Ministry of Finance should maintain a coordinating role for both functions. This role might include:

- development of professional standards, technical training and practice development;
- conduct of quality assurance and peer review activities; and
- a non-executive role on Ministry audit committees.

The transfer of responsibility to line ministries should be contingent upon the creation of an audit committee with the appropriate skills, authority and make-up to support and develop internal control and auditing practices.

Reform the Budgetary Cycle - The Ministry of Health should implement a performance monitoring program to support the introduction of a new program-based budgeting cycle. The Ministry of Finance should provide assistance and guidance to line ministries in developing performance measurement tools and techniques. These tools should be used to develop a formal monitoring program that reports on the extent to which specified key performance indicators are being achieved.

Line ministries should be responsible for providing quarterly reports to the Minister of Finance regarding planned and actual expenditure and the achievement of key performance indicators. Line ministries should carry an obligation to notify the Ministry of Finance as soon as they become aware of any significant variation to planned financial or performance related results. The Ministry of Finance should ensure that funds appropriated by the legislative council are allocated as mandated. Cash flow restrictions that exceed the commitment guidelines should be

communicated to line ministries as soon as they arise and line ministries should be provided with an accurate picture of any interim funding arrangements.

Re-engineer the System of Internal Control - The existing system of internal control is old-fashioned and labor intensive. The release of a new financial management system within the Ministry of Finance provides an opportunity for the Ministry of Health to re-engineer current practices. In particular the Ministry of Health should seek to: (i) implement control measures to detect and investigate fraud and over-servicing; (ii) re-engineer core financial management processes, i.e. collection of contributions, payment of accounts and procurement of services; (iii) expand the range of payment options available to contributors.

Fraud Control - The Ministry of Health should consider establishing a Compliance Unit with a specific resource allocation and suitable computing support to detect, investigate and prosecute instances of non-compliance and fraud. In the longer term, a computing application might be developed to identify high risk service providers and patients. Risk algorithms can be developed over time and used to identify individuals who receive benefits without entitlement, service providers who over-charge or over-service and employers who fail to contribute the full amount required in the terms of their contract.

Core Processes - The Ministry of Health, with the specific assistance and support of the Ministry of Finance, should re-engineer core financial management processes. These include: payment of accounts; collection of contributions; and procurement of services. Re-engineering should focus on transforming these processes by introducing more modern concepts of control that concentrate on risk management and the realization of opportunity. By way of a starting point, the ministry might choose to enlist external assistance to re-engineer a single process with a view to acquiring an in-house design capacity that will allow the ministry to maintain and expand the new process and move on to re-engineer other core financial management processes.

Service Level Agreements – The Ministry of Health should enter into agreements with service providers that guarantee a minimum period for payment based upon the date of receipt of a valid invoice. Guaranteed payment periods introduce a level of certainty that allows service providers to calculate fees based upon a specific period between invoice and payment. This, in turn, should help to reduce the premium for delay that many institutions are currently including in their fee for service.

Service providers should be offered terms based on an analysis of previous invoices and the extent to which these invoices have been complete and error-free. Institutions with a good-track record might be offered a short payment turn around period whereas, institutions with a poor invoicing history, could be offered a longer turnaround period based on the need to examine their accounts more closely. The Ministry of Health should review these agreements on an annual basis and make adjustments to the payment conditions offered in a new agreement based upon the reliability, completeness and accuracy of accounts submitted during the year.

Payment Options - Contributors should be encouraged to make electronic payments whenever it is economic to do so. Districts should be equipped to handle EFTPOS transactions for co-payments and patients should be given the option to pay electronically. Where a patient elects to pay electronically, they should provide credit card details before accessing medical services and given a sum total bill at the end of the visit.

Bulk contributors, such as large employers, should be forced to make electronic payments from a nominated bank account using either a direct debit or direct credit facility. Cash payments, from large contributors should attract a service fee. All electronic payments should be made to a consolidated Ministry of Health revenue account rather than the individual accounts currently operating within each district.

Establish a New Chart of Accounts - The existing chart of accounts does not support the accurate costing of specific services and/or service delivery outlets. Any medical service necessarily includes a number of overheads. In order to accurately establish the cost of a particular service all associated revenue and expenses should be considered. These overheads might include items such as plant and equipment, administrative charges, maintenance fees and capital replacement costs.

The Ministry of Health chart of accounts should be re-designed to facilitate the production of regular reports aligned to the programs specified in the budget. The chart of accounts should be re-developed in consultation with the Ministry of Finance and structured to support the new program budget structure and the preparation of regular financial performance reports.

Over time the Ministry of Health should consider further modifications to support the introduction of cost centers that allow the cost of services delivered from specific locations (or under particular programs) to be properly managed and reported. Ultimately, individual cost centers should be afforded a notional budget and given sufficient authority to manage their finances – including, the preparation of annual estimates, authorization of all associated expenditures, the maintenance of proper financial records and the regular reporting of financial activity.

The development of a new chart of accounts will necessarily involve the development of a finance manual which should incorporate definitions and processes that comply with the accounting standards of the government and, ultimately, International Public Sector Accounting Standards (IPSAS). This manual should be prepared in conjunction with the Ministry of Finance. The State Audit Bureau should be responsible for establishing that accounting practices comply with the relevant legislation and standards and operate in a sufficiently reliable manner to produce financial statements that are accurate, complete and fair. The development of a new manual might initially concentrate on the budget estimating process and the classification of transactions under a program structure.

Prepare Comprehensive Financial Statements - The annual financial report prepared by the Ministry of Finance is not a complete record of all health portfolio assets and liabilities. In addition to items such as salaries and payments for external services, the financial statements should also include a full statement of all assets and liabilities. This should include all non-current assets and liabilities such as plant and equipment and the accrued value of any depreciation of those assets.

Once financial responsibility for all health related activities has been transferred to the Ministry of Health, the ministry should develop accounting procedures (approved by the Minister of Finance) for the valuation and depreciation of assets. These values should be included in the annual Financial Statements. The Financial Statements should comprise a Balance Sheet, a Cash Flow Statement and an Operating Statement. The full Financial Statement should appear in the annual report. The Financial Statement should be signed by the Chief Financial Officer and the Minister. The Annual Report should include a section on corporate governance that specifically

reports on the reliability of the system of internal control. The accuracy, completeness and regularity of the Financial Statement should be certified by the State Audit Bureau.

The Ministry of Finance should plan to gradually develop the capacity to prepare an annual financial statement. The initial steps might involve the creation of a portfolio specific cash-based balance sheet supported by a statement of fixed assets. This report should be enhanced year on year until, say 2012, the Ministry is in a position to provide a comprehensive accrual-based financial statement.

PROJECTED TIMETABLE FOR REFORM

The following timetable is a preliminary view only and pre-supposes the agreement of the government to the options noted above and the availability of sufficient funds to carry out the reform. It should be noted that the tasks listed below are, in most cases, specific improvements that will form the basis of a ongoing program of continuous development and improvement.

TABLE 8: PROPOSED REFORM TIMETABLE

Activity	2009												2010											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1 Transfer Responsibility																								
1.1 Payment of Salary																								
1.2 Internal Control and Audit																								
2 Reform Budget Cycle																								
3 Re-engineer Internal Controls																								
3.1 Fraud and Over-Servicing																								
3.2 Core Processes																								
3.3 Payment option																								
4 Chart of Accounts																								
5 Financial Statements																								

Continuous Improvement - The activities recommended in this paper constitute the initial and foundation steps in a long-term program to improve the financial management systems of the Ministry of Health. Financial management systems are not static. They are constantly evolving to accommodate changing economic conditions, emerging technologies and dynamic risk drivers. To develop and maintain an effective financial management system requires an on-going development. This, in turn, obliges the Ministries of Health and Finance to develop an in-house design capacity to maintain and improve financial management on an on-going basis.

The Ministry of Health will need external assistance to implement the recommendations contained in this report. The external assistance should be very task-focused but must also incorporate a structured and comprehensive know-how transfer program. Key skills that the ministry should aim to acquire while implementing these recommendations include:

- Formal accounting knowledge in a public context (IFRS and IPSAS)
- Risk management
- Business process re-engineering
- Fraud detection and investigation

The long-term success of financial reform is largely dependent upon the extent to which the target organization is able to acquire the design capacity necessary to continue the reform process. A fundamental component of know-how transfer program is involves forming a genuine partnership between the external supplier and the client organization. The client must accept responsibility for the success of the planned activity and commit resources as planned and agreed with the external supplier.

The following resource estimates are based on an assumption that the Ministry of Health will be undertake these tasks with the assistance of an external supplier and will commit in-house resources sufficient to ensure that al tasks are completed on time and in accordance with specified requirements.

TABLE 9: TECHNICAL ASSISTANCE REQUIREMENTS

Task	Activities	Duration	FT/PT
Transfer of Responsibilities	Develop new procedures, implementation plan and training materials for payment of salaries and centralization of authority to approve access medical services abroad within the Ministry of Health.	3 months	FT
Transfer of Responsibilities	Develop Internal Audit Charter, guidelines for the operations of the Ministerial Audit Committee, the Strategic Audit Plan, the Tactical Audit Plan and associated risk planning tools.	6 months	PT
Budgeting Cycle	Develop revised program structure, estimating methods, evaluation criteria, performance measurement processes, reporting formats, approval procedures, implementation plans and training materials.	9 months	PT
Re-engineer core processes	For one single core process (say, payment of accounts) define current risks and opportunities, evaluate current system, develop Target Operating Model, develop control procedures, prepare and deliver Business Process Re-engineering training.	9 months	FT
Chart of Accounts	Assess existing system capacity, define cost centers, develop system of classification, define operational reporting requirements, prepare, design Chart of Accounts, deliver training materials and develop implementation plan	6 months	PT
Financial Statements	Define reporting formats, develop reporting procedures, define accrual procedures, prepare accounting standards, develop training materials, prepare and monitor implementation plan, develop cut-over procedures and	19 months	PT

Dependencies - Before commencing work on redeveloping the budgeting cycle, the Ministry of Finance will need to ensure that the Ministry of Health has complete information regarding the level of expenditure on salaries and external services. The transfer of ownership of the Internal Control and Internal Audit Groups will not affect the capacity of the Ministry of Health to assemble accurate and complete budget estimates. However, the Minister of Finance, might reasonably expect these particular safeguards to be in place and operating effectively before

transferring responsibility for the payment for salaries in particular over to the Ministry of Health.

Reforming the budget cycle is necessarily constrained by the defined timetable of budget approval and appropriation. Given supply draft estimates to the Ministry of Finance by the end of June then it is clear that work on the development of a new zero-based methodology and associated documentation standards will need to be finalized before the end of May. Subsequent development work regarding protocols for the settlement of disagreements and revision procedures might reasonably be completed after July. Reforming the internal control system is not dependent on other tasks and might reasonably commence and conclude when the capacity exists. However, given the Minister of Finance's duty of care to the public purse it seems sensible to commence with these reforms at the earliest possible date. The development of a new chart of accounts is a pre-requisite step in the process of preparing comprehensive, accrual based financial statements. In order to develop a new chart of accounts the Ministry of Finance will need to ensure that the general ledger system has the capacity and functionality necessary to expand the number of charge-codes currently used to classify revenue and expenses.

The Ministry of Health will need to allow for at least one full financial year to bed down the new chart of accounts and the preparation of a more comprehensive financial statement. During this time the Ministry of Health will need to run its existing accounting system and the new chart of accounts in parallel to ensure that all accounting items can be properly accommodated within the new structure of the chart of accounts. This same period can be used for the development of manuals and training material as well as the process of calculating the value of all non-current assets.

SUMMARY CONCLUSIONS

There are three key factors that are driving the need to reform the Ministry of Health financial management system: (i) the distribution of financial authority to line Ministries. This creates a need to improve financial control and provide adequate assurance to the government and the Ministry of Finance regarding the regularity and appropriateness of financial operations, (ii) the rising service costs and diminishing revenue from voluntary contributors. This has created a need to gain the best possible value from all services (including those provided internally within the Ministry of Health and those purchased from external suppliers). In addition the Ministry of Health needs to limit administrative expenditure and improve operational efficiency. (iii) the ongoing debate over the long-term sustainability of the General Health Insurance Scheme. This has created a greater need for detailed financial information that will allow the Ministry to assess the comparative costs and benefits of different strategic options.

In order to meet these needs the Ministry of Health needs to develop and implement a new financial management system. The ultimate aim of the new financial management system is the preparation of a comprehensive annual financial statement that fully discloses the financial performance of the health portfolio for a given financial year and uses practices that are in compliance with international standards. Achieving this goal will demonstrate the MOH has properly discharged its budgetary responsibilities and allowed users to accurately assess the long-term financial sustainability of the health portfolio.

CHAPTER V – MOH EMPLOYMENT AND HUMAN RESOURCE MANAGEMENT REFORMS

Recent MOH human resource employment policies have contributed to the expansive PA wage bill. During the years of economic downturn following the 2nd Intifadha in 2001, public sector agencies including the security services expanded employment of Palestinian workers. Between 2000-2005, total public sector employment increased by almost 70 percent with the majority of recruitment occurring in the education, health, social development and security sectors. The civil service wage bill expanded at the same time by more than 60 percent reaching about US\$ 1.1 billion in 2005. A decision to raise salaries in 2003 by an average 20 percent following the enactment of new civil service legislation contributed to the wage bill expansion. In the first quarter of 2006, PA expenditures on salaries represented around 66 percent of all public sector expenditures and 91 percent of all fiscal revenues. In 2005-2006, international donors began to express greater concern about the unsustainable public employment policies, especially after the PA failed to reach particular targets for wage bill containment in 2005.

The reasons for the expansion of total public sector employment in the West Bank and Gaza are varied. At the time of its establishment in 1993 the PA employed around 20,000 individuals, most of whom had worked previously with the Israeli Civil Administration. The total number of public sector employees almost doubled between 1995 and 2000. Part of this expansion was natural and related to the expanding security and welfare responsibilities of the PA; but the rate of growth - equaling around 12.3 percent per year – began to raise serious questions about fiscal sustainability. In the wake of the 2nd Intifadha, economic and employment conditions deteriorated as Israel tightened economic and security restrictions; and denied access to a large number of the 34,000 Palestinians working in Israel. The policy response of the PA in the face of declining private sector activity and rising unemployment levels was to step up employment in public sector institutions to absorb the growing number of unemployed.³³

A real change in public employment policy was signaled with the adoption of the Palestinian Reform and Development Plan (PRDP) in the last quarter of 2007. The PRDP, as explained earlier chapters, outlined the reform priorities of the PA during 2008-2010 centered around the pillars of governance, social affairs, economic and private sector development and infrastructure. In the area of public employment, the PRDP announced a freeze on real wages of public employees and a moratorium on new hiring by the public sector. The only exception was given to critical social sectors (health, education) which would be allowed to hire up to a maximum of 3,000 new employees. Along with these decisions the PRDP outlined the intended civil service reforms covering the areas of merit-based appointments, performance evaluations, leadership training, general pay and grading structure and modern human resource management systems.

MOH ROLE IN HUMAN RESOURCE DEVELOPMENT

The Ministry of Health (MOH) in the West Bank and Gaza is responsible for overall workforce planning and development in the sector; and is also the largest employer of health workers in the Palestinian Territories. By law the MOH is mandated with overseeing the licensing and monitoring of medical and auxiliary health professionals and for supervising the health education institutions under its authority.³⁴ Other stakeholders which also play a critical role in human

³³ World Bank Public Expenditure Review, 2007

³⁴ Public Health Law No. 20 (2004)

resource development for health are the Ministries of Higher Education, Finance, Planning; as well as the Government Personnel Council (GPC) and international donors. Over the last decade these stakeholders with the MOH acting as the main steward, initiated several attempts to implement plans to strengthen the Palestinian health workforce. One significant attempt was made in 2001 with the preparation of the first National Plan for Human Resources for Health.³⁵ The national plan, among other priorities, focussed on: (i) identifying education and training priorities (including continuous education) in needed clinical and non-clinical areas related to the health sector and (ii) developing modern systems for the effective management of human resources in the health sector.

Progress achieved by the first national plan thereafter was constrained by several important factors including the geographic separation of the West Bank and Gaza; shortfalls in financing, insufficient coordination between the sector stakeholders, information gaps related to priority education and training needs, and excessive centralization of the management of human resources. The general environment, too, with the beginning of the 2nd Intifadha, was focussed more on emergency management than the implementation of institutional and policy reform plans. The passage of the civil service law in 2005, however, signified an important attempt, despite the difficult development context, to modernize the general government system for public sector employment. The new civil service law laid down a standardized wage structure for all civil servants with five regular grades and rationalized, to a large extent, the prevailing system of allowances. While comprehensive and quite detailed, the new civil service law providing significant centralizing authority to the General Personnel Council.

The most recent plan to emphasize human resources for health is embedded in the new MOH National Strategic Health Plan for 2008-2010. This document provides crude projections of future human resource needs for physician, nursing and auxiliary health services by year 2015; and provides an overview of the current clinical educational programs and their number of graduates in the West Bank and Gaza. There are more than 85 educational programs (14 of them providing graduate level degrees) and over 1,484 graduated from them in 2004. The outdated information on the number of graduates indicates the absence of a comprehensive and updated database of human resources for health in the Ministry of Health. Among the priority areas for development, the new plan focused on the following issues: (i) developing and enforcing new licensing standards for Palestinian physicians; (ii) developing a system for accrediting education programs; (iii) strengthening continuous education programs; and (iv) developing a system for effective human resource management and planning sector-wide.

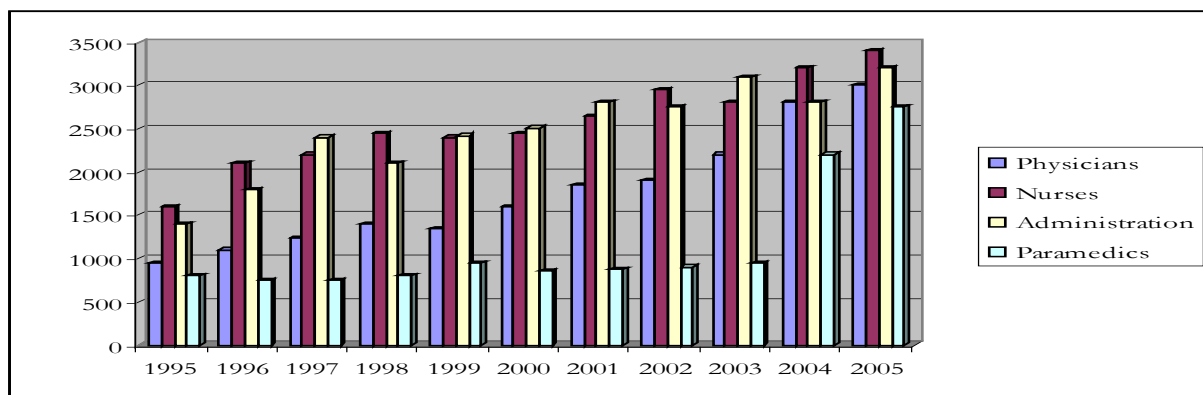
MOH EMPLOYMENT POLICY AND WAGE BILL GROWTH

The total number of employees working in the MOH rose from less than 7,500 in 2000 to 13,057 in 2006 – an increase of about 75 percent over six years. From 2006 to 2008, the total number of employees reversed course and actually decreased to 11,880. The categories of employees witnessing the largest expansion during the earlier period were physicians, dentists and pharmacists; followed by paramedical workers and administrators. Much of this expansion in the health workforce occurred in Gaza rather than in the West Bank. The largest one year increase in the MOH workforce was 18 percent from 2003 to 2004. Paramedics alone increased

³⁵ Hamdan M and Defever M 2003, 'Human Resources for Health in Palestine: A Policy Analysis', *Health Policy*, Vol. 64, 261-273.

by more than 100 percent from 978 to 2,199. This pattern of human resource growth reflects, again, the broader employment policies of the PA during a period of economic distress in the private sector. Figure 16 below indicates this increasing trend in MOH employment by type of professional category.³⁶

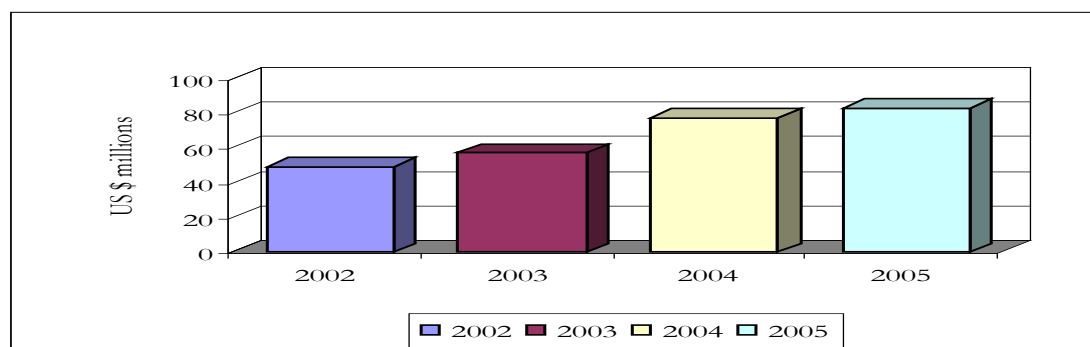
FIGURE 16: TRENDS IN MOH EMPLOYMENT BY CATEGORY OF EMPLOYEE



Source: World Bank Public Expenditure Review 2007

The expansive MOH employment practices resulted naturally in a concomitant increase in the MOH wage bill as revealed below in Figure 17. Per the overview of the health sector in Chapter I, salary expenditures increased from around US\$ 48 million in 2000 to US\$ 83 million in 2005. Much of this increase in the wage bill occurred, again, during the 2003-2004, with the policy decision to increase real average wages of civil service employees. Average salaries in Gaza during the 2000-2005 period were higher than those in the West Bank due to a higher number of senior health officials located at the central MOH offices in the Gaza Strip. Beyond 2005, MOH wage bill levels continued to rise -- but actual wage bill expenditures suffered severe disruptions and delays due to shortages in general fiscal revenues. With the formation of the Hamas-led government in January, 2006, overall donor support for the PA subsided significantly affecting the ability of the PA to cover salaries. During 2006-2007, delays in salary payments sometimes exceeded six month periods.

FIGURE 17: MOH WAGE BILL GROWTH FROM 2002 TO 2005



Source: MOH, 2006

³⁶ Sources: MOH National Strategic Plan 2007, Palestinian National Authority, World Bank Public Expenditure Review 2007.

PALESTINIAN HEALTH WORKFORCE AND MOH HUMAN RESOURCES

Comparing 2007 data on the Palestinian workforce with two neighboring countries indicates a relatively favorable situation in terms of the overall supply of certain categories of health professionals. The physician to population ratio for physicians in the PA is 2.07 whereas in Jordan and Egypt, the ratios are 2.67 and 1.46 respectively. The total number of physicians notwithstanding, there is a significant shortage in one category of physicians – family medicine specialists. There are only 2 registered family medicine specialists in Palestine. As for dentists and nurses, the ratios are comparable to those of Jordan and Syria; being slightly lower for dentists and marginally higher for nurses. There seems to be an excess supply of pharmacists in Palestine compared to the two neighboring countries. This trend is also confirmed by the MOH National Strategic Action Plan which indicates that the existing supply of pharmacists exceeds the current need by over 2,500 pharmacists. There is also a shortage of specialists in preventive medicine, psychiatry, radiology and neurosurgery according to the Ministry of Health. These comparative figures are provided below in Table 10.

Table 10: COMPARISON OF HEALTH HUMAN RESOURCES AMONG MENA COUNTRIES, 2007

Category	Number of Health Professionals					Staff per 1,000 ratio				
	Palestine			Jordan	Syria	Palestine			Jordan	Syria
	WB	Gaza	Total			WB	Gaza	Total		
Physicians	4,337	3,711	8,048	15,279	29,055	1.77	2.57	2.07	2.67	1.46
Dentists	1,355	680	2,035	4,891	13,994	.55	.47	.52	.85	.70
Pharmacists	2,242	1,600	3,842	8,087	15,152	.92	1.11	.99	.43	.65
Nurses	2,452	4,200	6,652	8,573	29,807	1	2.91	1.71	1.49	1.49

Source: National Strategic Action Plan 2008-2010, Jordanian MOH, 2008, Syrian MOH, 2008

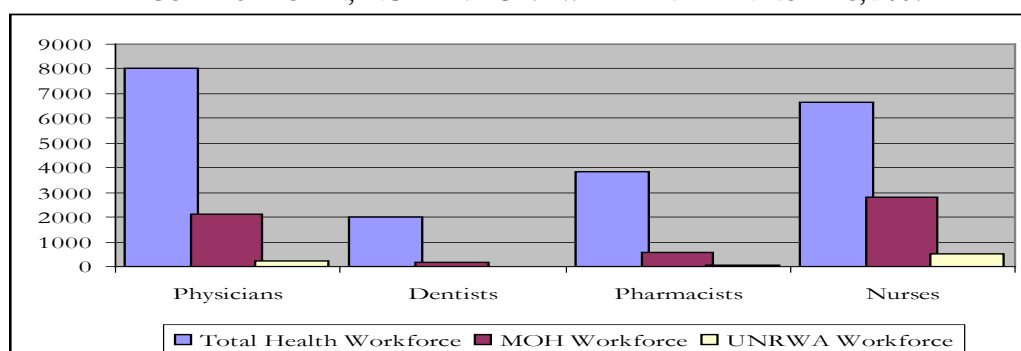
Another imbalance in the Palestinian health workforce is the geographical distribution of physicians and nurses between the West Bank and Gaza. The population ratios for dentists and pharmacists are fairly comparable; but the ratios for physicians and nurses indicate a substantial discrepancy in the allocation of human resources for health. The physician population ratio in Gaza is 2.58 whereas in the West Bank, it is 1.77. As to nurses, the discrepancy is even larger with an almost 3 to 1 difference between the Gaza and the West Bank population ratios. Such a geographic imbalance needs to be examined further by Palestinian health officials given its potential implications for the quality and cost of health care services in the West Bank.

Within the Palestinian health sector, the Ministry of Health represents the single largest employer employing 11,170 individuals in 2008. In terms of registered professionals, it employs around 26 percent of all physicians, 9 percent of dentists, 14 percent of pharmacists and 42 percent of nurses (excluding midwives). The remaining health professionals are either employed by UNWRA or the security health services; or work in the NGO and private sectors. The second largest employer of health professionals is UNRWA with a total health workforce of 1,411 individuals in the West Bank and Gaza, 55 percent of whom are physicians and nurses.³⁷ The second and third largest group of professionals are the administrators and the paramedical workers numbering 166 and 117 respectively. It is noteworthy that the administrative workers in UNRWA represent about 12 percent of the total health staff whereas in the MOH, administrative staff is 44 percent of the overall MOH workforce. This discrepancy points to

³⁷ UNRWA Annual Report, 2007

probable inefficiencies in the current composition of MOH staff. Figure 18 below illustrates the share of the workforce employed by the MOH.

FIGURE 18: TOTAL, MOH AND UNRWA HEALTH EMPLOYEES, 2007



Source: MOH, 2008 and MOH National Strategic Health Plan

The complete breakdown of MOH employees by category for the last two years is provided below in Table 11. During 2007-2008, the total number of MOH human resources decreased from 13,057 in 2006 to 11,170 in 2008 – a decrease of 9 percent in two years. The largest decreases were among specialist physicians and general practitioners, about 25 percent respectively over two years. Nurses also decreased in number by 21 percent. Some of this attrition may have been induced by disruptions in salary payments to health professionals during the 2006-2007 period causing them to leave public service. Other reasons could have been related to deliberate staff retrenchment decisions by the MOH. The only health professionals to witness an increase were the pharmacists. Their numbers increased by 30 percent from 297 in 2006 to 396 in 2008. Another important feature of the MOH human resource profile, as mentioned above, is the imbalance in the number of health professionals between the West Bank and Gaza. Although the West Bank has a larger proportion of the population than the Gaza Strip (65 percent as opposed to 35 percent), there are 161 MOH specialist physicians in the West Bank, for example, and 516 MOH specialist physicians in Gaza. Similar imbalances exist for general practitioners and administrative staff. The relatively high number of administrative workers in both the West Bank and Gaza is also a cause for concern given the efficiency implications for MOH services.

TABLE 11: HUMAN RESOURCES IN THE MINISTRY OF HEALTH FROM 2007 AND 2008

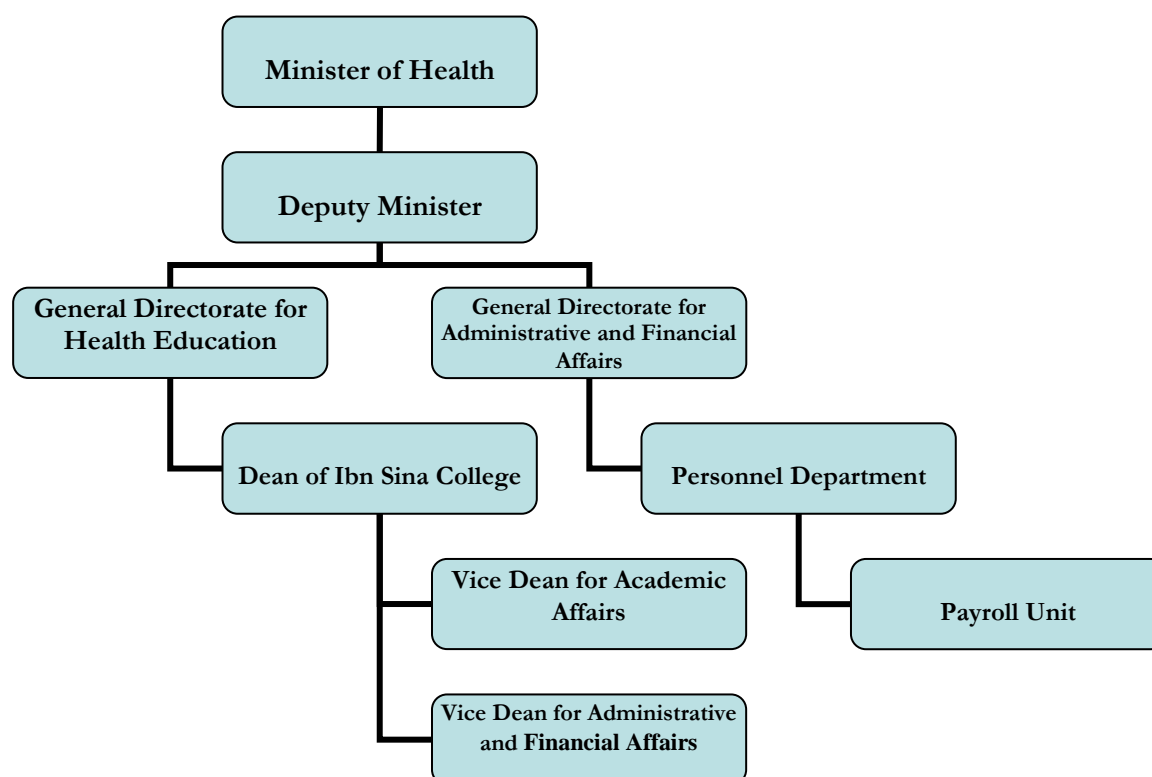
Group	2007 West Bank	2007 Gaza Strip	2007 Palestine	2008 West bank	2008 Gaza Strip	2008 Palestine
Specialized doctors	164	565	729	161	516	677
GP	410	783	1193	378	734	1112
Dentist	41	139	180	39	128	167
Nurses	1342	1464	2806	1323	1286	2609
Midwives	116	86	202	112	78	190
Pharmacists	209	337	546	204	312	516
Other hospital staff	475	547	1022	474	518	992
Administrative workers	1506	3696	5202	1464	3443	4907
Total:	4263	7617	11,880	4155	7015	11,170

Source (MOH, 2008)

CURRENT MOH ORGANIZATIONAL STRUCTURE AND HUMAN RESOURCE MANAGEMENT SYSTEM

The new organizational structure of the MOH in 2008 incorporates several important improvements over the previous organizational set-up. The new structure, as indicated earlier, integrates the outside referrals departments under the authority of a new general directorate for health insurance. This change brings together the two critical functions of the General Health Insurance scheme - collections and outlays - under one administrative unit. Other important changes are the creation of quality assurance units throughout the new organizational structure of the MOH and the granting of greater executive authority to the general directorates in the governorates in line with the decentralization agenda of the MOH. The one area in which there was no significant improvement relates to human resources. The new organizational structure, as depicted below in Figure 19 in an abridged version, has kept the 'personnel unit' separate from the General Directorate for Health Education. Human resource planning is also seemingly not incorporated formally into the new structure of the MOH. This administrative fragmentation does not foster the type of integrated operation needed between the effective 'management' of human resources and the 'development' of those same human resources.

FIGURE 19: NEW ORGANIZATIONAL STRUCTURE FOR MOH



Recruitment – The current recruitment policies of the MOH are governed by the broader civil service rules of the General Personnel Council (GPC). The Ministry of Health identifies its additional staffing needs and submits its initial request to the Ministry of Finance (MOF). This request is reviewed by both the GPC and the MOF; and if approved by the MOF from a budgetary standpoint, it is sent to the GPC to begin the public recruitment process. An announcement is posted in the official gazette for the new positions and all selected candidates are required to undergo examinations. The examination uses a point system for evaluation and each candidate is given a numerical grade based on her or his performance during the exam.³⁸ The candidates who pass the exam officially enter government payroll and are entered into the database of the MOH personnel department. This new system of recruitment, introduced by the 2005 Civil Service Law, brought greater uniformity and transparency to government hiring; but is prone to becoming overly centralized and bureaucratic. One area in which greater flexibility could be built into the public sector recruitment process centers around contractual workers and how they could be fit into the system to fulfill different short-term staffing needs of the different Ministries.

Remuneration - All civil service employees are paid based on a civil service scale of five regular grades and one special grade for high-level ministerial officials. The real average annual salary in 2005 was around US\$ 7,500 dollars per year or around US\$ 625 per month. Combined with the basic salary, MOH employees are also eligible for various allowances. These allowances can represent up to 35 percent of the total monthly remuneration and are divided into 6 different categories: family, transportation, specialty, rarity, job type and administrative allowances. The job type allowances include hazardous jobs and the administrative allowances are designated for high-level officials. Monthly salaries of MOH employees are displayed below in Table 12. The average monthly salary in both the West Bank and Gaza in 2007 was US\$ 725. In Gaza, the average salary was US\$ 703 whereas in the West Bank, it was US\$ 764. The only categories of professionals in Gaza with higher average monthly salaries than their peers in the West Bank were dentists, nurses and pharmacists – with the highest differential being among dentists.

TABLE 12: DATA ON MOH MONTHLY SALARIES IN 2007

Categories	West Bank No.	Average Salary \$ US	Gaza Strip No.	Average Salary \$ US	Palestine Human Resources	Average Salary \$ US
1	2	3	3	4	7	7
Specialized	164	1,232	565	1,126	729	1,150
GP	410	1,122	783	951	1,193	1,010
Dentist	41	757	139	934	180	893
Nurses	1,342	646	1,464	731	2,806	690
Pharmacists	209	690	337	723	546	710
Other hospital	475	597	547	643	1,022	621
Administrative	1,506	611	3,696	576	5,202	586
Total	4,263	764	7,626	703	11,889	725

Source MOH, 2008. Note: Exchange Rate = \$US 1.00 = NIS 4.23 (June, 2007).

³⁸ Sources: Civil Service Law (2005), World Bank Public Expenditure Review, 2007

The competitiveness of the MOH salaries relative to the private sector is still an open question. There is credible evidence that overall public sector wages including all benefits (i.e. allowances) are more remunerating than salaries in the private for the majority of public sector workers. This is due to the diminishing productivity of the private sector and the policy response of the PA to scale up the benefits of public sector employment. There is however countervailing anecdotal evidence suggesting that the remuneration levels, particularly for physicians, are not sufficiently high to cover their cost of living. This apparent trend has resulted in many physicians keeping ‘dual practices’ – working for the Ministry in the morning hours and working in their private clinics in the afternoon – contrary to the current regulation in place.³⁹

KEY ISSUES FACING HUMAN RESOURCE MANAGEMENT AND DEVELOPMENT

Several fundamental issues are still confronting the effective management and development of human resources in the West Bank and Gaza. These issues affect the MOH and the sector stakeholders alike and impinge upon their ability to discharge their basic functions.

Movement and access restrictions - The current restrictions in place by the Israeli authorities on the movement of Palestinian health professionals across different geographic regions within the Palestinian territories, particularly to and from East Jerusalem, hampers their ability to adequately perform their jobs. A recent press release by the Humanitarian Donor Coordination Office confirmed that since July, 2008, Israeli security authorities are only granting access to Palestinian health professionals working in East Jerusalem hospitals through two pedestrian checkpoints. Previously all Palestinian health workers with valid permits could enter East Jerusalem at any checkpoint. This reversal in policy has resulted in significant delays in personnel movement and disruptions in the delivery of health services by the hospitals. These movement barriers across and within the West Bank and Gaza have a demoralizing affect on the workforce and their provision of services.

Policy fragmentation - The existing policy fragmentation between the PA and the Hamas government in Gaza, if it continues, will severely restrict the ability of the MOH to holistically and methodically manage and plan its human resources. There are currently two de facto Ministries of Health with competing claims and over-lapping areas of authority. The political divisions which affect MOH services also play out in the broader medical and health communities. Differences between the PA and Hamas have resulted in wide-scale strikes by medical and health-related unions in Gaza affecting health service provision. The most recent strike initiated on August 30, 2008 led to a 34 percent drop in outpatient visits and a 32 percent reduction in surgical operations in Gaza during the month of September, 2008 – compared to the following month of October.⁴⁰ This fractious policy environment impedes progress to rationalize the management of human resources.

Inadequate management and planning - The Ministry of Health will need to adequately invest in the design and establishment of a modern management system for its human resources. The current system is both traditional and fragmented; and does not tie together in an integrated way the different dimensions of human resource development and planning. The current MOH organizational structure organizes ‘personnel’ around the traditional functions of ‘payroll’ and

³⁹ World Bank Public Expenditure Review, 2007.

⁴⁰ ‘Gaza Health Workers Strike’ November, 2008, WHO

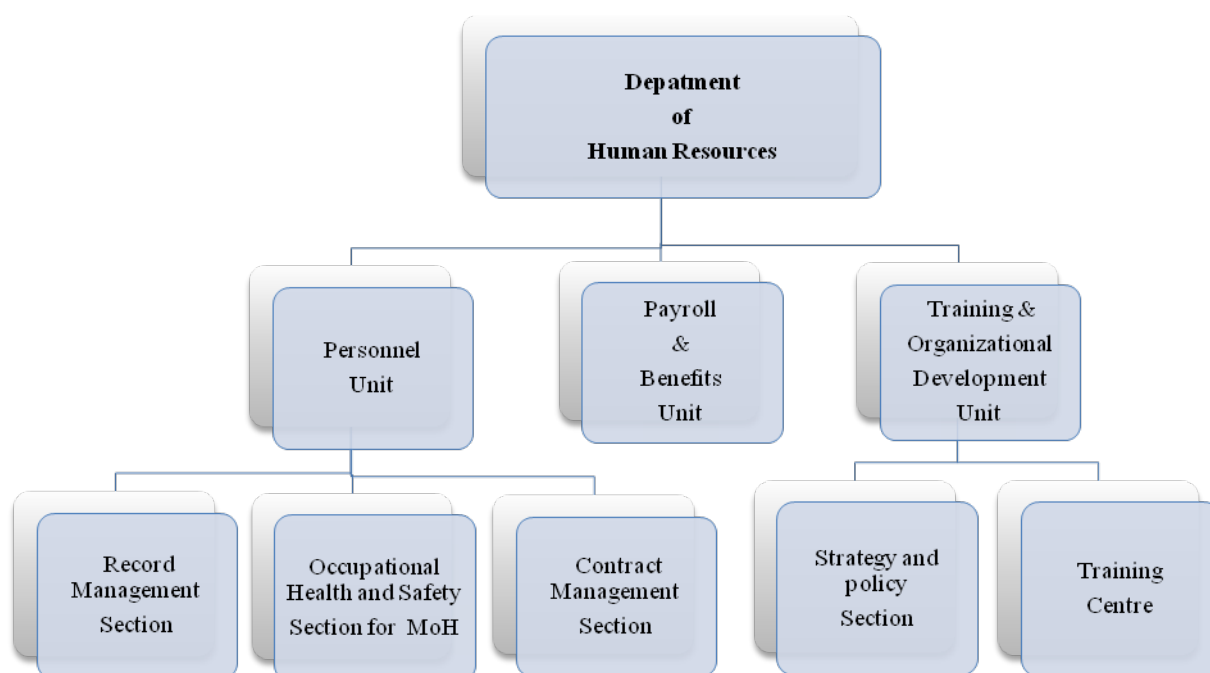
‘recruitment’ with no direct administrative links with the education and human resource planning departments in the MOH. The linkages between recruitment needs, performance evaluations, salaries and benefits, promotions, continuous education and training needs warrant an integrated and unified administrative structure for human resources within the Ministry. One specific reform proposal is outline below in the next section of the chapter.

Job training, career paths and annual performance appraisal - Aside from sufficient remuneration and a generally stable work environment, workers need to be incentivized through greater learning opportunities and the identification of clear career paths for them to follow. Changes in the recent civil service law improved remuneration levels (with the inclusion of various allowances) and the process of merit-based recruitment, but more needs to be done by the MOH to establish: i) clearer terms of reference (job descriptions) for employees, ii) a transparent mechanism for annual performance evaluations, iii) a system of promotions based on the performance evaluations; and iv) and the identification of career streams or ‘paths’ MOH employees can aspire toward. These issues combined with internal (on the job) and external learning opportunities can incentivize MOH staff towards more productive performance.

PROPOSAL FOR NEW MOH HUMAN RESOURCES DEPARTMENT

There are two important reform options related to the organizational structure of the MOH: (i) integrating and consolidating the Personnel Department into a new Human Resource Department and (ii) establishing a new training program to enhance the needed clinical and administrative training of the MOH human resources. Under a new and unified administrative unit, as explained above, human resource development professionals can communicate directly with the personnel officials to better determine the professional training needs of each MOH individual staff member. A proposed structure for the new MOH Human Resource Department is presented below in graphical form with items functions for each administrative sub-unit. Under the new department, there would be three sub-units responsible for ‘personnel’, ‘payroll and benefits’ and ‘training and organizational development’. Each sub-unit would be in charge of different dimensions of the new human resources management and development system. One new possible measure could be the establishment of MOH training centre to organize the needed continuous education programs. This function could also be provided by the local educational institutions under contract with the Ministry of Health. In developing the training program for health professionals, the Ministry of Health should coordinate closely with the Ministry of Higher Education to ensure future accreditation of the training program. Figure 20 below and the outline of the next page provide the general structure and functions of each of the units under the new department.

FIGURE 20: PROPOSED STRUCTURE FOR NEW MOH DEPARTMENT OF HUMAN RESOURCES



OUTLINE OF PRECISE FUNCTIONS OF NEW HUMAN RESOURCE DEPARTMENT

- **Personnel Unit**
 - Recruitment strategies
 - Employment services
 - Employee orientation
 - Labour relations
 - Classification/job evaluation
 - Compensation
 - Safety and prevention programs
 - Emergency measures
 - Return to work
 - Workplace health promotion strategies
 - Human resource information
 - Human resource processing
 - Payroll service
 - Reporting
- **Payroll and Benefits Unit**
 - Payroll administration
 - Pension administration
 - Benefits management
 - Worker's compensation

- Return to work
- **Training and Organisational Development Unit**
 - Development and diversity
 - Learning and development
 - Competency development
 - Performance management
 - HR planning
 - Training and support of information
- **Training centre**
 - Improvement in employees' skills and knowledge for their current job role
 - Increasing employee's generic skills
 - Compliance training
 - Organizational development
 - Talent management programs and succession planning
 - Employee career development

Along with a new organizational structure, there are three additional reform measures that should receive special attention by the Ministry of Health: (i) developing clear career paths for MOH employees; (ii) establishing a performance evaluation system based on transparent criteria and (iii) installing a modern IT system for human resource management and development (see Annex II for more details). These measures, as discussed above, will help enhance the effectiveness and overall accountability of the new human resource management and development system.

PROPOSED REFORM MEASURES, TIMETABLE FOR HR MANAGEMENT REFORMS AND TECHNICAL ASSISTANCE

As part of a new initiative to restructure the human resource management system in the MOH, there are several critical activities that can help underpin the new reform effort. The first activity would be to conduct a comprehensive study of the MOH human resource situation. This study could carry out with the technical and financial assistance of outside donors the following in-depth analyses: (i) a comprehensive situational analysis of all MOH human resources mapped down to each administrative unit; (ii) a motivational survey study examining the key factors affecting staff retention and staff attrition rates; (iii) a MOH remuneration benchmarking study comparing public-private remuneration packages in the West Bank and Gaza; (iv) conducting an assessment of current human resource management practices in the MOH; (v) implementing a workload analysis of different categories of MOH staff; (vi) simulating strategic workforce projections (improving upon the work already achieved for the preparation of the National Strategic Action Plan) and (vii) developing a comprehensive human resource development plan for the Ministry of Health.

The second activity would begin to improve the recruitment process and initiate the hiring of new staff based on the human resource development plan developed as part of the first activity. Under the current civil service law, all new recruits are required to undergo an examination prior to formal recruitment and are allowed significant flexibility in defining the requirements of the examination. This second activity would strengthen the recruitment process by reviewing the quality of existing job descriptions; reconfirming the required staff skills identified in the prepared human resource development plan; strengthen the personnel selection procedures

including the examination process for different categories of personnel; and developing a MOH recruitment handbook.

The third activity would focus on developing a medium-term training plan (2010-2012) for the proposed training centre under the new human resource department. This activity could be coordinated closely with the Palestinian Medical Council and would build on the previous two activities and would be divided into four phases: (i) identifying the core training areas of highest priority for MOH staff covering clinical (medical, nursing, auxiliary health, and non-clinical areas (procurement, financial management); this activity would become the basis for a continuous professional development program for the MOH; (ii) determining the way in which the training will be delivered; whether it will be in-house or through a formal contract with another organization; (iii) reviewing or developing curricula for chosen training areas and appointing the training faculty; and (vi) preparing and publishing the medium-term training plan for the year 2010-2012. The fourth activity which can be initiated from the very beginning is the acquisition and installation of a new IT system for human resource management in the MOH. Specifically the steps would be to identify the exact business and technical requirements of the new system, initiate the procurement process for both the hardware and software components, install and test the functionality of the system and then begin training for all users of the new human resource management information system.

A recommended timetable for these reforms and proposed technical assistance to support the reforms are outline below in Tables 13 and 14.

TABLE 13: PROPOSED TIMETABLE FOR HR MANAGEMENT REFORM TABLE

Name	2009
1. Conduct in-depth HR Analyses	
- conduct comprehensive mapping analysis	July-Aug
- carry out staff motivational survey	July-Aug
- conduct MOH remuneration benchmarking analysis	July-Aug
- analyze current HR management practices	July-Aug
- conduct workload analysis	July-Aug
- simulate strategic workforce projections	Sept-Oct
- preparation of human resource development plan	Sept-Oct
2. Recruitment	
- review of the job descriptions	Nov
- reconfirmation of required staff skills	Nov
- defining personnel selection procedures	Nov
- development of MOH recruitment handbook	Nov-Dec
	2010
3. Training	
- Identify core training areas	Jan
- Determine delivery method (in-house, by contract)	Feb
- Review/develop curricula and appoint training faculty	April/May
- Prepare training plan and calender for 2010-2012	June
4. Adopting new HR Management Information System	
- Specify business and technical requirements	July
- Acquisition of new system	Aug-Sept
- Installation and testing	Oct-Nov
- Training for users	Nov-Dec

TABLE 14: PROPOSED TECHNICAL ASSISTANCE

Task	Activities	Durations	FT/PT
Conduct In-Depth HR Analysis	Conduct comprehensive mapping analysis, implement staff motivational survey, conduct MOH remuneration benchmarking analysis, analyse current HR management practices, conduct workload analysis, simulate workforce projections, preparation of plan	9 months	FT
Recruitment	Review of job description, reconfirmation of required staff skills, defining personnel selection procedures, development of MOH recruitment handbook	4- 5 months	FT
Training	Identifying core training areas, determining delivery method, reviewing/developing curricula and appointing faculty, preparing training plan	4-5 months	FT
HR Information System (HRIS)	Specify business and technical requirements, acquire hardware and software of new system, install and test, and organize training for users	4-5 months	FT

SUMMARY CONCLUSIONS

The political and macroeconomic environment in the West Bank and Gaza during 2000-2006 induced a rapid expansion in public sector employment particularly in the health, education, social development, and security sectors. The severe economic stagnation and growing unemployment in the private sector, particularly during the 2001-2003 period, prompted the PA to expand the scope of public employment. The total number of MOH employees during 2000-2006 increased from 7,500 to 13,057 and the MOH wage bill similarly rose from US\$ 48 million in 2000 to US\$ 83 million in 2005. This rapid increase in MOH employment, particularly among paramedical workers in the first six years after 2000, reversed course during the 2007-2008 due to employment retrenchment policies imposed by the PA. The general pace of public employment had raised serious questions about fiscal sustainability prompting the PA to recommit to new reforms under the Palestinian Reform and Development Plan (PRDP) for the years 2008-2010. Despite the general hiring freeze announced by the PRDP, exception was made for education and health, allowing for the recruitment of additional employees (up to a maximum of 3,000) as deemed appropriate.

As part of a reform agenda, a new Civil Service Law was passed in 2005 to bring greater uniformity and transparency to the recruitment practices of the public sector. This initiative helped rationalize the employment practices of the different PA Ministries including the MOH. Additional reforms by the MOH itself in the areas of human resource management and planning could further rationalize MOH employment policies and its overall wage bill. These reforms cover the following five areas: (i) consolidating disparate human resource management functions under a new MOH department; (ii) conducting a series of in-depth analyses on human resources in the MOH (mapping analysis, staff motivational survey) and preparing a comprehensive human resource development plan; (iii) strengthening existing recruitment procedures and the development of a new MOH recruitment handbook; (iv) preparing a training plan and calendar for the period 2010-2012 and (v) adopting a new human resource management information system for the MOH. These reform measures could be implemented over the course of a year with the necessary technical and financial assistance of the donor community.

CHAPTER VI – PHARMACEUTICAL COST CONTAINMENT OPTIONS

INTRODUCTION

Overall spending on pharmaceuticals in the Palestinian National Authority (PA) has expanded in recent years despite increasingly limited resources in the public and private sectors. This expansion has been fuelled by several factors including a growing number of publicly procured medicines, higher demand from a growing population and high pharmaceutical prices due to existing trade barriers and new expensive drugs entering the Palestinian market. The purpose of this chapter is to explore different pharmaceutical cost containment options to help promote the affordability and access to medicines by Palestinian patients. Based on discussions with Ministry of Health (MOH) officials, special consideration is given to reforming the current pharmaceutical pricing system.

SECTOR BACKGROUND

The Palestinian pharmaceutical sector consists of: (i) a public sector which procures medicines according to an essential drugs list (EDL) first prepared in 2000 based on recommendations by the World Health Organization (WHO). This EDL has been reviewed several times by the MOH and the most recent update was in October 2007. The EDL now includes about 450 different medicines; (ii) a private sector in which medicines are available in privately owned pharmacies; and (iii) a NGO sector which serves a large segment of society including marginalized groups; and UNRWA which serves the refugee population (about 1.6 million persons out of 3.8 million⁴¹ inhabitants in the West Bank and Gaza (WBG)).

Overall availability of these medicines has fluctuated in recent years leading to major shortages in the public sector. A report by the donor community found a selection of such medicines (analgesics, antibiotics, anti-inflammatory) to be out of stock in one third of the examined primary health care centers.⁴² Recent data from the MOH, however, indicate a slight improvement of the situation. In 2008, 19 percent of medicines were found to be out of stock and for 9.5 percent less than one month of stock was left.⁴³ There are about 4,500⁴⁴ different products (with several pack sizes) on the market of which about 30-40 percent are not yet registered in the West Bank and Gaza. The pharmaceutical sector is regulated and administered by the Ministry of Health (MOH) yet the relevant legislation governing public sector regulation of the pharmaceutical sector needs strengthening. Moreover, there are inefficiencies in several key regulatory functions such as drug registration, quality control, inspection, licensing and storage. Consequently, the number of authorized medicines is different in the both parts of the country, leading to mistrust in the quality of available medicines.

⁴¹ Average annual population growth rate is 3 percent

⁴² Abed, Y.: Joint Health Sector Review. A Summary Report. Palestine, 2007

⁴³ Othman, R. Public procurement in Palestine. Presentation during the MOH & WB Pharmaceutical Workshop, Ramallah 22 July 2008

⁴⁴ Palestinian Pharmacists Association: Palestinian Pharmacy Handbook 2008. Jerusalem, 2008

PHARMACEUTICAL PRICES AND FUNDING

Price of medicines - Medicine prices in the private sector are often unaffordable for a large percentage of the population. Some 47 percent of the Palestinians (around 1.7 million persons) live below the official poverty line of 2.1 USD per person, and the unemployment rate is about 20 percent in the West Bank and 40 percent in Gaza.^{45,46} The average GDP per capita lies around USD 1,200⁴⁷ and private out-of-pocket expenditures on health care services account for 5.4 percent of GDP (USD 60/capita)⁴⁸. Excluding the private insurance schemes and small NGOs and charitable societies, the total pharmaceutical expenditure (including household expenditures) is estimated to be around 35-40 USD per capita per year as explained below.

Medicines prices in WBG are relatively high: both the public procurement prices and the prices in the private sector. A comparison with international median price ratios (MPRs) reveals that WBG procured generics for the public sector are on average 6.9 time more expensive than procurement prices achieved in international tenders (Table 17 reveals even greater differences in the private market). In addition, the average MOH procurement prices were found to be more than four times above the UNRWA average procurement prices for the same period.⁴⁹ A comparison with some neighboring countries shows that pharmaceutical prices in WBG are higher. For instance the lowest priced generic product (LPG) in the WBG public sector was on average 4.5 times more expensive than in Syria. The MOH also evaluated several recent procurement packages and found the prices to be partially higher than those in Israel.⁵⁰ These findings were also confirmed by a World Bank survey performed in 2008 (see Table 19 for details).

Funding of medicines - Although some segments of the funding of pharmaceutical are well documented, a great share of the expenses may not be quantified due to:

- the large number of funders (the Palestinian National Authority (PA), the UNRWA, donors like the EU, Saudi Arabia, the Cooperazione Italiana and the WHO, various NGOs, charitable community organizations, out-of-pocket spending of patients and in a few cases private insurance schemes);
- a significant part of the medicines provided having been donated in-kind. The percentage varies over the years very much depends on the donors' agenda and preference as well as the PA financial situation.

Pharmaceutical expenditure is the second largest item in the budget of the MOH, accounting for around 20 percent of total operational health expenditures, approximately 105 million USD in 2005. Between the years 2001 and 2005, MOH pharmaceutical expenditure has increased by 50 percent. Table 15 offers an approximate breakdown of the expenditures documented for pharmaceuticals in the latest available years, equaling an annual spending per capita of USD 35-40. Available data indicate that about 17 percent of the shown expenditure is spent on antibiotics and another 16 percent on chronic diseases like diabetes. Though pharmaceutical

⁴⁵ Four Year-Intifada, Closures and Palestinian Economic Crisis, World bank, Oct 2004

⁴⁶ Dweik, I. 2007, Assessment of the Pharmaceutical Sector in WBG with a Focus on Governance, World Bank

⁴⁷ IMF: Macroeconomic and Fiscal Framework for the West Bank and Gaza – first review of process. London 2008, Palestinian Central Bureau for Statistics

⁴⁸ House hold expenditure survey PCBS, Dec. 2004

⁴⁹ Dweik, I. 2007

⁵⁰ Hamidi, S. Pricing Policy in Palestine. Presentation during the MOH & WB Pharmaceutical Workshop, Ramallah 22 July 2008

expenditure levels in different countries are hard to compare⁵¹, data from the Western Balkan Countries show similar figures (e.g. Albania USD 26.5 per capita/year; Serbia about USD 60.0 per year/capita)⁵² The average per capita spending in the European Union (25 Member States excluding Bulgaria and Romania) amounted (based on euro purchasing power parities) to USD 386.1 per capita in 2005.⁵³

TABLE 15: PHARMACEUTICAL EXPENDITURE BY DIFFERENT PROVIDERS, 2004 AND 2005

<i>Provider/year</i> (figures in USD million)	<i>2004</i>	<i>2005</i>
MOH	17	20.9
UNRWA	6.3	6.5
NGOs (HWC & PMRS)	1.5	1.8
Total	24.8	29.2

HWC =Health Work Committees, MoH = Ministry of Health, PMRS = Union of Palestinian Medical Relief Committees, UNRWA = United Nations Relief and Works Agency for Palestine Refugees
Source: Dweik, I. 2007

As part of the MOH insurance scheme, patients currently have to pay a co-payment for medicines they receive from MOH facilities. The fixed co-payment per pack is NIS 3.0 (USD 0.75) for adults, and NIS 1.0 (USD 0.25) for children < 12 years. Contrary to the increasing trend in pharmaceutical expenditures, revenue data from West Bank facilities indicate an overall drop in revenues. This decline may be attributed to a larger number of payment exemptions. In 2005 revenues amounted to around 2.8 million USD, and in 2006 and 2007 these revenues declined to USD 2.2 million and USD 2.0 million respectively.⁵⁴ Pharmaceuticals offered in the public sector are essentially all purchased via public tenders, procured by the MOH and are largely funded by different donors. Apart from the public sector, medicines may be purchased in privately owned pharmacies with the cost to be fully covered by the patients.

MANUFACTURERS AND DISTRIBUTORS

Local industry - Six local pharmaceutical manufacturers (including one in Gaza) are currently serving about 40-50 percent of national demand for pharmaceuticals by volume, covering around 160 of the 450 EDL products. They supply both the private retail market and the public sectors represented by the MOH and also sell some of their products to the NGOs. The annual revenues are estimated to be 38 million USD (at ex-manufacturer prices) but the available data could be underestimated due to the common fact of in-kind rebates given to retailers. The approximate size of the Palestine pharmaceutical market is 105 million USD, with a dominance of the private market.⁵⁵

The overall quality of the medicines is rated as good⁵⁶; some companies have even received a provisional Good Manufacturing Practice certificate by the PA to support their export activities.

⁵¹ Variations could also result from other causes e. g. demography, overall health care status of the population, the structure of the health care system and the country public health priorities.

⁵² Imasheva/Seiter 2006 (Worldbank Nutrition Series)

⁵³ PPRI Report 2008 in: <http://ppri.oebig.at>

⁵⁴ Dweik, I. 2007

⁵⁵ Palestine Pharmacists Association 2008

⁵⁶ Quality assessment and reporting is not based on reliable post market surveillance.

Apart from essential drugs a good part of the production goes into copy products of on-patent branded pharmaceuticals like Plavix (substance: Clopidogrel).

High prices accepted from local manufacturers - As the PA recognizes the strategic relevance of the local manufacturers in the event of a permanent closure of the borders, bidding prices offered by local companies are usually 15 percent higher than those of outside competitors. These higher prices are normally accepted by the Ministry of Health. This is called preference pricing. By doing so a minimum supply of medicines is guaranteed in case of emergencies or war-like situations. Moreover, reliable evidence suggests that export prices of nationally manufactured medicines to foreign countries is up to 50 percent below the local sales price in the private market. In the case of a well functioning procurement system, however, and an elimination of trade barriers, potential competition should become more feasible and preference pricing will not be necessary.

Foreign suppliers and agents - Imported medicines include a wide range of generics that are provided by Israeli companies including from the largest manufacturer of generics in the world, the company TEVA. The imported drugs, especially the newly patented pharmaceuticals manufactured by international companies (e.g. Novartis) are provided through Palestinian suppliers and agents. Israeli companies cover about 15-20 percent of the public market as current procurement data provided by the MOH reveal. About eleven percent of all medicines are patented, branded medicines that are provided through several agents and sub-agents.

The prices of imported medicines are similar to those in Israel and often higher than in Arab countries with a similar GDP/head like Syria or Egypt. The reasons for this difference are the 'price-bands' defined by the headquarters of global pharmaceutical companies for the different regions of the world (so-called 'zoning' policies). In this respect WBG is usually considered to be – like Israel – in the Euro-zone, with prices adjusted to the average economic situation in Europe rather than to countries in MENA. There is also a number of copy-products ('me-toos') of patent-protected medicines on the market that are also accepted for bids in the public sector (e.g. in the latest MOH tender, a copy version of Atorvastatin 20 mg tablets was awarded a contract).

Retailers and Pharmacies - There is a very large but not particularly flourishing private sector including 83 drug wholesalers and importers and nearly 1,000 private pharmacies. In addition, medicines may be obtained in the 604 MOH health care facilities equipped with a medicines dispensary. Apart from the NGO and UNRWA service providers, in total, there is one pharmaceutical dispensary (pharmacies, health care facility, etc.) per 2,400 inhabitants, which is a very high ratio by international standards.

KEY ISSUES AND CHALLENGES

Current pricing policies in the public sector - Aside from medicines donated in-kind by donors, all medicines available in the public sector are bought via tenders. The officials responsible for all aspects of public procurement are those employed in the Procurement Directorate of the MOH based in the West Bank. Drugs procurement guidelines follow PA general laws and regulations for general goods and services and do not take into account the specialized nature of pharmaceuticals (e.g. regarding their patent situation) into consideration. Inclusion in tenders is of no economic value and leads to the procurement of drugs from the same supplier at inflated prices.

In general, pharmaceuticals are procured through two large MOH semi-annual tenders supplemented by purchases from the local manufacturers amounting to about 15 percent of the pharmaceutical budget. There is no clear policy, however, on the quantification methodology, i. e. how to determine the demand. Currently, the annual drug requirements are based on an objective quantification method, using historical data based on previous consumption trends and adjusted upward for population growth and increased number of facilities. These amounts are then readjusted based on the available budget. Drug requirements are estimated separately for the West Bank and Gaza, and then communicated from Ramallah to Gaza for consolidation, but with deliveries split between the West Bank and Gaza central medical stores.

The MOH also faces several impediments generating inefficiencies in the procurement of drugs. Since the number of international bidders for MOH tenders is usually low, the number of bidders per item ranges from one to at best six bidders. Around 50 medicines (10 percent) of the EDL usually end up with a single bidder and another 83 medicines with three bidders or less (Table 16). The MOH has no other choice than to buy from either Israeli companies, local manufacturers or the local providers at higher prices than those that could be achieved via more competitive tendering. Consequently the Palestinian market is fairly restricted to items that are produced locally and items registered in Israel.

TABLE 16: PUBLIC PROCUREMENT STATISTICS – PARTICIPATION IN RECENT TENDERS, 2008

<i>No. of offers</i>	<i>No. of items</i>	<i>% of Total</i>
0	47	10%
1	174	36%
2	143	30%
3	83	17%
4	25	5%
5	4	1%
6	3	1%
Total	479	100%

Source: MOH Procurement Unit, July 2008

The MOH is aware of the fact that prior registration of medicines as pre-qualification for bidding is a source of discouragement for international bidders. MOH representatives, however, support the idea to apply special procedures in the public procurement of medicines. The registration of medicines in WBG, for example, could become a condition upon contract award with registration occurring using a newly designed fast-track system.

Current pricing policies in the private sector - In the private market products are basically not procured but are purchased by the pharmacists directly from agents or local manufacturers. Pharmacy retail prices are quite high considering that GDP per capita averages around USD 1,200 and more than 45 percent of the population living on less than USD 2.1 per day. The reason for these high prices is that the list prices at the level of the manufacturers, importers or agents level are not regulated but are usually suggested by the manufacturers, agents or importers without consultation of the relevant authorities. Agents usually have exclusivity contracts⁵⁷ for the branded medicines they import guaranteeing them a monopoly position with reported profits of 100 percent and more since the maximum allowed add-ons are not regulated. They are

⁵⁷ Exclusivity contracts are a part of the market authorisation/registration process, to guarantee the availability of the medicine.

granted such contracts by both the Ministry of National Economy (MONE) and the MOH. The retail mark-ups on private sales are currently regulated by the MOH in agreement with the Palestine Pharmacists Association in a regressive form. The average mark-up is 25 percent for locally produced medicines and 15-20 percent for imported medicines. The VAT is 14.5 percent. The aforementioned pharmacy mark-ups are currently being evaluated and discussed by the MOH, but are likely to be only adjusted marginally. In addition to these mark-ups the pharmacists derive further incomes from bonuses they eventually receive (e.g. rebates in kind).

In principle, prices are fixed across the country and should not differ from one pharmacy to another. Each medicine is labeled with a sticker that displays: i) the retail price of the pack; ii) the wholesaler/agent or warehouse and iii) the pharmacy. The stickers are provided by the Palestinian Pharmacist Union and affixed on each medicine pack by the respective wholesaler/agent or warehouse. Any package identified by the inspection authorities without the label is subject to confiscation and the responsible pharmacist would face certain fines and penalties. Anecdotally, however, there is some evidence indicating that the labeled price on the pack is considered to be an indicator; the selling price could be different depending, for example, on the availability of the medicine on the market. Currently the PA has no access to data or statistics regarding the sales volume and prices of medicines in the private market. Examples, however, from other countries (e.g. Germany, Sweden or Austria) show that the respective Pharmacists Associations provide the authorities with such information due to mutual agreements.

Existing Trade Agreements - In stakeholder interviews, both industry representatives and officials contend that the 'Paris Protocol' Trade Agreement of 1993 between Israel and the PLO. (see Annex III on 'Protocol on Economic Relations') is one of the main barriers to trade and competition. According to these sources, Israeli authorities rely on certain stipulations ('standard requirements') in the Paris Protocol⁵⁸ to require that all pharmaceutical goods (and raw materials needed for production) entering the Palestinian Territories need to comply with Israeli process standards. This requirement means that all medicines not produced in Israel and not being donated in-kind by international organizations such as the UN are required to pre-register in Israel. The stated rationale of the Israeli authorities is that the medicines need to comply with Israeli public health standards and to avoid a potential backwash of medicines from Palestinian Territories into Israel.

These expensive and time-consuming pre-registration requirements are a major barrier to competitive trade and discourage interest in the Palestinian pharmaceutical market. Paragraph 10 of Article III of the Paris Protocol document states that any required standards 'may not constitute a non-tariff barrier'. One of the main reasons cited by Israel for the pre-registration requirement, again, is the public health concern about the backflow of low quality drugs into Israel. This issue could possibly be dealt with through a pre-qualification process allowing all medicines already certified by recognized international agencies to be brought into the West Bank and Gaza without having to be registered in Israel. Re-labeling into Arabic or re-branding these medicines could help mitigate against the flow back of these medications into the Israeli markets. A lifting of the current registration constraints could encourage many global manufacturers and traders to enter the Palestinian market. Combined with other pricing policies

⁵⁸ Art. III Para 10 states that for goods included in list B of the Annex to the Protocol – including pharmaceuticals, changes to stipulations of this paragraph can be imposed by Israel if this is due to '*... considerations of health, safety and the protection of the environment in conformity with Article 2.2 of the Agreement on Technical Barriers to Trade of the Final Act of the Uruguay Round of Trade Negotiations.*'

and an improvement in the Palestinian drug registration capacity, this change, if achieved, could lead to price reductions particularly for on-patent medicines.

This topic has been raised previously by Palestinian Authorities during the discussions of the Joint Economic Committee. Given its important effect on overall price levels of drugs in the West Bank and Gaza, it is highly advisable to place it once again on the negotiation agenda of the Joint Economic Committee.

Need for Cost Containment - In view of the growing demand for pharmaceuticals, the existing high prices of drugs and the general scarcity of resources, there is a clear need to adopt new cost containment measures. A comparison of pharmaceutical prices of publicly procured medicines and the lowest priced generics in the private sector in Palestine with international reference prices (see Table 17) reveal that, on average, publicly procured medicines are 6.9 times above the global market price and that the lowest priced generics in the private market are 9.7 times more expensive.

TABLE 17: NO. OF TIME MORE EXPENSIVE: PUBLIC PROCUREMENT PRICES* AND THE LOWEST PRICED GENERICS IN THE PRIVATE SECTOR COMPARED TO INTERNATIONAL REFERENCE PRICES**

Medicine name	EDL Core List	Public (MOH Procurement prices)	Private (Lowest priced generic equivalent in retail)
Amoxicillin cap, 250 mg	Yes	1.49	11.56
Ranitidine tab, 150 mg	Yes	3.70	8.33
Glibenclamide tab, 5 mg	Yes	7.69	23.08
Ciprofloxacin tab/cap, 500 mg	Yes	17.29	21.0
Metformin tab, 850 mg	Yes	4.62	5.20
Average		6.9	9.7

Source: <http://erc.msh.org>, World Bank survey 2007, * ESSP II (2002-2004) procurement price, ** Median price ratios according to the Management Sciences for Health (MSH) reference prices⁵⁹

In addition, MOH average procurement prices were found to be more than four times above the UNRWA average procurement prices for the same period as the Table 18 below illustrates. In view of these prices levels, adopting a competitive public procurement method (taking UNRWA as an example) will lead to a possible four-fold price reduction for off-patent medicines (generics) in the West Bank and Gaza Strip.

Generics priced comparably higher in WBG - Another problem is that the average price level of generic medicines or copy products with regard to their original brands is reported to be low. A small sample analyzed by the World Bank also revealed that some generics are even more expensive than the branded product. For instance the average price reduction achieved with generics in Europe is about 40 to 80 percent. Austria demands the first generic follower entering the market be 48 percent less expensive than the original product and each consecutive product to be 10 percent below this price.⁶⁰

⁵⁹ Management Sciences for health (MSH) reference prices are the medians of recent procurement supply prices offered by suppliers to developing countries for multi-source products.

⁶⁰ Hahl, C. ; Leopold, C. : Pharma Profile Austria, <http://ppri.oebig.at>, 2008

TABLE 18: COMPARISON BETWEEN THE MOH AND UNRWA PROCUREMENT PRICES OF SELECTED SUBSTANCES, 2002-2005 (IN USD)

Substance (name, dosage, presentation)	Unit	Unit price in USD	
		MOH	UNRWA
Allopurinol 100 mg Tablet	1000	14.67	12.10
Amidorone HCL 200mg Tablet	1000	78.00	18.90
Ethambutol 400 mg Tablet	1000	425.43	63.00
Mthyldopa 250 mg Tablet	1000	39.70	31.00
Thyroxin 100 Mcg Tablet	1000	59.15	1.60
Digoxin 0.25 Tablet	100	1.40	0.47
Nystatin Oral Suspension	BT	1.09	0.61
Aminophylline injection 25mg/1cc 10 ml injection	AM	0.25	0.18
Hydrocortison Sodium Succinate Injection (~ 100 mg of hydrocortisone)	AM	0.94	0.49
Water for injection in 10 ml ampoule	AM	0.1229	0.03
Average Price Difference	~ 4.8 (3 times excl. Ethambutol)		

AM = Ampoule, BT = Bottle, MOH = Ministry of Health, UNRWA = United Nations Relief and Works Agency for Palestine Refugees: Source: MOH tenders under the Emergency services support project (ESSP II), funded by the World Bank-TF, 2002-2005. UNRWA Procurement prices obtained from head quarter in Jordan.

OPTIONS AND LIMITATIONS OF CURRENT REFORMS

Compared to other economic sectors, the pharmaceutical sector consisting of a strong local industry and an extensive retail market is performing relatively well in the West Bank and Gaza Strip. The business environment, however, is characterized by political and economic uncertainties due to changing restrictions on access and movement by the Israeli authorities. These circumstances lead to a unique situation in which the Palestinian Authority has no control over its borders.

The MOH has recently initiated several important reforms: (i) an organizational reform of the MOH (establishment of a new procurement unit reporting directly to the Minister directly and a pharmaceutical policy unit reporting to the General Director of Pharmacy), (ii) the separation of the registration and inspection procedures; and (iii) the drafting of a new pharmaceutical pricing ordinance. These improvements notwithstanding, there is still room for further improvement.

Obstacles in procurement - As explained in the section above, the number of international bidders is usually very low and local manufacturers are allowed a higher 'preferred' price in procurement of medicines. Furthermore the average price level in WBG is above the price level in the region (see Table 18, for an example, of the price deviations). The reason for the low number of international bidders is due to a number of factors including: (i) the pre-registration requirement imposed by the Israeli authorities; (ii) the small size of the Palestine market; and (iii) and the risky business environment (medicines are sometimes delayed up to on month due to customs clearance with shipping cost being charged daily).

The existing procurement guidelines and legal framework for public procurement are both incomplete and insufficiently robust to provide a clear, rules-based environment for conducting

pharmaceutical public procurement.⁶¹ Under a new procurement law, customization of the standard bidding documents to address any particular technical or legal requirement related to the purchase of pharmaceuticals would have to be done through the ‘bid data sheet’, the ‘special conditions of contract’, and the ‘technical specifications’.

The MOH also includes all EDL medicines into one tender which does not provide it room for direct negotiations with certain pharmaceutical suppliers of expensive drugs. Another source of inefficiency is in the non-application of contractual sanctions and penalties against those who do not meet contractual terms. A further competition barrier is a reported ‘gentlemen’s agreement’ between local manufacturers.⁶² There is an apparent agreement to stay within a +/- 5 percent price band during the pricing of their products which results in higher pharmaceutical expenditures for the Palestinian Authority than necessary.

Reducing existing market barriers related to the Paris Protocol – As discussed above, the 1993 Paris Protocol (see Annex IIII) and especially its interpretation by the Israeli government has to be viewed as one of the most important market entry barriers for foreign manufacturers as well as for local importers. The current interpretation of the Protocol seems to deviate from the stipulations of the trade agreement. It is advisable that this issue be raised in the up-coming meetings of the Palestinian-Israeli Joint Economic Committee (JEC). According to Article II of the Agreement the purpose of the JEC is to solve problems related to the Paris Protocol.

It is also advisable that the Ministry of National Economy (MONE) recruits a legal expert specializing in trade and tariff agreements to thoroughly analyze the agreement, its references, amendments and annexes. This legal expert could provide a reasoned opinion regarding the interpretation of the Trade Agreement by the Israeli authorities. Through such a legal analysis, it can also be clarified if the requested pre-registration requirement may be replaced by a centralized European or US market authorization issued by EMEA (European Medicines Evaluation Agency) or the United States FDA (Foods & Drug Authority).

Single-channel supply system for imported medicines - Due to two factors – the Paris Protocol and the granting of exclusivity distribution contracts during marketing authorization – the importation of medicines is fairly protected, thus hindering parallel imports, i.e. imports of the same originator brands from different sources. In fact, importation is restricted to one source of origin from international companies, too. Hence, all on-patent medicines may be only supplied by one single agent, and the prices offered at time of drug registration are endorsed by the government regardless of the affordability and access for patients. The arguments used to justify these exclusivity contracts is the relatively high business risk the importers have to carry as delays in the payments of purchasers are reported to be quite common.

A price comparison of selected on-patent medicines in Israel and WBG reveals huge differences that may indicate disproportionate profit mark-ups (see Table 19 below).

⁶¹ West Bank and Gaza Country Procurement Issues Paper, June 2008

⁶² Information shared with the World Bank team during a meeting with an official from the Pharmaceutical Manufacturer’s Association, July, 2008.

TABLE 19: PRICE COMPARISON OF A NUMBER OF BRANDED MEDICINES BETWEEN ISRAEL AND THE WBG

	<i>In NIS including tax</i>	
Amaryl 2mg, 30 tablet	49	69
Amaryl 1mg, 30 tablet	29	43
Telfast 180 mg, 28 tablet	49	57
Tegretol CR, 200 mg, 50 tablet	39	64
Tegretol 200 mg, 50 tablet	30	64

Source: World Bank Survey, July 2008

Therefore it might be favorable for the PA to address the suppliers of these medicines directly, negotiate a CIF price⁶³ and purchase directly allowing the agents a fee for their logistical support.

Ongoing changes in the pharmaceutical pricing policy - Over the previous four months, the Ministry of Health was in the process of re-structuring the Palestine pharmaceutical pricing. In the following section the current set-up of the Drug Technical Committee is discussed and the draft version of a prepared ordinance on pharmaceutical pricing by the MOH will be outlined and also examined.

Drug Technical Committee and Drug Pricing Committees - The central decision-making body regarding pharmaceuticals is currently the MOH 'Drug Technical Committee' which consists of three sub-committees (pricing, registration and media). Since its establishment in 1998, its role and composition has changed several times. During the last three years its relevance has increased. In principle, the Pricing Committee is in charge of questions related to pharmaceutical pricing in the private and the public market, such as the regulation of the pharmacy remuneration scheme or the importation of medicines. Currently one of its main tasks is the development of a new pharmaceutical pricing scheme.

The composition of the Pricing Committee in March 2008 was a cause for concern given a potential for conflict of interest. The Committee consisted of:

- 1 Representative of the MoH Pharmaceutical Department (Chair)
- 1 Representative of the Palestine Pharmacist Association
- 1 Representative of the Ministry of National Economy (MONE)
- 1 Representative of the Palestine Importers Union
- 1 Representative of the Palestine Manufacturers Union

The decisions of the Pricing Committee are taken by majority vote. Under the previous scheme, the Minister of Health had no veto right, the Ministry of Finance was not represented and the different donors have no effective voice. The membership of the Ministry of National Economy (MONE) is also not entirely clear as its representative would have to represent the interests of both the pharmaceutical industry and the interests of Palestinian consumers and patients.⁶⁴ As the Technical Committee sets policies related to pharmaceutical pricing, it quite unusual to allow industry and professional bodies a majority vote in such a committee. It is recommended the MOH re-evaluate the set-up and the composition of the Technical Committee and to further define its role and decision making process.

⁶³ CIF= Cost, Insurance, Freight

⁶⁴ The Ministry of National Economy used to represent the following, potentially conflicting positions: Consumer protection, trade and export interests of local producers and commercial as well as economical issues.

Following discussions with the MOH, the composition of the Pricing Committee was changed by the addition of two further MOH representatives (from the Pharmaceutical Policy Department and the Registration Department) and a legal expert. The MOH also took over the representation of consumer interests from MONE. Furthermore it was clarified that the final decision on the planned pharmaceutical pricing ordinance will be taken by the Technical Committee (chaired by the Minister of Health) and consequently by the Council of Ministers.

Pharmaceutical Pricing Ordinance - The currently draft of the pharmaceutical pricing ordinance⁶⁵ lays out four different methods for pricing of innovator drugs and one method for generic drugs:

Innovators:

- Cost-plus method based on CIF & FOB prices for imported medicines (calculating the retail price of the product according to a cost sheet taking taxes and retail add-ons into consideration).
- External price referencing system, i. e. setting a price basing on the median price of the product in five countries (UK, Italy, Belgium, Jordan, and Saudi Arabia).
- Setting the retail price based on its retail price in the country of origin (e.g. using the Jordan retail price for medicines produced in Jordan)-
- Imposing a ceiling price for medicines, meaning that the WBG maximum retail price may not be higher than in Israel.

Generics (irrespective if they are registered in WBG or not):

- The requested price for the first generic or copy drug should not exceed 70 percent of the price of the originator drug when first registered and priced; or upon re-pricing it; or 70 percent of its current price whichever is less. The price of each successive drug is reduced by 10 percent. In addition the mark-up scheme for retailers shall be adjusted (see Table 20).

TABLE 20: DRAFTED PHARMACY MARK-UP SCHEME IN WBG USED FOR LOCALLY PRODUCED AND IMPORTED MEDICINES, 2008

Pharmacy purchasing price	Retail mark-up
NIS 5 – 50	35%
NIS 51 – 200	25%
NIS 201 – 400	20%
> NIS 401	10%

Source: Pharmaceutical Pricing Ordinance (draft as of July 2008)

There is considerable doubt whether the current draft will enable the MOH to reach its objective – the reduction of pharmaceutical prices in the West Bank and Gaza – since some of the articles could serve commercial objectives rather than public health objectives. For example the suggested cost-plus method as well the international price comparison heavily depends on the information provided by the suppliers (as they are meant to be the main source of pricing and sales data). Furthermore control possibilities by the competent authorities are limited because the market entrance (import) of pharmaceuticals is not subject to direct control of the PA

⁶⁵ Hamidi, S: Pricing Policy in Palestine. Presentation during the MoH & WB Pharmaceutical Workshop, Ramallah 22 July 2008.

authorities, thus making a cross-check of the provided (price) data very complex and time consuming. Consequently there is a substantial risk for biased information that could lead to even higher prices.

In addition, the proposed country basket for international price comparisons still largely consists of countries with a much higher GDP per capita and purchasing power than Palestine.⁶⁶ There are concerns that even if the lowest price derived from the four above mentioned pricing methods is taken the price level in WBG could still go up instead of down.

Beyond the 30 percent price reduction of a generic and the setting of a reference price for imported medicines based on the median price in the reference countries, the draft does not foresee any direct cost-containment measures. Examples for such additional measures could be an overall price cut, mandatory price reductions for original brands when their patent expires or the encouragement of price competition by e.g. stimulating multi-source ('parallel') import as described in point earlier. Furthermore, generic medicines already on the market are not considered for the 30 percent and successive 10 percent price reduction rule, which shall only be applied on any new generic or copy product coming into the market. This decision is seemingly influenced by the fact that most local industry products are 2nd or 3rd generic followers; hence their current price level would be affected if the price reduction rule would be applied for them, too. Observers fear that the current draft could, contrary to expectations, lead to higher prices for generics already available in the market. It could also wipe out price variations among suppliers. As already explained, in real competitive markets, generics are on average priced between 40-60 percent of the price of the original product. The draft also determines fixed mark-ups and regressive profit margins of for distributors and retailers like pharmacies. The current version features cumulative margins ranging from 80-96 percent depending on the price of the product.

Increase in revenues - Despite the limited options to increase revenues allocated for health care, one possible revenue enhancement approach could be to increase the rather low co-payment rates of NIS 3.0 (USD 0.75) respectively NIS 1.0 (USD 0.25) for children. A pre-condition for such an increase would be that the poorest and most vulnerable parts of the population (e.g. refugees without income possibilities) remain exempt and not be affected negatively by the pricing decision.

RECOMMENDED STRATEGIES FOR PHARMACEUTICAL COST CONTAINMENT

A) Redrafting a National Pharmaceutical Policy and Promoting Rational Drug Use

An important requirement for a comprehensive pricing and reimbursement policy is that all segments of the market are appropriately addressed, i.e. imported and local, registered and non-registered, single-source or multi-source, established or new products, procured medicines and those purchased in the private market. A national pharmaceutical policy should be developed which clearly defines the overall national objectives and outline the methods intended to achieve the defined goals.

B) Promoting Rational Drug Use

⁶⁶ The first version of the draft foresaw even more European countries like Germany to be included. The country basket was adjusted to its current form after comments of World Bank experts during the first mission.

Another cost-containment measure – directed at volume control more than price control – is the monitoring of prescribing behaviors of doctors and the introduction of prescribing guidelines. Such guidelines could for instance introduce limits on the duration of the prescribed drug treatment or also could encourage the use of generic medicines (to be accompanied by building trust in the quality of generic medicines through a search and elimination of counterfeits). Information on prescribing and dispensing practices needs to be consolidated into a database that allows for analysis and further policy decision making. Information can be retrieved and enable better accountability and system performance. Information on the number of physician visits and associated drug prescriptions by patient and facility could be very useful for monitoring. Decisions about doctors prescribing to family members should also be addressed in a way that avoids any possible conflict of interest and does not lead to an abuse of the system. In the long term, this issue could be addressed by the development of a magnetic, electronic card that identifies patients and their drug utilization history. Alternatives to the current flat-rate co-payment system, also, should be envisioned to discourage patients from using too many expensive medicines. Possible options for doing so include the introduction of a percentage based prescription charge representing a share of the total cost of the prescription or a combination of flat rates ones and certain percentage charges.

C) Reducing the Overall Price Level of Pharmaceuticals

Redrafting the pricing policy ordinance - One of the first priority measures should be the redrafting the Pricing Policy Ordinance which requires special attention to certain considerations (existing GDP per capita levels, market restrictions, monopoly providers). The draft should also contain a vision of the future pharmaceutical sector under an independent Palestinian state. Though the principles underlying the draft are suitable and similar to those in Jordan, Saudi Arabia and Egypt, the included measures ought to be developed further. Due to the comprehensive nature of the undertaking it might be useful to further analyze the implications of the proposed, partly overlapping, pricing methodologies. It is especially recommended to estimate its impact on the price level in the West Bank and the Gaza Strip.

A technical pricing expert could pilot some price comparisons (e.g. comparing the prices of the ten most prescribed and of the ten most expensive medicines with all four chosen methods including the international price comparison) and outline the estimated change in the price in a report to the Technical Committee. The lessons learned then will allow for a selection of the methodology that is most appropriate for a public health and governmental perspective.

In the long term a national medicine survey that tackles the availability by source of origin, agents and suppliers in the private and the public market could be conducted, perhaps by using the WHO Medicines survey tool (see www.haiweb.org). The survey information should include the lowest and the highest retail price as well as the average tender price of a medicine.

Improved price data collection - There is an observed deficiency in the monitoring, follow-up and analysis of information about prices of public tenders and in the private market. As sound data are a pre-requisite for the planning of pharmaceutical budgets and for market surveillance, it is suggested that efforts be devoted to improve data availability.

Though the MOH has made the first step to oblige the manufacturers and importers to notify the MOH about their prices, failures were reported. In the long term, a clearly determined approval procedure for price increases (e.g. by the Technical Committee) including an appeal

possibility for companies should be established. The process should include an operational manual that foresees, for example, the provision of information regarding the justification for price increases. Additionally it is suggested to enhance the role of the local Pharmacists Association in acquiring and analyzing the data from the private market through the pharmacists. In many countries (e.g. Germany, Sweden or Austria) the respective Pharmacists Associations provide the MOH with data on sales volumes and prices, suppliers of medicines.

Price negotiations - The MOH could be encouraged to not only operate based on the tendered price but to take it a step further and pursue strategic price negotiations. It is also suggested to define that the procured price may not exceed the registered, approved maximum price. For generics the MOH could opt to only pay the price of the available least expensive, quality-assured bioequivalent product in the market (same active ingredient(s), same presentation, dosage, strength), whereby patients would have to pay the price difference for the other, more expensive product out of pocket. In such a case, it must be guaranteed that this product is also in stock. As an encouragement for patients to accept the lowest priced generic the co-payment fee could be waived for these medicines.

Capping the profit shares of agents - The level of statutory price control at the importer and wholesaler level is rather limited compared to other countries and the basis for the claimed add-ons and profit mark-ups remains unclear. To get an overview of the actual profit margins of the agents and importers (which are claimed to be excessive by some stakeholders), they could be asked to provide evidence of payments such as reliable invoices and financial statements that indicate the purchase or import price. On the other hand the MOH could seek a copy of the original purchase invoices against which they made VAT tax claims from Israeli Authorities and compare it to the obtained financial information from importers and other sources such as customs. If the profit margin is found to be relatively excessive, the maximum allowed add-on could be regulated through a Ministerial Decree.

D) Further Encouragement of Competition

Exploring options for multi-source purchasing by the PA - The MOH and the MOF could stimulate competition for multi-source products by addressing potential foreign bidders directly and guaranteeing them a timely payment in the case of a contract award. In addition, the current practice of granting importers and distributors exclusivity contracts is not serving the overall public health goals of access, availability and affordability. Procurement for pharmaceuticals is a very specialized area. It differs from other standard goods because there is only one source available for medicines with valid patent protection. The MOH is encouraged to revise the national procurement guidelines and rather negotiate the prices of such medicines directly with the companies (not with their agents).

Promoting ‘parallel imports’ - The price of a medicine supplied by a multinational manufacturer may vary considerably from one country to another. The price charged in Palestine is the one fixed by the manufacturer in accordance with his appointed agent. In practice, the agents offer extremely high prices with minimal, if any, involvement from the government. Such practices could be prevented by a ‘parallel import’ system⁶⁷ operated by the government allowing the import of branded originals or already authorized generics at a lower price than the one charged by the official agent or other agents. For that purpose exclusivity right protection that

⁶⁷ Parallel import decision-making must be complemented with efficient quality safeguards and registration system that protects against counterfeit products.

benefits the importers interest without any consideration for the public health benefit should be restricted in future.⁶⁸

After having discussed with the foreign pharmaceutical companies their interest to market their medicines in the WBG, they could be directly invited to deliver medicines to the MOH and the public warehouses in WBG. Another longer-term option for the MOH is to purchase directly from UNRWA's international suppliers of generics to make use of economies of scale. As a temporary measure, goods meant for entry into the country may be purchased from international UN agencies that are exempt from complying with the broader Israeli registration requirements.

Fast-track registration - The MOH is aware that the pre-registration of medicines, as pre-qualification for bidding, is a source of discouragement for international bidders. The MOH representatives could support the idea of applying special procedures in the public procurement process. For example, the registration of medicines in the West Bank and Gaza could become a condition for contract award with registration taking place on a fast track system.

E) Minimize Trade Barriers

Reducing impact of existing trade barriers - Another import activity is a detailed legal review of the existing 'Paris Protocol' and its annexes. This trade agreement has been identified as a prime market barrier in the pharmaceutical sector. It is recommended that this trade issue be elevated to the highest policy levels and placed on the agenda of the next meeting of the Joint Economic Committee between the Palestinians and the Israelis. The focus of the discussion should be on ways to re-interpret the Paris Protocol in order to facilitate the easier entry of medicines into the Palestinian Territories. Another concern based on accounts from the pharmaceutical industry is that imports are arbitrarily rejected by the Israeli authorities (e.g. Ibuprofen gel caps) because they could also be purchased from Israeli companies. The pharmaceutical industry representatives could provide the MOH with information about these practices in preparation for the next meeting of the JEC.

F) Modifying Role and Composition of the Technical and Pricing Committees

Clarifying the role and composition of the Technical and Pricing Committees - The overall recommendations regarding the objectives and the composition of the Technical and the Pricing Committees have already been partially addressed by the MOH. For instance the number of the pricing committee members was enlarged to avoid conflict of interest (in the previous set-up three out of five members were either industry or retail representatives). There is consensus that in the future, the role of professional bodies, currently represented by the Pharmaceutical Association, the Pharmaceutical Industry Union and the Union of Importers, in the Technical Committee and its subcommittees should be limited to a consulting rather a decision making role (providers shall have a voice but not a vote in both Committees). It is also suggested that the decision making process within the Committees be better defined. The Pricing Committee has already started a discussion on process standards relating to their decision making process. What is still a concern is that no payer representative (Ministry of Finance or donors) is represented in the Pricing Committee.

⁶⁸ Removal of exclusivity contracts could be used as a policy measure to induce importers to negotiate.

SUMMARY CONCLUSIONS AND NEXT STEPS

The pharmaceutical sector in the West Bank and Gaza is split into a public market dominated by local manufacturers and Israeli companies with limited possibility for price controls by the PA; and a private market with free pricing on all levels. In the public sector about 450 medicines from the WHO Essential Drug List are provided in governmental owned facilities such as primary health care centers. A great number of patients, especially from the refugee population are also served by the UNRWA (United Nations Relief and Works Agency for Palestine Refugees) and other Non-Governmental Organizations and Charitable Communities. UNRWA focuses on primary health care and offers a selected number of medicines. Overall availability of these medicines fluctuated largely during the previous years, often leading to major shortages, in the public sector.

Currently the MOH, as the institution responsible for regulating the pharmaceutical sector, is procuring medicines in regular intervals but has to contend with a limited number of bidders (46 percent of all items in a recent MOH tender yielded none or one only one bidder). The lack of international bidders, combined with a so called 'preferred pricing' strategy for local manufacturers that grants them 15 percent higher prices than those of their international competitors leads to pharmaceutical prices above international reference prices or UN prices as well as above the prices in Israel (refer to Tables 16, 17 and 18). A major reason – besides the risky business environment - for the lack of international bidding is the cost associated with the requirements of the pre-registration process imposed by Israel.

The provision of imported branded medicines is subject to a monopoly situation, as agents are usually granted exclusivity contracts already at point of marketing authorization, thus limiting the purchasing options of the PA. It is also observed that the local manufacturers and importers have a relatively strong market position given the adopted preferred pricing strategy by the PA and the existing 'gentleman's agreement' for pricing. This position is also supported by the fact that the local manufacturers and importers had considerable influence in the pharmaceutical Technical Committee. This Technical Committee plays a major role in the pricing and reimbursement of medicines in West Bank and Gaza; and is also responsible for designing the new Pharmaceutical Pricing Ordinance.

These conditions lead to the unique situation in which local manufacturers and importers greatly influence the pharmaceutical pricing policy of the West Bank and Gaza. In most countries regulatory tasks like the drafting of a pharmaceutical law lies in the hands of the national authorities assisted by independent experts. Only lately, a high level European industry spokesperson declared that 'industry shall have a voice in pricing and reimbursement decisions but not a vote.'

As next steps, four courses of action as summarized in the following table.

TABLE 21: RECOMMENDED PHARMACEUTICAL COST CONTAINMENT MEASURES

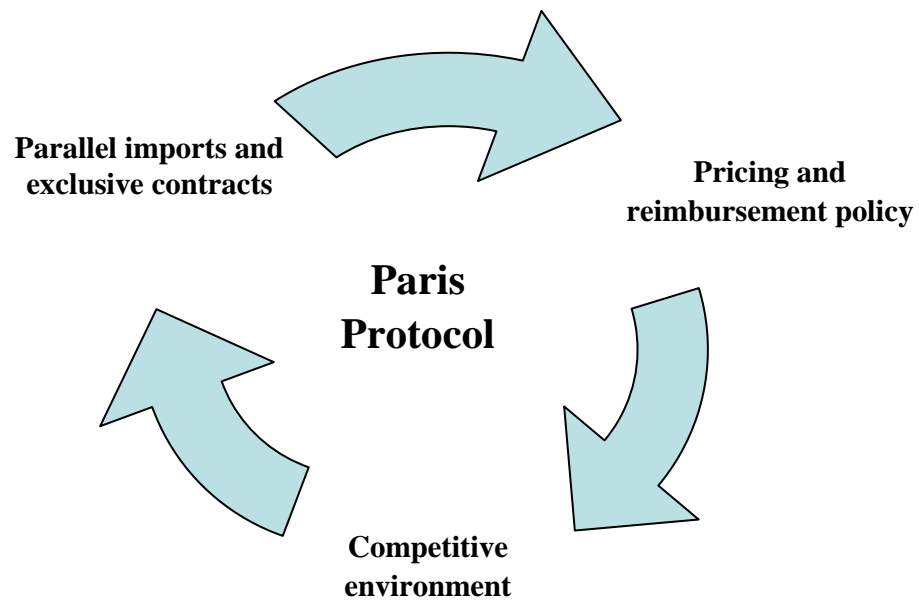
Recommendations	Proposed action	Feasibility	Fiscal Impact	Lead by
A) Preparing a National Drug Policy	- Prepare a new national drug policy	Possible	Intermediate	MOH
B) Promoting Rational Drug Use	- Develop an operational instrument to promote rational drug use, and the monitoring of prescription patterns			
C) Reducing the overall price level of pharmaceuticals	<ul style="list-style-type: none"> - Redraft the pricing ordinance after an evaluation of its objectives and impact. - Define that the procured price may not exceed the registered (approved) maximum price and try to cap the profit of agents. - Standardize the approval procedure for pricing requests by manufacturers/ importers (in the long-term price increases shall only be possible after approval by the Technical Committee). - Improve strategic price negotiations. - Seek reliable information on price by enhancing data collection e. g. in cooperation with the Pharmacists Association. - Measures shall be directed at procurement and private market 	High	Immediate	MOH
D) Further encouragement of competition and enhancement of procurement system	<ul style="list-style-type: none"> - Increase number of bidders in procurement by addressing potential foreign bidders for multi-source products directly <u>and</u> guaranteeing them a timely payment. - Long-term: Building up of electronic procurement - Customization of the standard bidding documents for Goods to address any particular technical or legal requirement related to the purchase of pharmaceutical products must be done through the Bid Data Sheet, the Special Conditions of Contract, and the Technical Specifications. - Not allow exclusive contracts of agents. - Try to seek “parallel imports” 	Possible	High	MOH MONE MOF
E) Minimize Trade Barriers	<ul style="list-style-type: none"> - Revise Paris Protocol and its interpretation by Israel. - Prepare a thorough dossier with a documentation of all unfavorable occurrences that impose non-tariff barriers (assisted by industry). - Start active discussions with the Israeli authorities on how to facilitate entry of medicines. - Improve efficiency of registration. 	Doable, but strong political support necessary	High	MONE together with Joint Economic Committee (JEC)

F) Modification of the Technical Committee and its subcommittee on Pricing	<ul style="list-style-type: none"> - Role and set-up should be redefined to avoid potential conflict of interest. - Voting process shall be made clear. - More weight for payers. - Involvement of independent experts in the field (one legal adviser already nominated). 	High	Linked to the draft pricing ordinance	MOH eventually jointly with MONE and MOF
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It is recommended that the Pharmaceutical Pricing Ordinance be revised and that the impact of the proposed pricing policy options be evaluated. It could be a good idea to introduce a pricing policy that allows for an ‘automatic’ incremental price reduction of a medicine if more comparators register on the market. This could be done by allowing them only a maximum price below the procured price. A possible way to overcome the current relatively high price level is by challenging the market with real competitive bidding through the introduction of potential generics manufacturers from EU and especially from neighboring countries with lower pharmaceutical price levels at comparable economic situations (e.g. expressed in GDP/capita and inflation rates). Given current availability of information, it is not possible to estimate potential savings that may be achieved with a different pricing system. It is reasonable to believe, however, that with the adoption of a real competitive public procurement method (taking UNRWA as an example) prices for off-patent essential medicines (generics) in West Bank and Gaza Strip could be reduced significantly.

Action Triangle- There are many potential obstacles to cost containment reform measures in the pharmaceutical sector due to issues beyond the control of the Ministry of Health. The proposed measures, identified above, were chosen based on their relevance and potential impact on the pharmaceutical budget. It is crucial, above all, to concentrate on removing trade barriers in the pharmaceutical sector as the single most important measure to contain costs in the pharmaceutical sector, as indicated below in Figure 21.

FIGURE 21: ACTION TRIANGLE FOR COST CONTAINMENT MEASURES



CHAPTER VII – PUBLIC SECTOR EXPENDITURES ON CONTRACTED SPECIALTY CARE SERVICES

INTRODUCTION

The recent expansion of public sector expenditures on contracted specialty care services, as with human resources and pharmaceuticals, contributed significantly to the overall rise in public sector health spending in the West Bank and Gaza. In 2000, referrals for outside tertiary care services reported by the Ministry of Health slightly exceeded 5,000 cases. By 2005 this figure exceeded 30,000 – a 500 percent increase in five years. Over 71 percent of these referrals were to providers in Jordan, Israel and Egypt. The remaining cases were primarily sent to private Palestinian providers in East Jerusalem. This increase, however, does not account for the publicly referred cases by the Humanitarian Aid Committee tied to the Cabinet which equaled an estimated 30,000 additional transfers in 2005 to outside providers in the private sector and overseas. In 2006, due to a steep fiscal crisis faced by the PA, overall outside referrals dipped substantially.

The factors driving this increase in outside referrals, according to the Ministry of Health officials, were several: (i) a general environment during the 2nd Intifadha which induced the Government to expand the number of outside referrals (deepening economic hardship; increased psychosocial stress on Palestinian households; higher incidence rate of conflict related injuries⁶⁹); (ii) an increase in the total number of beneficiaries under the Government Health Insurance (GHI) scheme as large numbers of non-contributing enrollees were brought under the scheme; and (iii) a loosening of the management and control mechanisms authorizing public sector referrals for specialized care services. There were two public sector mechanisms (MOH and the Humanitarian Aid Committee) with no clearly identified and transparent criteria to determine eligibility and clinical priority areas.

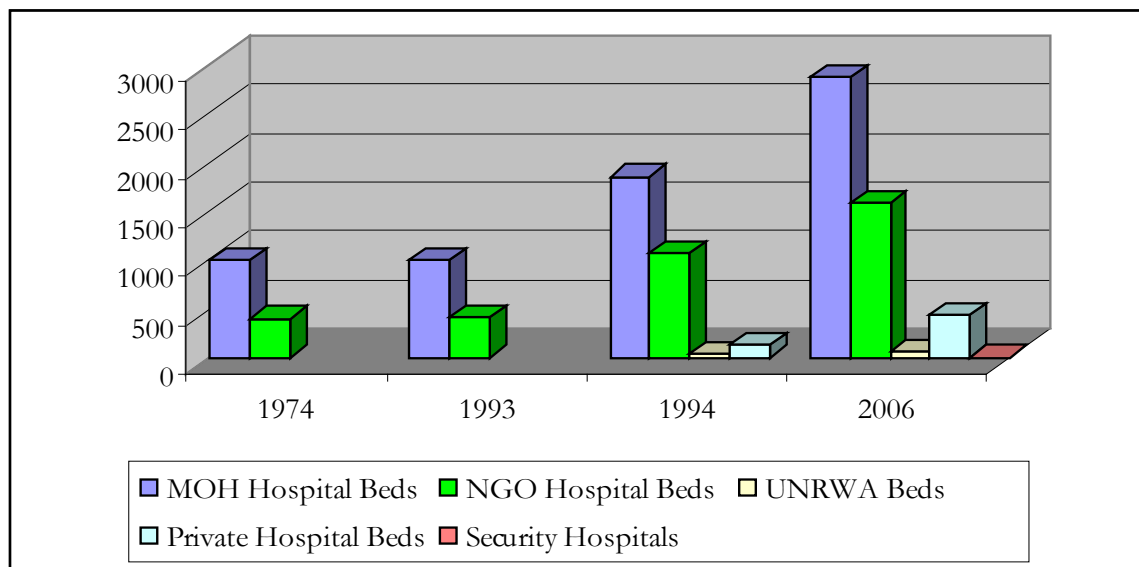
EVOLUTION OF HOSPITAL AND SPECIALTY CARE SERVICES

The development of hospital and specialty care services in the West Bank and Gaza Strip, not including East Jerusalem, witnessed two different phases of growth since 1974. Under the Civil Administration of the Israeli military, hospitals and hospital beds grew minimally over a near twenty year period from 1974-1993. The total number of government and non-governmental hospitals increased from 16 to 17 while total hospital beds increased by just under two percent. After 1993 the newly established PA initiated a public sector health service expansion plan in the new areas under its authority and encouraged similar investments by the private sector. Over the next 13 years, the total number of hospitals climbed rapidly to 69 including one UNRWA hospital, four security hospitals; and overall hospital beds increased by more than 200 percent. The most rapid increase was seen among NGO and new for-profit private hospitals specializing in maternity and obstetric care. Figure 22 below illustrates these two phases of development.⁷⁰

⁶⁹ Note: Palestinian hospital emergency departments, according to the Ministry of Health, treated 749,318 cases in 2003 – a 51 percent increase over 2000.

⁷⁰ Source: Nasser, T and Shani M, 'The Development of Palestinian Hospital Services', in Barnea T and Hussein R (eds), 2002, *Separate and Cooperate, Cooperate and Separate: The Disengagement of the Palestinian Health Sector and its Emergence as an Independent System*, Greenwood Publishing Group.

FIGURE 22: GROWTH IN HOSPITAL BEDS BY PROVIDER, 1974-2006



Source: Nasser T and Shani M, 2002. MOH Strategic Health Plan, 2008-2010. Note: hospital beds above do not include East Jerusalem hospitals.

East Jerusalem Health Providers – The East Jerusalem health providers have traditionally been the main providers of specialty care services in the West Bank and Gaza. There are nine hospitals in total with a total number of 578 beds – representing about twenty percent of all beds in the West Bank. A total number of 1170 employees work in these hospitals the majority of whom are Palestinians living outside of East Jerusalem. Six of the hospitals are associated with non-governmental charitable organizations (Al-Maqassid, Augusta Victoria, St. John, St. Joseph, Princess Basma and Palestinian Red Crescent) with a long-standing history of providing secondary and tertiary health services to the Palestinian population. The main specialty care services provided by these hospitals are in the areas of cardio-vascular surgery, in-vitro-fertilization (IVF), ophthalmology, nephrology and radiotherapy.⁷¹

The hospitals and health centers in East Jerusalem have special status among health service providers in the West Bank and Gaza. They are obliged to comply with Israeli health regulations, interacting with the Israeli Ministry of Health, but also act in accordance with the policy directions of the Palestinian Ministry of Health and treat a large number of referred MOH patients under contract. This situation with two authorizing environments renders it difficult to integrate the East Jerusalem health service providers into Palestinian plans to rationalize health services in the Palestinian Territories. One aspect which may benefit the Palestinian health system is the legal status of Palestinian residents of East Jerusalem. The fact that they are entitled to access health services in West Jerusalem can help reduce the pressure on East Jerusalem health providers and allow them to focus more on treating patients from the remaining areas of the West Bank and Gaza Strip.⁷²

Plans to Develop Specialty Care Services - With the rise of chronic diseases and injuries as a proportion of the burden of disease in the West Bank and Gaza, public and private investments

⁷¹ MOH Strategic Health Plan 2008-2010

⁷² Nasser T and Shani M, 2002.

in specialty care services have increased significantly since the establishment of the Palestinian Ministry of Health in 2003. The higher prevalence of heart disease, cancer, renal failure, diabetes and conflict-related injuries, as discussed in Chapter II, induced greater investments in expensive biomedical imaging technologies (computerized tomography scanning) and specialty care services (cardiac catheterization, renal dialysis, reconstructive surgery). These types of specialty care services require highly-developed clinical skills and sizable operational budgets to maintain the service quality of the equipment. Without appropriate budgeting and adequate planning to forecast the expected demand for specialty care services, taking into account demographic dynamics, anticipated shifts in the delivery of care (from inpatient to outpatient), changes in health technology, increased efficiency, geographic access barriers, and on-going supply-side investments, these long-term investments could lead to duplication, under-utilization and a decline in the quality of specialty-care services.

The rationalization of specialty care services in the Palestinian Territories proved a difficult task for the health authorities in the West Bank and Gaza since 1993. Prior to the handover of full authority to the Ministry of Health, a national 'Health Council' was formed in 1992 and mandated with preparing a strategic action plan for the sector. This plan, finalized in 1994, provided good base-line information on existing health infrastructure and service availability; and provided general projections of healthcare needs. Another strategic action plan developed in 1998 provided similar projections. Yet despite these efforts to produce national planning documents, effective and ongoing inter-sectoral planning to carefully guide the development of the sector did not occur. A combination of factors including MOH capacity constraints and weak public-private sector coordination prevented the development and implementation of an overall health service master-plan in the West Bank and Gaza.

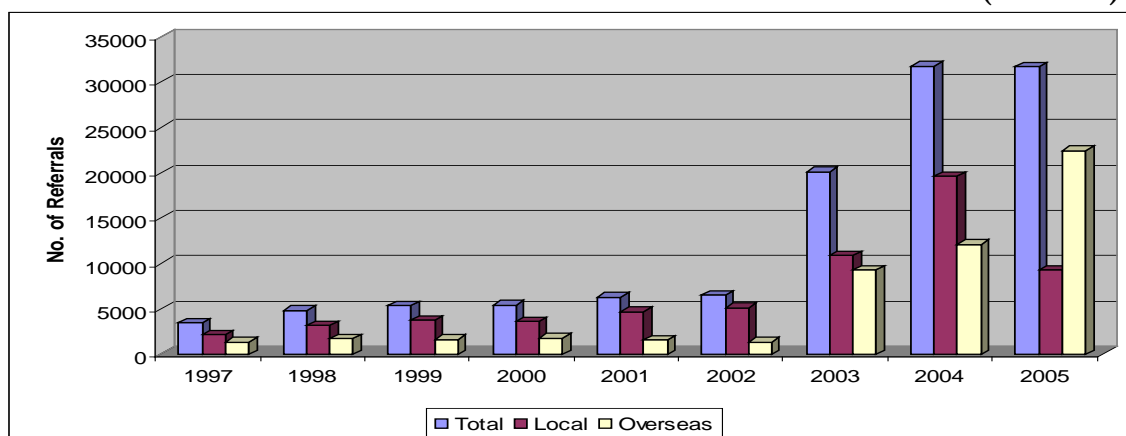
The most recent strategic health action plan for the years 2008-2010, developed after many years of political instability and emergency conditions, attempts a similar planning exercise. Health system reform pillars are outlined, projections for human resources and hospital beds based on demographic ratios and efficiency assumptions are provided, and specific efficiency-related criteria are specified for health service infrastructure expansion. While the strategic action plan does attempt to forecast human resource and hospital bed needs based on demographic projections and particular assumptions related to efficiency (occupancy, average length of stay), it does not make any assumptions about changes in health service delivery (e.g. shifting from inpatient to same day procedures). The plan also does not outline a general strategy for the development or purchasing of specialty care services. One of the follow-up exercises the MOH needs to undertake immediately, especially in view of the donor-driven assistance flowing towards infrastructure (building of new hospitals)⁷³, is to determine the type of specialty-care services it would like to build up internally; the services it would want to purchase from local private providers; and the specialty care services it would continue to purchase from overseas providers over the medium term.

⁷³ The Governments of Kuwait and Bahrain recently committed funds for the establishment of a 47 bed surgical hospital and a 27 bed pediatric hospital in Ramallah.

SPECIALTY CARE EXPENDITURE AND REFERRAL TRENDS

Available data from the Ministry of Health and previous analytical work undertaken by the World Bank point to a rapid increase in the number of specialty care referrals, particularly after 2003. This information does not include referrals authorized by the Humanitarian Aid Office connected to the Office of President. Even without these additional referrals, the number of cases transferred by the MOH increased by almost four four-fold between 2002 and 2003 – from 6,483 in 2002 to over 20,000 in 2003. In the next two years, an additional ten thousand cases pushing the total number to over 30,000. In a span of eight years between 1997 to 2005, the total number of MOH referrals increased by more than 800 percent. Throughout the eight years, local referrals constantly exceeded the number of overseas referrals except for 2005. In that year, referrals to providers overseas peaked at 22,475 cases. These trends in referrals are revealed below in Figure 23.

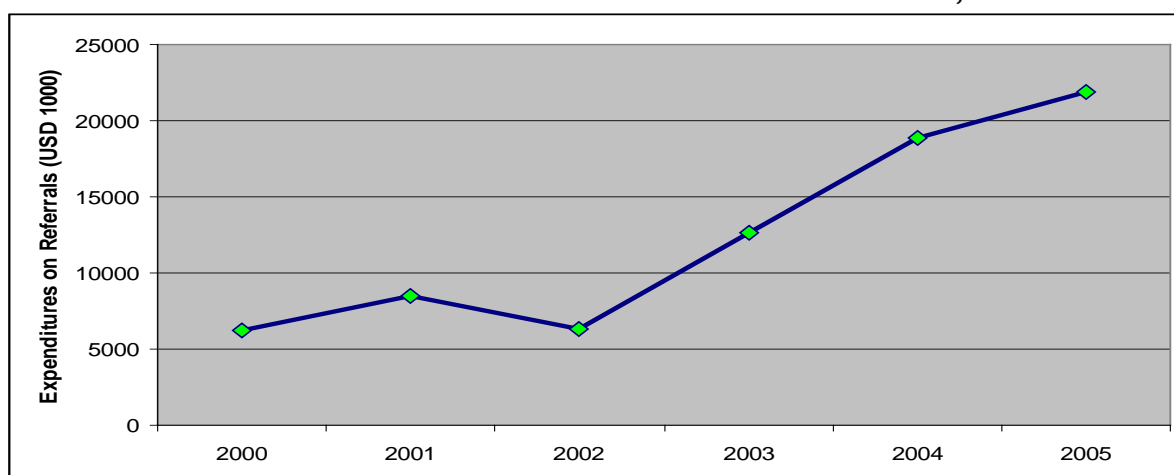
FIGURE 23: NUMBER OF LOCAL AND OVERSEAS SPECIALTY CARE REFERRAL (1997-2005)



Source: Ministry of Health, 2008. World Bank 2007 Public Expenditure Review

In terms of expenditures on outside referrals the spending trends mirror the rapid rise in the volume of cases. Overall expenditures increased from US\$ 6.2 million to US\$ 21 million between 2000 and 2005. As indicated earlier in Chapter II, total expenditures on public referrals actually exceeded an estimated \$US 60 million taking into account the accumulated liabilities authorized the Humanitarian Aid Committee. These expenditures flowed primarily to tertiary care providers in three areas of the West Bank and Gaza (the northern Governorates, East Jerusalem and the Gaza Strip), Jordan, Israel and Egypt. In 2006, information from the MOH indicates that around US \$ 25.5 million was spent on outside referrals with 45 percent of the spending flowing to overseas providers and 55 percent to local Palestinian providers (not including referrals to outside providers in the Gaza Strip and in Egypt). These data, although incomplete, point to a return in 2006 to a focus on referring patients to local providers rather than to overseas providers. These trends can be gleaned as well from Figure 24 and Figure 25 below.

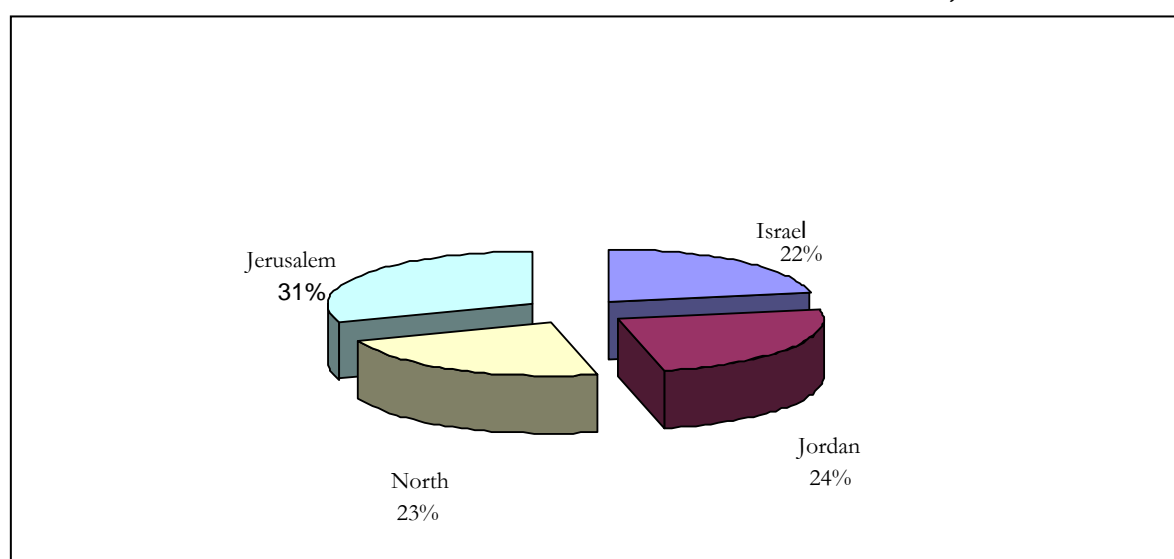
FIGURE 24: MOH EXPENDITURES ON OUTSIDE REFERRALS IN USD, 2000-2005



Source: Ministry of Health Strategic Action Plan 2008-2010

Two of the clinical areas in which the MOH has clearly relied on external providers are in the specialty areas of neurosurgery and cancers. While there is growing capacity in the area of cancer treatment, particularly in the East Jerusalem and northern Governorate hospitals, a large share of cases have been referred to Jordan and Israel in recent years. In 2006, 100 percent of MOH spending on neurosurgery referrals flowed to hospitals in Jordan and Israel while for cancer referrals, the figure was around 70 percent. For heart cases, the majority of spending was on services provided by local providers in East Jerusalem and northern governorate providers. The next two clinical areas in which there were large expenditures were ophthalmology and renal failure. The large spending on renal failure suggests a potential problem with the effective prevention of diabetes at a general level. This information is provided below in Table 22 and again, does not take into account the referrals to hospitals in Gaza and the Egypt; and thus provides a less than full picture of expenditure and referral trends by the MOH.

FIGURE 25: MOH SPECIALTY CARE REFERRALS BY LOCATION, 2006



Source: MOH, 200

**TABLE 22: CONTRACTED SPECIALTY CARE SERVICES BY
SPENDING LEVEL AND LOCATION OF PROVIDER IN USD, 2006**

	Local		Overseas		Total
Top Specialty Care Cases	Jerusalem	Northern	Jordan	Israel	
Cancers	1.84	.69	2.63	3.35	8.51
Neurosurgery			.71	.44	1.15
Cardiovascular	.974	1.52	.63		3.13
Ophthalmology	1.03	.83			1.86
Renal failure	1.03		.22		1.25
Orthopaedic surgery				.24	.24
Rehabilitation		.65			.65
General surgery				.20	.20
Other	2.89	2.2	1.99	1.39	8.47
Total	7.79	5.90	6.18	5.62	25.49

Source: MOH, 2008

KEY ISSUES

There are a number of key issues related to the development of a strategy for contracting out specialty care services by the public sector in the West Bank and Gaza. These key issues revolve around the strategic decision-making of the MOH and the type of specialty care services it would seek to invest in internally versus the services it would seek to purchase from local and overseas providers. For whatever specialty care services it would seek purchase outside its network of facilities, there are several important considerations the MOH should bear in mind as it builds up its own contracting capacity.

Health Promotion and Prevention Strategies

- The future demand for specialty care services will depend on the prevalence and incidence of non-communicable diseases (cancers, heart disease, diabetes, hyper-tension) and injuries by the general population. This demand can be influenced through the implementation of health promotion targeted at the main risk factors for non-communicable diseases and injuries namely over-nutrition, physical inactivity, and smoking. Prevention and early screening programs, particularly for cancers (mammography for breast cancer) and heart disease, can reduce the severity of illness and need to specialty care services. Building up the management information capacity of the MOH to better monitor certain inpatient utilization trends (i.e. diabetes short-term complication admission rate, congestive heart failure admission rate, uncontrolled diabetes admission rate, injuries from road traffic accidents) could help the Ministry assess the magnitude of preventable chronic conditions and better target its efforts in the areas of health promotion, prevention and injury control.

MOH Internal Capacity to Provide Specialty Care Services

- Strategic decisions will need to be taken by the MOH related to its own internal capacity to provide specialty care services. Building this capacity whether in the areas of neurosurgery, chemotherapy or reconstructive surgery necessitates a long-term investment and sustained commitment to build up the institutional and human resource capacity to provide such services. The MOH must weigh the costs of this investment and its ability to attract highly skilled health professionals against the benefits of

purchasing these services from outside providers with existing capacity. In the case of 'low volume-high cost' specialty care services, it is cost-effective for the MOH to continue purchasing these services from outside providers. As for high volume' services, a long-term investment decision needs to be made by the MOH based on criteria related to financing, technical capacity, existing service availability and its vision for its own role in the areas of specialty care services.

Encouraging Development of Specialty Care Services

- There are two policy tools available to the MOH to encourage the development of specialty care services in the private sector: (i) supply-side measures requiring pre-authorization by the MOH for large capital investments and (ii) demand-side measures influencing the development of specialty-care services through the purchasing decisions of the MOH. The first policy tool intrudes more into the free market decisions of the private sector and attempts to shape investments in specialty care services through overall health sector planning. Developing and maintaining an overall 'master-plan' for the sector, for example, could enable the MOH to possibly implement such supply-side measures. The second policy tool signals to the market what the MOH is prepared to purchase on behalf of its referred patients. Given the existing capacity constraints in the MOH, it would be advisable over the short-term to make use of the second policy tool to influence the investment decisions of the private sector.

How to Refer Patients and Purchase Specialty Care Services

- *Single Process for Referrals with Transparent Criteria and Guidelines* – The MOH needs to ensure there is a single process public patients referred for specialty care services outside the MOH with transparent pre-certification criteria and process guidelines. The use of pre-certification clinical criteria, already developed and standardized in developed countries⁷⁴, can help the MOH better monitor and rationalize the referral process.
- *Defining the Eligibility Rules* – Clear eligibility rules need to be determined by the MOH regarding access to specialty care services in the private sector. It is not entirely clear whether specialty care services are restricted only to those enrollees in the Government insurance scheme and their dependents or they are also available to the general population who also use MOH services. Defining these rules in a transparent way can strengthen the integrity of the referral process.
- *Defining, reviewing and updating the specialty care benefits* – As part of the MOH attempt to rationalize its expenditures on purchased specialty care services, it will need to develop a clearly defined list of specialty care services it will cover and purchase from outside sources. Vaginal deliveries, for example, are treated as 'specialty care' services by the MOH and purchased from the private sector. This list could explicitly itemize all those services included in the specialty care benefits package (a positive list) and state all other unlisted services would not be covered. This list would have to be regularly reviewed and updated given possible changes in health technology and MOH service availability.
- *Contracting and paying for specialty care services as a special procurement process* – The MOH needs to eventually establish its current contracting mechanism for specialty care services as a separate procurement process and not one integrated as part of the general procurement rules of the MOH. Purchasing clinical services through contracting is a highly complex

⁷⁴ Standardized pre-certification criteria for authorizing and managing inpatient specialty services are available through different international vendors such as Milliman or McKesson in the United States.

exercise and necessitates special clinical and analytical skills. This technical expertise is not usually available in general procurement departments of Ministries of Health and needs to be acquired and built up over time.

Purchasing Specialty Care Services from Overseas Providers

- *Concentrate on strategic relations with one or two large service providers* - The MOH has traditionally relied on a number of hospitals in Jordan, Israel and Egypt for specialty care services. These hospitals have included over four Jordanian hospital centers, four Israel hospitals and three Egyptian hospitals. Concentrating on developing strategic relations with a narrower list of overseas service providers could assist the MOH secure larger price discounts from these providers and enable better monitoring of patient management outcomes. This strategic approach will naturally be influenced by imposed movement restrictions on Palestinian patients and their access to Jordanian, Egyptian and Israeli health providers.

RECENT MOH REFORM EFFORTS TO RATIONALIZE SPECIALTY CARE CONTRACTING

As part of the medium-term reform agenda of the MOH, several measures are already being planned to further rationalize public sector spending on specialty care services. These measures can be categorized into three groups: (i) broad public health interventions targeting health promotion and prevention efforts related to non-communicable diseases and injury control; (ii) planning efforts to develop specific regulatory criteria for capital investments in specialty care services in the West Bank and Gaza and (iii) specific measures to reform and strengthen the contracting process within the Ministry. Some of these measures are outlined in the MOH Strategic Action Plan 2008-2010 and will be implemented over the medium-term while others have already been undertaken by the MOH.

On the broad public health interventions related to non-communicable diseases and injuries, the Ministry has incorporated public health programs targeting road safety, smoking cessation and cancer screening into its medium-term planning efforts. These health promotion and prevention priorities are clearly identified in its Strategic Action plan which also includes measureable implementation targets for the three year period. One area in which there is no mention or explicit programming is in diabetes prevention and management. Given its high-level of prevalence in the West Bank and Gaza and the risk it poses for other non-communicable diseases, namely cardio-vascular disease, it would be advisable to deliberately expand efforts in this important area of health prevention and promotion. While the Action Plan does mention road safety, smoking cessation and cancer screening, it does not provide the any specifics related to implementation plans and financing arrangements. Making investments upfront in effective health promotion and prevention can help reduce the growth in demand for specialty care services in the future.

The Ministry of Health has developed a set of regulatory criteria for expanding investments in specialty care facilities and services. These criteria adopt certain benchmarks for efficiency levels and cover intensive care facilities, open heart surgical hospitals, haemodialysis, lithotripsy and medical imaging services. Table 23 below provides a snapshot of a select number of these criteria. Although these regulatory criteria have been developed, it not yet clear under what mechanism they will be enforced and over what time frame. Embedding these criteria within a larger program for health sector master-planning, covering both the private and public sectors and supported by authorizing legislation, could provide the right mechanism to appropriately

regulate capital investments in specialty care services. Establishing a master-planning capacity would require additional investments in building-up appropriate technical expertise and a modern health information.

TABLE 23 : SELECT CRITERIA DEVELOPED BY THE MOH FOR EXPANDING INVESTMENTS IN SPECIALTY CARE SERVICES

New Facilities/ Services	Criteria of New Facilities/Services	Comments
Intensive care beds	Average occupancy rate in service area equals or exceeds 60 percent	Optimal occupancy is 85 percent
Neonatal intensive care beds	Average occupancy rate in service area equals or exceeds 80 percent	Optimal unit contains a minimum of 15 beds
Open heart surgery unit	350 adult operations and 130 pediatric operations in service area	Minimum capacity is 200 adult and 75 pediatric operations per year
CT Unit	Minimum annual average for service area is 3,000 procedures	Optimal unit should operate 40 hours per week
MRI Unit	Minimum annual average for service area 1,500 procedures	
Cardiac catheterization services	Minimum annual average for service area is 1,000 diagnostic equivalent procedures	5 procedures per day to 250 days per year
Lithotripsy	Minimum annual average for service area is 1,000 diagnostic equivalent procedures	

Source: MOH Strategic Action Plan 2008-2010

The most direct MOH efforts to rationalize public sector health spending on specialty care services have been in the area of contracting. This function was traditionally performed by an administrative unit within the MOH responsible for ‘special treatment referrals’ and was independent of the MOH Directorate responsible for the Government Health Insurance (GHI) scheme. Recently over the last eighteen months, the MOH consolidated ‘special treatment referrals’ under a new MOH General Directorate for Health Insurance and facilitated a Government decision to channel all public sector referrals through the MOH. The MOH also charged the new Directorate with the responsibility of developing stricter eligibility criteria for referrals, both in terms of clinical indications and location of services.

The most innovative reform undertaken by the MOH was in the development and adoption of a new contracting mechanism for purchasing services from hospital services. Since the establishment of the MOH in 1994, specialty care services were purchased from local hospital providers using non-competitive contracts with no pre-qualifying requirements regarding quality standards and service delivery capacity. With support from an external contracting specialist, the MOH developed a new contracting mechanism using a ‘request for proposals’ framework and a new ‘model’ contract for purchasing specialty care services. This new mechanism was implemented by the MOH for the first time in 2007-2008 in line with certain conditions required by external donors for continued financing of specialty-care services. The donor community, including the World Bank, had urged the MOH to strengthen its contracting capacity as a way to improve the efficiency of its spending and to ensure greater quality standards on the part of the contracted service providers.

The new ‘request for proposal’ RFP procurement method introduced by the MOH was an important step towards building a ‘strategic purchasing’ capacity within the Ministry. Prior to its introduction, purchasing of health services was not framed within a broader health policy objective and was not conducted using a transparent competitive approach based on a

prequalification process. The RFP issued by the MOH during the last quarter of 2007 clearly laid out the rationale and objectives behind the adoption of a new model contract and invited all interested specialty care providers, as part of the bidding process, to provide detailed information, inter alia, about their clinical staff, the quality of their physical infrastructure; the clinical and administrative data they collect and the range of services provided by their facilities. This information would be used to make new determinations about the eligibility of these providers to participate in the tendering process.

The RFP also identified the type and volume of clinical procedures the MOH would seek to purchase from the local hospitals in each geographic service area. The procedures consisted of over 90 separate ones and covered a wide range of specialties including cardiovascular surgery, ophthalmology, and obstetrics. Table 24 provides a summary snapshot of select high-impact tertiary care procedures (in terms of volume and cost) as well as a number of secondary care procedures. The list of secondary procedures indicates areas in which the MOH may currently face capacity constraints within its own service delivery system. These services, as indicated before, should be part of a specialty care package and need to be reviewed closely given the distortive effect they may have on MOH capacity levels in secondary care and on physician referral behavior. It has been noted that ‘dual practice’ policies – allowing physicians to work in both the public and private sectors – encourages the excessive referral of public cases to the private sector.

TABLE 24: SAMPLE OF SERVICES CONTRACTED BY MOH, 2007-2008

<i>Code</i>	<i>Specialty Care Procedures</i>	<i>Comments</i>
1.1	Cardiac catheterization	Provided by only a few hospitals in the WBG
1.4	Coronary artery bypass graft surgery	Provided by only a few hospitals in the WBG
1.9	Cardiac pacemaker implantation	Provided by only a few hospitals in the WBG
3-1	Craniotomy	Provided by only a few hospitals in the WBG
13-2	Chemotherapy	Provided by only a few hospitals in the WBG
14.4	Total hip replacement	
14.5	Total knee replacement	
16.1	Burn management cases	
	<i>Secondary Care Procedures</i>	
6.1	Surgical management	Should only be provided if part of tertiary treatment package
9.1	MRI	Not for routine screening purposes
9.7	CT scanning	Not for routine screening purposes
10.1	Vaginal deliveries	
10.2	Caesarian sections	Should only be provided if part of tertiary treatment package

Source: MOH RFP Package for Specialty Care Services, 2007-2008

The participating hospitals in the RFP process were invited to submit unit prices for all the clinical procedures listed by the MOH. These prices were meant to be all inclusive fees for each procedure covering direct and indirect service costs, administrative overhead and the capital depreciation costs. The selection process would be based on the lowest evaluated price, contingent upon pre-qualification, and considerations related to geographic access in view of the restrictions on access and movement. The RFP process, as indicated above, also provided an improved contract which contained a much wider set of technical and legal provisions. Under the new contract, the previous twelve articles were expanded to thirty one governing all aspects of the contractual relationship. The big differences were in the following three areas: (i) setting the broader health policy context and rationale for purchasing of specialty care services; (ii)

information and reporting; and (iii) detailing the obligations and rights of both parties to the contract (including the issues of sub-contracting, auditing, insurance, indemnity, dispute resolution, partial invalidity and confidentiality).

The innovation of this reform effort notwithstanding, it is clear that the MOH has insufficient procurement expertise to adequately manage the new contracting mechanism for the purchasing of specialty care services. After the issuance of the RFP in late 2007, bids were submitted in early 2008 by participating hospitals and thereafter the MOH moved to finalize the bid evaluation report and award the hospital contracts in line with the procurement guidelines of the World Bank which is partially funding the specialty care contracts and administering a multi-donor trust fund for the same purpose. Due to weak capacity within the MOH, an initial bid evaluation report failed to meet the reporting requirements of the relevant World Bank procurement guidelines governing the process. The PA, thereafter, recruited an external consultant to work with the MOH to finalize the bid evaluation report and all the necessary documentation. This process resulted in a year long delay between bid openings and probable contract awards.

It is critical for the MOH to evaluate the previous experience and begin to acquire the necessary clinical and management expertise to effectively administer this strategic contracting process more efficiently, particularly in view of the probable continued reliance on external donor funding. This expertise needs to be built up in a specialized procurement unit independent of the general procurement rules of the MOH. The staff in charge would develop skills in the management of clinical service contracts and performance monitoring. Over time these skills need to be supported by the use of common coding (for diagnoses, procedures, drugs) and modern computerized networking to better track utilizations trends and monitor overall hospital performance.

MEDIUM AND LONGER-TERM RECOMMENDATIONS

Four medium-term recommendations could be considered by the MOH to sustain the implementation of the new contracting mechanism for specialty-care services. The first and most urgent recommendation would be to recruit qualified individuals to lead and manage the hospital contracting unit in the MOH. These individuals would be tasked with developing specialized guidelines for the procurement of specialty care services and ensuring detailed familiarity with the accepted procurement guidelines of the donor community. External technical assistance ought to be sought by the MOH to build up this needed technical expertise. The second recommendation would be for the new contracting unit to review the list of services required by the MOH and update it based on changing capacity levels of local providers and the service requirements of the Ministry. One issue which should be focused on by the new unit is attempting to encourage the development of local capacity to eventually replace the need for high-volume overseas referrals.

A third recommendation is to work on harmonizing the utilization data collected from all service providers under contract by the Ministry. This harmonization effort could be in the form of a common discharge form specifying length of stay and using standardized coding for diagnoses, procedures, drugs and cause of death. This flow of information would be greatly facilitated in the future with full computerized networking between the MOH and the service providers. One important ingredient for computerized exchange – an electronic health data dictionary – has already been developed in the West Bank and Gaza. This dictionary defines how clinical and

administrative data are recorded and used by service providers throughout the health sector. A fourth recommendation would be to initiate an RFP process for overseas hospital providers, akin to the process followed for local providers. A set of service requirements and volume targets would be specified and overseas providers would be elicited to bid through a structured RFP and tendering process. Under this process, an adapted form of the model contract could be used with overseas specialty care providers.

As to longer-term recommendations, two could be considered by the MOH as technical expertise and management capacity continues to grow over the medium term. The first recommendation would be to begin to focus on developing a utilization review function in the MOH with the purpose of further rationalizing the referral process. This function would enable the MOH to better track utilization patterns, particularly among the high-impact cases, and reduce the volume of inappropriate care. Taken one step further the MOH could also develop a 'utilization management' function in which inpatient admissions and lengths of stay of MOH referred patients are, respectively, pre-certified and actively monitored by MOH staff. The pre-certification process could adopt and adapt standardized clinical criteria for admissions and inpatient lengths of stay already developed in high-income countries. This reform measure, to be effective, would require computerized networking between the MOH and the service providers, specifically for the claims processing system.

Another longer-term recommendation is the development of key performance indicators to evaluate the clinical risk and efficiency of contracted service providers. These performance indicators can be used to generate performance score cards for each hospital and allow the MOH to assess the performance of each hospital relative to others. The performance indicators would enable the MOH to evaluate the relative efficiency of a hospital adjusting for its case-mix parameters (i.e. characteristics of its patient population). Developing such a tool could strengthen the pre-qualifying process already developed by the MOH. This longer-term reform measure, as the one above, depends critically on the availability of electronic claims processing data. Implementing an electronic claims processing system is an expensive upfront investment, for both purchasers and providers – but has significant upside benefits in terms of better utilization control and more expeditious hospital payments.

PROPOSED TECHNICAL ASSISTANCE

There are several areas in which external technical assistance could help the MOH better rationalize its expenditures on specialty care services. These areas would focus on the following: (i) strengthening prevention and integrated management strategies for non-communicable diseases and injuries; (ii) developing a master-planning capacity in the MOH (same recommendation for technical assistance recommended in the health financing chapter) and (iii) strengthening the newly adopted contracting mechanism of the MOH. Table 25 provides a summary description and time frame for each of the mentioned areas. This external assistance should team up with local experts in implementing the proposed activities.

TABLE 25: PROPOSED AREAS FOR EXTERNAL TECHNICAL ASSISTANCE

	Strengthen Prevention and Integrated Management Strategies for Non-Communicable Diseases and Injuries	Timeframe	Estimated cost (US\$)
1	Strengthen prevention programs for road safety, smoking cessation, physical activity; and screening programs for cancer and heart disease. This activity would bring in international experts with best practice experience in designing national programs for smoking cessation, adult healthy living and road safety. Another set of experts would focus on building up existing screening programs for cancer and cardiovascular disease. As part of the activity, a full review of data-collection methods and existing registries will be reviewed.	2009-2010	\$300,000 for two visits by six international specialists and local experts in the areas of road safety, smoking cessation, adult health living, cancer and heart screening.
2	Design plan for scaling up prevention and integrated management of diabetes. The plan would focus on effective strategies for primary prevention (childhood and adult nutrition, physical activity) and the integrated management of diabetes across different levels of care (primary, secondary and tertiary). The integrated management part of the plan would benefit from international best practice in outcome-based monitoring of diabetes outcomes.	2009-2010	An international and local expert in diabetes prevention and management for three visits for \$ 150,000.
	Development of a Master-Planning Capacity in the MOH		
3	Establish Master-Planning Capacity in the MOH. The activity, with other involved donors, on building up the master-planning capacity of the MOH. International experts with extensive experience in preparing and maintain health sector master-plans would assist the MOH in building up its technical expertise and develop a system for continuous health sector master-planning.	2009-2010	\$250,000 for two international experts in health sector masterplanning and local experts for two missions.
	Evaluating and Strengthening Newly Adopted Contracting Mechanism		
4	Evaluation of Competitive Bidding Approach. This activity would conduct a full assessment of the competitive bidding approach for specialty care services initiated by the MOH in the Fall of 2007. This activity would involve a visit by an external contracting expert and the preparation of a comprehensive evaluation report.	2009	\$ 20,000 for a two week visit by international contracting specialist.
5	Contract Management. Under this activity, international hospital contracting and procurement specialists would assist the MOH in setting up a specialized procurement unit for hospital contracting. The activity would aim to develop special procurement procedures for contracting specialty-care services and build up the internal MOH expertise in international procurement guidelines.	2009	\$200,000 for an international hospital contracting and a procurement specialist for three visits.
6	Reviewing and Updating Contracted Services. An external clinical expert, in coordination with local clinicians, will assist	2009	\$ 60,000 for two trips by an

	the MOH in reviewing and updating its list of contracted specialty care services. This activity would aim at identify key priority areas for continued contracting, both internally and overseas. This activity would be coordinated with the activity to establish a master-planning capacity in the MOH.		international contracting specialist with clinical experience and a local expert.
7	Initiating RFP Process for Overseas Referrals. This task would help the MOH design and implement the RFP process and contract for overseas specialty care referrals. This activity can be undertaken following the completion of the evaluation report of the competitive bidding approach.	2010	\$ 50,000 for two visits by an international contracting specialist and a local expert.
8	Establishing Minimum Basic Data Set. This activity would review the current discharge forms used by all service providers and work on establishing a common minimum basic data set to be used by all specialty care providers. As part of this activity, efforts would be undertaken to develop a plan to further harmonize all administrative and clinical coding used by the services providers (e.g. diagnoses, procedures, cause of death) and to ensure convergence towards adopting the electronic definitions of the Palestinian health data dictionary.	2010	\$ 100,000 for two visits by an international utilization review expert and a health informatics specialist plus the assistance of local experts.

SUMMARY CONCLUSIONS

Over recent years, particularly since 2000, public sector spending on specialty care referrals ballooned, contributing to the rapid rise in overall public sector health expenditures in the West Bank and Gaza. This increased level of public sector spending on outside referrals resulted from a combination of factors; namely a deteriorating macro-economic and security environment leading to higher levels of poverty and unemployment; a rapid increase in the number of direct and indirect beneficiaries of the Government Health Insurance scheme; and the existence of two public sector mechanisms for authorizing referrals to the private sector and overseas (the MOH and the Humanitarian Aid Committee). Between 2000-2005, MOH referrals alone jumped from 5,000 to over 30,000 cases, 71 percent of which were to overseas service providers.

As part of its reform agenda, the PA and the MOH recently undertook several indirect and direct measures to contain and rationalize these public sector expenditures on specialty care services. The indirect measures involved efforts to design and implement new health promotion and prevention programs (smoking cessation, cancer screening). The direct measures involved the development of regulatory criteria for capital investments in specialty care services and facilities; and a move to strengthen the existing contracting mechanism with local providers through the development of a new model contract and the implementation of a competitive-based bidding approach. Due to technical capacity constraints in the MOH, implementation of this innovative approach suffered from long implementation delays and bottlenecks. Over the next two years, 2009-2010, it will be important for the MOH to evaluate, strengthen, consolidate and possibly expand (to include overseas referrals) this new contracting mechanism. External technical assistance would help facilitate and guides this process.

ANNEXES

Overall Assessment of the Draft Legislation

The draft legislation clearly states that the objective of the law is to create a new National Health Insurance Program (NHIP) administered by an independent agency to help meet the health needs of all Palestinian citizens. The comprehensive, mandatory and contributive design of the proposed program -- which includes elements of state subsidies and does not allow voluntary insurance or opting out -- realizes the principle of solidarity in an adequate way. The organizational structure of the NHIP is well devised; and the distribution of legal powers between the Board of Directors and the administration (CEO) are reasonably defined. Improvements, however, can be made to better harmonize the different aspects of the law and specific recommendations are made below. A proposed outline for a revised version of the draft legislation is also included below.

General Provisions

It is recommended that the law starts with a description of its purposes and scope: what is the purpose of a NHIP (e.g. to finance access to quality health services to all Palestinians, to establish a mandatory system of social health insurance and to define the legal status, objectives, structure, function and competence of the corporation)?

In the beginning of the law there should also be a list of principles that are guidelines for the implementation of all provisions of this law, e.g. social solidarity is the foundation of the NHIP wherein everybody contributes based on income to the financing of the system as determined in corresponding regulations. Enrolment shall be family-based, and entitlements shall be provided individually. Utilization of health care goods and services shall be based on medical necessity. There shall be no opting-out of complying with the full corresponding contributions to the NHIP. There shall be a separation of financing and provision of health care goods and services. The NHIP is exclusively a financial system; it is not a health care delivery system. Public and private providers who meet qualifying standards and requirements shall provide the health care goods and services under contracts with the Corporation.

It is recommended that a clarification be made to that the Corporation is a public body and not an enterprise of private insurance. This body can sue and can be sued. This body is financially independent (cf. Article 2). Should it be autonomous or should it be a part of the Government, dependant from the Ministry of Health orders, or should there be only a legal supervision of the Ministry?

General Remarks

According to Article 24 participation in the NHIP shall be mandatory for all taxpayers. People who do not pay taxes – and there will be many in the PA – are not obliged to participate the insurance. On the other hand, every citizen – whether a taxpayer or not – shall have the right to

⁷⁵ This review was prepared by Dr. Manfred Zipperer, Consultant to the World Bank.

benefit from NHIP services. This provision can be construed as contradictory and confusing. It is strongly recommended not to connect paying taxes with mandatory participation. NHIP is a contribution-related scheme with state subsidies. It is not a tax financed system. It is desirable that insurance coverage and eligibility to claim benefits should be tied up with enrolment and payment of contributions.

The NHIP shall cover all citizens. The draft uses two terms: ‘participant’ and ‘beneficiary’ which are defined in Article 1. Using these two terms may elicit confusion since everyone is insured under the NHIP and should be named as ‘insured’. Being insured one has to pay contributions (except social cases and unemployed, whose contributions are paid by third parties) and is eligible to receive benefits : no contribution – no benefits.

This construction does not solve the position of members of a family who do not have any own income and are not social cases or unemployed. In most countries with a contribution financed health insurance it is only the bread-winner who pays contributions. The contributions cover the bread-winner and his family members who do not have their own income. The whole family is insured, but the family members are insured without contributions and eligible for benefits. The disadvantage of this construction is as follows: the non earning family members depend on the bread-winner’s payment of contribution. If he does not pay the contribution or if his employer does not transfer the contribution to the Corporation, the whole family is insured but not eligible for benefits. This disadvantage may be avoided if the law obliges each family member without own income to pay a (moderate) contribution. But in most cases this will financially overburden the families. Perhaps the dilemma can be solved by contributions of the Ministry of Social Affairs for social cases. It is recommended that a family-based enrolment system is adopted under which the bread-winner’s contributions cover the whole family without extra contributions - but the entitlements of the single members of the family shall be provided individually and shall not depend on the bread-winner.

The draft legislation does not define the relations of the NHIP to the private health insurance sector. If there is only one NHIP that covers the whole population, the role of private health insurance might be a complementary one covering risks and benefits that are not component of the basic services package. No citizen should be allowed to opt out of the NHIP. Nevertheless there should be freedom of choice of voluntary private health insurance (duplicative, supplementary and complementary) after certified full payment of the NHIP contributions.

The draft does not define the relations between the NHIP and an accident insurance (work related injuries and diseases). If the NHIP covers also work related contingencies – this should be clarified in a provision – there should be an extra contribution for employers. In most countries these insurances are separated. Accident insurance is financed only by the employers and regulates its own service package. In this case provisions are necessary to avoid that health services are financed twice.

Definitions

It is recommended that these following definitions be added to Article 1:

- **Contributions:** Payment made by or on behalf of the insured person to the Corporation to receive a defined health services package.

- Co-payments : Payments patients have to make to receive health care goods and services at the point-of-service as determined by the Minister.
- Salary: Fixed remuneration for personal services paid by an employer to a person on a regular basis.
- Self-employed : An individual who operates a business, activity or service as a sole proprietor, independent contractor, or consultant and not under a labour contract.
- Wages : Payment for labour or services to a worker, especially remuneration on an hourly, daily or weekly basis or by the piece.

Board of Directors

The Board of Directors is the central unit of the Corporation that has to take important decisions. The membership should therefore be well balanced and not too numerous. It is recommended to take the same number of representatives of providers (hospitals : dean of faculty of medicine; out-patient physicians : one head of a physician' association; dentist : head of the dentist association; pharmacists : head of the pharmacists' association = 4 representatives) and of payers (one representative of employers, one representative of labourers resp. trade unions, one representative of the Ministry of Labour, one representative of the Ministry of Social Affairs = 4 representatives).

It is not advisable to include legal advisor on (cf. Article 5 Nr. 9) the Board. They should consult the Board and prepare its decisions but should not play a decisive role. It is also recommended to include in the list of authorities of the Board (cf. Article 6), that the Board should issue instructions and procedures for the operation of the Review Board and decide about disputes reported by the CEO.

Chief Executive Officer

Article 10 does not define the qualification of a CEO. "Competent" is not sufficient for such an important function. It is recommended to define the elements of the qualification, e.g. experience in health care financing, insurance or management. Article 10 does not lay down the period of years of the CEO's management. This should be done in any case. Four years are recommended.

As to the authority of the CEO, (Article 11) should be clearly state that he/she is the Secretary ex officio of the Board of Directors, shall prepare the agenda of the meetings, be responsible for the meetings of the Board, participate in the sessions with voice and no vote, and implement the decisions of the Board (cf. Article 11 Numbers 1 and 10). It is necessary for the work of the Corporation to demand submission of relevant documents and information from all natural and legal persons, public and private, regarding matters related to the implementation of this law. This concerns employers and contribution payers as well as providers. It is recommended to include this as part of the CEO's executive functions in Article 11. In number 6, greater elaboration of the desired quality standards and indicators would be advisable. In number 9 the purpose and content of the reports should also be clarified.

Services

Article 12 should make clear, that the NHI Corporation does not provide health services by itself. The Corporation is exclusively a financial system, it is not a health care delivery system. Therefore there should be a separation of financing (enrolment, collection of contributions, management, control of performance) and provision of health care goods and services (contracts, remuneration, quality control).

Article 13 raises some questions : Number 1 deals with out-patient treatment, Nr. 4 apparently with hospital treatment ("accommodation"). Why is there a misleading difference between Nr. 4 ("normal cases and emergencies") and Nr. 1 ? Necessary treatment also concerns normal cases and emergencies also in clinics. Number 5 comprises "cleaning". Does this mean taking away tartar? There is no provision concerning services and health care goods for handicapped persons, eg. wheel chairs or crutches. If such a provision is inserted there should be an approved basic medical devices list.

Article 13 last phrase allows participants to subscribe for additional health services for extra fees. If NHIP is allowed to offer additional services this opens the door to a two class medicine. It is an incentive for providers to deliver even covered services in the basic services package for extra fees. Moreover it is very difficult to calculate the fees in a manner that they cover the costs of the additional health services in a solidarity – oriented system. Additional services should be made available only by a separate private health insurance and not by the NHIP.

Service Providers

As indicated earlier, the NHIP does not provide health services by itself. They are delivered as benefits in kind (not paid cash by the patient and later reimbursed by the Corporation). This makes it necessary for the Corporation to contract with all providers. "Providers" does not only mean health care providers (e.g. hospitals, physicians, dentists) but also suppliers of health goods (e.g. medical devices, pharmaceuticals and related goods to be covered by the basic services package). Therefore the Corporation (i.e. the CEO, cf. Article 11 Nr. 4) has to contract not only with civil and private health institutions but with Government health institutions, too.

Article 11 Nr. 4 and Article 14 specifies no requirements for contracted providers. This would mean that the Corporation has to contract with all providers who offer their services regardless of their qualifications. It is strongly recommended to lay down in Article 14 some principles for the selection of qualified providers : All public and private health care providers who are duly licensed and meet regulatory requirements (set by the Board of Directors, cf. Article 6 Nr. 2) should be eligible to be considered for contracts with the Corporation. The CEO should determine the procedures for selecting providers who can participate in tenders and in direct contracts with the Corporation and the CEO should develop payment mechanisms. Prices of services and goods should not be fixed by the Corporation or any other competent authority but negotiated between the Corporation(e.g.the CEO) and the provider or the providers' association.

The Corporation should issue documents (e.g. a card) to insured persons upon their enrolment to serve as evidence of their eligibility .This document could be used for proper identification, eligibility verification (i.e. that contributions are duly paid) and utilization recording (e.g. for implementing a hardship clause for chronically ill patients) : All insured persons should be

obliged to present this health insurance card at the point of service. It is recommended that specific information about how the card should be used be inserted as a special provision after Article 14.

Eligibility

The NHIP shall cover all Palestinian citizens. Participation of foreigners is regulated in Article 15. It is recommended to add a provision concerning contributions of subscribed foreigners and to define who sets the fees and the list of health services and charges for foreigners not enrolled.

There should be a separate regulation for the effectiveness of health insurance coverage, not connected with the contribution rate (as done in Article 17). This provision should define the commencement of effective coverage for all groups of insured, not only PA employees and other employees.

There is no regulation for health insurance coverage of those who do not pay contributions though being obliged and being able to do so. It is recommended to stop benefits to them (and their family?) after having warned them and their employer by written mail.

Financing

It should be clarified that contributions of the insured may come from different sources :

Contributions from wages and salaries (employed person plus employer's share)

Contributions from income (self employed e. g. lawyers, physicians, architects, artisans, farmers)

Contributions for unemployed persons (by the Ministry of Labour)

Contributions for social cases (by the Ministry of Social Affairs).

It is recommended to introduce a provision that defines the assessment basis, the contribution rate, a monthly ceiling and a minimum amount per month, the procedure of paying the contribution for employed persons (cf. Article 21). If this will be left to implementing regulations (by whom ?) they should enter into effect with the law.

There is no provision concerning family members without income, pupils and students. Are they covered by State budget subsidies ? Or is this financial source earmarked for any shortfall in the Corporation's fund ? In this case it would be necessary to write it down in a special regulation.

A family-based solution is recommended : The contributions comprise the health insurance for spouses and minor children (possible age limit 16) living in the household without own income. These family members are insured without paying own contributions but have to be registered with the Corporation.

It is recommended that contributions for pupils and students should be paid by the Ministry of Education.

The term : "Contribution" should not be mixed up with "co-payment" (cf. Article 16 Nr. 6) or "fee" (cf. Article 17).

In Article 22 and 23 it is not clear who elaborates the internal bylaws. There should be a vital interest of the Ministry of Health to join this elaboration process because the Ministry is politically responsible for the functioning of the NHIP.

Co-payment

Health policymakers differ in their view of co-payments. Some view them as a possible restriction on the claim for benefits and other simply view them as a means of financing. The draft uses it as a source of financing the fund (cf. Article 16 Nr. 6) - though it also serves to influence the demand-side behaviour of the claimant. It is recommended not to change it- but to use the word "co-payment" instead of "contribution" (cf. Article 18 and 20).

There should only be one provision for co-payment and not two of them (cf. Article 18 and 20). Article 20 comprises all health services and mixes co-payment with price setting without providing a percentage rate whereas Article 18 sets 5 percent of the relevant cost of treatment. It is recommended that a co-payment be required in Article 18 for all insured : 5 percent of the cost of health services prices of which are set by decision of the Ministry of Health (not contracted with providers by the CEO ?) and 10 percent of the price of medication. Health providers should collect the co-payment directly from the patient and deduct it from the remuneration paid to them by the Corporation. Setting minimum and a maximum limits for co-payments is also advisable.

The enumeration of free services (cf. Article 19) where patients do not pay any co-payment is too extensive. It is uncertain whether 20 percent of health insurance returns will be enough. Nrs. 4-7 should be introduced at a later time when the financial situation of the Corporation will be stabilized. It is recommended to authorize the Minister of Health to extend the list if this can be justified financially. Nr. 3 should be reworded : Women during pregnancy, delivery and confinement.

It is recommended that a hardship clause be included for those patients who do not enjoy free services but may be overburdened financially by co-payment. This meets especially with chronically ill patients. There should be a maximum amount of co-payment for a certain period, perhaps depending from the income situation of the patient.

Conflict Resolution and Dispute Settlement

The Corporation should establish internal mechanisms for fair (cost and time) and effective dispute settlement. It is recommended that a review board be established in the Main Office dealing with disputes over issues of financing, payment, medical necessity and disagreement. The Board of Directors should issue instructions and procedures for the operation of the review board.

The CEO should report the review board's findings with his recommendation to the Board of Directors. The Board should have the right to approve or reject the recommendation of the CEO and if necessary forward it to the courts.

Penalties

Article 21 provides measures against employers who do not pay contributions in due order. This is the only sanction in the draft and will not be adequate as far as inspections, information and pharmaceuticals/health care goods are concerned. It is recommended to stiffen the penalty/sentence (fine/prison in severe cases with a maximum term) for any person who prevents employees of the Corporation personnel who are entitled to act as judicial officers from entering the work site, or not allowing them to access any records, books, documents and papers required in the course of executing this present law or declines to make available any data of information set forth in this law.

It is recommended to include a legal penalty/sentence for any person who may in bad faith give false details or abstains in bad faith from giving the details stipulated by this law together with the regulations and decisions executing thereof resulting in obtaining payments from the Corporation wrongfully.

It is also recommended to include a legal penalty/sentence for any staff member or contracting doctor, pharmacist, supplier of health care goods and so on, who may assist any beneficiary or the like who receive medical care from the National Health Insurance, in obtaining medicines or other goods either wrongfully or when these are not required to be prescribed by medical traditions. Furthermore for any person who may receive any medicines or other medical goods then dispose of the same to another.

Effectiveness, Transitional Provisions

It is recommended to bring into effect the provisions of the law in a gradual manner and to lay this down in a special provision : At the date of the publication all regulations concerning general provisions, organization regulations and enrolment, three months later all regulations concerning revenue collection, contributions and services should come into force.

Members of the current health insurance systems should remain in their system unless they become insured in the NHIP. This should happen with the second step, i. e. three months after publication.

Proposed Structure of the Draft Legislation

Chapter I (General provisions and definitions) should define the purpose and scope of the law, the principles of National Health Insurance, its relation to the private Health Insurance and describe definitions.

Chapter II (Organization of Health Insurance) should describe the establishment of the Corporation, the organization (Main Office and branches), objectives of the Corporation and its relation to the Ministry of Health (supervision).

Chapter III (Board of Directors) should comprise the appointment of the Board, the members, jurisdictions, procedure (meeting, decisions) and the duty to report regularly.

Chapter IV (Chief Executive Officer) should describe his/ her appointment and his/her jurisdictions.

Chapter V (Eligibility) should define the persons eligible for benefits : All Palestinian citizens and certain foreigners

Chapter VI (Covered services) should describe the basic services package, participants` co-payment , free services and a hardship clause for people who do not get free services but are financially overburdened by co-payment.

Chapter VII (Financing) should define the sources of financing, the contributions of the insured and their employers, contributions of other Ministries, State budget subsidies and revenue collection.

Chapter VIII (Providers of Health Care Goods and Services) should comprise the principle how benefits are provided, the selection of qualified providers and the qualification for Health Care Providers.

Chapter IX (Conflict resolution and dispute settlement) should comprise a general provision how to resolve conflicts, provisions on a review board and on a Medical Service which supports the Corporation in medical questions.

Chapter X (Penalties) should provide penalties when inspections by the Corporation are declined, necessary information is kept back, pharmaceuticals and medical goods are sold by beneficiaries unlawfully and data protection is violated.

Chapter XI (Transitional provisions, coming into force) should provide regulations concerning the transition from the current system (State Insurance, Voluntary Insurance, Corporate Health Insurance, Al-Aqsa Intifada Insurance) to the National Health Insurance and the coming into force of different regulations of the law.

Chapter I General Provisions and Definitions

- § 1 Purpose and Scope of the Law
- § 2 Principles
- § 3 Relations to Private Insurance
- § 4 Definitions

Chapter II Organization of Health Insurance

- § 5 Establishment of the Corporation
- § 6 Main Office of the Corporation
- § 7 Objectives of the Corporation
- § 8 Relations to the Ministry of Health (Supervision, Auditing)

Chapter III Board of Directors

- § 9 Appointment of the Board
- § 10 Members
- § 11 Jurisdictions
- § 12 Meetings
- § 13 Decisions
- § 14 Reports

Chapter IV Chief Executive Officer

- § 15 Appointment
- § 16 Jurisdictions

Chapter V Eligibility

- § 17 Palestinian Citizens
- § 18 Foreigners

Chapter VI Covered Services

- § 19 Basic Services Package
- § 20 Co-Payment
- § 21 Free Services
- § 22 Hardship Clause

Chapter VII Financing

- § 23 Sources of Financing
- § 24 Contributions of the Insured
- § 25 Contributions of the Employer
- § 26 Contributions of the Ministry of Social Affairs
- § 27 Contributions of the Ministry of Labour
- § 28 Collection of the Contributions
- § 29 State Budget Subsidies

Chapters VIII Providers of Health Care Goods and Services

§ 30 Principle

§ 31 Selection of Qualified Providers

§ 32 Qualification for Health Care Providers

Chapter IX Conflict Resolution and Dispute Settlement

§ 33 General Provision

§ 34 Review Board

§ 35 Medical Service

Chapter X Penalties

§ 36 Inspections

§ 37 Information

§ 38 Pharmaceuticals

§ 39 Data Protection

Chapter XI Transitional Provisions, Coming into Force

§ 40 General Provision

§ 42 First Step

§ 42 Second Step

ANNEX II: HEALTH REFORM OPTIONS SIMULATION TOOLKIT (HROST)

The World Bank recently developed and operationalized a health reform options simulation toolkit (HROST) which is a computer-based model designed to simulate financial and other projections related to the health sector. The model can be used to estimate future trends pertaining to coverage, use of services, revenues and expenses; and it can also be used to evaluate the impact of reforms on health sector financing and different distributional outcomes (income, age and gender). One of the strengths of the model is that it generates a consistent numerical framework for health system analysis and policy decisions.

Some of the policy questions it can help answer include

- What is the projected national health spending by financing agents, sources, functions (using the National Health Accounts framework)?
- What are the projected financing requirements for the Government?
- What are the required premium and co-payment levels
- How would different options change financing requirements and distributional effects

The model consists of six input modules and four output modules. The input modules cover the areas of population, coverage, utilization, general (macro economic assumptions) revenues and expenditures and the output modules cover the areas of population, coverage and utilization, wages and spending, and financial flows. The model has been used by World Bank teams to evaluate health insurance reform options in both Lebanon and Jordan.

Data Requirements for HROST

HROST is a data-driven model and thus requires reliable information to generate the simulations. Since complete data are never available in most middle and low-income countries, assumptions are made based on comparable countries and contexts.

There main data requirements to run HROST are grouped into three categories:

- Demographic data by age and gender
 - population,
 - mortality,
 - fertility,
 - net migration
- Economic data
 - GDP,
 - inflation,
 - interest rates,
 - employment, wages
- Health system
 - coverage rates by insurance scheme and income group
 - utilization rates by age, gender, coverage status, type of service
 - administrative costs by insurance scheme, government

- public health programs
- public/private spending
- price/unit cost by type of service, financing agent, coverage status
- premium/contributions, collection rate, government transfers, other revenues by insurance scheme

ANNEX III: PREPARING A BUSINESS APPLICATION FOR A NEW HUMAN RESOURCE MANAGEMENT INFORMATION SYSTEM

As part of the overall effort to reform the HR system in the MOH, business specifications for a modern human resources software application should be identified to help operationalize the new human resource development and management system. Without a new IT system for human resources, it will be difficult to manage and monitor the performance of the MOH staff

Cost estimates for a modern HR management information system are as follows:

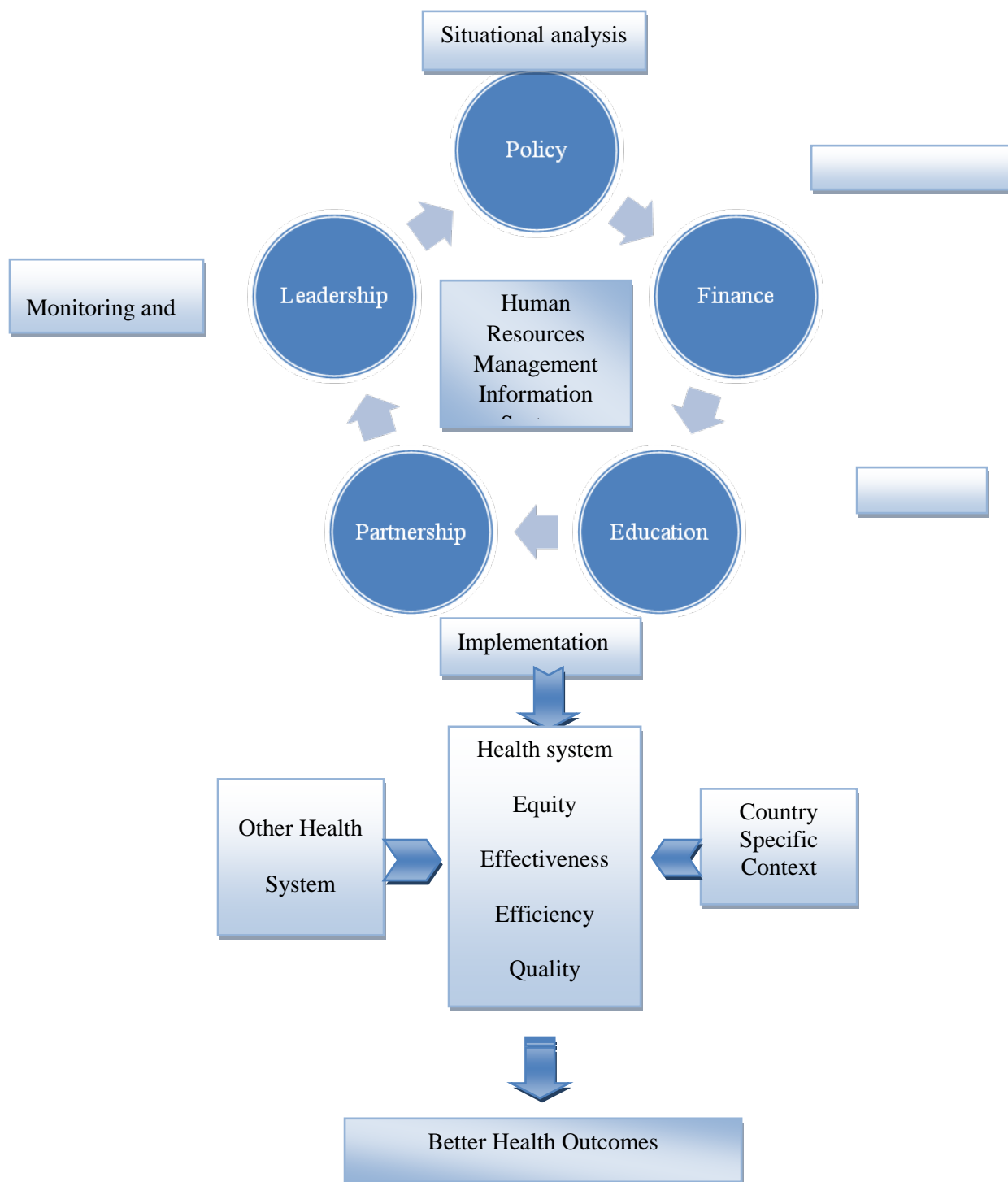
Human Resources Management Information System - (Software and licence)	95 000 €
Installation and testing	35 000 €
Training of trainers (2 weeks)	25 000 €
<hr/>	
Total	155 000 €

This new management information system would: (i) help the MOH move beyond the traditional approach of personnel administration to a more modern concept of human resources management (HRM); (ii) give more weight to the integrated, interdependent and systemic nature of the different components of HRM when preparing and implementing policy and (iii) foster a more proactive attitude among human resources (HR) policy-makers and managers

In designing the business requirements of the new management information system, certain critical questions need to be considered by decision-makers in the MOH; (i) is HR an integral element of the reforms agenda, from pre-planning through to implementation and evaluation? ; (ii) Is there sufficient capacity to implement the necessary changes in HR, and to deal with the challenges that will arise? and (iii) Does the health care workforce understand the need for the reforms? To what extent does it support the reform plan?

The following schematic underscores the importance of effective human resource management information systems for the mission of the Palestinian Ministry of Health.

FIGURE 18: CENTRAL ROLE OF HR MANAGEMENT INFORMATION SYSTEM



ANNEX IV - PROTOCOL ON ECONOMIC RELATIONS
(Only Preamble and Articles I-III Included)

between

the Government of the State of Israel
and
the P.L.O., representing the Palestinian people

Paris, April 9, 1994

PREAMBLE

The two parties view the economic domain as one of the cornerstone in their mutual relations with a view to enhance their interest in the achievement of a just, lasting and comprehensive peace. Both parties shall cooperate in this field in order to establish a sound economic base for these relations, which will be governed in various economic spheres by the principles of mutual respect of each other's economic interests, reciprocity, equity and fairness.

This protocol lays the groundwork for strengthening the economic base of the Palestinian side and for exercising its right of economic decision making in accordance with its own development plan and priorities. The two parties recognise each other's economic ties with other markets and the need to create a better economic environment for their peoples and individuals.

Article I: FRAMEWORK AND SCOPE OF THIS PROTOCOL

1. This protocol establishes the contractual agreement that will govern the economic relations between the two sides and will cover the West Bank and the Gaza Strip during the interim period. The implementation will be according to the stages envisaged in the Declaration of Principles on Interim Self Government Arrangements signed in Washington D.C. on September 13, 1993 and the Agreed Minutes thereto. It will therefore begin in the Gaza Strip and the Jericho Area and at a later stage will also apply to the rest of the West Bank, according to the provisions of the Interim Agreement and to any other agreed arrangements between the two sides.
2. This Protocol, including its Appendixes, will be incorporated into the Agreement on the Gaza Strip and the Jericho Area (in this Protocol - the Agreement), will be an integral part thereof and interpreted accordingly. This paragraph refers solely to the Gaza Strip and the Jericho Area.
3. This Protocol will come into force upon the signing of the Agreement.
4. For the purpose of this Protocol, the term "Areas" means the areas under the jurisdiction of the Palestinian Authority, according to the provisions of the Agreement regarding territorial jurisdiction. The Palestinian Jurisdiction in the subsequent agreements could cover areas, spheres or functions according to the Interim Agreement. Therefore, for the purpose of this Protocol, whenever applied, the term "Areas" shall be

interpreted to mean functions and spheres also, as the case may be, with the necessary adjustments.

Article II: THE JOINT ECONOMIC COMMITTEE

1. Both parties will establish a Palestinian-Israeli Joint Economic Committee (hereinafter - the JEC) to follow up the implementation of this Protocol and to decide on problems related to it that may arise from time to time. Each side may request the review of any issue related to this Agreement by the JEC.
2. The JEC will serve as the continuing committee for economic cooperation envisaged in Annex III of the Declaration of Principles.
3. The JEC will consist of an equal number of members from each side and may establish sub-committees specified in this Protocol.
A sub-committee may include experts as necessary.
4. The JEC and its sub-committees shall reach their decisions by agreement and shall determine their rules of procedure and operation, including the frequency and place or places of their meetings.

Article III: IMPORT TAXES AND IMPORT POLICY

1. The import and customs policies of both sides will be according to the principles and arrangements detailed in this Article.
2.
 - a. The Palestinian Authority will have all powers and responsibilities in the sphere of import and customs policy and procedures with regard to the following:
 1. Goods on List A1, attached hereto as Appendix I locally-produced in Jordan and in Egypt particularly and in the other Arab countries, which the Palestinians will be able to import in quantities agreed upon by the two sides up to the Palestinian market needs as estimated according to para 3 below.
 2. Goods on List A2, attached hereto as Appendix II, from the Arab, Islamic and other countries, which the Palestinians will be able to import in quantities agreed upon by the two sides up to the Palestinian market needs as estimated according to para 3 below.
 - b. The import policy of the Palestinian Authority for Lists A1 and A2 will include independently determining and changing from time to time the rates of customs, purchase tax, levies, excises and other charges, the regulation of licensing requirements and procedures and of standard requirements. The valuation for custom purposes will be based upon the GATT 1994 agreement as of the date it will be introduced in Israel, and until then - on the Brussels Definition of Valuation (BDV) system. The classification of goods will be based on the

principles of "the Harmonized Commodity Description and Coding System". Concerning imports referred to in Article VII of this Protocol (Agriculture), the provisions of that Article will apply.

3. For the purposes of para 2(a) above, the Palestinian market needs for 1994 will be estimated by a sub-committee of experts. These estimates will be based on the best available data regarding past consumption, production, investment and external trade of the Areas. The sub-committee will submit its estimate within three months from the signing of the Agreement. These estimates will be reviewed and updated every six months by the sub-committee, on the basis of the best data available regarding the latest period for which relevant data are available, taking into consideration all relevant economic and social indicators. Pending an agreement on the Palestinian market needs, the previous period's estimates adjusted for population growth and rise in per-capita GNP in the previous period, will serve as provisional estimate.
4. The Palestinian Authority will have all powers and responsibilities to independently determine and change from time to time the rates of customs, purchase taxes; levies, excises and other charges on the goods on List B, attached hereto as Appendix III, of basic food items and other goods for the Palestinian economic development program, imported by the Palestinians to the Areas.
5.
 - a. With respect to all goods not specified in Lists A1, A2 and B, and with respect to quantities exceeding those determined in accordance with paras 2(a) & 3 above (hereinafter - the Quantities), the Israeli rates of customs, purchase tax, levies, excises and other charges, prevailing at the date of signing of the Agreement, as changed from time to time, shall serve as the minimum basis for the Palestinian Authority. The Palestinian Authority may decide on any upward changes in the rates on these goods and exceeding quantities when imported by the Palestinians to the Areas.
 - b. With respect to all goods not specified in Lists A1 and A2, and with respect to quantities exceeding the Quantities, Israel and the Palestinian Authority will employ for all imports the same system of importation, as stipulated in para 10 below, including inter alia standards, licensing, country of origin, valuation for customs purposes etc.
6. Each side will notify the other side immediately of changes made in rates and in other matters of import policy, regulations and procedures, determined by it within its respective powers and responsibilities as detailed in this Article. With regard to changes which do not require immediate application upon decision, there will be a process of advance notifications and mutual consultations which will take into consideration all aspects and economic implications.
7. The Palestinian Authority will levy VAT at one rate on both locally produced goods and services and on imports by the Palestinians (whether covered by the three Lists mentioned above or not), and may fix it at the level of 15% to 16%.
8. Goods imported from Jordan, Egypt and other Arab countries according to para 2(a)(1) above (List A1) will comply with rules of origin agreed upon by a joint sub-committee

within three months of the date of the signing of the Agreement. Pending an agreement, goods will be considered to have been "locally produced" in any of those countries if they conform with all the following:

- a.
 - i. They have been wholly grown, produced, or manufactured in that country, or have been substantially transformed there into new or different goods, having a new name, character, or use, distinct from the goods or materials from which they were so transformed;
 - ii. They have been imported directly from the said country;
 - iii. The value or the costs of the materials produced in that country, plus the direct processing costs in it, do not fall short of 30 percent of the export value of the goods. This rate may be reviewed by the joint committee mentioned in para 16 a year after the signing of the Agreement.
 - iv. The goods are accompanied by an internationally recognized certificate of origin;
 - v. No goods will be deemed as substantially new or different goods, and no material will be eligible for inclusion as domestic content, by virtue of having merely undergone simple combining or packaging, or dilution with water or other substances, which do not materially alter the characteristics of the said goods.
9. Each side will issue import licences to its own importers, subject to the principles of this Article and will be responsible for the implementation of the licensing requirements and procedures prevailing at the time of the issuance of the licenses. Mutual arrangements will be made for the exchange of information relevant to licensing matters.
- 10. Except for the goods on Lists A1 and A2 and their Quantities - in which the Palestinian Authority has all powers and responsibilities, both sides will maintain the same import policy (except for rates of import taxes and other charges for goods in List B) and regulations including classification, valuation and other customs procedures, which are based on the principles governing international codes, and the same policies of import licensing and of standards for imported goods, all as applied by Israel with respect to its importation. Israel may from time to time introduce changes in any of the above, provided that changes in standard requirements will not constitute a non-tariff-barrier and will be based on considerations of health, safety and the protection of the environment in conformity with Article 2.2. of the Agreement on Technical Barriers to trade of the Final Act of the Uruguay Round of Trade Negotiations. Israel will give the Palestinian Authority prior notice of any such changes, and the provisions of para 6 above will apply.**
11.
 - a. The Palestinian Authority will determine its own rates of customs and purchase tax on motor vehicles imported as such, to be registered with the Palestinian Authority. The vehicle standards will be those applied at the date of the signing of the Agreement as changed according to para 10 above. However, the Palestinian Authority may request, through the sub-committee on transportation, that in special cases different standards will apply. Used motor vehicles will be imported only if they are passenger cars or dual-purpose passenger cars of a

model of no more than three years prior to the importation year. The sub-committee on transportation will determine the procedures for testing and confirming that such used cars comply with the standards' requirements for that model year. The issue of importing commercial vehicles of a model prior to the importation year will be discussed in the joint sub-committee mentioned in para 16 below.

- b. Each side may determine the terms and conditions for the transfer of motor vehicles registered in the other side to the ownership or use of a resident of its own side, including the payment of the difference of import taxes, if any, and the vehicle having been tested and found compatible with the standards required at that time by its own registration administration, and may prohibit transfer of vehicles.

12.

- a. Jordanian standards, as specified in the attached Appendix I, will be acceptable in importing petroleum products into the Areas, once they meet the average of the standards existing in the European Union countries, or the USA standards, which parameters have been set at the values prescribed for the geographical conditions of Israel, the Gaza Strip and the West Bank. Cases of petroleum products which do not meet these specifications will be referred to a joint experts' committee for a suitable solution. The committee may mutually decide to accept different standards for the importation of gasoline which meet the Jordanian standards even though, in some of their parameters, they do not meet the European Community or USA standards. The committee will give its decision within six months. Pending the committee's decision, and for not longer than six months of the signing of the Agreement, the Palestinian Authority may import to the Areas, gasoline for the Palestinian market in the Areas, according to the needs of this market, provided that:

- 1. this gasoline is marked in a distinctive colour to differentiate it from the gasoline marketed in Israel; and
- 2. the Palestinian Authority will take all the necessary steps to ensure that this gasoline is not marketed in Israel.

- b. The difference in the final price of gasoline to consumers in Israel and to consumers in the Areas, will not exceed 15% of the official final consumer price in Israel. The Palestinian Authority has the right to determine the prices of petroleum products, other than gasoline, for consumption in the Areas.
- c. If Egyptian gasoline standards will comply with the conditions of sub-para (a) above, the importation of Egyptian gasoline will also be allowed.

- 13. In addition to the points of exit and entry designated according to the Article regarding Passages in Annex I of the Agreement for the purpose of export and import of goods, the Palestinian side has the right to use all points of exit and entry in Israel designated for that purpose. The import and export of the Palestinians through the points of exit and entry in Israel will be given equal trade and economic treatment.

14. In the entry points of the Jordan River and the Gaza Strip:

a. Freight shipment

The Palestinian Authority will have full responsibility and powers in the Palestinian customs points (freight-area) for the implementation of the agreed upon customs and importation policy as specified in this protocol, including the inspection and the collection of taxes and other charges, when due.

Israeli customs officials will be present and will receive from the Palestinian customs officials a copy of the necessary relevant documents related to the specific shipment and will be entitled to ask for inspection in their presence of both goods and tax collection. The Palestinian customs officials will be responsible for the handling of the customs procedure including the inspection and collection of due taxes. In case of disagreement on the clearance of any shipment according to this Article, the shipment will be delayed for inspection for a maximum period of 48 hours during which a joint sub-committee will resolve the issue on the basis of the relevant provisions of this Article. The shipment will be released only upon the sub-committee's decision.

b. Passengers customs lane

Each side will administer its own passengers customs procedures, including inspection and tax collection. The inspection and collection of taxes due in the Palestinian customs lane will be conducted by customs officials of the Palestinian Authority. Israeli customs officials will be invisibly present in the Palestinian customs lane and entitled to request inspection of goods and collection of taxes when due. In the case of suspicion, the inspection will be carried out by the Palestinian official in a separate room in the presence of the Israeli customs official.

15. The clearance of revenues from all import taxes and levies, between Israel and the Palestinian Authority, will be based on the principle of the place of final destination. In addition, these tax revenues will be allocated to the Palestinian Authority even if the importation was carried out by Israeli importers when the final destination explicitly stated in the import documentation is a corporation registered by the Palestinian Authority and conducting business activity in the Areas. This revenue clearance will be effected within six working days from the day of collection of the said taxes and levies.

16. The Joint Economic Committee or a sub-committee established by it for the purposes of this Article will deal inter alia with the following:

1. Palestinian proposals for addition of items to Lists A1, A2 and B. Proposals for changes in rates and in import procedures, classification, standards and licensing requirements for all other imports;
2. Estimate the Palestinian market needs, as mentioned in para 3 above;
3. Receive notifications of changes and conduct consultations, as mentioned in para 6 above;
4. Agree upon the rules of origin as mentioned in para 8 above, and review their implementation;
5. Coordinate the exchange of information relevant to licensing matters as mentioned in para 9 above;

6. Discuss and review any other matters concerning the implementation of this Article and resolve problems arising therefrom.
17. The Palestinian Authority will have the right to exempt the Palestinian returnees who will be granted permanent residency in the Areas from import taxes on personal belongings including house appliances and passenger cars as long as they are for personal use.
18. The Palestinian Authority will develop its system for temporary entry of needed machines and vehicles used for the Palestinian Authority and the Palestinian economic development plan. Concerning other machines and equipment, not included in Lists A1, A2 and B, the temporary entry will be part of the import policy as agreed in para 10 above, until the joint sub-committee mentioned in para 16 decides upon a new system proposed by the Palestinian Authority. The temporary entry will be coordinated through the joint sub-committee.
19. Donations in kind to the Palestinian Authority will be exempted from customs and other import taxes if destined and used for defined development projects or non-commercial humanitarian purposes. The Palestinian Authority will be responsible exclusively for planning and management of the donors' assistance to the Palestinian people. The Joint Economic Committee will discuss issues pertaining to the relations between the provisions in this Article and the implementation of the principles in the above paragraph.