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DEVELOPING THE OCCUPIED TERRITORIES

An Investment in Peace

6

HUMAN RESOURCES AND SOCIAL POLICY

A World Bank Publication

DEVELOPING THE OCCUPIED TERRITORIES

AN INVESTMENT IN PEACE

Volume 6: Human Resources and Social Policy

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NIS 1.00	=	US$ 0.361
US$ 1.00	=	NIS 2.764
JD 1.00	=	US$ 1.453
US$ 1.00	=	JD 0.688

GLOSSARY OF ABBREVIATIONS

CBS	=	Central Bureau of Statistics
GDP	=	Gross Domestic Product
GHS	=	Government Health Service
GNP	=	Gross National Product
IBRD	=	International Bank for Reconstruction and Development
ILO	=	International Labour Organization
JD	=	Jordanian Dinar
NGO	=	Non Governmental Organization
NIS	=	New Israeli Sheqal
UNDP	=	United Nations Development Program
UNICEF	=	United Nations International Children's Emergency Fund
UNRWA	=	United Nations Relief and Works Agency
WB	=	West Bank
WHO	=	World Health Organization

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PREFACE

1. At the request of the sponsors and organizers of the Middle East Peace Talks, the World Bank has been supporting the work of the Multilateral Working Group on Economic Development and Regional Cooperation by providing analyses of the key economic issues and developmental challenges facing the Middle East region. At its second meeting in Paris in October 1992, the Working Group requested the Bank to expand its contribution to include, *inter alia*, an assessment of the development needs and prospects of the economies of the West Bank and the Gaza Strip (commonly referred to as the Occupied Territories). In response to this request, a Bank mission visited the Occupied Territories during the period January 21-February 24, 1993. The mission comprised five teams focusing on the following areas: Private Sector Development, Agriculture, Human Resources, Infrastructure and Macroeconomics. Each team was in the field for about two weeks. The mission was led by Prem Garg who, together with Samir El-Khouri, stayed in the field throughout to provide continuity and guidance to the five teams. The staffing of the five teams was as follows:

Macroeconomics:	Michael Walton (Team Leader) Samir El-Khouri (Fiscal Analyst) Ishac Diwan (Macroeconomist)
Private Sector Development:	Albert Martinez (Team Leader) Robert Mertz (Financial Sector Specialist) Joseph Saba (Legal Specialist) Dileep Hurry[1] (Regulatory Environment and Tourism Specialist)
Agriculture:	Gert van Santen (Team Leader) Ulrich Kuffner (Water Resource Engineer) Merle Jensen[1] (Horticulture Specialist)
Infrastructure:	Alastair McKechnie (Team Leader) Ulrich Kuffner (Water Resource Engineer) Lawrence Hannah (Urban Specialist) Nail Cengiz Yucel (Transport Sector Specialist) Ted Moore[1] (Power Engineer)
Human Resources:	Fredrick Golladay (Team Leader) Maureen Field[1] (Education Specialist) Radwan Ali Shaban[1] (Human Resource Economist)

2. Mission members travelled extensively in the West Bank and Gaza, visiting municipalities, farms, businesses, industries, academic institutions, refugee camps and NGO-run facilities. Mission members also travelled in Israel, as needed, and paid several visits to Amman. The representatives of the key bilateral and multilateral donors in Jerusalem, Tel Aviv and Amman responsible for the Occupied Territories were kept briefed about the work of the mission. Close contact was also maintained with the field staff of UN agencies.

1/ Bank consultant.

3. The Bank mission was received warmly by all sides, who took keen interest in the work of the mission and provided superb logistical and counterpart support for the field work. The main counterparts on the Israeli side were the Bank of Israel and the Civil Administration in charge of the Occupied Territories. On the Palestinian side, the main counterparts were the Technical Committees of the Palestinian Team to the Peace Conference, consisting mainly of Palestinians who are members of the bilateral or multilateral peace teams. The Ministry of Planning was the main contact on the Jordanian side. The Bank would like to thank all concerned parties, especially the Israeli, Jordanian and Palestinian hosts, for the excellent support and cooperation that the Bank mission received for this field work.

4. This report is based on the findings of the above mission. The report is in six volumes:

- **Volume I** provides a summary ***overview*** of the key findings and recommendations of the study. After commenting selectively on the current socioeconomic situation in the OT and its evolution over time, it discusses prospects for sustainable development in the future and outlines the priority agenda of policies and programs needed to promote such development.

- **Volume II** explores the strategic choices at the ***macro*** level that will be faced by the OT in the future and the implications for economic relations between the OT and the rest of the region. The study looks at the current situation and its evolution over the past 25 years. The study then examines several policy choices for the future affecting the structure of development in the OT. Finally, it outlines some illustrative scenarios for the future, focussing on the consequences of current developments in the region.

- **Volume III** reviews the performance of the ***private sector*** (including, in particular, the industry and tourism sectors) in the OT. The study assesses the environment in which the private sector operates and its future prospects and makes recommendations for accelerating private sector development in the future.

- **Volume IV** reviews the evolution and structure of the ***agricultural*** sector in the OT; analyzes its current characteristics; assesses OT competitiveness in the immediate and longer term; outlines the main policy options and their implications; and provides a preliminary assessment of sectoral financial and technical assistance (TA) needs.

- **Volume V** assesses the current situation in the ***infrastructure*** sectors (electricity, water supply and sanitation, transport, housing and solid waste services) in the OT; identifies the major issues confronting these sectors; and outlines priorities for TA and investment needs. As local authorities are major institutions in the delivery of public services in these sectors, the study also includes a review of their current situation and makes recommendations for improving the functioning of municipalities.

- **Volume VI** reviews the current status as regards ***human resource*** development; analyzes options for enhancing individual welfare and labor productivity in the OT; and outlines investment and TA priorities for strengthening existing programs and for laying the foundation for later reforms.

5. It is worth highlighting two limitations of this study right at the outset. First, a number of key issues bearing upon the future development of the OT (e.g., the allocation of land and water resources, the disposition of Israeli settlements in the OT, the future status of expatriate Palestinians, the territorial issues surrounding Jerusalem and, most importantly, the nature of the proposed "self-governing" arrangements for the OT) are the subject of ongoing bilateral negotiations between the Israelis and the Palestinians. The resolution of these issues is likely to be based primarily on political and security considerations. As the Bank mission to the OT was a *technical mission*, with neither the mandate nor the expertise to deal with political or security aspects, this study does not take any positions on issues that are on the agenda for bilateral negotiations. The focus instead is on policies, institutions and investments--where optimal choices are largely invariant to the eventual political arrangements to be agreed at the bilateral negotiations. Thus, for example, while analysing, where appropriate, the economic links between East Jerusalem and the West Bank and Gaza, the report avoids making any judgements regarding the future status of East Jerusalem.

6. Second, the study has had to cope with very serious *data gaps and inconsistencies*. Much of the data on the OT are, directly or indirectly, from official Israeli sources. There are, however, serious gaps in the OT data base. A population census has not been carried out in the OT for more than 25 years. As a result, most of the demographic and labor force data are based on extrapolations and on sample surveys, the reliability of which are undermined by problems of nonresponse, especially since the onset of the *Intifada* (popular uprising) in 1987. Data on East Jerusalem and on Israeli settlements in the OT, both of which are treated as part of Israel by the official Israeli sources, are mostly unavailable. Data available on trade between the OT and Israel and on the profitability and competitiveness of the agricultural, industrial and service enterprises are also very limited. Data on the OT from Palestinian and Israeli nonofficial sources are sparse and selective. Also, Palestinian data, when they exist, are often based on *ad hoc* surveys that do not lend themselves easily to cross-sectional or longitudinal comparisons. In many instances, data differ between sources, and, even when the same source is used, there are gaps and apparent inconsistencies. Given these data problems, the report uses estimates that appear most plausible in light of the mission's field observations. In cases where the data differences among various sources are particularly sharp (e.g., population, unemployment and social indicators), the report attempts, where possible, to examine the reasons for these differences and to indicate the implications of alternative estimates for the results of the analysis.

7. In view of the limitations on the mission mandate, the data difficulties and the time and resource constraints, this study can only be considered a beginning. The analysis in the study, especially for the longer term, is necessarily incomplete; as, and when, progress is made in the bilateral negotiations, the study will need to be updated and expanded to take account of the agreements reached. Also, notwithstanding the care exercised in locating and interpreting the data from various sources, the empirical underpinnings of this study leave something to be desired, and, therefore, the conclusions of the study should be treated only as indicative of broad trends and priorities. Further, in-depth studies and project feasibility work will be required before the findings of this report could be used to make operational decisions.

8. An earlier draft of this report was discussed with the Israeli, Jordanian and Palestinian authorities by a Bank mission to the region during July 12-26, 1993. Where appropriate, the report has been revised to incorporate the comments received by the mission during the July discussions.

EXECUTIVE SUMMARY

1. The broad purposes of this report are, first, to help define the options for enhancing individual welfare and labor productivity in the Occupied Territories and, second, to contribute to the development of a strategic plan for pursuing these goals in the future. The report focuses on three sectors: health, education and social welfare. It concludes that the development of a coherent policy framework and the creation of effective public sector institutions are prerequisites for improvements in the contributions of these sectors. The report also suggests investments that should be undertaken over the next decade in order to strengthen existing programs and to lay the foundations for the implementation of sectoral reforms.

2. The published literature on social conditions and needs in the Occupied Territories is very large, but many of the data are highly controversial. Hence, the empirical basis for assessing policy alternatives is unsatisfactory. Nonetheless, the broad outlines of a sound policy are clear. In the case of health, improving access to basic services should be assigned greater priority than either increasing the supply of hospital services or increasing the technical sophistication of care. In contrast, in the education sector, improvements in fundamental areas, such as curriculum development and teacher training, are needed to enable the system to offer quality instruction and, thus, to expand employability and productivity. A comprehensive, but simple, system of social protection is needed to replace the patchwork of categorical programs that now serve some, but not all, members of the community. In all three areas, the creation of unified, coherent programs is an urgent priority.

A. Historical Background

3. The weaknesses of programs in the social sectors are due primarily to a pervasive lack of coherence in policies and programs. The variety of systems of health, education and social policy that coexist in the Occupied Territories grows out of a remarkably complex history. Following the war of 1948, and the creation of the state of Israel, the West Bank became a part of Jordan and the Gaza Strip came under the control of Egypt. The health and education policies of the two governing countries were then introduced into the territories by Egypt and Jordan. In 1950, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) was created by the United Nations in order to provide humanitarian assistance and employment opportunities to displaced Palestinians. UNRWA was also assigned the task of providing social services to refugees. Its education programs were made to follow the outlines of the government education systems, but its health programs were allowed to follow different paths. Israel occupied the Gaza Strip and the West Bank in 1967, but retained the policies and structures that were introduced earlier by Egypt and Jordan. Israel has made only minor modifications to sector policies and institutions since that time. The most important of these reforms has been to replace a policy of free government health services with one in which care was to be financed by a government-sponsored health insurance scheme and user fees. Charitable and profit --seeking institutions quickly emerged to compete with the government service. Small changes have also been made in the operation of government health care institutions. The educational policies and practices that Israel took over in 1967 have been left largely unchanged.

4. Expenditures on health, education and social welfare programs are now controlled by five clusters of institutions, none of which is either responsive, or accountable, to the entire community.

Access to their services often depend upon the recipient's status, past or current. About 30 percent of the population of the Gaza Strip and the West Bank benefit from the Israeli Government's health insurance plan, and slightly more than 60 percent of school children in the Occupied Territories attended government schools in 1991. Half of the residents of the Occupied Territories are registered refugees and, thus, entitled to the free primary and secondary education, health care and relief services provided by UNRWA. Residents of the larger towns have access to sophisticated health and education services supplied by charitable organizations. People living in poorly served areas have begun to receive basic health and social services from networks of grass roots voluntary organizations that have expanded very rapidly since 1987. Those who can afford to pay have access to high quality private health and education services.

5. Three primary sources of financial support may be identified for these various activities. In 1991, the Civil Administration spent US$125 million on health and education services in the Occupied Territories, with 90 percent of this total allocated to recurrent expenditures. UNRWA spent a total of US$85 million in order to provide health, education and relief services in 1991. Nongovernmental organizations, both charitable and for-profit, added approximately US$185 million.

B. Human Resources

6. The de facto Palestinian population of the Occupied Territories was 1,769,000 at the end of 1992, according to the Israeli Central Bureau of Statistics (CBS). However, independent research suggests that there may be a downward bias in the CBS estimates of 10-15 percent. This suggests that the resident population may have been as much as 2 million people at the end of 1992. The rate of natural population increase has been rising over the period 1968-91, from a low rate of 2.2 percent in 1968 to 4.1 percent in the West Bank and 5.0 percent in Gaza Strip in 1991. A decline in mortality drove the acceleration of population growth initially, but starting in the mid-1980's, the increase seems to have been due to a rise in birth rates. About half of the population is now less than 15 years of age. The share of the population over 35 years of age has declined continuously from 25 percent in 1967, to 18 percent in 1990.

7. About 308,000 persons --34 percent of the adult population-- are members of the labor force. If age cohort-specific participation rates were to remain unchanged, the labor force participation rate for the male population 15 or older years would increase from 72 percent over the period 1986-1991 to 75 percent in the year 2000; the total number of workers would then be about 470,000.

8. The emigration rate from the Occupied Territories has been quite high since 1967. There was a large wave of politically motivated migration immediately following the Israeli occupation, but high rates of migration have continued since, as well. In 1985, about 40 percent of families in the Occupied Territories had one or more family members residing abroad. It is estimated that currently 3,000,000 to 3,500,000 Palestinians live outside of the Occupied Territories. How many of these might return to the Occupied Territories would depend upon a variety of factors including the agreements reached in bilateral negotiations and the perceptions of expatriate Palestinians concerning future economic opportunities in the Occupied Territories.

C. Health

Health Status

9. Health conditions in the Occupied Territories are fairly typical of lower-middle income, developing countries. The infant mortality rate is about 45 infant deaths per thousand live births, and life expectancy is about 66 years. The communicable diseases of childhood have largely been overcome, and gastrointestinal and respiratory infections remain major problems only in the Gaza Strip. High rates of respiratory and skin infections continue to be reported by residents of refugee camps due to residential crowding and poor environmental sanitation. Food supplies are adequate in quantity and fairly well distributed. The customary diet is rich in proteins and fiber and low in animal products, but it is deficient in some micronutrient, most notably iron. Moderate and severe malnutrition are virtually unknown. The West Bank reports rates of cardiovascular disease, hypertension, diabetes and cancer characteristic of industrialized countries. Nonetheless, many residents of the Occupied Territories are dissatisfied with the quality and accessibility of health services. This dissatisfaction is based primarily on observations of very large differences between the range and quality of services available in the Occupied Territories and in Israel.

Institutions and Finances

10. Health services are provided in the Occupied Territories by clusters of institutions operated by the Civil Administration, UNRWA, private voluntary organizations and private, for-profit providers. Each cluster focuses on the needs of a distinct segment of the population. In 1991 the Civil Administration managed about 37 percent of all expenditures on modern health care. UNRWA's share was about 10 percent. The voluntary and for-profit sectors together controlled more than half of all spending on health care.

11. ***Civil Administration.*** The institutions operated by the Civil Administrations in the Gaza Strip and the West Bank are still recognizable as descendants of the Egyptian and Jordanian systems. Until 1974, when a government health insurance scheme was introduced, residents of the Gaza Strip and the West Bank were entitled to free health care from these facilities. Now only members of the government health insurance scheme may receive comprehensive care at government facilities without charge. (They may also obtain services that are not available within the Occupied Territories from Israeli hospitals; 597 patients were referred to Israeli hospitals in 1990). Prenatal care and preventive services are provided by the Civil Administration, without charge, to all children under the age of three years. In addition, those injured by the Israeli Defense Force and those infected with highly contagious diseases are treated free of charge.

12. All Palestinian employees of the Civil Administration, and of municipal authorities in the Occupied Territories, are required to join the government insurance scheme. Palestinians who are employed by Israeli firms also are required to participate. Reports of the numbers of families enrolled in the government scheme vary enormously. The budget of the Civil Administration estimates the revenues for 1992 from health fees to be US$25 million, implying that about 75,800 households (a fifth of the total population) were covered. Persons who are not enrolled in the government health insurance scheme may purchase services from government clinics and hospitals; revenues from patient charges may represent as much as 20 percent of the total resources available to the public sector.

13. About 61 percent of the government health budget is devoted to the operation of acute care hospitals, and only about 28 percent is spent on primary care and public health services. The remaining 11 percent is committed to other public health functions, including the inspection of sanitary conditions and disease surveillance. This pattern of resource allocation has resulted in the underprovision of basic outreach services, especially in relatively isolated areas.

14. *UNRWA.* UNRWA offers basic health care without charge to 940,000 registered refugees. It also contracts with private and government hospitals for the provision of secondary care to refugees. In addition, UNRWA reimburses refugees for sixty percent of the cost of hospital care obtained from outside the UNRWA system; however, the funds budgeted for this purpose typically are exhausted by the end of the eighth month of the fiscal year.

15. In 1991 UNRWA spent about US$20 million on health programs in the Occupied Territories. Nearly US$12 million of this was allocated to activities in the Gaza Strip. Approximately 58 percent of the total budget was devoted to primary prevention and health promotion activities, while hospital care consumed the remaining 42 percent. The UNRWA budget is supported by some 60 governments and a dozen charitable organizations.

16. *The Voluntary Sector.* Private voluntary organizations are responsible for about a fifth of spending on health care. Most private medical charities were established after the introduction of the government health insurance scheme in 1974 and were provided with generous external assistance during the 1980s by Middle Eastern countries and private donors. These institutions offer modern curative care from very well-equipped clinics and charge patients for their services. Since the onset of the Intifada, a group of grass-roots non-governmental organizations have expanded dramatically. They provide very basic preventive and promotive care, emphasizing health education, maternal and child health care and outpatient-management of chronic conditions. The activities of the voluntary sector are not closely supervised or regulated and, as a consequence, reflect a very wide range of aims and policies.

17. *Private Health Care.* About US$25 million was spent in 1991 on health care produced by private for-profit organizations; this represents nearly 12 percent of total health care expenditures. In addition, more than twice that amount was spent by households on pharmaceuticals; about half of private spending on drugs was for over-the-counter pain killers. Most private expenditure is financed from user fees, but a private insurance company does offer health insurance to about 10,000 households. Insurance benefits may be used to pay for care from approved sources in either the public or private sector.

18. Largely because of a proliferation of health care providers, the cost in 1991 of providing health care to the residents of the Gaza Strip and West Bank represented about 7 percent of Gross National Product (GNP) or about 9 percent of Gross Domestic Product (GDP).

Health Care Facilities

19. Government health care services are produced at 14 hospitals and 165 primary health care clinics. The 14 hospitals had a total of 1,546 beds in 1990. Most government clinics are fully staffed for only one or two days a week. The Civil Administration has not increased the number of beds in government hospitals since 1967. Even so, the bed occupancy rate is 62 percent; this low rate of utilization of government hospitals is due in part to economic barriers.

20. UNRWA provides its services through a network of 42 health centers, 9 of which are located in the Gaza Strip. Most facilities in the Gaza Strip have well equipped diagnostic laboratories. A staff of 82 physicians serve the more than a half million refugees in the Gaza Strip. Facilities in the West Bank are generally less extensive but, nonetheless, include 13 diagnostic laboratories. A staff of 61 physicians care for about 400,000 registered refugees. UNRWA also operates feeding centers, dental clinics, maternity centers and a 34-bed hospital. Five private, voluntary hospitals in the West Bank and two government hospitals in the Gaza Strip are used to deliver secondary care.

21. About half of all primary health care facilities are owned and managed by private, voluntary organizations. Between 720 and 750 physicians (approximately a third of all physicians practicing in the Occupied Territories) work at clinics in the voluntary and for-profit sectors. About 200 physicians and about 800 nurses are employed by non-governmental hospitals. Thirty percent of acute care hospital beds and half of all hospitals are operated by the NGO sector. For-profit, private providers are also important sources of care, but little is known about their activities. Most are public employees working after hours.

Special Initiatives

22. The Civil Administration has worked with several external agencies to improve health care and environmental conditions in the Occupied Territories. It has cooperated with UNICEF since 1985 in developing a program to provide prenatal and child care to high-risk groups in small, isolated villages. Other initiatives have included programs to identify and manage high risk pregnancies, provide training and continuing education to traditional midwives, and provide rehabilitation services and physical therapy.

23. The Palestinian medical charities have also made significant contributions to health care. The subsidies delivered through these initiatives have been financed mainly with private donations from the Gulf and grants from official bilateral sources. In addition, grass-roots non-governmental organizations (known among Palestinians as "national" voluntary organizations) have grown rapidly since the beginning of the Intifada in 1987. These groups have promoted initiatives aimed at the care of mothers and children, treatment of minor illnesses, control of infectious diseases and health education. These programs have grown at an explosive rate; more than a hundred clinics were constructed between 1988 and 1990. The impacts of these initiatives are not yet reflected in health statistics and indicators.

Sector Problems

24. The Occupied Territories devote an unusually large share of their resources to the health sector and do not obtain the health impact from this expenditure that they should. Several reasons for poor performance are apparent. First, most social resources are being used to provide costly, high technology, hospital-based care for the benefit of the relatively well to do. Second, very small, inefficient hospitals have been allowed to proliferate (68 percent of all hospitals have fewer than 100 beds). Third, highly specialized procedures are being carried out by units that are too small either to exploit economies of scale or to provide physicians and staff with enough practice to maintain skills. Finally, too little attention is being given to reaching out to underserved groups, especially women.

Recommendations

25. The development of a sound policy environment will be required in order to address these problems. Present inefficiencies are rooted in the fragmentation of responsibility, not only for the delivery of health care, but also for the management of subsidies to the sector from the government

budget and external donors. This problems is intensified by the lack of a broad sense of accountability to the public. A responsible body must be created to develop a coherent health policy and to coordinate activities in the sector. Since a large number of highly diverse and effective organizations now populate the sector, such a body should not seek to control sector activities directly, but rather should seek to achieve greater coordination.

26. Policies should, at the same time, seek to interrupt the link between refugee or employment status and entitlement to subsidized health care. In assembling a set of policies, issues of health care finance, service standards, investment in technology and quality assurance should be addressed. In view of the large fraction of GDP already being committed to the sector, policies should also stress increasing the internal efficiency of the health sector and controlling the overall costs of health care, rather than expanding the system, particularly at the hospital level. Sanitation should be further improved, and a larger fraction of cases of acute diarrhea should be treated with oral rehydration fluids. Acute respiratory infections should be diagnosed earlier and treated with appropriate drugs. The onset of chronic diseases due to such conditions as hypertension and diabetes should be controlled at primary health care level with appropriate diet and drug therapy.

D. Education and Training

27. A strong commitment to education is reflected in the formal attainments of the populations of the Occupied Territories: Palestinians are among the most highly educated of any Arab group. Much of the higher education has been acquired from European and North American institutions. Nonetheless, basic and secondary education provided in the Occupied Territories is generally of poor quality.

Institutions of the Education Sector

28. The institutions found in the education sector in the Occupied Territories are much less complex than those found in the health sector. The Occupied Territories are served by two distinct systems of education: the Egyptian system in the Gaza Strip and the Jordanian system in the West Bank. These two system are organized differently, pursue distinct objectives and employ separate examination systems. The Civil Administration supervises all primary and secondary educational institutions. Services are provided by the Civil Administration, UNRWA and a small number of private (principally charitable) organizations. Schools operated by the Civil Administration enroll about 62 percent of all primary and secondary school students; UNRWA provides schooling to about 31 percent of the students; and the voluntary and private, for-profit institutions serve less than 8 percent. In 1991 enrollment in primary schools was equivalent to about 102 percent of the estimated population aged 6-12. (The excess enrollment is due to either underestimation of the school age population and/or the enrollment of overage students.) Because of frequent strikes and curfews, many schools have been closed from half to a quarter of the time since 1987.

29. Vocational education and technical training are offered by both the Civil Administration and UNRWA. Vocational and technical education have a very poor public image and have never been a serious part of the education program. Israel established additional vocational training centers in the main cities of the West Bank and the Gaza Strip, after 1967, in order to prepare semi-skilled laborers for employment in the Israeli economy. Most courses are only a few days in length and are designed to

enable Palestinians to meet the formal requirements of the Israeli labor market. The most common course prepares students to take the written examination for a license to drive a truck in Israel.

30. Insufficient effort has been made to assess the training needs or evaluate the outcomes of training courses. The Civil Administration Labour Staff Officer, responsible for Civil Administration vocational training activity has met with local employers regularly, to identify vocational training needs in the Territories. Furthermore, the Civil Administration has run an employment follow-up of some of the vocational training graduates in order to evaluate how effective the programs are in practice. Teaching subjects such as communications, has been prohibited because the equipment could easily be used for military purposes. Courses have focused on the mastery of crafts and have provided little instruction in organization and management; training for self-employment has been almost totally neglected. Both public and private vocational schools are seriously underfunded, and, hence, facilities are inadequate and equipment is often obsolete.

31. All university and most community college instruction is supplied by private, voluntary organizations. Higher education institutions are supervised by the Higher Education Council, which is composed of representatives of the colleges and universities and elected leaders from the education sector. There are 20 community and teachers' training colleges in the West Bank and one in the Gaza Strip. Four of these are administered by the Civil Administration, three by UNRWA, nine by the Council for Higher Education and five by private entities. The community colleges offer technical training (e.g., engineering), agricultural, commercial (business administration), paramedical, social services and teachers' training programs.

32. There are eight universities in the Occupied Territories: six in the West Bank --including an open university-- and two in Gaza. According to the Council for Higher Education, there were a total of 16,368 students and 1010 faculty in Palestinian universities during the 1991-92 academic year. Universities are too small to be able to provide economically the laboratory and library facilities required for advanced study, particularly in the sciences. Approximately 40 percent of university students in the West Bank are women. The universities have played a major role in the political activities of the Territories. Because of this, they were closed from the beginning of the Intifada until 1992 when the Civil Administration began to allowed designated faculties to reopen.

33. Efforts are being made, in the main by charitable institutions, to combat a significant problem of illiteracy among Palestinian adults. Some 170 centers in the West Bank are run by voluntary organizations, but there is a growing need for more and better equipped centers. In the Gaza Strip there are 27 centers; the Palestinian Red Crescent Society plays a major role in supporting these centers. The Civil Administration provides literacy training at about ten vocational training centers. The Higher Committee for Literacy and Adult Education coordinates literacy training activities.

Education Finance

34. The total expenditure for all levels of academic education is about US$170 to 175 million a year. This represents a per capita expenditure of US$90-100 per resident of the Occupied Territories and corresponds to approximately two-thirds of the amount being spent per capita on health care.

35. Total expenditure on education for grades 1-12 in 1991 for the Occupied Territories was between US$140 and US$150 million. The Civil Administration spent US$58 million in 1991 and has budgeted US$80 million for 1992. The UNRWA 1991 education budget for the Occupied Territories was

US$52 million: two-thirds for the Gaza Strip and one-third for the West Bank. Per student expenditures were about US$153 in government schools: US$334 per student in UNRWA schools in the Gaza Strip and about US$425 at UNRWA schools in the West Bank. These per student expenditures represent between 15 and 25 percent of per capita GDP. Neighboring Arab countries are spending on average between 11 (Iraq) and 22 (Morocco) percent of per capita GDP, per student. Differences in unit costs are due to variations in salaries and to greater expenditures on teaching materials and the maintenance of facilities in UNRWA schools. Private primary and secondary schools are financed largely or entirely with student fees; they attract paying students because they are perceived to offer a better education. Private spending on primary and secondary education totaled about US$13 million in 1991.

36. Per student costs for college and university education range from US$1,500-2,000. The total cost of university level education is about US$27 million a year. Students are charged fees of US$400-500 per year. The universities are financially autonomous. They have obtained about two thirds of their funds from private and foreign donors in the past. Because of sharp drop in foreign donations and significant decrease in fee income due to lengthy closures since the onset of the Intifada, many universities now face financial crises. Most are now depleting staff retirement funds in order to meet essential expenses. Several have been unable to pay faculty salaries for months at a time and, as a result, have experienced faculty strikes. Libraries, laboratories, textbooks and other educational materials and computer facilities are deteriorating.

Education Resources

37. About 18,600 teachers were employed during the 1991-92 school year. Two-thirds of these teachers (a total of 12,496) were working for the Civil Administration, and about 22 percent were employed by UNRWA. The private sector employed slightly fewer than 10 percent of all teachers. The lowest student-teacher ratio was found in the private sector in the Gaza Strip where there were only 16.9 students per teacher; the highest student-teacher ratio was found in UNRWA schools in the Gaza Strip where the ratio was 36.1 students per teacher. The average school enrolls about 400 students. Many schools are housed in converted residences and many others are operated on double shifts.

38. At present, most teachers have a two-year diploma from a community or teachers' college. Under Jordanian Law, all West Bank teachers must have a minimum qualification of Bachelor of Arts degree by 1997. Some efforts have already been made to provide in-service training at teacher training institutes and universities.

Problems

39. The school curricula have been borrowed from Egypt (for the Gaza Strip) and Jordan (for the West Bank). The contents of the two curricula and methods of instruction have not been revised significantly since the beginning of the Occupation in 1967, but textbooks have been updated periodically. The present curricula emphasize the recall of facts rather than higher level cognitive skills, including analysis and synthesis. Present materials afford students few opportunities to participate actively in learning; to develop and apply skills in formulating researchable or solvable problems; or to draw on a wide range of knowledge, skills and analytic methods to illuminate real-world problems. Curriculum reforms are being pursued by both Jordan and Egypt, but classroom activities have not yet been affected.

40. The qualifications of educational personnel in almost all positions need to be strengthened. A reform of both pre-service and in-service teacher education is urgently needed. Present teaching methods

do not take advantage of recent advances in educational theories, practice and technologies. There is a need to strengthen the skills of administrators and planners, as well.

41. School buildings are generally in a poor state of repair. Libraries, laboratories and recreational facilities are generally inadequate, as are supplies of textbooks and teaching materials. Libraries and laboratories are inadequate throughout the university system.

42. The frequent closing of schools since the beginning of the Intifada is reported to have led to an increase in dropout rates, a breakdown in discipline and deterioration of student achievement. The needs of those school children who should have been attending school during this period are poorly documented but clearly require urgent attention. Widespread violence has also produced an alarming growth in the population that is physically or mentally disabled. Some 37 training institutions have been created to address the needs of these groups. About 2,900 persons are enrolled in these institutions, most of which are privately operated.

Recommendations

43. An extensive education planning process should be initiated to consider the goals, possibilities and resources for a unified education system for the Gaza Strip and West Bank. Planners, administrators and curriculum experts should be given training in carrying out these tasks. Personnel exchanges across institutions could prove useful. A program to replace inadequate and insufficient educational facilities should also be developed.

44. A revised curriculum should be developed that can be adopted on both the West Bank the and Gaza Strip. It should not only give attention to the modernization of content and teaching methods, but should also link curricula to broad economic, social and cultural objectives. As the development of curricula is time-consuming and costly, consideration should be given in the short term, to adapting materials from abroad, especially in the sciences and mathematics.

E. Social Welfare and Relief Programs

45. The legal environment and the programs that protect the welfare of workers and provide relief to the needy draw upon elements of many separate and uncoordinated systems. The partition of Palestine in 1948 led to the introduction of Egyptian and Jordanian labor laws and social programs in the Occupied Territories. The creation of UNRWA ensured that registered refugees were entitled to an alternative collection of protections and benefits; a large number of international voluntary organizations have been created since 1950 to provide humanitarian aid to refugees. The adoption by the Government of Israel of an open borders policy following the 1967 war extended the benefits of many of Israel's social welfare programs to Palestinians working in Israel. These developments have yielded a patchwork of relief programs that ensure that some, though not all, the residents of the Occupied Territories receive assistance in meeting their basic needs.

Institutions and Programs

46. The core of the social welfare system for the residents of the Occupied Territories is the collection of programs operated by UNRWA. About half the population of the Occupied Territories are registered refugees. Of the US$98 million UNRWA spent in the Gaza Strip and in the West Bank in

1991, about US$12.6 million was allocated to relief and social programs. Ninety percent of the budget for relief and social services programs was used to provide direct assistance to needy refugees. In addition, UNRWA administered a number of projects serving especially vulnerable groups such as widows, the aged and the physically disabled; these programs continue to be funded from special contributions. Relief and social service programs focus on "special hardship cases" to whom food, shelter, clothing and other survival needs are offered. UNRWA also operates a modest loan program for special hardship cases.

47. Palestinians who work for Israeli employers are required to participate in the Government of Israel's national social security scheme. All taxes that are applied to Israeli workers were imposed on foreign (Palestinian) workers to ensure that the latter do not cost employers less than Israeli workers and, thus, have a competitive advantage in labor markets. These deductions finance a wide range of benefits to Israeli workers but only a very limited set of benefits to Palestinians. The taxes contributed on behalf of Palestinians that are not used to pay for benefits to them are transferred to the budget of the Civil Administration. The amount deposited represents 11.8 percent of wages paid. The Government of Israel reports that the total amount transferred was about US$23 million in 1992; this amount is equivalent to what should have been collected from 36,100 full time workers employed at the minimum wage. This suggests that Israeli firms substantially underreport the employment of Palestinian workers.

48. Collective bargaining agreements represent the principal source of social security benefits in Israel. The agreements define the benefits to be provided to workers and the contributions to be made by workers and employers in order to finance these benefits. Palestinian workers are required to participate in these programs. The combined contributions of employers and employees in the private construction sector represent 37 percent of wages. The benefits under the collective agreement are supposed to be available to all workers, but residency in Israel is required to benefit from most programs. The disposition of the unused funds collected from Palestinians is not clear. Palestinian staff of the Civil Administration and municipal authorities located in the Occupied Territories participate in social insurance schemes that provide them pensions and health care. The Civil Administration also operates a Social Welfare Department that provides indigent families with food, medical insurance, education assistance and cash stipends.

49. Residents of the Gaza Strip are employed under the provisions of Egyptian labor law. The law regulates conditions of employment, including the minimum age for workers and the maximum hours of work; however, they do not provide for compensation in the event of work-related injuries or accidents nor provide for pension benefits, health insurance coverage, maternity benefits or severance pay.

50. The Jordanian labor law applies to workers in the West Bank. It regulates the employment of women and children and prescribes the maximum hours of work per day and week. It requires that employers provide annual leave, severance pay and compensation for workplace injuries. The Jordanian law does not provide for pension rights, old age insurance, survivor benefits, compensation for work related disabilities, health insurance or family benefits.

51. The most important sources of financial security and social protection for residents of the Occupied Territories have been individual savings and private, intra-family transfers. Palestinians have, for many years, successfully sought employment abroad and have saved a very large fraction of their earnings. Reliable information on the management and use of worker remittances is not available, but anecdotal information suggests that many households are able to retire very early and to live on the income obtained from these savings. The collapse of employment opportunities in the Gulf in 1991, and

the losses of savings that occurred with the freezing of accounts in Gulf banks in 1991, may have seriously impacted this approach to achieving income security.

Deficiencies in the Social Insurance System

52. The provisions for social security for the residents of the Occupied Territories are patchy, inequitable and inadequate. The Palestinians living in the Gaza Strip and the West Bank participate in programs reflecting their refugee and employment status. About half of the total population of the Occupied Territories qualify for assistance from UNRWA. Its programs of relief and social services are targeted on "special hardship cases" in which the head of household is female. Approximately 8 percent of the refugee population benefits from these programs. However, UNRWA supplements these benefits with a quite extensive program of health benefits and with shelter services in the camps. Many refugee families also qualify for benefits from other sources and do not employ the services of UNRWA.

Recommendations

53. Resources to support a comprehensive social welfare program are unlikely to become available to a self-governing Palestinian authority over the next few years. Moreover, over the longer term such an authority will be called upon to replace those benefits that have been provided to the very needy by UNRWA and the Civil Administration. It will be faced with demands for the maintenance of in-kind transfers to registered refugees, including free health care, subsidized housing services and assistance in the education of children. These in-kind subsidies constitute a significant safety net for persons with refugee status; large numbers of people maintain their refugee status simply in order to remain qualified for these programs in the event of a personal economic crisis.

54. The public sector will have to develop a basic program of social protections and ensure that the resulting list of services receives broad political endorsement. The list should provide for the handicapped, elderly, orphaned and widowed, but it should not seek to replace reliance on private transfers and personal savings. The public sector should facilitate the operation of benefit programs that are self-financing from employee and employer contributions but should, in the near term, avoid the development of programs that draw heavily on general public revenues for their financing.

55. The public sector should also encourage the development of private institutions that supply financial services, including health and life insurance companies and pension schemes. A very small insurance industry already exists in the West Bank; with the creation of an appropriate regulatory and legal environment, that industry could contribute significantly to meeting the community's need for economic security.

F. Financial Requirements

56. Investments of US$475 to US$550 million will be required over a period of ten years in order to address the needs that have been identified in this report and to replace depreciated equipment and facilities. About US$12 million would be required for technical assistance and the remainder would be needed for capital investments (including design, construction supervision and the like). Roughly US$35 million could be invested immediately in the rehabilitation of social facilities and urgent expansion of services. These estimates are very approximate because the underlying analyses have been based on

sketchy data. Before final decisions are taken, a more thorough investigation of the health, education and social welfare sectors should be undertaken. Such a study should be carried out by a team of local and international experts and should allow sufficient time to thoroughly examine the facts and institutions in these sectors.

I. INTRODUCTION AND BACKGROUND

1.1 The broad purposes of this report are, first, to help define the public policy options for enhancing individual welfare and labor productivity in the Occupied Territories and, second, to contribute to the development of a strategic plan for introducing these policies in an environment in which the bureaucracy is directly accountable to its clients. The report focuses on three sectors: health, education and social welfare.

1.2 Social conditions in the Occupied Territories are fairly typical of lower middle-income countries. Life expectancy at birth is about 66 years, and the infant mortality rate is about 40-45 deaths per thousand live births. The pattern of disease and the burden of morbidity are also characteristic of this group of countries: Infections of the gastrointestinal and respiratory systems are the leading causes of death among infants and children, and high fertility is a further important threat to child health. Adult onset diseases play a modest role at present in determining the health of the population, but they are becoming more common.

1.3 All children are being offered the opportunity for a basic education. However, the quality of this education and the contributions it is making to the productivity of the labor force are not as great as one might reasonably hope or expect. The deficiencies in the education program are due primarily to weaknesses in the school curriculum and to antiquated teaching methods. In addition, frequent school closures due to strikes and curfews have played an important role in undermining educational achievements since the beginning of the "popular uprising" (*Intifada)* in December 1987.

1.4 The patchwork of programs intended to enable families to deal with emergencies and extraordinary health care costs are adequate for some segments of the society, but they are entirely inadequate for many others. Access to basic health care is assured for perhaps 60 percent of the population, and old age pensions are available to no more than a quarter of households. Unemployment benefits and compensation for work-related injuries and illnesses are available to a minority of Palestinians.

1.5 The published literature on social conditions and needs in the Occupied Territories is vast but, at the same time, highly controversial. Hence, the empirical basis for identifying policy problems or evaluating policy alternatives is weak. Nonetheless, it is clear that substantial advances could be achieved in all three of these areas --health care, education and social welfare-- without significantly increasing public sector spending. The development of a coherent policy framework and the creation of effective public sector institutions are the keys to increasing program effectiveness and ensuring equitable access to benefits. In the case of health, improving access to basic services should be assigned priority, and, at the same time, expanding the production of hospital services and increasing the technical sophistication of care should be delayed. In the education sector, fundamental improvements in areas such as curriculum and teacher training are needed to enable the system to offer quality instruction and, thus, to contribute fully to employability and labor productivity. The impact of social welfare programs could be increased by reducing the range of benefits being provided and, instead, focusing on the provision of a very basic level support to the most needy members of the community. The criteria for eligibility for social benefits should be redrafted to remove the anomalies created by categorical programs for refugees, civil servants and foreign workers. In all three areas, the creation of unified, coherent programs is an

urgent priority. The report identifies investments that should be undertaken in the near term in order to strengthen existing programs and to lay the foundations for later reforms, and it lays out, in general terms, a program of capital expenditures that will be required over the longer term.

Box 1.1: The Issue of Jerusalem

The city of Jerusalem has occupied a central place in the history of three great religions - Judaism, Christianity and Islam. It has also played a major role in shaping the economic, social and political lives of the Middle East Region for over three thousand years. Therefore, an important aspect of the current conflict in the Region centers on the control of Jerusalem.

The 1948 war led to partition of Jerusalem into the Eastern and Western parts. At the end of the 1967 War, East Jerusalem was occupied by Israeli forces. Following the occupation, the Jerusalem city limits were expanded by Israel to include some surrounding areas from the West Bank. The expanded city was annexed by Israel on July 30, 1980. Arab residents of Jerusalem have been given the option of obtaining Israeli citizenship although very few have chosen to do so. Israel views Jerusalem as its historic capital and maintains that Jerusalem must never again be a divided city.

Actions taken by Israel were considered invalid by the United Nations, which called upon Israel to refrain from taking any action that would alter the status of Jerusalem. Although the international community has not recognized the Israeli annexation of East Jerusalem, Israel continues to exercise authority over the area and considers it an integral part of Israel and not subject to further negotiations. The Palestinians insist that East Jerusalem is part of the West Bank as per the pre-1967 borders and that Israel should withdraw from all areas occupied during the 1967 war as per the United Nations resolutions.

There are important economic links between the West Bank and Gaza Strip and Jerusalem. Decisions concerning Jerusalem would, therefore, have important implications for future economic prospects and priorities for the Occupied Terrotories. The following are among the most important of these links:

- The tourist potential of the West Bank is critically dependent on the ancient religious sites of Jerusalem.
- Major north-south transportation links in the West Bank pass through Jerusalem.
- The only tertiary care hospital and some of the best secondary care hospitals available to the West Bank population are located in East Jerusalem.
- East Jerusalem houses much of the Palestinian financial services, marketing facilities, and social and cultural infrastructure.
- Qalandia airport, a potential outlet for linking the West Bank with regional airports, is within annexed Jerusalem.
- Parts of East Jerusalem are an integral part of the power network covering the area from Ramallah to Bethlehem.

Considering that the question of Jerusalem is essentially a political matter, this report should not be construed as taking any position on this issue. Therefore, while analyzing the links where appropriate, this report has endeavored to avoid making any recommendations that might imply prejudging the status of Jerusalem.

A. Organization of the Report

1.6 The report is organized into five chapters. The remainder of this chapter reviews the history of social development in the Gaza Strip and the West Bank since 1948. Chapter 2 describes the human resources of the Occupied Territories. Chapters 3, 4 and 5 examine in turn the health, education and social welfare sectors in the Occupied Territories. These three chapters review the current status of efforts in each sector, describe the programs and institutions that are now addressing needs, summarize the financial and real resource commitments being made to the area and identify the principal problems of the sector. Finally, these chapters suggest initiatives that would help to overcome these problems. Chapter 6 summarizes the findings of the report, and outlines investment priorities.

B. Historical Background

1.7 The weaknesses of programs in the social sectors are due more to a lack of coherence in policies and initiatives, rather than to a lack of resources or to the mismanagement of particular programs. This incoherence is the result of the duplication and competition introduced into the system through the creation, over the past 45 years, of several largely independent authorities in each sector. This complex organizational environment has grown out of an extraordinary set of historical developments. With improvement of the policy environment, it will be possible to address, efficiently, additional needs, but this will require that more funds are found.

1.8 When Israel was created in 1948, the Gaza Strip came under the control of Egypt and the West Bank became a part of Jordan. In 1950 the United Nations introduced a third major player into the area by establishing the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA). UNRWA was intended to provide direct international assistance and essential social services to Palestinians displaced as a result of the 1948 war. Persons whose means of livelihood had been destroyed as a result of the settlement, and who could prove residency in Palestine for at least two years prior to the settlement, were registered as refugees. The refugees were provided with education, health care and relief services, as well as temporary shelter (tents and camping gear), food and clothing. The UNRWA refugee camps have since become permanent settlements. All Palestinians who can trace their ancestry (along the male line) to refugees continue to be entitled to benefit from these programs. Because the demands on its budget exceed its resources, UNRWA has recently been forced to introduce nominal charges for health care services provided by private hospitals.

1.9 Since the end of the 1967 Middle East War, the Government of Israel has occupied the two territories. A military government was established to maintain order and to safeguard the welfare of the citizens of the Occupied Territories. The occupying military government continued the policies and programs that had been introduced in the Occupied Territories by the Egyptian administration and the Government of Jordan. In addition, civil servants working in the West Bank, including health workers and teachers, were kept members of the Jordanian civil service and continued to be paid in part from funds provided by the Government of Jordan. In November 1981 the functions of the military government were reorganized into two branches. The Israeli Defense Force was assigned the task of maintaining law and order, and the Civil Administration was given the responsibility for advancing the welfare of the Palestinian population.

1.10 Over the past 25 years, the military government has made several modifications to the social programs that had been operated by the Governments of Egypt and Jordan for the benefit of the

Palestinians prior to 1967. These changes have been introduced primarily in order to reduce costs, but, in some instances, they were instituted in order to improve efficiency. The most important of these changes was to halt the free provision of medical care to everyone from government health facilities. In 1974, the military government began to impose user charges on those who did not enroll in the newly created government health insurance scheme. Both charitable and profit-seeking institutions quickly emerged to provide health care in competition with the fee-for-service health care system. Several of these institutions were highly successful in attracting funding for the construction and operation of health centers and polyclinics from Arab countries. This funding enabled them both to purchase modern medical equipment not available in government health facilities and to charge fees that were substantially less than the cost of producing the services. Since the beginning of the popular uprising in 1987, several groups of grass-roots voluntary organizations expanded very rapidly in order to provide basic health care. These groups have sought both to increase the supply of primary health care and to reduce the dependency of the Palestinian people on the Israeli Civil Administration. Since 1974, when charges for the use of government health care facilities were first introduced, the proportion of the population relying on the government health care system has fallen from nearly 90 percent to less than a third.

1.11 The Palestinian graduates of both government and private schools in the West Bank are examined by local officials under the supervision of the Civil Administration and representatives of the Ministry of Education of Jordan. Graduates in the Gaza Strip are examined by Egyptian officials. Therefore, all schools, to the maximum extent possible, pursue the curriculum and instructional methods of the examining countries. Presumably because of the difficulties that have been encountered in obtaining the latest teaching materials, the performance of Palestinian students has generally not been as good as that of Egyptian and Jordanian students. Private schools have sprung up that provide better teaching materials, smaller classes and richer course offerings than either the government or UNRWA offers.

C. The Present Situation

1.12 Health, education and social welfare programs are now controlled by five clusters of institutions. These institutions are not accountable to the entire Palestinian community even though they have responsibility for the allocation of subsidies provided from domestic taxes and international aid. The costs of these programs are met from a poorly understood combination of user fees, local taxes, private donations and international contributions. Access to these services is allocated among people on the basis of their membership in predefined groups rather than on their individual need for services or their financial circumstances. About 30 percent of the population of the Gaza Strip and the West Bank benefit from the Israeli Government's health insurance plan, and slightly more than 60 percent of school children in the Occupied Territories attended government schools in 1991. Half of the residents of the Occupied Territories are registered refugees and, thus, entitled to free primary and secondary education, basic health care and relief services provided by UNRWA. High technology health care is provided in Israeli hospitals to insured persons. Residents of the larger towns have access to sophisticated health and education services produced by charitable organizations. The subsidies from official donors and private benefactors are distributed in nontransparent ways. People living in poorly served areas have begun to receive basic health and social services from a fast-growing network of voluntary organizations. Those who can afford to pay have access to high quality private health and education services.

II. OVERVIEW OF THE STOCK OF HUMAN RESOURCES

A. Population Estimates

2.1 The Israeli Central Bureau of Statistics (CBS) estimated the de facto[1] Palestinian population of the West Bank to have been 1,052,000 and the population of the Gaza Strip to have been 717,000 at the end of 1992. Thus, the total population of the Occupied Territories would be roughly 1,769,000 persons at the end of 1992. The CBS estimates were obtained by updating the census of population conducted in September 1967; cumulative reported births were added to the census figure and cumulative estimates of deaths were subtracted. Further adjustments were made for net emigration in order to obtain an estimate of the resident (de facto) population. Table 2.1 presents CBS population estimates for the period 1967-1993, along with the estimates for each year of natural increase and net emigration employed in updating the census.

Alternative Population Estimates

2.2 Independent researchers have tested the CBS estimates of population using a variety of techniques. These studies have fairly consistently concluded that the official estimates of population undercount the true population. This finding has been attributed to two principal causes. First, the 1967 Census may have undercounted the population in 1967. It was conducted only three months after the occupation, under a military curfew, using Arabic-speaking Israelis. Therefore, respondents are suspected of not cooperating fully with interviewers. On the other hand the curfew significantly reduced the likelihood that individuals would not have been counted because they were absent from their homes. Second, the estimates of the number of births may be underestimated as well. Infants born at home and who die early in life are often not reported to the authorities. While CBS statisticians correct for the under-recording of infant mortality by using appropriate estimates of infant mortality, they do not make a similar correction for the under-reporting of the births of these infants.

2.3 Several alternative estimates of the population of the Occupied Territories have been prepared. The Arab Thought Forum conducted a survey in the Spring of 1992 in which village and community leaders were asked to estimate the population of their communities.[2] The study estimated that the population of the West Bank was 1,281,000 and that of the Gaza Strip was 758,000. A second study conducted by Benvinisti and Khayat and based on a survey carried out in the mid-1980s in more than 100 villages in the West Bank, concluded that the number of West Bank *residents* was approximately 14

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[1] The "de facto" estimate counts those who are in the territory at the time of the census, and excludes those who are outside the territory for whatever reason. The official estimates exclude the Palestinians of East Jerusalem and the Jewish settlers in the Occupied Territories.

[2] Arab Thought Forum, *Final Report on Population Agglomerations Survey in the West Bank and Gaza Strip*. Jerusalem, vol. 1, No. 2, 1992.

Table 2.1: The De Facto Palestinian Population of the West Bank and Gaza Strip: 1967-1992

Date	West Bank			Gaza Strip			Total	
	Initial Population	Natural Increase Rate	Net Emigration Rate	Initial Population	Natural Increase Rate	Net Emigration Rate	Total Population	Population Growth Rate
Nov 1961	806	-						
1966	-	-		455	-			
May 1967	846							
Sep 1967	596	0.50	2.18	390	0.85	3.13	986	-1.92
1968	586	2.22	2.70	381	2.18	8.48	967	-2.77
1969	583	2.32	-0.22	357	2.80	0.81	940	2.33
1970	598	2.49	0.84	364	2.58	0.91	962	1.66
1971	608	2.85	0.41	370	3.03	0.65	978	2.41
1972	623	2.91	1.17	379	3.22	1.06	1001	1.90
1973	634	2.95	-0.05	387	3.31	-0.44	1021	3.28
1974	652	3.08	0.43	402	3.56	0.45	1054	2.83
1975	670	3.08	2.25	414	3.62	0.85	1084	1.57
1976	675	3.33	2.13	426	3.78	0.99	1101	1.82
1977	683	3.32	1.49	437	3.73	.66	1121	2.31
1978	696	3.10	1.35	451	3.75	1.04	1147	2.13
1979	708	3.29	1.78	463	3.56	1.04	1171	1.91
1980	719	3.19	2.41	445	3.80	1.15	1163	1.50
1981	724	3.20	2.17	457	3.88	1.16	1181	1.69
1982	733	3.34	1.08	470	3.79	0.66	1202	2.60
1983	749	3.36	0.36	477	3.81	0.21	1227	3.24
1984	772	3.55	0.75	495	4.08	0.97	1266	2.92
1985	793	3.42	0.63	510	3.90	0.57	1303	3.00
1986	816	3.37	0.63	527	4.10	0.68	1343	3.01
1987	838	3.55	-0.08	545	4.33	0.61	1383	3.67
1988	868	3.55	0.40	566	4.53	0.48	1434	3.50
1989	895	3.76	1.46	589	4.88	1.16	1484	2.86
1990	916	4.20	-0.27	610	5.05	-0.25	1526	4.80
1991	957	4.16	-0.98	643	5.12	-0.06	1600	5.13
1992	1006	4.90	-0.51	676	5.03	-1.01	1682	5.17
1993	1052	n.a.	n.a.	717	n.a.	n.a.	1769	

Sources: Data for Nov. 1961 are based on Census of Population in Jordan. Population estimates for 1966 and May 1966 are taken from Fawzi A. Gharaibeh, *The Economies of the West Bank and Gaza Strip*, Westview Press, 1985, p. 29. Data from Sep. 1967 (time of Census) onward are taken from Central Bureau of Statistics, *Statistical Abstract of Israel 1992*, No. 43, Table 27.1.

Remark: Natural increase and net emigration rates are presented relative to the initial population.

percent higher than estimated by the CBS while the *permanent* West Bank population was roughly 24 percent higher than reported by the CBS.[3] A survey of the Gaza Strip carried out in 1990 found 750,000 people living there at the beginning of 1990 --about 23 percent more than the number reported by the CBS.[4] A census of the population of the Hebron district (except Hebron city) carried out in 1985 found the population to be 12.5 percent greater than the corresponding CBS estimate.[5]

2.4 An alternative estimate of the population of the Gaza Strip has been obtained from an examination of the numbers of individuals registered with the Israeli Ministry of Interior. This source of data has been expected to overestimate the population because the death and migration subsequent to the registration may not have been accurately recorded. However, based on a fairly accurate and recently updated registration of the identity cards of all Gaza residents, the Israeli Economics Officer for the Gaza Strip reports that the "registered" population of Gaza Strip in 1992 was 831,000 people, while the "resident" population was 740,000.[6] The estimate of the resident population is 10 percent higher than the corresponding CBS estimates, while the estimate of the registered population is approximately 24 percent higher than the CBS estimate of the de facto population.

2.5 These studies, while in no instance able to claim a high degree of statistical rigor, nonetheless as a group strongly suggest that a downward bias in the CBS estimates of the resident population of roughly 10-15 percent. The CBS readily concedes the possibility of an undercount but disputes the magnitude suggested by these studies. It argues instead that the magnitude at the undercount is likely to be on the order of 3-4 percent. The CBS notes that the 1967 census was conducted during a curfew; thus, since people were confined to their homes the census was likely to have obtained an exceptionally complete count of the number of residents. In addition, the CBS points to the high degree of consistency between its estimates of population and the numbers of children reported to be entering school, or being immunized. Finally, the CBS cites the similarity between the number of new identity cards issued to residents of the Gaza Strip and its estimate of the population of the Strip. An adjustment of 12 percent provides for the largest plausible estimate of the undercount. This adjustment would imply that the resident populations of the West Bank and Gaza Strip in the end of 1992 were no more than 1,200,000 and 800,000 people, respectively, with a combined total population of no more than 2 million people.

The Permanent Population

2.6 The *permanent* (de jura) population is defined as everyone who has a legal right to reside in the territory. The number of Palestinians from the Occupied Territories living abroad appears to be about 350,000. This figure has been obtained from data on the net annual migration flow since the beginning of 1969,[7] and the assumption that migrant Palestinians have had the same rate of natural increase as those who remained behind. These assumptions imply that 227,000 from the West Bank and 120,000 people

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[3] Meron Benvinisti and Shlomo Khayat, *The West Bank and Gaza Atlas*, The West Bank Data Project, 1988.

[4] Mahmoud M. Okasha, *Population and Labor Force in Gaza Strip: A Statistical Survey*, October 1990, Published by the Arab Thought Forum, Jerusalem.

[5] University Association of Hebron, *Population of the Hebron District: A Demographic Study*, May 1987, in Arabic, pp. 228-231.

[6] Interview with the World Bank mission, 3 February 1993.

[7] We start the analysis from 1969 as earlier migrants are assumed to have responded to the political shock of occupation and are thus treated as "displaced" Palestinians.

from Gaza Strip were living abroad in 1992. However, many have lost their right to return because they have failed to renew their exit visas. (One must renew the exit visa after three years by appearing annually at any Israeli consulate abroad; alternatively, a relative of the person living abroad may apply on his or her behalf at the offices of the Civil Administration. At the end of six years the applicant must reapply in person at the Civil Administration offices). In addition, children born abroad to nonresidents sometimes have been unable to acquire the right to enter to the Occupied Territories, particularly where one of the parents was not a Palestinian from the Occupied Territories. A household survey conducted in 1985 found that 76.3 percent and 62.4 percent of the West Bank and Gaza migrants, respectively, held valid Israeli-issued visas. Thus about 173,200 people from the West Bank and 74,900 people from the Gaza Strip were legally entitled to return to the Occupied Territories. These numbers imply that the permanent Palestinian population of the West Bank and Gaza Strip may have been as great as 2.2 million people at the end of 1992.

Recent Trends

2.7 Table 2.2 presents crude birth rates, crude death rates, and the natural rates of population increase for the West Bank and Gaza Strip prepared by the CBS for the period 1968-1992.[8]

2.8 ***Rate of Natural Increase.*** The rate of natural population increase has been rising over the period 1968-91, from a low rate of 2.2 percent in 1968 to 4.2 percent in the West Bank and 5.1 percent in Gaza Strip in 1991. A decline in mortality drove the increase in the natural population growth in the early period, but starting from the mid-1980s, the natural rate of population increase seems to have been increasing primarily in response to changes in the birth rate.

2.9 ***Crude Death Rates.*** Crude death rates have declined over the period of the occupation, from roughly 20 deaths a year per thousand population in the late 1960s to roughly 5 deaths per thousand in the early 1990s. The decline has been due in large part to the shifting age composition of the population: a population that is, on average, younger is expected to have a lower death rate. The trend for the Occupied Territories is similar to that for Jordan;[9] this is not surprising since standards of living in Jordan are comparable to those in the Occupied Territories.

2.10 A survey conducted recently by UNICEF and the Jerusalem Family Planning and Protection Association provides independent estimates of death rates. The study concluded that the estimated infant mortality rates for the West Bank and Gaza Strip both were 42 per thousand in 1988. This figure is consistent with the infant mortality rate estimated by CBS demographers, but nearly twice as high as the rates reported by the Israeli Ministry of Health and UNRWA.[10]

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[8] See *Statistical Abstract of Israel 1993*, and U. O. Schmelz, et. al., *Multiplicity Study of Births and Deaths in Judea-Samaria and Gaza Strip - North Sinai*, Technical Publication Series No. 44, Central Bureau of Statistics.

[9] See previous note.

[10] See *A Survey of Infant and Child Mortality in the West Bank and Gaza Strip*, UNICEF and Jerusalem Family Planning and Protection Association, Interim Report, December 1992.

Table 2.2: Indicators of Population Natural Increase - Crude Birth Rates and Estimated Crude Death Rates, 1968-1992

	WEST BANK			GAZA STRIP		
Year	Births Per Thousand	Estimated Deaths Per Thousand	Rate of Natural Increase	Births Per Thousand	Estimated Deaths Per Thousand	Rate of Natural Increase
1968	43.90	21.70	2.22	42.00	19.50	2.25
1969	43.30	20.40	2.29	46.70	18.90	2.78
1970	43.90	18.70	2.51	43.60	18.00	2.56
1971	45.90	17.80	2.81	46.80	16.90	2.99
1972	45.90	17.10	2.88	47.90	16.00	3.19
1973	45.50	15.70	2.98	49.60	17.10	3.25
1974	46.10	15.70	3.04	49.90	14.80	3.51
1975	45.40	14.80	3.06	51.50	15.80	3.57
1976	46.80	13.70	3.31	51.90	14.60	3.73
1977	45.40	12.50	3.29	49.50	12.80	3.67
1978	43.40	12.60	3.08	49.90	12.90	3.70
1979	44.10	11.40	3.27	49.80	13.40	3.64
1980	42.10	10.40	3.17	47.60	10.10	3.75
1981	41.80	9.90	3.19	47.50	9.20	3.83
1982	42.20	9.10	3.31	46.20	8.60	3.76
1983	42.10	9.00	3.31	45.80	8.30	3.75
1984	43.20	8.20	3.50	48.80	8.60	3.99
1985	41.30	7.60	3.37	45.40	7.00	3.84
1986	40.00	6.70	3.33	48.60	6.90	4.17
1987	41.30	6.50	3.48	47.70	5.20	4.25
1988	40.60	5.70	3.49	50.20	5.80	4.44
1989	43.10	5.90	3.72	53.80	5.90	4.79
1990	46.90	5.80	4.11	54.70	5.50	4.92
1991	47.30	6.80	4.05	56.10	6.20	4.99
1992	44.70	5.60	3.91	54.60	5.80	4.88

Sources: Birth rates were obtained from various statistical abstracts of the CBS. The CBS computed these figures as reported births divided by the de facto population for that year. Estimated death rates were estimated by the CBS based on models and comparisons with neighboring countries.

Remark: Rates are measured relative to mid-year populations.

2.11 ***Crude Birth Rates***. Between 1968 and 1974, birth rates increased by 2.1 per thousand in the West Bank and 8.0 per thousand in the Gaza Strip. These increases have been explained by the normalization in the marriage market and the re-unification of families after the 1967 War.[11] In addition, there may have been greater under-reporting of births in the early years of occupation.[12] Between 1975 and 1985 birth rates declined by approximately 5 per thousand in both the West Bank and Gaza Strip. However, birth rates began increasing again in the mid-1980s, rising from 45 to 56 per thousand between 1985 and 1991 in the Gaza Strip, and later in the West Bank-from a low point of 40 per thousand in 1986, to 47 per thousand in 1991. Analysis of the sudden surge in birth rates is beyond the scope of this report but is crucially important, particularly to the extent that the underlying reasons are related to "temporary" causes that would disappear with political normalization or "permanent" changes that reflect a structural shift in attitudes, cost-benefit calculus, and practices. It has been suggested to the mission that the age at marriage has declined since the Intifada, reflecting a general decline in the cost of marriage ceremonies.

2.12 ***Net Migration***. The emigration rate from the Occupied Territories has been quite high since 1967. There was a large wave of politically motivated migration in the period immediately following the Israeli occupation, but high rates of migration have continued since, as well. The peak occurred during the oil-boom of 1974-1982, suggesting that much of it was economically motivated. The emigration rate began to decline in 1982 because of the reduced demand for Palestinian labor that accompanied the oil-induced recession in the region and the introduction by Jordan of administrative controls on the movement of Palestinians from the Occupied Territories, starting in 1982.[13] During the Gulf War, many Palestinians returned from working in Kuwait, and many others were no longer welcome in the Gulf countries.

2.13 In 1985, about 40 percent of families in the Occupied Territories had one or more family members residing abroad. Table 2.3 illustrates the migrant selectivity: migrants were overwhelmingly males, in the age group 21-35, and highly skilled. Migrants from the West Bank and Gaza can be found throughout the World, but the largest group has migrated to the oil-exporting Arab countries, with Jordan a close second.

Age Composition of the Population

2.14 About half of the population of the Occupied Territories is less than 15 years of age; the population in Gaza Strip is slightly younger due to higher fertility. The Palestinian population has become younger during the 1980s, due mainly to the high and increasing fertility and to declining child mortality. The share of the population over 35 years of age has declined steadily from 25 percent in 1967 to 18 percent in 1990.

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[11] See p.51 in U. O. Schmelz, et. al., *Multiplicity Study of Births and Deaths in Judea-Samaria and Gaza Strip-North Sinai*, Technical Publication Series No. 44, Central Bureau of Statistics.

[12] See p. 8 in *Housing Requirements in the Future Independent Palestinian State 1987-2007*, A Study for the U.N. Center for Human Settlements (HABITAT), Commissioned from Birzeit University, August 1989.

[13] see Hussein Yousef, *The Demography of the Arab Villages of the West Bank*, Unpublished Ph. Thesis, University of Durham, July 1989, p. 377.

Table 2.3: Characteristics of Palestinian Migrants in 1985

Indicator	West Bank	Gaza Strip
Percent of Families with a Member Abroad	40.3	39.4
Males as Percent of Migrants	66.9	80.0
Age Distribution of Migrants (Percentages in 1985)		
Less than 21 Years of Age	4.62	4.24
21-35 Years of Age	69.23	58.18
36-50 Years of Age	23.08	33.64
More Than 50 Years of Age	3.08	3.94
Marital Status		
Percent Single	29.9	22.1
Percent Married	68.9	77.9
Percent of Migrants Employed as Supervisors, Managers or Technicians	52.68	55.79
Percent with Valid I.D. for Return to Occupied Territories	76.3	62.4
Percent of Migrants by Country of Destination		
Jordan	30.15	7.27
Arab Oil-exporting Countries	42.77	67.88
Other Arab Countries	2.92	13.33
America	11.69	1.82
Europe	8.92	6.67
All Others	3.54	3.03
Reasons for Migrating		
Percent Seeking Work	48.62	55.45
Percent Seeking Education	18.92	13.33
Percent Joining a Spouse	29.54	16.97
Percent Politically Motivated	2.92	9.40

Source: Assembled from various tables in Abdel-Fattah Abu Shokor, *External Migration from the West Bank and Gaza Strip and its Economic and Social Impact*. Jerusalem: Arab Thought Forum, 1990, in Arabic.

B. Participation in the Labor Force

2.15 Out of the 834,000 persons estimated by the CBS to be 15 years of age or older in 1991, 37 percent were in the labor force. The labor force participation rates for females were very low; in 1991 only 8.8 percent and 1.7 percent of the female population aged 15 years or older in the West Bank and Gaza Strip, respectively, were economically active. (See table 2.4) These female participation rates are much lower than those found in nearby Arab countries. The crude labor force participation rate was the lowest reported by any economy in the world; approximately 19 percent of the population was economically active in 1991. In comparison, the crude participation rate for selected countries were 39 percent for Israel, 24 percent for Syria, 27 percent for Egypt, 27 percent for Iran, 29 percent for Bangladesh and 49 percent for the USA. This unusually low rate was due in large part to the youthfulness of the population.

2.16 The male labor force participation rate averaged 72.6 percent and 68.8 percent of the population 15 years and older, over the years 1987-1991 in the West Bank and the Gaza Strip, respectively. Male labor force participation rates were at their highest levels in the late 1980s and early 1990s, due in part to fairly low emigration rates since 1982. Approximately 92 percent of males aged 25-44 years old were in the labor force in 1991. The participation rate for males aged 18-44 years old has generally risen over the period 1986-1991 in both the West Bank and Gaza Strip, with the most impressive increase in the group 25-34 years old. The 1986 participation rates of the age group 15-17 was 30.4 percent in the West Bank and 29.4 percent in Gaza Strip. By 1991, these rates dropped to 25 percent in the West Bank but fell to 14.6 percent in the Gaza Strip.

Education and Participation

2.17 The relation between years of schooling and labor force participation is mixed. For females, higher education attainments are associated with higher participation rates. However, the relationship between male participation rates and education is not as consistent. In 1991, the participation rate was highest for males with 5-6 years of schooling followed by those with 7-8 years of schooling and university graduates (16 or more years of schooling). However, over the period 1987-1991, the only groups that increased their participation rates significantly were university graduates and those with 13-15 years of schooling; the participation rate for all other educational groups has either stagnated or declined.

C. Unemployment

2.18 The estimates of unemployment rates prepared by the CBS rely on the ILO definition of unemployment, whereby those who actively sought work during the week prior to the interview and who had worked less than one hour during that week were regarded as unemployed.[14] During the early years of 1969-1973, unemployment rates *declined* from the double-digit region to roughly 1 percent of the labor

[14] The 1992 unemployment rate is for only the first 3 quarters of the year; it was provided by CBS officials. The unemployment rates refer to the labor force aged 15 or older years from 1986 onward, and to the age group 14 or older years prior to 1986. The implication of this change is insignificant for rates of unemployment because the participation rate of the 14-year old group is less than 30 percent and their unemployment rates are not likely to be sizably different from the rest of the labor force. Therefore, the difference between the two definitions is likely to fall within 0.1 percent of the measured unemployment rate.

Table 2.4: Labor Force Participation Rate in OT for Adult Population: 1968-1991

Year	Size of Labor Force (In Thousands)		Participation Rate West Bank (Percent)			Participation Rate Gaza Strip (Percent)		
	West Bank	Gaza strip	Total	Male	Female	Total	Male	Female
1968	92.9	53.5	30.1	56.0	8.2	29.3	58.8	6.3
1969	114.5	58.2	36.5	62.2	13.4	30.8	61.9	4.9
1970	118.5	62.4	36.7	61.4	14.3	31.7	63.1	5.0
1971	119.8	61.8	36.3	62.0	12.8	30.8	61.8	4.4
1972	126.6	64.6	37.6	66.5	11.0	31.5	64.0	3.9
1973	127.8	68.6	37.4	66.6	10.8	32.6	65.7	4.0
1974	138.9	73.4	39.1	66.1	14.3	33.6	66.7	4.5
1975	133.9	72.7	36.5	61.9	12.8	32.3	64.6	4.1
1976	131.3	76.4	35.4	59.7	12.8	33.0	65.6	4.3
1977	128.6	77.4	33.9	57.4	11.9	32.3	64.0	4.1
1978	132.9	80.7	34.1	56.8	12.8	32.3	64.1	3.6
1979	133.9	79.7	33.6	56.9	11.7	32.8	65.1	3.5
1980	137.2	81.3	34.2	57.7	12.4	33.5	65.5	4.3
1981	135.4	82.8	33.6	57.8	11.2	33.5	66.0	3.7
1982	142.9	82.3	35.2	60.0	12.5	33.4	66.0	3.2
1983	150.2	85.8	35.7	62.1	11.0	32.8	64.2	3.8
1984	160.0	87.9	36.7	63.7	11.1	33.2	65.5	3.3
1985	159.2	92.0	35.9	63.9	9.5	33.0	65.4	2.9
1986[a]	173.6	95.6	37.8	66.7	10.5	33.4	65.7	3.0
1986	172.2	95.1	39.0	69.1	10.8	34.4	67.6	3.1
1987	182.2	101.7	40.0	72.2	9.5	36.0	71.1	3.0
1988	188.1	101.2	41.0	73.3	10.4	34.7	68.9	2.4
1989	189.1	101.2	40.3	73.6	8.5	33.6	66.8	2.0
1990	199.7	108.0	40.8	72.6	9.8	34.4	68.6	1.9
1991	200.3	111.8	39.4	71.3	8.8	34.3	68.4	1.7

Source: Various issues of *Statistical Abstract of Israel*, published by the Israeli CBS.

Remark: (a) Data in this table prior to 1986 refers to adults who were 14 years or older, but data from 1986 onward refers to those who were 15 years and older. Two sets of data are given for 1986, the first using the earlier definition while the second uses the newer.

force. This decline resulted from migration of Palestinians from the Occupied Territories to Jordan and other Arab countries, and from an expansion of job opportunities in Israel. During the period 1974-1982 the average unemployment rate was 1.2 percent and 0.4 percent in the West Bank and Gaza Strip, respectively. Since 1982, unemployment rates have been increasing, as the demand for Palestinian labor in both the Israeli and Arab labor markets stagnated. The unemployment rates for the West Bank and Gaza Strip in the first 3 quarters of 1992 were 5.6 percent and 3.2 percent in the West Bank and Gaza Strip, respectively. Younger workers tend to be over-represented among the unemployed. Unemployment increases with education, with the highest rate of unemployment found among university graduates.

2.19 The labor market of the Occupied Territories is characterized by a high turnover and a large (and rising) fraction of workers employed part-time. The proportion of employees from the West Bank working full time was greater than 93 percent in every year between 1984 and 1987, but this ratio dropped to 66 percent, 74 percent, 83 percent, and 83 percent in the years 1988, 1989, 1990, and 1991, respectively. A similar pattern was observed for Gaza Strip. High turnover results from the participation of roughly a third of the Occupied Territories labor force in the market for day laborers in Israel.

2.20 Several Palestinian economists have challenged CBS estimates of unemployment. For example, using a sample survey, Abu-Shokor estimated the unemployment rate in 1985 to be 9.1 percent in the West Bank and 2.7 percent in Gaza Strip; CBS estimates for the same year were 5.0 percent and 1.2 percent.[15] These differences reflect the small sample (approximately 1,000 potential labor force participants in the West Bank and Gaza Strip) and adoption by Abu-Shokor of a definition of "unemployed" that did not conform to that of the ILO. A sample survey of 700 households in Gaza suggested that the 1989 unemployment rate in Gaza was 20.8 percent for the labor force over 16 years of age.[16] The definition of the unemployed used in this study conformed to that of the ILO. Recently, a reanalysis of CBS data produced an unemployment rate in the West Bank and the Gaza Strip of 27.2 percent; however, this study adopted a definition of the unemployed that included "part-timers", those "temporarily absent from work" and the roughly 15,000 prisoners in Israeli jails.[17]

Wages and Labor Markets

2.21 During the Intifada, the number of Palestinians working in Israel initially declined. However, by the end of 1992 employment in Israel had returned to its pre-Intifada level --about 115 thousand people. Palestinians working in Israel earn wages at, or somewhat below the Israeli minimum wage (about NIS1,400 a month, in early 1993). Nonetheless, these wages are substantially higher than wages earned in the Occupied Territories; a school teacher earns about NIS900 a month, for example. The Israeli labor market places upward pressures on wages in the Territories. In 1990, the wage premium

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[15] See pp. 90-102 in Abdel-Fattah Abu-Shokor, *Labor Market in the West Bank and Gaza Strip*, Nablus: An-Najah National University, 1987, in Arabic.

[16] See p. 4 and 32 in Mahmoud K. Okasha, *Population and Labor Force in Gaza Strip, A Statistical Survey*, Jerusalem: Arab Thought Forum, October 1990.

[17] See p. 17 in A. Abu-Shokor *Unemployment in the Occupied Palestinian Territories: 1968-1991*, a paper presented at a seminar held at the U.N. ESCWA in Amman, November 30, 1992.

for working in Israel was about 22 percent.[18] Palestinian university graduates do not command a wage premium over non-graduates because the jobs open to graduates rarely utilize their education.

D. Population Prospects

2.22 Table 2.5 presents population projections through the year 2002. These projections were prepared in 1982 by the CBS relying on several assumptions about fertility and net migration.[19] The lowest population projection assumed a net emigration rate of 1.0 percent annually and a sharp decline in the total fertility rate --from 6.5 in 1982, to 3.8 by the year 2002 in the West Bank, and from 7.2 to 4.5 in the Gaza Strip. The high growth scenario assumed no change in the total fertility rate and zero net migration in both the West Bank and Gaza. The estimated growth of population in the Occupied Territories since 1982 has been closer to the assumptions underlying the highest growth scenario. It seems reasonable to assume that net migration will be zero, on average, over the next decade and that fertility will stabilize. Under these assumptions, the CBS high growth projections would continue to be the most appealing. The end-of-year population estimate for 2002 would then be 1,071,000 for Gaza and 1,550,000 for the West Bank. The total population would then equal 2,621,000 people.

2.23 On the other hand, if the analysis were based on 1992 population estimates of 800,000 for Gaza and 1,178,000 for the West Bank, and the assumption that the rate of natural increases for the Gaza Strip were 4.0 and 3.5 percent for the West Bank, then the population of the Gaza Strip would be 1,184,000 and of the West Bank 1,661,000 in the year 2002.

Labor Force Prospects

2.24 The male labor force may reach 265,300 in the West Bank and 166,100 in the Gaza Strip by the year 2000. If age cohort-specific participation rates were to remain unchanged, the overall male labor force participation rate for the population 15 or older years would increase from 72 percent over the period 1986-1991 to 75 percent in the year 2000 in the West Bank, and from 69 percent to 71 percent in the Gaza Strip. This increase arises because of changes in the age-composition of the population. The projected size of the female labor force at the end of year 2000 is 33,800 in the West Bank and 4,700 in the Gaza Strip. Therefore, the projected size of the total labor force in the year 2000 is 299,100 in the West Bank and 170,800 in the Gaza Strip. This represents an average annual growth of 4.1 percent in the West Bank and 4.7 percent in Gaza Strip over the period 1990-2000.

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[18] See Joshua D. Angrist, *Wages and Employment in the West Bank and Gaza Strip: 1981-1990*, July 1992, Falk Institute Discussion Paper No. 92.02, The Hebrew University, Jerusalem.

[19] See Central Bureau of Statistics, *Projections of Population in Judea, Samaria and Gaza Area up to 2002, Based on the Population in 1982*, Special Series No. 802, 1987.

Table 2.5: Population Projection for 2002 Year-end Resident Population
(In Thousands)

	Gaza Strip	West Bank	Total
1991: CBS Year-end Estimate	676	1006	1682
1992: CBS 1991 Estimate Projected to End 1992	717	1052	1769
1992: CBS Estimate Adjusted for Possible Under-Reporting	800	1178	1978
CBS Forecasts			
1992 Scenario IV	702	1042	1742
1992 Scenario V	712	1057	1769
2002 Scenario IV	992	1429	2421
2002 Scenario V	1071	1550	2621
Projections for 2002 Based on CBS Estimates of Population and Projections of the Rate of Natural Increase			
Gaza: 3.5%; West Bank: 3.0%	1003	1407	2410
Gaza: 4.0%; West Bank: 3.5%	1052	1476	2528
Gaza: 4.9%; West Bank: 3.9%	1147	1535	2682
Projections for 2002 Based on Adjusted CBS Estimates of Population and Projections of the Rate of Natural Increase			
Gaza: 3.5%; West Bank: 3.0%	1128	1583	2711
Gaza: 4.0%; West Bank: 3.5%	1184	1661	2845
Gaza: 4.9%; West Bank: 3.9%	1290	1727	3017

III. HEALTH CARE

A. Introduction

3.1 This chapter describes the efforts that are being made to protect the health of the residents of the Occupied Territories, assesses the weakness in these efforts and outlines the initiatives that would be required to address these shortcomings. The remainder of chapter is divided into six sections. The first section offers an overview of the current status of health in the Territories. The second section describes the institutions that provide preventive and curative services in the Gaza Strip and the West Bank. The third section presents the information that can be found on the financial and real resources that these institutions are committing to the sector. The fourth section discusses the programs that are being carried out and assesses their impact on health. The fifth section examines the deficiencies in these programs and identifies measures that promise to overcome these problems. The final section sets forth recommendations.

B. Health Status

An Overview

3.2 In spite of formidable data problems, a fairly broad consensus exists regarding the general outlines of health conditions in the Gaza Strip and in the West Bank. Life expectancy, infant mortality and patterns of morbidity in the Occupied Territories are believed to be fairly similar to those typically found in lower-middle income countries. Palestinian and Israeli experts agree that life expectancy at birth is 65 to 66 years. The infant mortality rate is 40-45 infant deaths per thousand live births. Gastrointestinal and respiratory infections are reported as major problems in the Gaza Strip but not in the West Bank. High rates of respiratory and skin infections continue to be reported by residents of refugee camps due to crowded housing and poor environmental sanitation. The communicable diseases of childhood --mumps, whooping cough, tetanus, measles and polio-- have been largely controlled through a successful child immunization program. Moderate and severe malnutrition are virtually unknown. Food supplies are adequate in quantity and fairly well distributed. The customary diet is rich in proteins and fiber and low in animal products but provides too little of some micronutrient --particularly iron. Weaning practices generally are also sound. The West Bank reports high prevalence rates for cardiovascular diseases, hypertension, diabetes and cancer-- diseases usually associated with highly developed countries. However, these findings may reflect the selectivity of the sample produced by well-equipped clinics and by the aggressiveness of diagnostic efforts at these facilities.

3.3 The pattern of disease is expected to be somewhat different in the Gaza Strip than in the West Bank. The two areas are distinct in terms of environmental conditions, economic circumstances, social situations and social services. Nonetheless, the reports that are available do not reveal major differences, except in the area of chronic, adult-onset diseases.

Conditions in the Gaza Strip

3.4 The Government of Israel reported an infant mortality rate for the Gaza Strip for 1990 of 26.1 infant deaths per thousand live births. It had estimated the infant mortality rate for 1980 to have been 43 and for 1970 to have been 86. These reports suggest that dramatic improvements in infant health have been achieved since the occupation began. However, these figures are disputed by Palestinian leaders. Some of the controversy can be attributed to definitions and methods of measurement. The Israeli figure is based on the estimated number of births and the infant deaths reported to the Civil Administration by health care providers and households. The reporting of deaths by the government health service and by UNRWA is probably quite complete, but about 35 to 40 percent of all births occur at home and are not supervised by a physician or qualified midwife. Some births are not reported as well. The infant death rate is likely to be much higher among those who give birth at home, not only because the quality of medical care is lower, but also because this group is more likely to be economically and socially disadvantaged. Those households that do report births and deaths typically delay reporting; thus, births that lead to death in the early months of life are unlikely to be reported at all. The number of infant deaths is believed to be substantially underestimated and, therefore, the official estimate of the infant mortality rate is thought to biased downward. Studies of infant deaths among disadvantaged groups suggest that the mortality rates may be in the range of 70 to 120 for this group. If one assumes that the Government's estimates of infant deaths are correct for the 60 percent of children delivered at official health care facilities and that the remaining 40 percent of births suffers a mortality rate of 70 per thousand, then the overall infant mortality rate in Gaza in the 1990s would be about 45 deaths per thousand live births.

3.5 Table 3.1 reproduces estimates of the principal causes of infant deaths in 1991 by age at death. Nearly 40 percent of infant deaths occurred during the first week of life. Slightly less than half of these deaths were caused by birth trauma or prematurity; the second and third leading causes were respiratory conditions and hypothermia. Slightly more than half of infant deaths occurred between the ages of one month and one year. The causes of death in this group are distributed uniformly over the 15 classifications of the WHO International Classification of Diseases, Revision 12.

Table 3.1: Leading Causes of Infant Mortality

Causes of Death	% of Deaths
Certain Conditions Originating in the Perinatal Period (ICD9 code 760-779)	25.7
Other Diseases of the Respiratory System (ICD9 code 446, 480-519)	22.6
Congenital Anomalies (ICD9 740-759)	15.1
Diseases of the Digestive System (ICD9 530-579)	13.3
Signs, Symptoms and Ill-defined Conditions (ICD9 780-799)	8.1
Other	15.2

Source: Statistical Report of Health Services in Judea and Samaria 1988, Table 13.

3.6 The number of children born live to the average woman over her reproductive life (the "total fertility rate") for the Gaza Strip is reported to be among the highest in the world. The Government of Israel estimated the total fertility rate to be 7.2 births per woman in 1987. The crude birth rate is reported to have risen sharply since the beginning of the Intifada; according to the Israeli Central Bureau of Statistics, in 1985 there were 45.4 births per thousand population and in 1991 there were 56.1. The reasons for this 25 percent increase in the crude birth rate have not been analyzed rigorously, but part of the explanation is thought to be that the age at marriage for females dropped considerably after 1987.[20] Despite the significant differences between the Gaza Strip and the West Bank in environmental conditions, health care provision, economic circumstances and reported patterns of disease, estimates of life expectancy are the same.

3.7 A rough indication of the contribution of specific diseases to death and to temporary and permanent disability can be obtained from analyses of presenting complaints and diagnoses reported by health facilities. Table 3.2 presents results for the Gaza Strip. Observers of the Gaza Strip report seeing a remarkably high incidence of trauma; this is presumably due both to a neglect of occupational and highway safety, and to the violence that has accompanied the Intifada.

3.8 The per capita availability of calories in the Gaza Strip was approximately 2,612 kcal a day in 1987, which is adequate but certainly not generous. Incomes are distributed quite equitably in the area, implying that access to food is quite equitable as well. Moreover, the customary diet is relatively inexpensive and nutritionally sound. Traditional weaning practices entail the early introduction of whole grain breads and highly nutritious pastes made from legumes and oil seeds. The unimportance of malnutrition is suggested by the Palestinian literature, which has noted that the extent of malnutrition is so slight that the problem is not easily recognized.

3.9 Living conditions in the Gaza Strip are much worse than per capita incomes would lead one to expect.[21] Nearly three-quarters of the population are registered refugees, and 55 percent of these people live in refugee camps operated by UNRWA. Environmental conditions in the camps are generally poor. Most of the camps have no organized system of sewage collection, and none has an adequate system of sewage treatment for collected wastes. All of the camps are provided with solid waste collection facilities, but none is served by a proper disposal site.

3.10 Outside the camps, solid wastes are collected at neighborhood collection bins, and about a third of the population is served by the system. Large containers are placed at central places in communities. The containers are collected at intervals and dumped at surface disposal sites, where the organic wastes are allowed to decompose and combustible materials are burnt. Properly designed sanitary land fills have not been constructed anywhere in the Gaza Strip; wastes often leach into the aquifer, thereby contaminating drinking water supplies.

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[20] Palestinian observers argue that the violence and uncertainty that has accompanied strikes and curfews during the intifada has led parents to seek the security of early marriages for their daughters, and that the emergency has also resulted in a reduction in social demands for expensive ceremonies.

[21] For a fuller discussion of living conditions in the Gaza Strip and West Bank, please see *Developing the Occupied Territories: An Investment in Peace, Volume V: Infrastructure*, The World Bank, August 1993.

Table 3.2: Principal Diagnoses for Patients Visiting the Government Health Service, 1989

Disease	ICD9 Codes	Number of Visits	Percent of Visits
Diseases of the Upper Respiratory Tract	460-465, 470-478	139,642	24
Other Diseases of the Respiratory System	466, 480-519	74,360	13
Diseases of the Skin and Subcutaneous Tissue	680-709	52,549	9
Diseases of the Musculoskeletal System and Connective Tissue	710-739	51,429	9
Diseases of Other Parts of the Digestive System	530-579	48,871	8
Endocrine and Metabolic Diseases, Immune Disorders	240-259, 270-279	26,682	5
Hypertensive Disease	401-405	26,241	4
Diseases of the Urinary System	580-599	18,118	3
Disorders of the Eye and Adnexa	360-379	16,875	3
Ischemic Heart Disease	410-414	15,475	3
Diseases of the Ear and Mastoid	380-389	14,012	2
Diseases of the Blood and Blood-Forming Organs	280-289	11,534	2
Intestinal Infectious Diseases	001-009	8,963	2
Other		69,784	12
TOTAL		591,206	100

3.11 More than half of households in camps are served by a piped water supply in the dwelling, and two-thirds have good access to some source of piped water. In more than 90 percent of cases, the water is disinfected at the source. Inadequate supplies of water, poor water quality and unsanitary disposal of

liquid and solid wastes nonetheless contribute to a high incidence of gastrointestinal and parasitic infections. In addition, the fluoride content of the groundwater in the area north of Gaza City is reported to be high enough to lead to the mottling of teeth and bone disease.

3.12 Crowding is a problem throughout the Gaza Strip, but it is especially acute in the refugee camps. The average household in the Gaza Strip has 2.7 persons per room; half of Gazans live in households in which the number of persons per room is greater than 2. Crowding facilitates the spread of diseases transmitted through personal contact and airborne respiratory secretions. The very high rates of dermatological and respiratory infections can be traced to crowding.

3.13 The use of government health care services has been inhibited by the strikes and curfews that have accompanied the Intifada. The incidence of personal injuries has risen sharply due to related violence; however, the magnitude of this problem is difficult to assess. Wounded persons have been reported to be reluctant to present their injuries to government hospitals for fear of being arrested. Health workers have encountered difficulties in getting to clinics and hospitals because of border closures and road blocks. These problems have compounded the effects of the Intifada on health in the Territories.

Conditions in the West Bank

3.14 The natural environment in the West Bank is generally healthier than that in the Gaza Strip. Population densities are much lower, drinking water supplies are both generally safer and more abundant, housing is less crowded and incomes are --on average-- substantially higher. In addition, only about 9 percent of the population lives in refugee camps, and the camps are much smaller. These advantages lead one to expect substantially better health conditions in the area.

3.15 The information on health conditions is even more sketchy for the West Bank than for the Gaza Strip. The Government of Israel reports that in 1990 22 infant deaths occurred per thousand live births in the West Bank. As in the case of the Gaza Strip, this figure represents the number of infant deaths reported by health care providers and individual households divided by the estimated number of births. The Government of Israel reports that two-thirds of births in the Gaza Strip and West Bank occurred at a hospital or medical center in 1992. UNRWA also reports that the patients at its clinics experience an infant mortality rate of about 22 deaths per thousand live births. Palestinian leaders dispute these estimates of the infant mortality rate; they note that studies of isolated communities have produced estimates in the range of 80 to 100 deaths per thousand live births, suggesting that the true infant mortality rate is somewhere between 40 and 45 deaths per thousand live births. The failure of a healthier environment to lead to better health may be due to poorer access to health care.

3.16 The total fertility rate for the West Bank is reported by the Government of Israel to be 6.5.[22] Like the estimate for the Gaza Strip this figure is based on very limited, and statistically suspect data. Both Government of Israel and Palestinian sources estimate life expectancy at birth for those born in the West Bank to be about 65 years. Estimates of life expectancy are highly sensitive to estimates of infant and child mortality; because the latter are in dispute, the estimates of life expectancy must be regarded with some suspicion as well.

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[22] Yaqub Lama and Mario Ferraro, *General Survey of Health Services in the Occupied Territories*, Ministry of Foreign Affairs, Government of Italy, Jerusalem, 1989.

Recent Trends in Health Conditions

3.17 Knowledgeable experts agree that considerable improvement in health conditions has been achieved during the 25 years of military occupation. Over this period, life expectancy has increased by about 10 years; the infant mortality rate has been reduced from about 80 to about 40 to 45; and the childhood communicable diseases, including polio and measles, have been brought under control. The pace of improvement since 1967 appears to have been somewhat slower in the Gaza Strip and in the West Bank than in Jordan and Syria.

3.18 While significant progress has been achieved over the past 25 years, additional gains are clearly technically feasible. The infant mortality rate could be reduced further if adequate prenatal care were provided to a larger proportion of pregnant women. Both the incidence of diarrheal disease and the severity of diarrheal episodes could be dramatically reduced if sanitary facilities were improved, and the treatment of acute diarrhea with oral rehydration fluids were extended to a larger fraction of the population. The toll attributable to acute respiratory diseases could be cut back sharply with better clinical management of these conditions. The onset of chronic diseases due to such conditions as hypertension and diabetes could be slowed substantially with appropriate diet and drug therapy.

C. Health Care Institutions and Finances

3.19 Health services are provided in the Occupied Territories by four clusters of institutions operated by the Civil Administration, UNRWA, private voluntary organizations and private, for-profit providers. Each cluster focuses on the needs of a distinct segment of the population. In 1991 the Government produced about 37 percent of all modern health care. The voluntary and for-profit sectors now provide more than half of all health care, with UNRWA contributing about 10 percent. Together these institutions spend about US$200 million a year (US$110 per capita). These funds are used to provide public health services, such as the inspection of restaurants and food processing plants, and disease surveillance, as well as preventive, promotive and curative health care services. Each cluster of health care institutions responds to the needs of a distinct segment of the Palestinian health care market, but their clientele overlap considerably.

Civil Administration

3.20 The institutions operated by the Civil Administrations in the Gaza Strip and in the West Bank are still recognizable as descendants of the Egyptian and Jordanian systems. Until 1974 when a government health insurance scheme was introduced, all residents of the Gaza Strip and West Bank were entitled to free health care from these facilities. After the introduction of the insurance scheme, the share of the population able to use these facilities dropped sharply.

3.21 Members of the government health insurance scheme are eligible for care at government facilities without charge; they may be referred to an Israeli hospital for services that are not available within the Occupied Territories, but this care must be financed by the Civil Administration. Prenatal care and preventive services rendered to children under the age of three years are provided by the Civil Administration without charge. In addition, those injured by the Israeli Defense Force and those infected with serious, highly contagious diseases, such as cerebrospinal meningitis, typhoid fever, tuberculosis, and sexually transmitted diseases, are treated free of charge.

3.22 All Palestinian employees of the Civil Administration and of municipal authorities in the Occupied Territories are required to join the government health insurance scheme. Palestinians who are legally registered employees of Israeli firms are required to participate as well. The rate for health insurance is US$24 a month for a worker employed by the Civil Administration and all of his dependents under the age of 16 years. Persons employed by private Israeli firms pay US$29 a month. Individual families may enroll in the scheme as well, but the premium is then US$34 a month. The number of individuals enrolled voluntarily dropped sharply in the late 1980s primarily as a result of large increases in premiums. The Civil Administration reports a sharp increase in enrollment in Gaza in 1992--from 22 to 45 percent of the population.

3.23 Estimates of the total numbers of families enrolled in the government health insurance scheme vary enormously.[23] The budget of the Civil Administration estimates the revenues for 1992 from health fees to be US$25 million, implying that about 75,800 households (a fifth of the total population) were expected to be covered. In addition, persons who are not enrolled in the government health insurance scheme may purchase services from government clinics and hospitals; total revenues from patient charges may represent as much as 20 percent of the revenues available to the public sector.

3.24 Persons who are not enrolled in the government health insurance scheme may purchase services from government clinics and hospitals on a fee-for-service basis. In 1992, an outpatient consultation cost US$17, and hospital care cost US$150 a night. Other representative charges include US$22 for a chest X-ray, US$70 for a normal delivery and US$160 for a CT scan with contrast media. Laboratory examinations are billed at a flat fee regardless of the number of tests conducted; in 1992, the charge was US$23. Total revenues from charges levied on uninsured patients are not reported by the Civil Administration but several researchers have produced indirect estimates; these range from US$5-8 million. If the fee receipts projected by the Civil Administration included these charges, then the estimated number of insurees would be reduced by between a quarter to a third.

UNRWA

3.25 UNRWA offers basic health care without charge to 940,000 registered refugees living in the Occupied Territories. Some 540,000 of these refugees (nearly three-fifths of the total) live in the Gaza Strip where they form about 72 percent of the total population. In contrast, about 400,000 registered refugees live in the West Bank where they represent about a third of the total population.

3.26 UNRWA provides secondary medical care through one hospital operated by the agency, five voluntary sector hospitals and two government hospitals. The sole UNRWA hospital is a 34 bed facility located in the West Bank in the city of Qalqiliah. The cooperating private, voluntary hospitals are all in the West Bank and Jerusalem. They provide a total of 236 acute-care beds for use by refugees. UNRWA also contracts with the Civil Administration for the use of 75 of its psychiatric beds and 75 of

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[23] Consultants engaged by WHO and UNRWA to study health insurance options report that at the beginning of 1992 about 119,600 families were enrolled; that 48,000 of these families were living on the Gaza Strip; and that the remaining 71,600 were residents of the West Bank. Slightly more than half of the enrollees were Palestinians working in Israel. An additional 18 percent (21,500 families) were Palestinians employed by the Civil Administration who are required to join the scheme. About 18,300 indigent families were reported to have been enrolled by the government using general tax revenues to pay their insurance premiums. Only 14,300 families were reported to have enrolled voluntarily. A study conducted in 1989 by the Italian Ministry of Foreign Affairs concluded that only 46,000 households were enrolled at that time. The principal differences between the two estimates appear in the categories "employees of Israeli firms" and "social cases". Many Palestinian workers employed in Israel are not properly registered and thus are not enrolled in the health insurance scheme and many others are employed on a daily basis and hence not entitled to the benefits devised for regular "monthly" employees.

its tuberculosis beds. In addition, UNRWA reimburses refugees for 60 percent of the cost of hospital care obtained outside the UNRWA system. Many refugees are unable to advance the costs of using government or voluntary sector services and, thus, are unable to take advantage of this assistance. Nonetheless, the funds budgeted for this purpose typically are exhausted by the end of the eighth month of the year. In March 1993, UNRWA introduced a modest charge for the use of hospital services and for care at hospital outpatient clinics.

The Voluntary Sector

3.27 Private voluntary organizations are responsible for about a fifth of spending on health care. Most private medical charities were established after the introduction of the government health insurance scheme in 1974 and many were provided with generous external assistance during the 1980s by Middle Eastern countries and private donors. Since the Gulf war in 1991, many of these sources of funds have dried up; thus, many of these groups have turned increasingly to donors in North America and Europe for support. Most voluntary organizations charge for their services. Fees depend on the financial capacity of the patient's family. The basic fees for physician services range from US$1.50 for an outpatient consultation with a general practitioner to US$4-7 for consultation with a specialist. Hospitalization costs range from US$8 to US$55 a night. Routine deliveries cost US$60-US$120. These organizations offer modern curative care, often from very well-equipped clinics. Since the onset of the Intifada, several "grass-roots" non-governmental organizations (NGOs) have flourished. They provide very basic preventive and promotive care, emphasizing health education, maternal and child health care and outpatient-management of chronic conditions. The activities of the voluntary sector are not closely supervised or regulated and, as a consequence, reflect a very wide range of aims and policies.

3.28 The most prominent NGOs providing health care are now the Red Crescent Societies, the Patients' Friends Societies and the Women's Union Societies. A number of other smaller charitable organizations were also active in the sector prior to the partition, including local Islamic Zakat Charitable Funds. These groups are organized as local NGOs but are most affiliated with local and international organizations as well. The Women's Union Societies were formed during the 1920s under the British mandate and were intended to deal with a variety of social concerns.

3.29 The grass-roots NGOs include the Health Services Council, the Health Care Committees, the Union of Health Work Committees and the Union of Palestinian Medical Relief Committees. These organizations were formed in order to provide an institutional framework for securing greater Palestinian independence in meeting the need for basic health services. Each of these groups has a close tie to one of the leading Palestinian political factions. These organizations have succeeded in more than doubling the number of primary health care facilities serving the Occupied Territories over the six years since the beginning of the Intifada.

3.30 Many of the more established NGOs have pursued the aim of providing Palestinians with access to the best and most modern diagnostic technology. The Red Crescent Societies and the Patient's Friend Societies have been especially fervent advocates of making high quality, high technology medicine available in the Occupied Territories. Not surprisingly, the leadership of many of these organizations is composed of medical specialists, many of whom practiced abroad for years. As a result, the Occupied Territories have a much larger stock of high-cost equipment than one would expect for an economy able to spend perhaps US$100 a year per capita for health services. For example, the West Bank has five privately owned CT scanners.

Private Health Care

3.31 Little is known about private medical practice. Most private clinics are operated for only a few hours a day, usually by well known specialists. The typical private clinic is believed to serve only three to five patients a day. A total of about US$25 million was spent in 1991 on private care, according to a UNRWA/WHO study of health care financing. In addition, households spent about US$55 million on pharmaceuticals. In order to put these numbers in perspective, one should note that the same study found that total spending by the Civil Administration for health care was about US$45 million. Most of the expenditure on private health care is believed to go to noted specialists who work full time in the government or private voluntary sector. Many of the clinics operated by private practitioners are provided with equipment not available at public or voluntary clinics. Private health care is financed from user fees or by private health insurance.

D. Uses and Sources of Funds

3.32 Total expenditures on health care from all sources have been estimated at about US$200 million for 1991. This corresponds to about 7 percent of GNP or about 9 percent of GDP and represents an expenditure of approximately US$110 per capita.

Civil Administration

3.33 The Civil Administration reports that it spent about US$45 million on health programs in the Occupied Territories in 1990/91 and that it expects to have spent US$52 million in 1992. About 55 percent of this current account expenditure went to the West Bank and the remainder went to the Gaza Strip. The principal source of funds was the government-operated health insurance scheme, but some funds were obtained from patient fees; the Civil Administration does not provide a detailed accounting of sources of funds, but knowledgeable observers suggest that fee income may have represented as much as 20 percent of the total funds available to the public sector for health programs. About 61 percent of the health budget is devoted to the operation of acute care hospitals, and only about 28 percent is spent on primary care and public health services. The remaining 11 percent is committed to public health functions, including the inspection of sanitary conditions and disease surveillance.

UNRWA

3.34 In 1991 UNRWA spent about US$20 million on health programs in the Occupied Territories. Nearly US$12 million of this was allocated to activities in the Gaza Strip. Approximately 58 percent of the total budget was devoted to primary prevention and health promotion activities, while hospital care consumed the remaining 42 percent. The UNRWA budget is supported by some 60 governments and a dozen charitable organizations.

The Voluntary Sector

3.35 The Palestinian NGO sector is financed from a very broad group of donors, including both charitable groups and bilateral agencies. For example, the Union of Health Work Committees lists 12 institutional donors in its 1991 annual report. This group of donors includes American Medical Relief for Palestine, The Jerusalem Fund/USA, the Mennonite Central Committee, the Pontifical Mission, Medical Aid to Palestine/UK and Medical Aid to Palestine/Canada. The NGO sector also depends on

donations from individuals. Until the Gulf war many of the NGOs received substantial support from the Gulf countries and Saudi Arabia.

Private Health Insurance

3.36 A private insurance company offers health insurance to about 10,000 households; most of the enrollees are employees of Palestinian manufacturing enterprises. The annual premium is US$131. The benefits may be used to purchase care from approved sources in either the public or private sector. The rates are agreed with the approved sources; in 1993, US$4.35 is being paid for an office visit with a general practitioner and US$8.70 for visit to a specialist. The maximum benefit per year is US$2900.

3.37 Tables 3.3 and 3.4 summarize the financing of the health care system. These tables are based on surveys of health facilities and health spending undertaken by consultants to UNRWA and WHO. (The two surveys provide independent and inconsistent estimates.) One should recall that this study found substantially higher spending on health care than earlier studies. The UNRWA/WHO consultants report much greater enrollment in the Government's health insurance scheme than Palestinians have estimated in the past. The enrollment figures are based on the number of valid insurance cards held at the time of the study, as reported by the Government of Israel. The estimates of donations may be overstated.

Table 3.3: Uses of Funds by the Health Care Sector, 1991
(Millions of US$)

Object of Expenditure	Civil Administration	UNRWA	NGOs	Private	Total
Acute Hospitals	25.2	5.5	29.3		60.0
Mental Hospitals	1.6	7.8	8.6		18.0
Primary Care	12.0		1.0	25.0	38.0
Pharmaceutical	5.0			55.0	60.0
Eye care				5.0	5.0
Dental care				9.3	9.3
Ambulances				0.8	0.8
Community Mental Health				0.7	0.7
Medical Services				5.0	5.0
TOTAL	43.8	13.3	38.9	100.8	196.8

Source: UNRWA/WHO, "Universal Health Insurance for the West Bank and Gaza Strip," (Draft Report, 1992).

Table 3.4: Sources of Funds for Health Care, 1991
(Millions of US$)

	Millions of US$	Per Cent
Health Insurance	43.6	18
GHS Plan	42.0	18
Private Insurance	1.6	01
Private Expenditures	89.5	38
Purchase of Drugs	56.2	24
Private Health Care	21.0	09
Private Dental Care	9.3	04
Eye Care	5.0	02
Medical Devices	2.0	01
UNRWA Budget	13.3	06
International and Private Donations	18.4	08
Donations from Arab Funds	59.0	25
TOTAL	236.9	1.00

Source: UNRWA/WHO, "Universal Health Insurance for the West Bank and Gaza Strip," (Draft Report, 1992).

3.38 These estimates of health care expenditures suggest that per capita spending is about US$110 a year. (The population figures on which estimates of per capita spending must be based are themselves subject to a wide range of error.) If these estimates are roughly correct, then the Occupied Territories would be spending an amount equal to about 7 percent of GDP, or approximately 9 percent of GNP, on health care.

E. Health Care Facilities and Staff

3.39 Government health care services employ about 685 physicians and about 1,556 nurses. About 170 of the physicians and 450 of the nurses are assigned to hospitals. The Civil Administration operates 14 hospitals and 165 primary health care clinics. The 14 hospitals had a total of 1,477 beds in 1992. Twenty-five years earlier, at the onset of military occupation, the number of beds in government hospitals was about the same. Since the population of the Occupied Territories has more than doubled over the

period of occupation, this implies that the number of residents per hospital bed has more than doubled as well.

3.40 In its report for 1991 to the World Health Organization on the health of the Palestinians in the Occupied Territories, the Government of Israel reported its intention to increase the number of government beds in the Occupied Territories to 2,650 by the year 2000 - an increase of 70 percent. The number of beds currently in operation and the projected numbers in the year 2000 are reported in Table 3.5.

Table 3.5: Actual Number of Government Hospital Beds in 1990 and Projected Number for 2000

Hospital	Number of Beds 1990	Projected Number of Beds 2000
WEST BANK		
Jenin	55	140
Tulkarem	64	136
Nablus-Watanee	86	124
Nablus-Rafidia	122	181
Ramallah	136	207
Beit Jallah	64	91
Jericho	50	50
Hebron	103	141
GAZA STRIP		
Shifa (Gaza City)	380	660
Nassar Pediatric (Gaza City)	115	0
Ophthalmic (Gaza City)	35	0
Psychiatric (Gaza City)	34	0
Central Hospital	0	200
Khan Younis	225	400
Ahli (Gaza City)	75	100
TOTAL	1477	2650

3.41 The Civil Administration also provides primary health care from a network of basic health clinics. The primary health care system has a total staff of about 500 persons, of whom 95 are physicians, 300 are nurses and about 100 are sanitarians and medical technologists. The term "clinic" is used by Israeli authorities to refer to a specific health care activity rather than to a physical facility. This practice has caused considerable confusion about the actual level of effort. A single facility may offer a prenatal

clinic, a post-natal clinic, a well-baby clinic and a diabetes clinic and, thus, be reported by the Civil Administration as four clinics. Outside observers suggest that the number of government facilities offering primary health care is probably about half the number of clinics officially reported. Moreover, most clinics operate on a part-time basis. For example, in 90 percent of the government clinics in the West Bank, a physician was present for two or fewer days a week.

UNRWA

3.42 UNRWA provides most of its services through a network of 42 health centers providing basic health care. Eight of the nine health centers located in the Gaza Strip have well-equipped diagnostic laboratories; all nine UNRWA health centers in the Gaza Strip provide maternal and child health services. UNRWA employs 82 physicians (of whom 37 are general practitioners) to serve more than a half million refugees in the Gaza Strip. Thirty-three health centers are located in the West Bank; only thirteen of these have a diagnostic laboratory. UNRWA employs 61 physicians to care for about 400,000 registered refugees in the West Bank. UNRWA also operates 46 supplementary feeding centers, 15 dental clinics, 8 birthing centers and 15 free-standing laboratory facilities. UNRWA runs a 34 bed hospital in Qalqiliah. In addition, UNRWA contracts with private, voluntary hospitals to supply secondary care to refugees. UNRWA contracted for the use of 350 hospital beds in voluntary and government hospitals in 1992. (See Table 3.6.) A capital drive is under way to raise US$25 million to construct a 232 bed hospital in Gaza; the Gaza hospital is scheduled to be opened in 1995.

Table 3.6: Hospital Beds Contracted by UNRWA

Name of Hospital	Number of Beds Contracted
Augusta Victoria, Jerusalem	104
St. John's Ophthalmic Hospital, Jerusalem	14
Caritas Baby Hospital, Bethlehem	12
Al-Ittihad Hospital, Nablus	30
Al-Ahli (Evangelical) Hospital, Gaza City	40
Bethlehem Government Psychiatric Hospital	75
Bureij Government Tuberculosis Hospital, Gaza	75

3.43 UNRWA reports that it provides about 3.7 million patient contacts with the primary care system a year. This implies an average of about 3.7 encounters per capita with the health care system a year. This average lies near the upper end of what might be expected; middle income countries typically report an average of 2.5 to 4.0 encounters per capita per year.

Non Governmental Organizations

3.44 About half of all primary health care facilities are owned and managed by private, voluntary organizations. Between 720 and 750 physicians (approximately a third of all physicians practicing in the Occupied Territories) work at clinics in the voluntary and for-profit sectors. About 200 physicians and about 800 nurses are employed by non-governmental hospitals. Thirty percent of acute care hospital beds and half of all hospitals are operated by the NGO sector.

F. Special Initiatives

3.45 The Civil Administration is working with several external agencies to improve health care and environmental conditions in the Occupied Territories. It has cooperated with UNICEF since 1985 in increasing access to primary health care in the Hebron district. This program aims at providing prenatal and child care to high risk groups in isolated, small villages. It focuses especially on the management of diarrheal diseases, the prevention of childhood communicable diseases, the treatment of respiratory infections and the improvement of self-care. The program provides six months of full-time training to a community member with a high school certificate. The trained village health worker then identifies high-risk pregnancies, follows up on well-child care (including immunization), monitors the nutritional status of small children and works with local leaders to improve environmental sanitation. The village health worker also coordinates periodic visits from a public health team and facilitates referrals to urban health care facilities when that is needed. The UNICEF/Civil Administration Extended Primary Health Care Project operated in 49 villages at the end of 1987.

3.46 A program to identify high-risk pregnancies was launched by the Government Health Service in 1988. It includes the introduction of a set of guidelines and a referral form for the processing of pregnant women, the orientation of all staff posted at maternal and child health centers and village health rooms, and the creation of high-risk pregnancy clinics. Eight of these clinics have been developed in the West Bank, seven of which now operate from district hospitals; two clinics have been created in the Gaza Strip. UNICEF has assisted in the training and continuing education of traditional midwives. In 1990 all practicing midwives in the Gaza Strip attended a UNICEF sponsored course and received equipment for home deliveries.

3.47 The Civil Administration has also worked with several groups providing rehabilitation services to persons with serious injuries. A 30-bed rehabilitation center has been constructed in Ramallah by the Swedish organization, Diakonia. The Friends of the Sick (Patients' Friends Society) has constructed a rehabilitation and physical therapy center in Bet Jallah with financial assistance from the Government of Italy, the CDF and UNDP.

3.48 The Civil Administration has also launched a number of initiatives to improve hospital services. It introduced a new, computerized, hospital discharge information system in 1991; this system classifies patients under the International Classification of Diseases, Revision 9. The records are analyzed periodically to evaluate utilization and outcomes. Improvements have been made in radiology services in several hospitals. Intensive care units have been added in Nablus, Ramallah and Gaza City, and open heart surgery and neurosurgery departments were added to Ramallah hospital in 1987.

3.49 The lack of government investment in hospital bed capacity remains a particularly contentious issue. In addition, the Civil Administration has been very slow in granting permits to nongovernmental

institutions to construct additional private hospitals. These public policies have had the largely positive effects of encouraging greater reliance on outpatient care, including primary prevention of disease and self-care, and of forcing more efficient use of hospital facilities and resources. Since 1967, the average length of stay in hospitals has declined from 6.8 to 3.2 days. The present length of stay compares favorably with that of many Western countries. The occupancy rate for government hospitals has continued to decline as well. In 1991 hospitals operated by the Civil Administration operated with only 62 percent of beds occupied on average. The low occupancy rate is due in part to economic barriers to hospital utilization.

Private Sector Initiatives

3.50 The Palestinian medical charities have made significant improvements in health programs in recent years. The Patient's Friends Society of Hebron has undertaken the construction of a 300-bed hospital, the 40-bed obstetrics wing of which is expected to open in 1993. Smaller bedded polyclinics are being developed by charitable organizations in Gaza City, Tulkarem and Hebron. These initiatives are being financed from private donations, as well as aid from the Gulf and official bilateral sources.

3.51 The grass-roots voluntary organizations have developed very impressive programs of primary health care. These groups have prepared detailed plans for the provision of mother and child care, the treatment of minor illnesses, the control of infectious diseases and health education. These services are typically rendered from converted residences. The growth of these programs has been explosive with more than a hundred clinics constructed between 1988 and 1991. The facilities that have been created and the staff that has been employed are very impressive.

3.52 Most of these initiatives represent reasonable responses to the health needs of the Palestinians. The impacts of improvements in primary health care are not yet reflected in health statistics and indicators, but one must bear in mind that these data are of limited value because they are poorly collected and unrepresentative. The aggressive efforts being made by the voluntary sector to strengthen primary health care should pay off quickly in terms of reduced infant and child mortality, as well as improved maternal health. The efforts of the Civil Administration to improve maternal and child health are likely to have a more modest effect, primarily because of the growing reluctance to utilize government services. Some efforts by the Civil Administration and voluntary organizations to upgrade hospital services may be inappropriate, especially in areas of diagnostic imaging and sub-specialty care. Proposals to provide additional capacity for heart surgery, organ transplantation and oncology care should be carefully evaluated, particularly in view of the small population base and the uneconomic size of many hospitals in the Occupied Territories.

G. Sector Problems

3.53 The health outcomes that are being reported suggest that significant gains have been made over the period since 1967. Over the past quarter century, the infant mortality rate has declined by roughly half. Life expectancy has increased by more than a decade over the same period. At issue is not whether the health of the Palestinians has improved over the period but rather whether the pace of improvement has been as great as it could have been. The more rapid pace of progress in Jordan than in the Gaza Strip and the West Bank is cited by Palestinians as evidence that inadequate efforts have been made under rule by the Israeli Civil Administration. Much of the credit for improvements in health can be traced to the prevention of diseases transmitted under poor sanitary conditions and hence must be attributed to

improvements in educational status and general living conditions rather than to the expansion at health services as such. Still, the health services delivered by the Civil Administration, UNRWA, the charitable and voluntary organizations and private providers of health care have played a substantial role. The work of the nongovernmental sector has been especially significant. In 1967 over 85 percent of all health services delivered in what are now the Occupied Territories were produced by the public sector; by 1991 the Government's share had shrunk to about 37 percent. Over the same interval, private voluntary and for-profit health care grew from a negligible share to represent about a third of health care expenditures and more than half of patient contacts.

3.54 However, the Occupied Territories have devoted an unusually large share of available resources to the health sector, and the health impact has been more modest than should have been obtained from this expenditure. Several reasons for this disappointing performance are apparent. First, most social resources are being used to provide costly, high technology, hospital-based care for the benefit of the relatively well-to-do. Second, very small, inefficient hospitals have been allowed to proliferate (68 percent of all hospitals have fewer than 100 beds). Third, highly specialized procedures have been carried out by units that are too small to either exploit economies of scale or provide physicians and staff with enough practice to maintain skills. Fourth, access to many services has been blocked for specific groups of people because of the segmentation of the health care market introduced by the insurance scheme and the provision of free care to refugees. Finally, too little attention has been given to reaching out to underserved groups, especially women; more than a third of all deliveries continue to occur without supervision by a trained health worker, for example.

3.55 The root causes of these problems are to be found in a lack of coherent policy and an absence of sector planning. Several unrelated institutions are providing services to distinct groups within the area. Moreover, the Government Health Service could not charge current premiums and provide the level of service nominally available to those with government health insurance, let alone all residents of the Gaza Strip and the West Bank. At the same time, UNRWA appears to be achieving roughly comparable health outcomes with much smaller per capita outlays of funds. Part of the explanation for this apparently superior performance is that UNRWA is extracting subsidies from the hospitals that provide it with contract beds for refugees, but the more important explanation appears to be that UNRWA is focusing more sharply on the primary prevention of disease. The voluntary sector presents a remarkably diversified picture. The older and more established private voluntary organizations have in several instances clearly overinvested in expensive medical technology; this phenomena appears to be a legacy of the period when private and official donors from the Gulf were generous supporters of these institutions. The voluntary organizations founded since 1987 have obviously operated with more modest budgets and have made much more careful choices about both the services that they wished to offer and the technologies that they wished to adopt.

3.56 The fragmentation of decision-making in the health sector is also revealed in the proliferation of small hospitals and bedded medical clinics. In order to exploit the most important economies of scale in the operation of a community hospital, it is necessary to build a minimum of about 150 beds. The ideal size of a hospital in the Occupied Territories may be somewhat smaller because of the relatively low cost of qualified manpower in the area. However, 68 percent of all hospitals have fewer than 100 beds, and 20 percent have fewer than 50 beds. In addition, 11 private maternity hospitals exist, none of which has more than 35 beds (the average has only 16). Rationalization of the hospital sector would entail a considerable reduction in the number of institutions and would lead to a significant reduction in costs. In addition, rationalization of the hospital sector would contribute to improvements in the quality of care. The numbers of procedures being carried out by specialized units are not large enough to provide

physicians and nurses with enough practice to operate at peak skill and efficiency. For example, Ramallah hospital is reported to be doing 40 to 50 open heart operations a year --roughly one a week. This is no more than a third of the minimum number that a hospital team should seek to perform in order to maintain its skills and proficiency.

H. Recommendations

3.57 The development of a sound policy environment will be required in order to address these problems. As noted above, present inefficiencies are rooted in the fragmentation of responsibility, not only for the delivery of health care but also for the management of subsidies to the sector from the government budget and external donors. Thus, a responsible body must be created to develop a coherent health policy and to coordinate activities in the sector. Since a large number of highly diverse organizations now populate the sector, and a newly formed self-governing authority will initially have limited administrative capacity, the bureaucracy should not seek to control sector activities directly but rather should seek to facilitate greater coordination. Policies should, at the same time, seek to interrupt the link between refugee or employment status, and entitlement to subsidized health care. In assembling a set of policies, issues of health care finance, service standards, investment in technology and quality assurance should also be addressed.

3.58 In view of the large fraction of GDP already being committed to the sector, policies should increasingly stress increasing the internal efficiency of the health sector and should try to control the overall costs of health care, rather than to expand the system, particularly at the hospital level. Sanitation should be further improved, and a larger fraction of cases of acute diarrhea should be treated with oral rehydration fluids. Acute respiratory diseases should be better managed. The onset of chronic diseases due to such conditions as hypertension and diabetes should be controlled with appropriate diet and drug therapy.

3.59 The total cost of the investments required to address the needs identified in this chapter and to continue to replace worn out and obsolete equipment and facilities over the next decade is likely to be US$175 to 200 million. The greatest priority within this program of investments is the expansion of the basic health care system. The second highest priority ought to be given to the rehabilitation and renovation of existing health facilities, including hospitals. Gaps in the current health care infrastructure should be filled through the development of a burns unit, a cancer care program and a laboratory for the control of communicable diseases should also be given high priority.

IV. EDUCATION AND TRAINING

A. Introduction

4.1 The Palestinians have demonstrated a strong commitment to education. Enrollment in basic education (grades 1-6) is equal to about 102 percent at the age group 6-12. Palestinians are credited with having one of the highest proportions of their population completing higher education of any Arab group.

4.2 This chapter describes the efforts that are now being made to educate and train the children of the Gaza Strip and the West Bank; it outlines the steps that would have to be taken in order to rectify deficiencies in these programs. The rest of the chapter is divided into five sections. The first section describes the institutions that provide education and training services. The second section presents the information available on the financial and real resources that have been committed to the sector. The third section discusses the programs that are being carried out and assesses their effectiveness. The fourth section describes the weaknesses in programs that the chapter has identified and suggests initiatives that ought to be considered in order to rectify these problems. The final section summarizes the chapter's recommendations.

B. The Institutions of the Education Sector

4.3 The institutions of the education sector are much less complex than those found in the health sector. The Occupied Territories are served by only two distinct systems of education: the Egyptian system in the Gaza Strip and the Jordanian system in the West Bank. However, these two systems pursue distinct objectives, are organized differently, and employ separate examination systems. The Civil Administration supervises all primary and secondary educational institutions. Schools are operated by the Civil Administration, UNRWA and a small number of private (principally charitable) organizations. The Civil Administration enrolls about 62 percent of all primary and secondary school students in its institutions. UNRWA provides schooling to about 31 percent of the students, and the voluntary and private, for-profit institutions serve less than 8 percent. Preschool and higher education is dominated by nongovernmental organizations. Because of frequent strikes and curfews, schools have been closed often since the onset of the Intifada.

Kindergartens

4.4 About 10 percent of five-year-olds living in the Gaza Strip, and about 15 percent of the same age group living in the West Bank, attend preschools. In both the Gaza Strip and the West Bank preschool education is offered primarily by the private sector, usually by charitable institutions, women's associations, religious groups or individuals but also, in a few instances, by for-profit organizations. UNRWA and the Civil Administration provide preschool education to a very small number of children living in the West Bank. Preschool teachers are not required to possess any formal qualifications, but most have passed the examination for graduation from secondary school, and a few have obtained a Bachelors degree. Very few teachers have taken any courses in pre-school education. Most kindergartens do not have a formal curriculum with clear objectives and goals. Educational materials and equipment are limited due to the scarcity of funds.

The Schools

4.5 Following the partition of Palestine in 1948, the Governments of Egypt and Jordan introduced their education systems into the Gaza Strip and the West Bank, respectively. The Israeli military government has retained these arrangements since 1967. The structure and content of the curriculum, teaching materials and examinations are obtained from Egypt and Jordan. Israeli officials censor the contents of books and journals in order to ensure that politically provocative materials are not disseminated through the schools. Education officials from the two countries continue to assist in the examination of graduates of schools in the Gaza Strip and in the West Bank. The Civil Administration supervises all educational institutions and continues to review the content of the curricula of public, private and UNRWA schools and to regulate the construction and extension of school facilities.

Vocational Education

4.6 Vocational education and technical training are offered by the Civil Administration, UNRWA and private institutions. Vocational and technical education has never been viewed by the Palestinian community as a serious part of the education program. Israel established additional vocational training centers in the main cities of the Gaza Strip and the West Bank, after 1967, to prepare semi-skilled laborers for employment in the Israeli economy. Most courses were only a few days in length and were designed to enable Palestinians to meet the formal requirements of the Israeli labor market. The most common course has prepared students to take the written examination for a license to drive a truck in Israel.

4.7 The Civil Administration determines the curriculum of vocational and technical schools (public, UNRWA and private). Its Labour Staff Officer meets with employers in Territories to identify training needs. The Civil Administration also follows up on selected graduates of training programs in order to evaluate their effectiveness. The Government of Israel prohibits the teaching of some subjects such as maintenance of communications equipment, because the equipment required might be used for military purposes. Employers are not involved in setting training policy. Courses focus on the mastery of craft skills and provide little instruction in areas such as organization and management. Training for self-employment has been almost totally neglected. Both public and private vocational schools are seriously underfunded. The problems created by a scarcity of funds are compounded by restrictions on the importation of equipment for educational and training purposes. As a consequence, facilities are inadequate, and equipment is often obsolete.

Community and Teachers' Training Colleges

4.8 There are 20 community and teachers' training colleges in the West Bank and one in the Gaza Strip. Four of these are administered by the Civil Administration, three by UNRWA, nine by the Council for Higher Education and five by private entities. The community colleges offer technical (e.g., engineering), agricultural, commercial (business administration), paramedical, social service and teachers' training programs. All community colleges in the West Bank require the Jordanian secondary school leavers examination (the *Tawjihi)* for admission to two-year diploma courses. In the past, graduates of the community colleges have not been allowed to transfer to West Bank universities.

Universities

4.9 There are 8 universities in the Occupied Territories: 6 in the West Bank --including an Open University-- and two in the Gaza Strip. All are under the supervision of the Council for Higher Education, and all were established with private Palestinian funds. The objectives of Palestinian universities are: to meet society's needs by providing experts, technicians and specialists in all fields; to prepare scientists and researchers, inventors and innovators; and to conduct scientific research, both theoretical and applied. The universities have played a major role in political activities in the Territories. Because of this, they were closed by the Israeli authorities at the beginning of the Intifada, and were allowed to reopen partially, beginning in 1990. By 1992, the universities had resumed operations. However, access to the universities has continued to be restricted because of difficulties with passes and travel permits for both faculty and students. Considerable duplication of courses and departments among universities has emerged in response to this problem. During the 1991/92 academic year, there were a total of 16,368 students and 1,010 faculty in Palestinian universities. Approximately 40 percent of the university students in the West Bank were women.

Literacy Education

4.10 Illiteracy remains a significant problem among Palestinian adults. Within the group 35-44 years of age, 28.5 percent of women are illiterate compared to 7.4 percent of men.[24] Efforts are being made, in the main by charitable institutions, to combat this problem. The Higher Committee for Literacy and Adult Education coordinates literacy training activities. There are some 170 centers in the West Bank run by the various associations, but there is a need for more, and better equipped, centers. In the Gaza Strip there are 27 centers; the Palestinian Red Crescent Society is playing a major role in supporting the program. The Higher Committee for Literacy and Adult Education coordinates literacy training activities. The Civil Administration provides literacy classes at ten vocational training schools.

Services to the Handicapped

4.11 About 30,000 handicapped persons lived in the Occupied Territories in 1990, according to UNESCO. This number is believed to have increased considerably over the past two years because of violence associated with the Intifada; Palestinian sources report that over 43,000 people were injured between 1987 and 1993 in connection with the uprising. These reports claim that about 11,000 persons have suffered significant, permanent physical disabilities.

4.12 In 1990 there were 37 institutions in the Gaza Strip and the West Bank for educating students with handicaps. One of these institutions was run by the Civil Administration; 9 were administered by foreign missions, and 27 were privately operated. The total enrollment in these institutions was 2,907. They deal with problems of deafness, blindness, mental retardation, physical impairment and multiple handicaps. These centers are understaffed and underfinanced, and their staffs need additional, specialized training. Despite the tremendous growth in the prevalence of mental health problems since 1987, little has been done to address this issue. The Gaza Community Mental Health Program was established in 1990 to begin to confront the problem.

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[24] Statistical Abstracts of Israel 1992, No. 42.

C. Education Finance

4.13 The total expenditure for all levels of academic education is about US$170 to US$175 million a year. This represents a per capita expenditure of about US$90 per resident of the Occupied Territories and corresponds to approximately three-quarters of the amount being spent per capita on health care.

4.14 The Civil Administration spent US$58 million in 1991 and has budgeted US$80 million for 1992. Over 70 percent of its recurrent expenditures were devoted to the West Bank and the remaining roughly 30 percent were committed to the Gaza Strip. The UNRWA 1991 education budget for the Occupied Territories was US$52 million --two-thirds for the Gaza Strip and one-third for the West Bank. Per student expenditures in 1991 were about US$153 in government schools, US$334 per student in UNRWA schools in the Gaza Strip and about US$425 in UNRWA schools in the West Bank. Differences in unit costs were due to differences in salaries and to greater expenditures on teaching materials and the maintenance of facilities in UNRWA schools.

4.15 The private sector educates about 8 percent of students enrolled in primary and secondary schools. Most of these institutions are financed largely or entirely with student fees and are able to attract paying students because they are perceived to offer a richer curriculum or better education. A common rationale for sending children to a private primary or secondary school is to gain access to special programs in music, art and foreign languages. Figures on per student expenditures are not available for the private sector, but it appears reasonable to assume that costs are roughly the same as those experienced by UNRWA. If one accepts this assumption, then private spending on primary and secondary education totaled about US$13 million in 1991.

4.16 The total cost of university education is about US$27 million a year. Per student costs for college and university education range from US$1500-2000. Students are charged fees of US$400-500 per year. The universities are financially autonomous. They have received substantial assistance from private and foreign donors in the past. Because of a sharp drop in foreign donations and a significant decrease in fee income due to the lengthy closures of universities since the onset of the Intifada, the universities now face financial crises. Most are now depleting staff retirement funds in order to meet essential expenses. Several have been unable to pay faculty salaries for months at a time and, as a result, have experienced faculty strikes. Libraries, laboratories, textbooks and other educational materials and computer facilities are deteriorating, as well.

D. Education Resources

Instructional Staff

4.17 The Council for Higher Education reports that 18,594 teachers were engaged in teaching school in 1991/92. Table 4.1 presents the numbers of students and teachers, and the student-teacher ratio for the two regions and for government, UNRWA and private schools. Two-thirds of these teachers (a total of 12,496) were employed by the government sector, and about 22 percent were employed by UNRWA. The private sector employed slightly less than 10 percent of all teachers. The ratio of students to teachers varied among regions and sectors by a factor of 2.2. The lowest student-teacher ratio was found in the private sector in the Gaza Strip where there were only 16.9 students per teacher; the highest student-teacher ratio was found in UNRWA schools in the Gaza Strip where there were 36.1 students per teacher.

Obviously, the averages for a region obscure variations within the area. At present, roughly two-thirds of teachers have only a two-year diploma from a community or teachers' college. Under Jordanian Law, all West Bank teachers must have a minimum qualification of a Bachelor degree by 1997. Some efforts have already been made to provide in-service training at teacher training institutes and universities.

Educational Facilities

4.18 The average school is reported to enroll about 400 students. The largest schools are found in the Gaza Strip (703 students per school); this figure no doubt reflects both the high population densities that prevail there and widespread double-shift operation of schools. The lowest average is found in the Ramallah district where the average school size is 273 students. Table 4.2 presents the numbers of schools in each district for each level of education.

Table 4.1: Total Numbers of Students and Teachers
by Supervising Authority and Region 1991/92 School Year

Authority	Region	Total Number of Students	Total Number of Teachers	Student/Teacher Ratio
Government	West Bank	280,682	9,720	29
	Gaza	97,689	2,776	35
	Total	378,371	12,496	30
UNRWA	West Bank	43,593	1,456	30
	Gaza	100,863	2,800	36
	Total	144,456	4,256	34
Private	West Bank	40,208	1,696	24
	Gaza	2,463	146	17
	Total	42,671	1,842	23
Total	West Bank	364,483	12,872	36
	Gaza	201,015	5,722	35
	Total	565,498	18,594	30

Source: Council for Higher Education

4.19 The Civil Administration constructed about 200 school rooms in 1991. At that time, 317 rooms were being rented. With a growing population and large numbers of classrooms operating double shifts, the need to add classrooms, especially for public schools, is clear. In view of the rapid rate of growth in the school age population (more than 4 percent a year), a program for replacing the current school

structures and adding not only classrooms, but also libraries, laboratories and recreational facilities, is required over the medium- and long-term.

4.20 The quality of the teaching staff does not appear to be adequate. This judgement is based on the level of training that is being provided (and required) and the methods of training observed in teacher training institutions. Too much emphasis is given to the recall of fact and mastering of terminology. In the medium-and long-term, a concerted program of upgrading teacher education and retraining teachers is required. This is particularly urgent in basic education but is also necessary at the technical college and university levels. Teachers require access to new educational technologies and training in their use. In addition, teachers need to become familiar with recent developments in cognitive theory. Exchanges with overseas institutions through scholarships and fellowships should be pursued. Twinning arrangements with educational institutions in the region, in Europe and other parts of the world should be encouraged.

Table 4.2: Number of Schools by Location 1991/92 School Year

Location	Basic Level	Academic Secondary	Vocational Secondary	Total
Jenin	118	38	1	157
Tulkarem and Qulqilia	120	51	1	172
Nablus	126	44	1	171
Ramallah	156	51	3	210
Bethlehem and Jericho	91	29	3	123
Hebron	169	37	1	207
Gaza	245	39	0	286
TOTAL	1025	289	10	1326

Source: Council for Higher Education

4.21 School buildings are generally in a poor state of repair. Broken windows and doors, leaky roofs and faulty sanitary facilities are common. Some of these problems can be traced to the violence that has plagued the Occupied Territories, especially since 1987. However, a significant part of the problem must be attributed to inadequate preventive maintenance and delays in executing minor repairs. The rehabilitation of decaying facilities is clearly one of the leading priorities in the education sector. In addition, many schools occupy buildings that were constructed as private residences and, thus, do not have adequate provision for sanitation or sufficient play areas. While these deficiencies do not seriously affect

the effectiveness of schools, they should be kept in mind when the development of the sector is being discussed.

Educational Materials and Equipment

4.22 Data on the availability of teaching materials, library books and laboratory equipment, regrettably, are not available. Anecdotal accounts and the mission's observations suggest that supplies of these inputs are highly inadequate in both quality and quantity. Modern educational materials, teaching aids and equipment are required from preschool through university level. Donors have contributed hardware to some institutions, but training is required in the use and maintenance of the equipment and materials. In the medium- and long-term, considerable resources will be required to update equipment and educational materials to ensure the relevancy of studies at all levels.

E. Education Processes

The Curriculum

4.23 Schools in the Occupied Territories rely on curricula that were developed during the 1960s by the governments of Egypt (for the Gaza Strip) and Jordan (for the West Bank). Teaching materials have been updated periodically, but significant changes have not been made in either objectives or teaching methods. Egypt and Jordan are both now revising their curricula. Several more years will be required before this process affects classroom teaching. The present curriculum emphasizes the mastery of facts rather than higher-level cognitive skills, including analysis and synthesis. The teaching methods that are typically used to impart this knowledge stress the one-way transmission of knowledge from the teacher to the student. In order to prepare students for roles in an expanding and rapidly changing economy, the curriculum needs to be updated to prepare students to deal successfully with novel problems. This implies that the school curriculum should be strengthened to develop capacity to mobilize information, evaluate both evidence and argumentation, and apply general knowledge to the solution of specific, unfamiliar problems.

4.24 Representatives of the Palestinians have not participated formally in the ongoing efforts to modernize and strengthen programs of primary and secondary education in Egypt and Jordan. Palestinian leaders should be participating in discussions of the relevance of both or either system to the needs in the Occupied Territories, or should be working to prepare a curriculum and instructional program of their own.

Pedagogy

4.25 The systems of primary and secondary education now being implemented in the Occupied territories rely heavily on education practices established in the 1950s and early 1960s. While most of these practices remain valid, the major advances in cognitive theory, teaching practices and educational technologies achieved over the past four decades needs to be brought to bear on classroom teaching. In particular, the present system of education affords children few opportunities to participate actively in learning; to apply their skills in formulating researchable or solvable problems; or in drawing on a wide range of knowledge, skills and analytic methods to illuminate real-world problems.

Educational Quality

4.26 The education now being provided to children living in the Occupied Territories does not meet reasonable quality standards. The evidence on school quality is of two kinds. First, the resources being supplied are inadequate in both quantity and quality, and second, the performance of Palestinian children on standardized tests falls far below international norms and expectations.

4.27 As previously noted, the Civil Administration has attempted to maintain a systems of education in the Occupied Territories that is as much like those of Egypt and Jordan as possible. It has been successful in providing reasonable numbers of teachers, and through the use of many school buildings for two shifts a day, it has kept average class size reasonable. However, the quality of the instructional staff, though similar to what has been mandated in the past by Egypt and Jordan, leaves a great deal to be desired. Both Egypt and Jordan have launched efforts to raise the minimum qualifications of primary school teachers from a two-year post secondary certificate granted by a two year community college or teacher training institute, to a bachelors degree from a four year college. The government of Jordan has decreed that all teachers should have attained the higher qualification, by 1997. As of 1992, only about a third of the primary school teaching staff met the new standard.[25]

4.28 Evidence on the outcomes of education has recently become available. The testing program of the International Assessment of Educational Progress --a twenty country international comparative study of student achievement in science and mathematics-- was administered in June 1992 to children in the West Bank by the Jordanian National Center for Educational Research and Development. The investigation was financed by UNICEF and carried out under the supervision of the Educational Testing Service. The average score for students in the West Bank was 52.2 on the science test. This compares with a score of 57.6 in Jordan and 69.7 in Israel. The highest average score --77.5-- was achieved by South Korea. The West Bank placed twentieth in a field made up of twenty countries and the Occupied Territories; Jordan placed eighteenth and Israel placed eighth. On the mathematics examination, the West Bank achieved an average score of 33.6 compared with 40.4 for Jordan and 63.1 for Israel. The West Bank ranked nineteenth among the twenty-one participants; Jordan placed seventeenth and Israel placed ninth. Most alarmingly, Palestinian students performed especially poorly on test items that required them to use several skills to deal with novel tasks --precisely the sort of capacity that the economy is expected to require in the future.

4.29 Analyses of the comparative performance of students enrolled in government, UNRWA and private schools reveal that the worst outcomes have been achieved by the UNRWA schools, even though they are more generously supplied with teachers and teaching materials. The underlying explanation for this finding has not been established, but the hypothesis that the social conditions that prevail in the camps may play a major role cannot be ruled out.

4.30 The quality of education is believed to have fallen sharply since 1987. The principal reason for this presumed deterioration has been the dramatic reduction in the length of the school year, resulting from the numerous curfews and strikes that have accompanied the Intifada. For expample, during the 1990/91 school year, children enrolled in UNRWA schools in the West Bank lost 40 percent of school days due to official closures; by 1991-92, losses had declined to 17 percent of all scheduled school days.

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[25] Attaining a higher qualification does not necessarily guarantee a better teacher, but it does help to insure that teachers have mastered the subject matter that they are expected to teach.

It should be noted that time-on-task (the amount of time actually spent in school on school work) has been found to be the single most powerful determinant of student achievement. The Intifada has also been associated with an increase in discipline problems, declining academic standards, and increased repeater rates.

F. Sector Problems

Curriculum

4.31 The school curricula should be examined, at all levels of education and by all providers in order to develop and implement a medium- and long-term framework for curriculum development. Some initial discussions have already taken place between UNRWA and the Council for Higher Education. Representatives of private schools should be included in the deliberations also. In the medium-, and even long-term, a program for curriculum development should be established. Ideally, a unified curriculum should be established for both the West Bank and Gaza in order to minimize the cost of developing and producing teaching materials. A unified curriculum would also facilitate the mobility of teaching staff between the two areas of the Occupied Territories. As the process of developing curricula is costly in time and resources, it may be advisable, in the medium-term, to purchase existing relevant curricula from abroad and modify in order to reflect local concerns and interests.

Teacher Qualifications

4.32 The qualifications of educational personnel in almost all positions need to be upgraded. In addition, the teaching staff needs to be reoriented to the expectations of the revised curriculum; the introduction of more participative learning methods will require particular attention. Thus, reform of both pre-service and in-service teacher education is urgently needed. Teachers in the government schools appear to have the greatest need of upgrading their qualifications and extending their experiences. Some efforts have already been made to run in-service teacher training courses in some of the teacher training institutes and universities. A continuation and expansion of this training is necessary, especially in the areas of cognitive theory and practice.

Facilities

4.33 School buildings are generally in a poor state of repair. Libraries, laboratories and recreational facilities are generally inadequate, as are supplies of textbooks and teaching materials. Deficiencies in libraries and laboratories are especially critical in the university system. A study of the inventory of school facilities is needed to form the basis for planning their rehabilitation and upgrading.

Bureaucratic Regulation and Restriction

4.34 The current official practice of limiting access to library materials and censoring textbooks should be reviewed. In private institutions and some UNRWA centers, the present policy of not granting permits to build, extend and update school premises should be relaxed. These practices have, in some cases, forced voluntary agencies to return funds to donors because of lengthy delays in gaining permits or outright refusals to grant them. Much more cooperation between the Civil Administration, private and UNRWA education providers, and donors should be sought. If the major problems are to be resolved,

easier access to one another's institutions, facilities and expertise must be granted. Seminars and workshops, where the experiences of educationists may be shared, should be developed.

Vocational Education

4.35 Economic development will require a labor force skilled in acquiring new technologies in order to meet changing conditions. In the short term, in order to make training courses more relevant to economic needs, program and course design could be addressed by local committees composed of those responsible for vocational and technical education, educational and subject area specialists, and local business people. Areas of particular relevance include agriculture, food processing and manufacturing.

4.36 In the medium- and long-term, community colleges should be encouraged to upgrade their faculties and recruit staff to provide more specialized, technically advanced education. Greater stress should be place on the development of mid-level technicians to bridge the gap between craftsmen and highly specialized engineers. Programs based on those available in polytechnics would appear to be more appropriate to the future employment and economic needs of the Occupied Territories. Community colleges could focus future attention on polytechnic type curricula. A detailed review of the curricula provided by the community colleges might help to avoid duplication of educational programs. The universities should be encouraged to review their policy of not admitting graduates of community colleges.

Special Education

4.37 The frequent closing of schools since the beginning of the Intifada has led to a deterioration in the quality of education and an escalation of behavioral problems. The needs of children who should have been attending school during this period are poorly documented but clearly require urgent attention, nonetheless. Widespread violence has also produced an alarming growth in the population that is physically or mentally disabled. The needs of these sections of the community, while largely unquantified, require urgent attention. In the short-term, more facilities and centers are required, staffed by professional people. In the medium- and long-term, special training is required in these areas. Counselors, literacy teachers, career counselors and vocational guidance experts are required as a necessary part of a modern educational system.

Education Administration

4.38 Reference has already been made to the need to upgrade teachers' qualifications at all levels of education. There is also need to professionalize planners and administrators to enable them to carry out the planning and management functions that have been neglected in the past. Training is needed in administration, fiscal management and education planning. Personnel exchanges across institutions could prove useful. In the medium- and long-term, professional qualifications in education administration should be required of heads of schools, colleges and universities.

Higher Education Infrastructure

4.39 University libraries and laboratories are woefully inadequate. Because enrollments are small, these institutions cannot justify investments in serious research libraries and laboratories. The mission of each institution, and the resources required to enable it to fulfill its mission should be decided through a systematic and formal mechanism for inter-institutional cooperation. A system of shared library (and

perhaps laboratory) facilities should be explored. The use of electronic technology to provide access to journals and scholarly books should also be supported. The possibilities of developing specialized universities and of encouraging cross registration to allow institutions to achieve economies of scale should be investigated.

G. Recommendations

4.40 The quality of education offered to children in the Occupied Territories urgently needs to be improved. As a first step, an education reform process should be launched in order to initiate debate on the aims and objectives of the education program. This process should lead to the adoption of new course contents that provide students with greater skills in the manipulation of ideas and the application of concepts and disciplines to the solution of novel problems. In order to accelerate the reform process, the possibility of borrowing curriculum and teaching materials from Arab countries should be explored. In the longer term, the contents of education programs in the Gaza Strip and West Bank should be unified. The quality of teaching should also be given attention. Teachers should be trained in the use of forms of teaching/learning that provide students with greater opportunities to practice their newly acquired skills. Both pre-service and in-service training programs for teachers should be established. Additional training should be offered to policy analysts, planners, and administrators, as well. The education system should seek to strengthen the participation of parents and communities in the running of schools in order to strengthen both governance and accountability.

4.41 Efforts should also be made to strengthen post secondary education. The vocational education systems should be redirected to enable it to development generic skills rather specific craft skills. It should aim at make its graduates highly trainable and thus responsive to the opportunities that are likely to become available in what promises to be a rapidly changing economic environment. Higher education should focus its attention on providing very high quality training at community colleges and universities. The community college system should direct its resources particularly to the development of well trained mid-level technical workers such as medical technologists, electronic repairmen and accountants. The university system should seek to consolidate its programs and to develop mechanisms for the sharing of expensive laboratories, libraries and other specialized teaching resources. The possibility of creating a cooperative agreement for the enrollment of students from other institutions at each university should be explored. The development of new, specialized faculties should be a pursued only after careful evaluation of the financial feasibility of providing a high quality program and the probable demand for instruction.

4.42 The total cost of the investments necessary to implement these recommendations is approximately US$375-400 million. The highest priority should be attached to ensuring that the quality of the basic education being provided is brought up to a high standard. The second highest priority should be assigned to protecting investments in the university system by consolidating and rationalizing programs and facilities.[26] Third priority should be given to the rehabilitation and modernization of facilities that have fallen into disrepair in recent years. A modest program of improvements to the vocational education system would form the fourth priority. In addition about US$3-4 million a year should be spent on the

[26] A financial crisis now faces the university system because of a sharp drop in foreign donations to the sector; temporary assistance is required to restore the financial viability of the universities. This crisis must be resolved ultimately through the creation of local funding mechanisms. In the meanwhile, the sector requires assistance of about US$20 million a year in order to continue to operate.

routine replacement of worn out and obsolete facilities and equipment. The timing for implementation of these priorities should reflect the constraints imposed by the Peace Process and the scheduling of activities, as well as sector priorities.

V. SOCIAL WELFARE AND RELIEF PROGRAMS

A. Introduction

5.1 The partition of Palestine in 1948 led to the creation of extraordinary social and economic problems. The international community's first step in responding to these problems was to found UNRWA in 1950 in order to provide assistance to dislocated families. UNRWA responded initially with a variety of emergency relief measures aimed at meeting the basic human needs of the Palestinian refugees. Since 1950, a number of international voluntary organizations have been created in order to provide further humanitarian aid to the refugees.

5.2 This chapter attempts to describe the welfare programs that are now available to the Palestinians living in the Gaza Strip and the West Bank, to identify the deficiencies in the resulting safety net and to suggest measures that might be taken to strengthen and improve these provisions. The chapter is divided into four sections. The next section describes the institutions and programs that protect and benefit the residents of the Occupied Territories. The third section presents information on the funds being committed to these programs and their current effects. The fourth section examines the weaknesses in these programs and suggests areas in which modification should be made.

B. Institutions and Programs

5.3 The legal environment and programs that protect the welfare of workers and provide relief to the needy draw upon elements of many separate and uncoordinated systems. The partition of Palestine in 1948 led to the introduction of Egyptian and Jordanian bureaucracies and programs in the Occupied Territories. The creation of UNRWA ensured that registered refugees were entitled to an alternative collection of protections and benefits. In addition, a large number of international voluntary organizations have been created since 1950 to provide humanitarian aid to refugees. The adoption by the Government of Israel of an open borders policy following the 1967 war extended the benefits of many of Israel's social welfare programs to Palestinians working in Israel. These developments have yielded a patchwork of relief programs and social protections that ensure some, though not all, residents of the Occupied Territories receive assistance in meeting their basic needs.

UNRWA

5.4 The core of the social welfare system serving the residents of the Occupied Territories is the collection of programs operated by UNRWA. UNRWA was created to aid persons who lost their means of livelihood as a result of the partition of Palestine in 1948 and who in addition could demonstrate that they had resided in Palestine for at least two years prior to the partition. About 900,000 persons were designated as refugees at that time. Refugee status is passed along the male line to successors; in 1992 about 3.5 million persons worldwide were registered as refugees. About two-thirds of registered refugees live outside the Occupied Territories. Of the nearly 1 million living in the Occupied Territories, about 540,000 live in the Gaza Strip and about 400,000 live in the West Bank.

5.5 In 1991, UNRWA had a budget of about US$255 million; of that amount US$98 million was spent directly on programs in the Gaza Strip and the West Bank. UNRWA spent US$12.6 million for relief and social programs in the Occupied Territories in 1991. About 90 percent of the budget for relief and social services programs is spent on providing direct assistance to needy refugees. Relief and social service programs focus on "special hardship cases" to whom food, shelter, clothing and other survival needs are offered. UNRWA reports having provided assistance to about 58,000 special hardship cases in the Occupied Territories in 1991. About 17 percent of households are headed by women; a special program for these women assists in coping with family problems and in developing job skills. UNRWA also operates a modest loan program for special hardship cases. In addition, a number of governments provide special contributions to support projects serving especially vulnerable groups such as widows, the aged and the physically disabled. Many of the special contributions are in-kind rather than in cash. In 1991, 305 staff, including welfare workers, instructors and distribution team members, were assigned by UNRWA to administer programs of assistance to the Gaza Strip and the West Bank. These staff members operated food distribution centers, women's program centers, youth activities centers and community rehabilitation centers. The case load for UNRWA welfare workers is 257 clients each.

Government of Israel

5.6 Palestinians who work for employers located within Israel are required to participate in the Government of Israel's national social security scheme. This scheme is financed from contributions by employees (5.35 percent of wages), and contributions by employers (7.35 percent of wages). For Israeli workers these deductions finance old age and survivors insurance, maternity benefits, family allowances, workman's compensation insurance, insurance for accidents outside the work place, disability benefits, income replacement during reserve military service, nursing home care, severance pay in the event of the bankruptcy of the employer and unemployment compensation. In several instances, these programs provide only nominal benefits; for example, the old age and survivor's insurance program pays only about US$90 a month to beneficiaries. Palestinian workers are not entitled to any of these benefits other than maternity pay, workman's compensation and severance pay in the event of bankruptcy of the employer.

5.7 Since 1970, all Israeli employers have been required to pay employment taxes, regardless of the nationality of the worker. The taxes for Palestinian workers are assessed and collected by the Payments Section of the Employment Department of the Israeli Ministry of Labor. All Palestinian workers employed in Israel are supposed to be registered with the Employment Department and assigned by it to an employer. Wages are paid to the Employment Department, which assesses and collects relevant taxes and issues a check to the worker for his net pay. All taxes applicable to Israeli workers were imposed on foreign (Palestinian) workers so that the latter would not cost employers less than Israeli workers and, thus, have a competitive advantage in the labor market. The amount of social security taxes collected for programs that are not provided to Palestinian workers are transferred by the Government of Israel to the Civil Administration. These transfers are deposited to an "equalization fund" (also called the "deduction fund") and are used to finance programs benefiting the residents of the Occupied Territories. The taxes that are deposited to the fund represent 11.8 percent of wages paid. The Government of Israel estimated the contribution to the fund to be about US$25 million in 1991. This corresponds to earnings of about US$195 million; at the minimum wage, these earnings would have been obtained by about 36,000 Palestinians working full time. This is a substantially smaller number than commonly believed to be employed in Israel and probably reflects widespread failure to comply with labor laws. In addition, many Palestinians work only part time. Israeli sources estimate that only about 30 percent of Palestinians working in Israel in 1987-1990 were properly registered with the Israeli Employment Service.

Social Benefits under Israeli Labor Agreements

5.8 Collective bargaining agreements represent the principal source of social security benefits in Israel. Histadrut, the umbrella labor organization, represents about 95 percent of all workers employed in Israel and concludes labor agreements with all major industry groups. The union sets the minimum wage and agrees with industry representatives on the benefits to be provided to workers and the contributions to be made by workers and employers in order to finance these benefits. These schemes pay for supplementary old age pensions, unemployment compensation, health insurance and other agreed benefits. The worker's contribution varies from 5.5 to 6.0 percent of wages. The employer agrees to rates depending on the branch of activity, but ranging from 12.5 percent (industry and services) to 37.33 percent (private construction). The contributions are collected from employers on behalf of Palestinian workers by the Israeli Employment Service, which, as noted earlier, serves as the payroll section for all Palestinians working legally in Israel. The benefits under the collective agreement are supposed to be available to all workers, but residency in Israel is required to benefit from some of the programs. The extent to which Israeli employers have been willing to hire Palestinian workers illegally is clearly in part due to the high employment taxes charged for those registered with the Employment Service.

Civil Administration

5.9 Palestinian staff of the Civil Administration and of Palestinian municipal authorities participate in a special social insurance scheme. This scheme provides old age pensions, paid vacation, sick leave, maternity leave, workman's compensation, survivors benefits and disability insurance. Civil servants are also required to participate in the government health insurance scheme. The Social Welfare Department of the Civil Administration provides cash benefits, food, health care and social services to the needy. Five offices serve the Gaza Strip and six provide assistance in the West Bank. Each office is headed by an Arab manager. At mid-year 1993, about 36,800 members of 9,300 families were benefiting from some form of social assistance provided by the Civil Administration. About 13 percent were receiving a comprehensive package of aid that includes food, medical insurance, exemption from school fees and a cash stipend. The vast majority were receiving a smaller package of aid that excluded education benefits. About 17 percent were being given only food. The remaining 9 percent were receiving either a cash allowance or free health insurance. In addition to its program of aid to dependent families, the Social Welfare Department offers counselling and vocational training to delinquent youth, provides rehabilitation services to the handicapped and supports youth clubs for children from "distressed" families. Finally, the Department oversees the activities of about 200 private, charitable organizations in the West Bank; this practice follows that established by the Government of Jordan.

Labor Law in the Gaza Strip

5.10 Residents of the Gaza Strip are employed under the provisions of the Egyptian labor law. These laws regulate the conditions of employment, including the minimum age for workers and the maximum hours of work; however, they do not provide for compensation in the event of work-related injuries or accidents nor provide for pension benefits, health insurance coverage, maternity benefits or severance pay.

Labor Law in the West Bank

5.11 The Jordanian labor law applies to workers in the West Bank. It regulates the employment of women and children and prescribes the maximum hours of work per day and week. It requires that employers provide annual leave, severance pay and compensation for job-related injuries. The Jordanian law does not provide for pension rights, old age insurance, survivor benefits, compensation for work-related disabilities, health insurance or family benefits.

Private Transfers

5.12 The most important sources of financial security and social protection for residents of the Occupied Territories have been individual savings and private transfers. Palestinians have, for many years, successfully found employment abroad and have saved a very large fraction of their earnings. Reliable information on the management and use of worker remittances is not available, but anecdotal information suggests that many households are able to retire very early and to live from the income obtained from these savings. The collapse of employment opportunities in the Gulf in 1991, and the losses of savings that occurred with the freezing of accounts held in Gulf banks in 1991, may have seriously impacted this approach to achieving income security.

C. Deficiencies in the Social Insurance System

5.13 The provisions for the social security of the residents of the Occupied Territories are patchy, inequitable and inadequate. The Palestinians living in the Gaza Strip and the West Bank participate in programs reflecting their refugee and employment status. About half of the total population of the Occupied Territories qualifies for assistance from UNRWA. Its programs of relief and social services are targeted on "special hardship cases" in which the head of household is female; approximately 8 percent of the refugee population benefits from the programs so targeted. However, UNRWA supplements these benefits with a quite extensive program of health benefits and with shelter services in the camps. Nearly half (about 49 percent) of the population of the Occupied Territories is entitled to such assistance; many of these families also qualify for benefits from other sources and do not employ the services of UNRWA.

D. Recommendations

5.14 The resources needed to operate a comprehensive social welfare program certainly will not be available to the Occupied Territories within the interim period. Nonetheless, good governance demands the replacement of the current patchwork of benefits provided to the very needy by UNRWA and the Civil Administration with a more equitable, unified system of protections. The benefits of these programs should be targeted on the most vulnerable --the elderly without families and female-headed households, particularly those without significant assets. In addition, the system of in-kind transfers and subsidies should be analyzed and rationalized. Access to free or highly subsidized services (including health care, subsidized housing services and assistance in the education of children), now available only to registered refugees, should be extended to others on the basis of relevant criteria, rather than refugee status. At present large numbers of people maintain their refugee status simply in order to remain qualified for these programs in the event of a personal economic crisis. A social survey is needed in order to assess the effectiveness of the social insurance system in alleviating poverty.

5.15 Over the longer term, a basic program of social protection that has broad political endorsement needs to be developed. The list should provide for the handicapped, elderly, orphaned and widowed but not seek to replace reliance on private transfers and personal savings. The public sector should facilitate a benefits program that is self-financing from employee and employer contributions but should, in the near term, avoid the development of programs that draw heavily on general revenues for their financing.

5.16 The public sector should also encourage the development of private institutions that supply financial services, including health and life insurance companies and pension schemes. A very small insurance industry already exists in the West Bank. With the creation of an appropriate regulatory and legal environment, that industry could contribute significantly to meeting the community's need for economic security.

VI. CONCLUSIONS AND RECOMMENDATIONS

6.1 The central finding of this report has been that the programs that now serve the people of the Occupied Territories are inadequate, but that their deficiencies are rooted primarily in poor governance and defective policy rather than a scarcity of resources alone. Because of the exceptional history of the area, the institutions that supply health care, education and social welfare services have been accountable not to the community but rather to segments of the population. These institutions have obtained funds from conventional domestic sources, including general revenues, special taxes and user charges, but they have also relied extensively on foreign grants and private donations. This pattern of funding has led to uncoordinated efforts; overspending on capital equipment in some sectors and underspending in others. Moreover, the implicit subsidies provided with these grants and donations have been allocated in such a way that many needy people have been denied services, or at least services of reasonable quality.

6.2 An acceleration of social development in the Gaza Strip and the West Bank will require the creation of institutions that are more accountable to their clients, governed and operated under transparent rules, and equitable in their treatment of all residents of the area. These changes will have to be erected around institutions that provide for participation by the affected public and that are seriously accountable, either through the market or through a political mechanism. In view of the political complexity of the area, many political mechanisms are not likely to be workable; hence, markets and competition should be given greater attention than is customary. This implies that the usefulness of such devices as education vouchers and "portable" health insurance benefits, together with the broad regulation of the market environment, should be the major focii of public policy debate.

6.3 Investments of between US$475 to US$550 million will be required to respond fully over the next ten years to the needs that have been identified in this report and to needs to replace worn out and obsolete facilities and equipment. This estimate is very rough because the underlying analyses have been based on insufficient data. A thorough investigation of the health, education and social welfare sectors should be undertaken before investment decisions are made. Such a study should be carried out by a team of local and international experts and should allow sufficient time to thoroughly examine the facts and institutions in these sectors.

6.4 The following table offers very rough estimates of the technical assistance and investment requirements of the program.

Table 6.1: Summary of Financial Needs

Category	Short Term	Medium Term	Long Term
Studies and Technical Assistance		(US$ M)	
Studies of Strategic Choices for Social and Human Resource Development	1.0		
Feasibility Studies for Rehabilitation and Expansion of Schools	1.0	1.5	
Feasibility Studies for Rehabilitation and Expansion of Health Facilities	0.5	1.0	
Studies for the Modernization of Vocational Education	1.0		
Socioeconomic Surveys	1.0	2.5	
Feasibility Studies for Construction of Facilities for the Care of Burn Victims and Cancer Patients, and of a Public Health Laboratory	0.5		
Provide Training and Travel Fellowships for Education Planners and Administrators	0.5		
Prepare Program for Upgrading Pre-Service and In-Service Teacher Training	1.5		
Total	7.0	5.0	
Investment Projects			
Provide In-Service Training to Teachers		15.0	
Rehabilitate Primary and Secondary Schools		50.0	
Renovate and Upgrade Health Facilities		30.0	
Construct and Equip Facilities for Care of Burns Victims and Cancer Patients, and Public Health Laboratory		10.0	
Upgrade School Libraries and Laboratories		15.0	
Upgrade Pre-Service Teacher Training		25.0	
Modernize and Expand Vocational Education		15.0	
Create Programs of Post-Graduate and Public Health Education		10.0	
Develop Networks and Strengthen Universities		20.0	15.0
Mount Emergency Program for Supplementing the Education of Post-Intifada Students		10.0	
Replace Depreciated and Obsolete Education Infrastructure		30.0	35.0
Replace Depreciated and Obsolete Health Infrastructure		20.0	30.0
Develop and Produce a Basic Education Curriculum			40.0
Increase Capacity of the Education System			80.0
Increase Capacity of the Health Care System			50.0
Total		250.0	250.0

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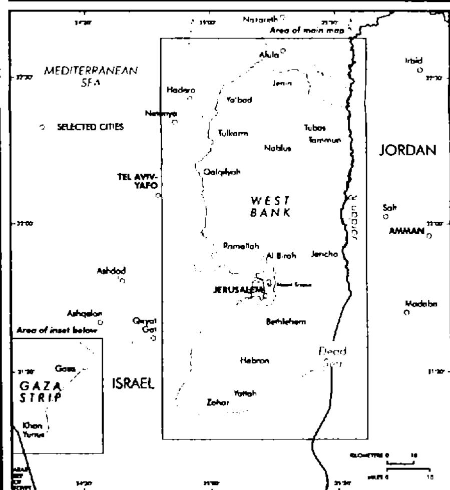
OCCUPIED TERRITORIES WEST BANK AND GAZA STRIP

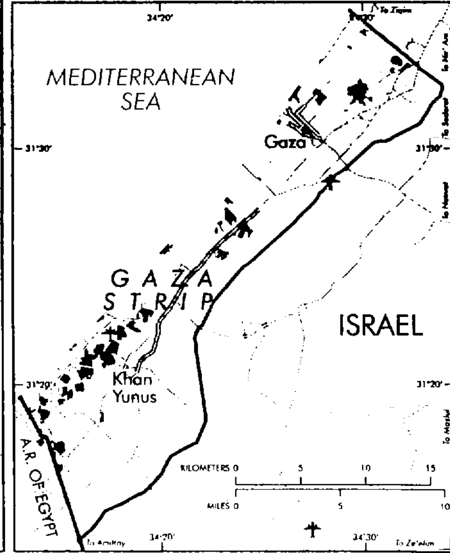
AIRPORTS / AIRFIELDS
MAJOR HIGHWAYS
TWO OR MORE LANES, HARD SURFACED ROADS
RAILROADS
BUILT-UP AREAS
UNRWA REFUGEE CAMPS
ISRAELI SETTLEMENTS
ARMISTICE DEMARCATION LINES, 1949
NO-MAN'S LAND AREAS, ARMISTICE DEMARCATION LINE, 1949
JERUSALEM CITY LIMIT, UNILATERALLY EXPANDED BY ISRAEL JUNE 1967; THEN ANNEXED JULY 30 1980
INTERNATIONAL BOUNDARIES

MEDITERRANEAN SEA
Jenin
Ya'bad
Tubas
Tulkarm
Tammun
Noblus
Qalqilyah
TEL AVIV-YAFO
Lod International Airport
ISRAEL
WEST BANK
JORDAN
Jordan R.
Ramallah
Al Birah
Jericho
JERUSALEM
Mount Scopus
Old City
Bethlehem
DEAD SEA
Hebron
Yattah
Zohar

KILOMETERS 0 5 10 15
MILES 0 5 10

The denominations used and the boundaries shown on this map do not imply, on the part of The World Bank Group, any judgement on the legal status of any territory or any endorsement or acceptance of such boundaries.





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The World Bank

Headquarters
1818 H Street, N.W.
Washington, D.C. 20433, U.S.A.

Telephone: (202) 477-1234
Facsimile: (202) 477-6391
Telex: WUI 64145 WORLDBANK
RCA 248423 WORLDBK
Cable Address: INTBAFRAD
WASHINGTONDC

European Office
66, avenue d'Iéna
75116 Paris, France

Telephone: (1) 40.69.30.00
Facsimile: (1) 40.69.30.66
Telex: 640651

Tokyo Office
Kokusai Building
1-1 Marunouchi 3-chome
Chiyoda-ku, Tokyo 100, Japan

Telephone: (3) 3214-5001
Facsimile: (3) 3214-3657
Telex: 26838

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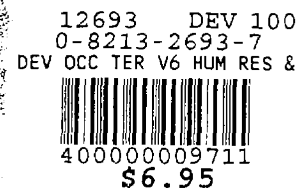

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