MINISTRY OF HEALTH
HEALTH SYSTEM ASSESSMENT REPORT

PALESTINIAN HEALTH SECTOR REFORM AND DEVELOPMENT PROJECT: "THE FLAGSHIP PROJECT"

DECEMBER, 2008

USAID
FROM THE AMERICAN PEOPLE

Towards a better health

MINISTRY OF HEALTH HEALTH SYSTEM ASSESSMENT REPORT

PALESTINIAN HEALTH SECTOR REFORM AND DEVELOPMENT PROJECT: "THE FLAGSHIP PROJECT"

DECEMBER, 2008

Contract No. 294-C-00-08-00225-00

This publication was produced for review by the United States Agency for International Development. It was prepared by Chemonics International, Inc and partners.

ACKNOWLEDGMENTS

The production of this document constitutes an important step for the development and reform of the Palestinian health sector not only in its high value content but also in how this assessment exemplified genuine cooperation between the MoH, USAID, and stakeholders, including donors, involved in the health system.

Special thanks are due to USAID for making this work possible through awarding Contract No. 294-C-00-08-00225-00 to Chemonics and its partners to implement The Palestinian Health Sector Reform and Development Project ("The Flagship Project").

Deep appreciation and thanks are also extended to His Excellency Dr. Fathi Abu Moghli, the Minister of Health and his team in the technical working groups, ably led by the Deputy Minister of Health Dr. Anan Masri, who conducted the assessment with support from the Project team. They worked hand in hand to generate the valuable information reflected in this assessment report.

CONTENTS

ACRONYMS

DG	Director General
DHS	Demographic and Health Survey
EDL	Essential Drug List
GDP	Gross Domestic Product
GMP	Good Manufacturing Practices
GS	Gaza Strip
GSP	Good Storage Practices
GHI	Governmental Health Insurance
HIC	Health Information Center
HR	Human Resources
ID	Institutional Development
IDF	Israeli Defense Force
IT	Information Technology
LAN	Local Area Network
MENA	Middle East North Africa region
MIS	Management Information System
MoF	Ministry of Finance
MoH	Ministry of Health
MoI	Ministry of Interior
NGO	Non Governmental Organization
NHPSPC	National Health Policy and Strategic Planning Council
OJT	On the Job Training
PNA	Palestinian National Authority
PCBS	Palestinian Central Bureau of Statistics
PER	Public Expenditure Review
PH	Public Health
PHCs	Primary Health Care services
PHIC	Palestinian Health Information Center
PLC	Palestinian Legislative Council
QA	Quality Assurance
QI	Quality Improvement
SOPs	Standard Operating Procedures
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees
UPL	Unified Procurement Law
USAID	United States Agency for International Development
VHRW	Village Health Room Worker
WB	West Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The Palestinian Health Sector Reform and Development Project ("The Flagship Project") is a five-year USAID project aimed at supporting a functional, democratic Palestinian health sector in meeting its priority public health needs. Its objective is to strengthen the institutional capacities and performance of the Ministry of Health (MoH), select NGO health service providers, and select educational and professional institutions. The project will achieve this objective through three main components: (1) supporting health sector reform and management, (2) strengthening clinical and community-based health, and (3) supporting procurement of health and humanitarian assistance commodities.

One of the project's priorities is to support the MoH in implementing reforms needed for quality, sustainability, and equity in the health sector. To initiate this process, the Project supported the MoH in conducting a rapid and comprehensive needs assessment of the health sector. The purpose of the assessment was to identify the strengths and weaknesses of the health system, and prioritize areas for intervention that complement the Palestinian National Strategic Health Plan. The assessment will inform project activities in the form of institutional development plans that will ensure alignment with the MoH's national strategic objectives for health sector reform.

The project utilized the USAID's Health Systems Assessment Approach tool. In implementing the assessment, the team adopted a new approach: the Ministry of Health conducted the assessment, with support from the USAID Flagship project team. The purpose of implementing this new approach was to ensure Palestinian ownership of the assessment, buy-in to its recommendations, and sustainability in reforms. It has been about a year since the development of the MoH's three-year National Strategic Health Plan. As such, and as acknowledged by the MoH, the assessment serves as an update to the National Strategic Health Plan.

The assessment was conducted over a six-week period beginning October 22, 2008. The Flagship team moved rapidly to establish rapport and an effective working relationship with the MoH. The project held three participatory meetings with the MoH to introduce the assessment, distribute, and adapt the USAID's Health Systems Assessment Tool to the Palestinian setting, and agree to the assessment process and timeline. The Deputy Minister of Health established six technical working groups within the MoH to conduct the assessment with technical and administrative support from Flagship Project team. The working groups were organized in accordance with the assessment tool's technical modules: (1) governance (2) health finance, (3) health service delivery, (4) human resources, (5) pharmaceutical management, and (6) health information systems.

Following three weeks of information gathering, the MoH technical working groups presented their findings and strategies for action to an audience including the Minister, Deputy Minister, USAID officials, and MoH staff. This report is a compilation of the findings and suggested strategies identified by the MoH.

Summary of Assessment Findings

The assessment, conducted by MoH staff, revealed the following strengths, weaknesses, opportunities, and threats facing the Palestinian health sector:

Strengths	• High level of commitment and resilience by health sector staff to maintain a functioning health system under extreme political and economic hardship. • The active and important complementing role of UNRWA, private for-profit, and not-for-profit NGOs in contributing to the provision of health care. • An adequate level of general understanding of the need for a viable public health system. • Recent efforts to establish streamlined and strengthened systems that will avoid heavy reliance on political leadership. • A notable contribution from civil society organizations and the private sector in providing much needed health services particularly at the primary and secondary health levels. • Emphasis by MoH to having a strategic approach to the sector. • Increased effort on the part of the MoH to widen participation in planning. • A reasonable coverage of public, NGOs and private health infrastructure and overall geographic access to a health facility is relatively high and is fairly equitably distributed throughout the West Bank and Gaza. • Ample protocols and norms on the quality of primary and secondary health care. • A national health insurance system that covers two thirds of the population.
Weaknesses	• Obstacles to general understanding of the need for a functioning public health system. • Perception that quality of care provided in public facilities is not adequate. The perception of quality in private, NGOs, and UNRWA facilities is higher, but neither the technical level of quality nor the efficiency is known. • Lack of local resources to finance the public health sector. • Periodic or continual enforcement problems when applying regulations. • Local community participation in planning and policymaking is still inadequate. • More efforts needed to systematize transparency. • Need to strengthen the coordination and integration between different health care providers. • Lack of a conducive regulatory environment that would encourage more participation from the private sector. • Access to adequate health services by various segments of the population is still low due to financial and geographic barriers. • In many instances, quality protocols for primary and secondary health care are not implemented. • Lack of health sector legislation such as the Health Insurance Law and Public Procurement Law. • Insurance premiums are largely equitable however the poor spend a higher percentage of their income on co-payments. • Not all poor people are exempt from paying health insurance premiums. • Referrals to hospitals abroad lack consistent criteria. • There is some lack of human and institutional capacity at several levels of the public health system.
Opportunities	• The Flagship Project constitutes a major opportunity to develop and reform the sector. • The understanding of international donor community to the developmental needs of the health care system and the reform process. • Any positive prospect in the peace process will lead to significant improvement in economic conditions which will lead to better life quality. • The donor community is still supportive to provide assistance to the Palestinian National Authority. • The existence of a vibrant private sector that is willing to invest in the health sector.
Threats	• Operational and logistical challenges in the Palestinian territories (access restrictions, closures, roadblocks etc..) • Heavy reliance of the Palestinian National Authority on donor funding to cover both capital investment and running costs. • The uncertainty regarding the peace process and future scenarios. • The inability of the Palestinian National Authority to adequately raise the salaries of public servants due to lack of sufficient financial resources. • The internal political rift has led to the existence of two separate public health systems in the West Bank and Gaza. • Deterioration in the economy and declining workforce participation rates (the poverty rate is more than 60 percent and the GDP decreased by 30 percent).

Analysis of the strengths and weaknesses of the health system resulted in the identification of priority areas for reform by the MoH assessment working groups. The following list represents the key reform areas identified during the assessment that deserve immediate attention and support:

- Creating a Center of Excellence at the Palestine Medical Complex
- Developing a comprehensive and integrated health information system
- Implementing the new compulsory government health insurance program
- Developing a process for relicensing of medical professionals
- Improving continuing medical education
- Design accreditation of facilities program
- Strengthen service delivery and clinical guidelines
- Strengthen donor coordination
- Support implementation of the procurement law

NEXT STEPS AND CONCLUSIONS

The USAID Flagship team will support the MoH in developing institutional development plans that will turn their list of priorities into reality. The development plans will allow the MoH to specify how they aim to achieve their priority goals, and to solicit technical assistance and procurement support from the USAID Flagship team. In addition, a similar assessment and corresponding institutional development plans will be conducted for NGO health service providers, in close coordination with the MoH.

The assessment succeeded in more than identifying priority reform needs of the Palestinian health sector. The assessment introduced several new opportunities to MoH staff, such as conducting a self-assessment and presenting the findings, and developing their own set of recommendations to the Minister and Deputy Minister of Health, their colleagues, and USAID. The process exemplified cooperation and coordination between the MoH and all stakeholders. The process also promoted openness, transparency, and accountability among MoH staff that had to take a critical look at the system and their role in strengthening it. Perhaps most significantly, however, the assessment process helped to achieve genuine ownership, buy-in, and dedication to reforming the health sector from the MoH. As expressed by the Minister of Health to his staff at the first assessment-related workshop: “If this project is a success, it is because of you. If it fails, it is also because of you.”

This report begins with a brief description of the health system assessment approach and methodology (Section 1). Section 2 provides a description of the socio-economic environment in which the Palestinian health system operates (the Core Module of the assessment). Section 3 presents the findings of each of the six technical working groups in the

following six technical modules: (a) governance, (b) health finance, (c) health service delivery, (d) human resources, (e) pharmaceutical management, and (f) health information systems. Section 4 presents the summary and analysis of the assessment findings. Section 5 presents the MoH's priority areas for reform. Section 6 presents the next steps and conclusions.

SECTION 1: HEALTH SYSTEM ASSESSMENT APPROACH & METHODOLOGY

The assessment was conducted over a six-week period beginning October 22, 2008 (see Annex A for Assessment Timeline). The Flagship team moved rapidly to establish rapport and an efficient working relationship with the MoH. To that end, the Flagship Project held three participatory meetings to introduce the project, ensure that the project's objectives are in alignment with the MoH's National Strategic Health Plan, and introduce the assessment. The USAID Health Systems Assessment Tool was introduced and distributed to the MoH staff during a workshop meeting held on October 22, 2008. The assessment process was explained and MoH established six working groups to conduct the assessment with technical and administrative support from Flagship team members.

The assessment proceeded along three simultaneous tracks:

- *Desk Review*. As numerous assessments have been conducted of the health system by international and Palestinian organizations and institutions, the Flagship Project team conducted a thorough desk review of already existing studies and assessments. The desk review provided information on the current status of the health sector, as well as strengths and weaknesses that have been identified by other groups. The desk review allowed the team to capitalize on existing knowledge of the issues and challenges facing the health system. (See Annex 2 for Key Desk Review Documents.)
- *MoH self assessment*. As described, the assessment tool was adapted by the Flagship Project to serve as a self-assessment tool for the MoH. The Minister of the MoH directed the Deputy Minister of Health to manage the assessment and establish six working groups to lead the assessment, in accordance with the six technical assessment modules: 1) governance, 2) health finance, 3) health service delivery, 4) human resources, 5) pharmaceutical management, and 6) health information systems. (See Annex 3 for MoH assessment working groups). Likewise, the Flagship Project identified staff to support each of the working groups during the assessment.
- *Stakeholder input*. The team also consulted with stakeholders outside the Ministry of Health to ground-truth/validate the assessment findings.

Process

One of the first tasks in implementing the assessment was to adapt the USAID Health Systems Assessment Tool to the Palestinian context. On October 29, 2008, the Flagship Project team met with the MoH health system assessment working groups to review the assessment tool and adapt it to address areas of priority concern to the Palestinian system. Following the adaptation meeting, the working groups convened separately with their Flagship staff member counterpart to conduct the assessment throughout the following three weeks. Assessment findings were drafted by the MoH, shared, and discussed with Flagship staff. Based on the assessment findings, the working groups identified areas of priority concern to the Ministry and health sector at large. The assessment findings and priority areas were presented by MoH staff to the Ministry, USAID, and the team at a health assessment workshop on November 25, 2008. This workshop represented one of the first times that MoH staff were given the opportunity to present their priority needs to such an audience. The workshop resulted in developing consensus about the highest priority needs of the MoH (see Sections 4 and 5, and Annex E). The selected priorities will then serve as the basis by which

the MoH, with USAID Flagship Project support, will develop institutional development plans aimed to achieve the selected goals.

SECTION 2: BACKGROUND (CORE MODULE)

Overview

The West Bank (including East Jerusalem) and Gaza Strip are two (non-contiguous) territories with a total population of 3.9 million. 2.5 million people live in the West Bank in an area of 5,634 square km. In the Gaza Strip, 1.4 million people live within a narrow zone of land along the Mediterranean Sea with an area of 362 square km. The Gaza Strip has one of the highest population densities in the world, ten times greater than the density of the West Bank. Refugees number 1.5 million and comprise 32 percent of the total population of West Bank and 71 percent of the total population of Gaza. About 40 percent of the Palestinian population is below 15 years of age (Palestinian Central Bureau of Statistics, 2007).

The West Bank and Gaza is suffering from a weak economic situation. Real gross domestic product (GDP) in 2007 was 4.1 billion USD, making it the "worst performing economy in the Middle East North Africa sub-region (MENA)" (UNRWA, 2008)[1]. The unemployment rate reached 45 percent in Gaza and 24 percent in the West Bank in 2007. According to a United Nations Development Program (UNDP) Report from July 2007, 58 percent of Palestinians live below the poverty line, and 30 percent of the population lives in extreme poverty.

The Palestinian territories have had relatively adequate health indicators compared to other lower middle-income countries and their neighbors in the Middle East. However, the negative socioeconomic impact of the political conflict has affected access to health care and is undermining progress in health status.

Table 1: Health Indicators, 2006 (MoH Annual Report, 2006)

INDICATOR	2006
Life Expectancy	71.1 (Males) 73.2 (Females)
Neonatal Mortality (per 1,000 live births)	11.9
Infant mortality rate (per 1,000 live births)	15.7
Under five mortality rate (per 1,000 live births)	19.1
Maternal mortality ratio (per 100,000 live births)	6.2[2]

West Bank and Gaza is in the midst of an epidemiological transition. The fertility rate is high, (4.6 children per woman), while infant and under-five mortality rates are low. Non-communicable diseases are the main cause of overall mortality among the population. For children between the ages of 1-4 years the leading cause of mortality is injuries and accidents. Gastroenteric and parasitic diseases, which have declined substantially since the 1980s, remain as important health problems as a result of conflict. Acute and chronic malnutrition, anemia, and other micronutrient deficiencies are prevalent and increasing, according to demographic health surveys carried out in 2004.

[1] http://www.reliefweb.int/rw/RWB.NSF/db900SID/EGUA-7GUQ4B?OpenDocument

[2] MoH annual report 2006. Note: Reliability of data has been questioned by various entities in the NGO and international community due to questions related to timing, completeness, and accuracy.

A. Political and Macroeconomic Environment

The Palestinian National Authority (PNA) was established in 1994 after the signing of the Oslo Agreement. It is a parliamentary system with three distinctive powers: Legislative, Executive and Judiciary. The Legislative Council with elected members conducts legislative practices. The President is the head of the state and is directly elected from the Palestinian population. The President, with the agreement of the Palestinian Legislative Council, nominates the Prime Minister. The Palestinian territory is administratively divided into 16 governorates: 11 in West Bank and five in Gaza.

The West Bank and Gaza have been impacted by decades of conflict including wars, "*intifadas*" ("uprisings"), military incursions, and internal civil strife and violence between supporters of rival Palestinian political factions. Restrictions on the movement of people and goods, and limited Palestinian control over taxes and trade also contribute to a challenging economic and development context.

B. Health System Organization and Provision of Services

The Palestinian health system is a complex web of governmental, non-governmental, UN, and private sector health institutions providing health services to a population living in the West Bank and Gaza. The four major groups of health providers are the 1) MoH, 2) Palestinian NGOs, 3) United Nations Relief and Works Agency for Palestinian Refugees (UNRWA), and 4) the private sector. According to the World Bank's most recent Public Expenditure Review from 2007, the health sector has been the most vulnerable and most affected by the conflict and closures, roadblocks, and financial disruptions.

The MoH has two main responsibilities. It serves as the administrative and regulatory body for the Palestinian health system, while at the same time is the largest provider of health services. As mandated in the Palestinian Public Health Law, the main roles and responsibilities of the MoH are:

1. Regulating and supervising the provision of health care in the West Bank and Gaza
2. Planning the health care services in coordination with different stakeholders
3. Enhancing health promotion to improve the health status
4. Development of the human resources in health sector
5. Management and dissemination of health information
6. Ensure national health expenditure being allocated according to population needs.

The MoH is also one of the largest employers in West Bank and Gaza. In 2005 the MoH employed about 12,000 people. Health care professionals working in the governmental hospitals and clinics are salaried public employees. The Ministry of Health has traditionally been housed in the Gaza Strip, with offices also located in Nablus, West Bank, where the Deputy Minister of Health sits. Conventionally, the Minister of Health in Gaza administers Gaza departments directly, and the Deputy Minister administers West Bank departments and programs from Nablus. The geographical division between the West Bank and Gaza, histories under Jordanian and Egyptian rule, and restrictions on travel between the two territories resulted in two defacto government health systems: one for the West Bank and one for Gaza. The separation has led to great difficulty in unifying the health sector, and created redundancy in positions and bureaucracy. The current political separation of the West Bank and Gaza thwarts efforts to standardize the health sector.

The MoH owns and manages 24 out of the 78 hospitals in the West Bank and Gaza, representing more than 50 percent of the total beds (MoH National Strategic Plan, 2008), and most (60 percent) of the primary health care centers (MoH Annual Report, 2005). MoH services are vast and include primary health care (PHC), hospital care including emergency medical services, support services, immunization, health management information system, human resource development, health research, health insurance, inspection, and licensing. Primary health care is considered to be the "backbone" of the Palestinian health system. There are 15 types of services offered through primary health clinics[3]. The MoH outsources specific tertiary care and advanced diagnostic services as part of its referral, or "special treatment abroad" system. Referrals for special cases are referred to local NGO and private sector provides within the West Bank and Gaza, and abroad to Jordan, Egypt, and Israel.

The governmental health system is typically overburdened, with high utilization rates and long waiting times. Most governmental hospitals, including the Ramallah Hospital, the MoH's largest facility in the West Bank, operate above an occupancy rate of 80 percent. Ramallah Hospital, the largest MoH hospital in the West Bank, usually has an occupancy rate of more than 80 percent.

Local non-governmental NGOs are the second largest providers of health services in the West Bank and Gaza. NGOs provide primary, secondary, and tertiary services. The MoH has mandated the largest Palestinian NGO — the Palestinian Red Crescent Society — with pre-hospital emergency and ambulatory services and blood banks. NGOs also provide outpatient and inpatient care, psychosocial support, rehabilitation services, and health promotion and education. Health care providers in the NGO sector are usually salaried employees[4].

NGOs played a critical role in providing health care before the creation of the MoH in 1994. They were established during the Israeli civil administration with the purpose of the filling the gap in services. With the establishment of the MoH, and subsequent policy emphasis on expanding governmental health services (see discussion below), the prominence of NGOs has declined since pre-1994. However, they continue to provide most secondary and tertiary care services, especially for underserved and vulnerable populations in rural areas.

UNRWA was created in 1950 and is mandated with providing health services for the 1.3 million Palestinian refugees living in the West Bank and Gaza. It operates about 50 primary health centers. Health services include primary and some secondary care, disease prevention and control, family health, health education, physiotherapy, and psychosocial support. UNRWA's annual health budget makes up for about 10 percent of the MoH's total budget. According to the Health Sector Review Report (2007), UNRWA's total budget for the health sector is US$22.26 million.

Private sector health includes clinics, hospitals, pharmacies, laboratories, radiology, physiotherapy, and rehabilitation centers. Private sector involvement in health is fairly limited, though growing. Accurate numbers and data on private sector health care are not available. However, MoH estimates that as of 2006, "the private sector operated nearly 433 beds, in 23 hospitals, many of which were specialized maternity beds, and some private diagnostic units." (MoH National Strategic Health Plan, 2008).

[3] MoH National Strategic Plan 1999-2003
[4] MoH Annual Report, 2006

SECTION 3: SUMMARY OF ASSESSMENT FINDINGS AND OPTIONS FOR PRIORITY INTERVENTION

This section presents summaries of the assessment findings for the six technical areas assessed by the Ministry of Health: (A) governance; (B) health finance; (C) health service delivery; (D) human resources; (E) pharmaceutical management; and (F) health information systems. For each module, discussion is divided into two sections: (1) situation analysis/current status and (2) priority areas for reform and intervention.

A. Governance

Health systems are directly affected by the quality of governance in a country. USAID has described effective health governance as the process of "competently directing health system resources, performance, and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people." As such, this assessment covered six dimensions of governance in the health sector: information/assessment capacity, policy formulation and planning, social participation and system responsiveness, accountability, and regulation.

The discussion of health system governance in the West Bank and Gaza is divided into two sections. The first outlines the current status of the health system per dimension described above. Then the report presents priority areas for institutional development (ID) interventions, when applicable. Priority areas were derived from assessment findings by the MoH governance working group under the leadership of the Deputy Minister of Health, and were aligned with the priorities outlined in the MoH National Strategic Health Plan. In addition, the priority areas were checked with other available past assessments of the health sector in the West Bank and Gaza.

A1. Assessment Findings for Health System Governance: Current Status

Information/assessment capacity

Information/assessment capacity refers to the information available to decision makers and stakeholders on health trends, health system performance, and health policy options.

As will be discussed in detail in Section F.1, the health information systems module, the MoH has made tremendous efforts to improve the collection and utilization of data on the health sector. Currently, the Palestinian Health Information Centre (PHIC) collects health related data that includes vital statistics and clinic-based data, and publishes an annual report "Health Status in Palestine."

There are several critical aspects that require improvement in areas related to data reliability and quality, timeliness and extent of data use. The health information systems module includes a comprehensive list of recommendations to raise the capacity of the MoH in data collection and usage.

Policy formulation and planning

Central to governance is having a government planning process that functions, and appropriate processes in place to develop, debate, pass, and monitor legislation and regulations on health issues.

The MoH is currently implementing the National Strategic Health Plan – Medium Term Development Plan, 2008 – 2010. The development of the plan has been regarded as a timely exercise that guided policy-makers through a thorough planning process in which health sector policy issues were agreed upon and addressed through the identification of strategic objectives and development of an implementation plan. The planning process was strengthened through by the creation of the National Health Policy and Strategic Planning Council (NHPSPC), Health Sector National Reform Committee, and capacity-building of the MoH planning unit[5].

The development of the National Strategic Health Plan was fairly participatory. The MoH utilized the NHPSPC as a venue for participatory planning. The NHPSPC brought NGOs and the private sector together to discuss, review, amend, and approve the National Strategic Health Plan. However, some NGOs maintain that the participatory process could have been improved by adding other mechanisms to solicit citizens' participation and feedback.

One of the important issues related to policy formulation in the health sector is the absence of policy formulation and implementation at the Palestinian Legislative Council. This is due to the current internal political turmoil between the West Bank and Gaza.

Participation and system responsiveness

Involving stakeholders such as civil society organizations and the private sector in planning, budgeting, and monitoring health sector actions is integral to ensuring good governance in the health sector. In particular, this will help to improve governance, transparency and accountability and to help improve the community's understanding of and support for MoH policies and processes.

The MoH has made efforts to include different partners and various stakeholders from civil society and the private sector in policy making and planning process. The establishment of the National Health Policy and Strategic Planning Council (NHPSPC) has been a move towards that direction; however its role needs to be strengthened.

In addition, the MoH needs to enhance and strengthen its efforts to engage additional national actors in health policy development and action. For example, service delivery among the various service providers is not planned and coordinated in such a way to avoid duplication. As such, duplication of services creates a financial burden on the health system. Therefore, there is a need to review, integrate, and streamline service delivery policies.

[5] The overall goal of the Council is to draw national health policy, endorse national health strategic plans and enhance coordination and integration within the health sector. The council includes the representatives of all stakeholders in the health sector.

Accountability

Accountability involves the existence of rules on publishing information about the health sector, a functioning free, popular and scientific press, watchdog organizations, and consumer protection from medical malpractice. With the formation of the present cabinet, the MoH has taken several steps to enhance its accountability to Palestinian citizens through encouraging more media coverage of health issues and establishing more open channels of communication with various stakeholders. Most efforts have been at the central level; little has been done at the governorate and community levels. Open channels of communications between the MoH and citizens need to be encouraged and institutionalized.

Regulation

Regulation refers to the capacity for oversight of safety, efficacy, and quality of health services and pharmaceuticals, as well as the capacity for enforcement of guidelines, standards, and regulations. It also involves the perception of the burden imposed by excessive regulation.

The MoH mandate is currently outlined and governed by the Public Health Law:

- Regulating and supervising the provision of health care in the West Bank and Gaza
- Planning the health care services in coordination with different stakeholders
- Enhancing health promotion to improve the health status
- Development of the human resources in health sector
- Management and dissemination of health information
- Ensure national health expenditure being allocated according to population needs.

The law describes the responsibilities of the MoH both as a service provider and as a regulator. There is an ongoing dialogue regarding the dual role of the MoH and how this duality would affect its ability to regulate the sector. The MoH however maintain that they are satisfied with the current role as stipulated by the health law. Therefore, as stated in the National Strategic Health Plan, one of the MoH's priority areas is to translate the law into rules and regulations. The MoH would also like to concentrate more of its service delivery role in the primary health care sector, and encourage NGOs and the private sector to provide secondary and tertiary services.

Internally, the MoH lacks a comprehensive and detailed mandate that clearly defines roles and responsibilities for each of the MoH departments and institutions. This has led to the personalization of work in the Ministry and impaired the establishment of a strong public institution that is independent of the individuals. In addition, this leads to duplication of efforts within the Ministry, as well as conflicting agendas between some departments and directorates.

A2. Possible Options for Strengthening Health System Governance

To improve the MoH's capacity to govern the health system in a manner that is open, transparent, accountable, equitable, and responsive to needs, the MoH identified the following as priority areas for intervention:

Strengthen the information/assessment capacity of the MoH by:

- Increasing MoH capacity to provide valid, accurate, relevant and timely data for decision making at all levels of the system (patient, facility and health care system levels).
- Increasing MoH capacity to utilize data in planning and informed policy formulation.

Strengthen policy formulation and planning by:

- Strengthening MoH capacity in health policy making and in strategic planning .
- Enhancing the MoH capacity to engage other partners and stakeholders in policy formulation and planning[6].
- Strengthening the capacity of NHPSPC.

Enhance participation and system responsiveness by:

- Strengthening coordination and integration between different health care providers so that policies are streamlined and not duplicative.
- Encourage community involvement in health steering, planning and monitoring committees at community, governorate, and national levels.

Ensure accountability by:

- Establishing rules governing publishing health sector information.
- Encouraging the press to play a role disseminating and monitoring health issues.

Improve regulation and regulatory capacity of the MoH by:

- Strengthening the regulation and coordination functions of the MoH.
- Finalizing the Public Health Laws corresponding regulations[7].
- Updating, standardizing, and enforcing Palestinian standards for licensing and accreditation of human resources and facilities in the health sector.
- Strengthening the capacity of governmental regulatory agencies to enforce existing legislation and regulations to provide oversight of the health sector, health services and products.

B. Health Finance

Health financing is a key determinant of health system performance in terms of equity, efficiency, and quality. Health financing encompasses resource mobilization, allocation, and distribution at all levels of the system (central to local) to respond to "the health needs of the people, individually and collectively in the health system. Health financing refers to the "methods used to mobilize the resources that support basic public health programs, provide access to basic health services, and configure health service delivery systems."[8] By understanding how the government health system and services are financed, programs and resources can be better directed to strategically complement the health financing already in

[6] MoH National Strategic Health Plan, 2008.

[7] The Deputy Minister of Health pointed out that the Institute of Law at Birzeit University is helping the Ministry to accomplish this task. However, the work is slow.

[8] Schieber and Akiko, 1997.

place. This section is organized around the following three key functions of a health financing system: 1) revenue collection, 2) pooling of resources, and 3) purchasing of services. The findings from the assessment have been organized in several steps. First, the critical issues related to responding to these three functions are analyzed. Next, the priority areas for action as identified by the MoH through the assessment are presented. The priority areas are also aligned with the priorities outlined in the MoH National Strategic Health Plan and verified with other available past assessments of the health sector in the West Bank and Gaza.

B1. Assessment Findings of the Health Finance System: Current Status

Revenue Collection

The government health sector has been operating at a deficit since the establishment of the Palestinian National Authority in 1994. Government liabilities have considerably exceeded the revenues from health insurance, co-payments and the general tax revenues allocated to the health sector. International donors financed a significant portion of health expenditures.

Public health expenditures occupy a substantial share of all public expenditures and GDP. Between 2000 and 2006, MoH allocations represented 8-11 percent of total public funds. According to World Bank estimates, total spending on health represents 13 percent of GDP, one of the highest in the region. These high rates however are the result of a major drop in GDP and not a dramatic increase in health expenditures. In other words, had the economy continued to grow at levels as in the years prior to 2000, the present health spending would not have exceeded 8 percent of GDP.

Although accurate data on per capita health expenditures are not available, the per capita health spending declined from $122 in 1996 (WHO estimates), to $111 in 1998 (World Bank estimates), down to $67 in 2005 according to RAND corporation estimates. With 58 percent of the population falling under the poverty line, (World Bank estimates), an increasing number of households are not able to allocate adequate personal resources to essential health care. (See Annex D: Flow of Funds: Health Financing System).

The main sources of health financing are:

1. General taxation;
2. Health insurance premiums, fees and co-payments;
3. Private for-profit investments;
4. International donors including UNRWA;
5. Household expenditures.

These funding sources are highly unpredictable, causing major challenges toward establishing longer-term development goals for the health sector. A major portion of tax revenues are controlled by Israel and are not always transferred to Palestinian authorities. Budget allocations from the Ministry of Finance were not always reliable. For several years, beginning in 2003, MoH received no funding from MOF to pay for non-salary expenditures. Staff salaries were not paid on a regular basis either.

Political decisions influence the financial viability of the Government Health Insurance (GHI). Following the second *intifada*, political leaders issue decrees absolving certain beneficiaries from paying insurance premiums and co-payments without allocating funds to pay GHI for the lost revenues caused by the waiver. While enrollment almost doubled,

revenues declined by more than one fourth. Currently, more than half of all persons eligible for health insurance no longer pay for it. The increased liabilities were not reflected in the budget planning process.

Contributions from donors are influenced by political factors. They fluctuate on an annual basis. Private investments are being affected by the turmoil in the international financial markets. With unemployment exceeding 30% according to World Bank figures and remittances declining as a result of the international financial crisis the ability of many Palestinians to seek medical services will be further reduces. Consequently, the future curative care cost, which could have been prevented, may escalate even further.

Resource pooling: Government

In 2004, the health sector was financed by MoH (18 percent), private households in the form of direct patient payments including insurance premiums and fees (43 percent), and international donors (39 percent). According to the Health Sector Review Report 2007, almost half (49 percent) of public funds were directed to hospitals compared to only 29 percent for primary health care.

Through 2004, the MoH annual budget has been at around $100 million. Of that budget, 58 percent is reserved for salaries, 25 percent for drugs, medical supplies and vaccines, 11 percent for operating services, and six percent for referral for treatment abroad. Within the MoH budget, the most noticeable trend is the steep rise in the budget provision for salaries, especially since 2003. Salaries as a proportion of total budget expenditures increased to 60 percent by 2004. Expenditures on special treatment referrals also increased sharply reaching $55 million by 2005 compared to only $5 million in 2000. The increased expenditures on salaries and special treatment referrals left very little for critical operating and pharmaceutical needs leading to serious quality concerns.

Resource allocation: Government Health Insurance (GHI)

GHI is the predominant health insurance in the West Bank and Gaza. It covers primary, secondary and tertiary curative care. Enrollment in the GHI is compulsory for government employees and voluntary for all other individuals and households, as well as groups organized around a firm or workplace. Beneficiaries fall in five categories: compulsory, voluntary, workers in Israel, special hardship cases and contracts. Premiums constitute five percent of a monthly salary. Enrollment increased to cover 60 percent of total population.

However, the majority of the insured are not paying premiums. This development seriously undermines the MoH's ability to generate badly needed revenues to finance health services. Premiums were waived for households that lost jobs in Israel or have been hurt in clashes with Israel. GHI revenues have seen major fluctuations. The number of Palestinian workers in Israel has decreased and the compulsory insured were not paid for several months, thus no deductions were made from their salary for health insurance premiums.

Allowing voluntary enrollment created the risk of adverse selection; those who chose to enroll were disproportionately sick. Because people could enroll at a time of their choosing, they had the incentive to stay out of the system until they become sick or injured. For example, UNRWA pays for people to enroll in the government insurance program when they

are diagnosed with cancer. The net effect of such practices has been a great increase in liabilities than in revenues.

Purchasing of Services

Treatment abroad, referring to all inpatient or outpatient care or treatment outside of Palestinian Ministry of Health institutions, constitutes a large proportion of the MoH budget. These include nongovernmental health organizations or private health facilities in the West Bank, Gaza, and East Jerusalem, and hospitals in Israel, Jordan, Egypt, or elsewhere.

In 2005, treatment abroad constituted 43 percent of the MoH's total expenditure budget[9]. According to the World Bank Public Expenditure Review (PER) of 2007, special treatment referrals now account for about one-quarter of the MoH budget. However, total expenditure on specialized treatment for the sector by the government is considerably higher than figures indicate, as less than half of the total net expenditure comes from MoH budgets and the remainder comes from the President's Office[10].

[9] MoH Annual Report, 2005
[10] World Bank, Public Expenditure Review 2007

Critical Issues in Health Financing

- The high degree of uncertainty and unpredictability over the availability and size of health funding.
- The high degree of dependence on donor funding which raises serious doubt about the sustainability of several key programs.
- The financial viability of the Government Health Insurance suffers from a variety of legal, economic and political factors which undermine the MoH's ability to generate revenues to sustain the program. Since the PA's decision to insure certain groups of beneficiaries without charging any premium, the majority of the insured do not pay premiums.
- Health expenditures are driven by increasing wage expenditures to finance unplanned public employment, largely as a welfare function. The expanding salary expenditures reduce the funds available for operating costs with severe impact on quality outcomes.
- Health expenditures spent on referrals abroad have been on the rise, reducing funds available for operating costs. A total of 30,000 cases were referred outside of MoH facilities in 2005, costing over US$ 60 million, or which 40 percent were spent in neighboring countries.
- Donors financed the bulk of capital investments in the past decade.
- While Palestinian households have good physical access to health facilities, more than two-thirds (68 percent) of the West Bank population reported the high cost of health services was the main reason for not seeking medical care. The World Bank reported that a significant segment of the population is unable to access health services for financial reasons. It also reported that the poorest population quintile spent 40 percent of their income on medical expenses; a staggering financial burden.
- Because of restricted movement in some areas which may limit access to health services, there exists some duplication of activities with less than optimum resource allocation.
- Injuries due to conflict related trauma, estimated at 25,000 permanent disabilities and 46,000 other disabled persons, require special programs with a much higher average cost as compared to programs for the general population, thereby reducing the amount of resources available for preventive and general care.
- MoH prices for pharmaceutical procurement were quiet high and fluctuated significantly. The World Bank reported that the MoH average procurement prices were much higher than the UNRWA average procurement prices for the same period.
- Ongoing emergencies, severe budget crises, fluctuating and declining donor funding have increased the financial gap between available resources and requirements for services, especially for budgeted items in addition to salaries. By 2005, outstanding MoH debts amounted to $55 million, one-third of which was for medical supplies and pharmaceutical firms. These firms were increasingly unwilling to deliver their product to the MoH without immediate payment.

B2. Recommended Next Steps

- Initiate a dialogue with all stakeholders to agree on a minimum set of dependable resources over the next five years to make effective use of the available limited resources for development oriented activities beyond emergency related services. This would enable the development and use of a framework for the donors to plan their assistance to meet the local priority needs. A carefully orchestrated and coordinated

financial support framework would help to minimize duplication and ensure some stability and predictability in the flow of resources to priority health needs. The use of a financial support framework would also optimize complementarities of services provided by the MoH, NGOs, UNRWA and private sector providers. The outcome would be a **development plan for the sector** that would address immediate and long-term uncertainties. It would avoid the present financial situation that presses the MoH into an acute response mode responding to emergencies rather than taking the long-term view of the overall needs of the sector

- The MoH reviewed and assessed the present GHI, identified its weaknesses and prepared a thoughtful proposal that would overcome its current shortcomings and would put the system on a sustainable track. The MoH is seeking technical assistance from the World Bank and ongoing support from the Flagship Project in coordination with other donors to operationalize the design and implement the new insurance scheme. The review process includes the definition and quantification of services costing as a guide to the pricing structure of the health insurance system. The Flagship Project will support the Ministry in moving forward with initiating the studies and supporting the coordination efforts to implement the new system in the shortest possible time.
- Pass legislation and implement the proposed government health insurance law.
- Implement rigorous criteria and guidelines to prioritize referral treatment including means and modes of purchase of services outside the MoH, avoid duplication and carry out cost effective analysis,
- Develop capacity within the MoH to be strategic in terms of planning for procurement of drugs, equipment, and supplies over a period of time (one to three years).
- Adopt and implement a drug procurement plan that includes efficient mechanisms for drug pricing, quality assurance and distribution. The plan should encourage national pharmaceutical production.
- Design a careful plan to finance the “non salary” operating and maintenance costs of the recurrent budget to ensure quality service provision.
- Increase the proportion of resources allocated to preventive care and primary health care in order to reduce late diagnosis and future high treatment costs of diseases.
- Adopt and implement an efficient accounting system to monitor and track revenues and outstanding payments.
- Increase revenues through fines on health threatening products and from hazardous behaviors to finance preventive care program.

C. Service Delivery

Health service delivery is defined by the WHO as the way “inputs are combined to allow the delivery of a series of interventions or health actions.” Health service delivery encompasses the resources that come together to be transformed into “curative, preventative, promotive, and rehabilitative services” (USAID Benin Health System Assessment, 2006).

Health services (primary, secondary, emergency, and rehabilitative care) are provided by five main entities: the MoH, NGOs, UNRWA, the private sector, and the medical military

services. The MoH is the main provider of primary and secondary health care. NGOs are the main providers for tertiary, emergency/ambulance services, and rehabilitative care. UNRWA provides mostly primary services to the refugee population and the still quite nascent private sector provides secondary care.

C1. Assessment Findings for Health Service Delivery: Current Status

C1a. Availability of Service Delivery

According to WHO, availability of coverage refers to the proportion of people for whom sufficient resources have been made available, the ratio of human and material resources to the total population, and the proportion of facilities that offer specific resources, equipment and material, and other health services delivery necessities[11]. In other words, it is the degree to which health facilities are functional, adequately staffed, equipped, and supplied that are available to the population in the country.

Primary Health Care

MoH is considered the major provider of primary health care services; it operates 413 out of 651 PHC facilities (63.4 percent). Local NGOs operate 28.4 percent of PHC facilities, followed by UNRWA that operates 8.2 percent of the facilities. The private sector contributes to some PHC and public health services; however data about the specific contribution (e.g. of #, type of providers and quality of services) provided by the private sector in the PHC sector is lacking[12].

The ratio of PHCs to the population meets the international standard: slightly over 5000:1, with 129 PHCs in the Gaza Strip and 525 in the West Bank. Clear standards describing the minimum equipment required to adequately equip the PHCs have been developed by MoH, as well as a classification system of the PHCs.

Tables 2 and 3 below provide data about the population served, number and type of providers, and the distribution of facilities by level and location (West Bank and Gaza).

MoH primary health care facilities are organized using the following classification system:

Level I:
A facility with one health worker or nurse that serves a location of 2,000 capita or less and provides on a daily basis the basic preventive services; mother and child health care and immunization, curative services; first aid. Home visits are made by the nurse and a general practitioner would visit the facility once or twice a week

Level II:
A facility where a doctor, nurse and midwife provide different services for a locality of 2,001 – 6,000 capita. In addition to the basic preventive services, this level also provides curative treatment and some lab tests on a daily basis.

Level III:
A facility that provides level II services in addition to specialized medical consultation mainly for mother and child health services for a locality of 6,001 – 12,000 population. It also provides laboratory services.

Level IV:
IA "comprehensive health centre" that serves more than 12,000 population, and provides more specialized services than those provided in level III. It also provides medical consultation and psychological, dental care and radiology services mainly x –ray and ultrasound (if not present elsewhere in the service area).

PHC facilities are classified into four levels according to the type of service provided, population size, distance to the nearest PHC facility, and availability and type of health services at the nearest facility (see box). All stakeholders in the health sector aim to improve access to PHC services, especially for marginalized groups. There is also an emphasis on improving the efficiency and effectiveness of PHC services.

As shown in Table 2, the distribution of staff in MoH PHC facilities ranges from one employee in level I to more than 20 employees in level IV. In addition to the above

[11] WHO, 2001a
[12] "National Strategic Health Plan – Medium Term Development Plan, 2008 – 2010" published by the Palestinian National Authority, January, 2008 (available on-line at http://www.palestine-pmc.com/pdf/6-2-08.pdf).

mentioned levels there are mobile clinics that provide outreach service to small remote localities and to areas that are geographically isolated from the main territory. The need for these mobile clinics is increasing as more areas of the Palestinian territories are isolated. According to the National Strategic Health Plan, no Level 1 services are being provided in Gaza (refer to Table 3).

Table 2: Classification of PHC and PH facilities in the West Bank and Gaza[13]

Criteria	Level			
	I	II	III	IV
Population	Up to 1000	2001-4000	6001-12000	Over 12000
Minimum Area (m^2)	120	180	240	420
Health Education	+	+	+	+
Mother and Child Health	+	+	+	+
First Aid	+	+	+	+
General Practitioner	Part time	Full time	Full time	Full time
Specialist	-	Once monthly	Twice monthly	Twice weekly
Laboratory	Peripheral I	Peripheral II	Peripheral III	Peripheral IV
Ultrasound	-	Once monthly	Twice monthly	Twice weekly
Dental care	-	-	-	+/-
X- ray	-	-	-	+/-

Table 3: Distribution of MoH PHC facilities by location and level of services provided in 2006:[14]

Area	Level I	Level II	Level III	Level IV	Total
West Bank	88	184	76	8	356
Gaza	0	31	19	7	57
Total	88	215	95	15	413

Secondary Health Care

The number of hospital beds in all hospitals doubled between 1994 to 2006 (MoH, NGOs, private, and UNRWA). Availability of hospital beds is now estimated at 12.9 beds/10,000 people. Hospitals are located within cities and urban centers. People residing outside the cities in villages face difficulties reaching hospitals, especially those hospitals in Jerusalem due to limited movement and access into and out of the West Bank. A specific shortage of type of beds and health care services was noted for patients requiring rehabilitative hospital care (shortage of 46 rehabilitation beds). No need for psychiatric beds was projected until 2015; however, the MoH health plan aims to develop community-based mental health services.

[13] MoH National Strategic Health Plan, 2008
[14] MoH National Strategic Health Plan, 2008

Service Delivery by NGOs

NGOs have played an important role in providing health care services through providing primary and secondary health care. NGOs are the second largest hospital provider, operating and controlling 1,582 beds in 28 hospitals representing 31.6 percent of the total hospital beds. Private hospitals, Police Medical Services and UNRWA operate 8.6 percent, 1.4 percent and 1.3 percent of the hospital beds respectively.[15]

In addition, civil society organizations are the main providers of rehabilitative services to the disabled through a community-based rights approached program funded by the donor community. These community-based rehabilitative programs focus on changing attitudes, awareness of the causes of the disability, and integrating disabled persons into the family and the community as appropriate for their age – either through education or work programs. The MoH refers and covers the cost of cases that need referral to the appropriate specialized referral center. e.g Abu Raia in Ramallah, Princess Basma Center in Jerusalem, or the Bethlehem Arab Society for Rehabilitation that are operated by NGOs.

There is consensus that greater cooperation is needed between the MoH and NGOs service providers in order to maximize service delivery and avoid duplication of services, which in turn has a large financial burden on the system (see organization of service delivery, below).

Role of the Private Sector[16] in Service Delivery

The private sector plays a crucial role in providing health care services to youths (15-29) with 60.9 percent seeking care from the private sector. Data describing the distribution of services provided to youth by type of non-public provider/institution is as follows[17]: 44.8 percent of youth (15-29) go to a private physician for treatment (60.9 percent in WB and 23.8 percent in GS), and 21.6 go to UNRWA centers for treatment (8.8 percent in WB and 38.1 percent in GS).

It is strongly recommended that a link between the MoH and the private sector providers be established to ensure that private sector services are monitored, of high quality, and are effectively utilized to promote the health of Palestinians and a reporting system should be established describing the morbidity and number of patients seen by the private sector

C1b. Organization of Service Delivery

Organization of service delivery has been defined by the WHO as choosing the appropriate level for delivering interventions and the degree of integration.

The structure of the Palestinian health care system, which is composed of several service providers, has its positive and negative attributes. On one hand the diversification of health services has enabled the health system to better face the challenges brought on by the political situation. It has, on the other hand led to duplication and scattering of services provided that resulted in a burden on the young state of limited resources. Therefore, there is a need to review and evaluate the performance of the different health care providers and to promote partnership and integration of comprehensive services among all providers.

[15] National Strategic Health Plan, Medium Term Development Plan 2008-2010. p. 28
[16] Private sector refers to non-public (non-MoH and non-NGO) facilities.
[17] Palestinian Family Health Survey (2006).

The public health law describes the role and responsibilities of the MoH in providing preventive, diagnostic, curative and rehabilitation services, constructing health facilities, licensing and monitoring other health care providers, and setting systems and bylaws for regulating medical practice and all other health related professions to the overall stewardship role over the health system.

The MoH set its organogram to define the relationships and links between the different technical and administrative levels within the Ministry. Moreover it defines the responsibilities and tasks of each level. The organizational structure has been approved by the ministers' cabinet and will be soon implemented to guarantee the performance development of all technical and administrative levels.

C1c. Level of informational continuity of care

Medical records are centralized in both hospitals and clinics. Within the hospitals and clinics, information about the patient can be identified, stored and retrieved. However, there is no linkage or transfer of information between the clinics and the hospitals. Furthermore the information in the medical record needs to be complete and reviewed for accuracy. The continuity of care across different levels of care is problematic in terms of communication, transportation, and referral.

C1d. Quality assurance of care

To assure the clinical quality of health services, health systems must define, communicate, and monitor the level of quality of care. Defining quality of care is often achieved by establishing national evidence-based standards, which represent an ideal of how clinical care should be implemented and continuously reviewed.

Improving the quality of health care has been on the national agenda since 1994 with the establishment of a central unit for quality improvement. The World Bank has supported quality improvement efforts through health system development projects that took place between 1996 and 2005. In 2005, the MoH established the quality improvement department which contributed to the development of outpatient clinic operation protocols, surgical department operation protocols and clinical protocols. The major quality improvement challenge is the need to introduce nationwide quality standards for licensing all health services in order to certify health personnel of all cadres to operate in health sector. This can be accomplished through the endorsement of laws and bylaws under the MoH leadership. Moreover, there are challenges in accomplishing this: lack of preparedness of technical personnel to lead improvement process, and the need to build capacities of health personnel to adopt quality improvement approaches through formal and on-the job training including district and clinic based staff training. In general, the supervision system needs to be strengthened. Supervisors need to establish supportive supervisory approaches that include using updated supervisory tools and a more holistic approach (for example forming teams) for oversight of services provided by the facility rather than by specific programs.

In general, QI interventions such as clinical practice guidelines or clinical pathways, provider reminder systems, supportive supervision and supportive supervision tools or quality based financial incentives, are not widely used in the Palestinian health system; nor are institutional process as continuous QI or total quality management. However some efforts are under way

to increase the use of evidence-based protocols and guidelines and supportive supervision. This work has been funded by international donors and supported by MoH.[18] It is recommended that supervisors be encouraged to conduct a "supportive supervisory" visit as opposed to an inspection. The activity needs to be conducted in a non-threatening way, be supportive with timely feedback and the supervisor viewed as a member of the team at the facility.

C2. Possible Options for Strengthening Health Service Delivery

Strengthening PHC services

- Upgrade clinics by shifting certain Village Health Room Workers' (VHRW) clinics from Level 1 to Level II in accordance with Palestinian MoH criteria. Moreover, shifting certain Level II clinics to Level III and improvement of Level III clinics. This can be made possible by providing well-trained appropriately qualified staff, appropriate medical equipment including lab drugs/supplies, and furniture including emphasis on infection prevention and respect for privacy of patients.
- Improving human resource capacity by reviewing job descriptions and training staff at each level to perform the job expectations using best practices.
- Provision of current protocols, guidelines, and job aids and training of staff (both formal and through OJT).
- Respond to training needs to include all types of staff providing PHC services (including doctors, nurses, midwives, and laboratory technicians).
- Provision of equipment and strengthening the system to use and maintain the proper functioning of the equipment including staff training on how to use the equipment, when to perform routine maintenance, order spare parts, and replace outdated equipment.
- Available and regular resupply of the essential drugs.
- Improve existing referral system in order to track the initial referral as well as the counter referral and determine the appropriateness of the referral (e.g. unnecessary referral to hospital)
- Review PHC programs to focus on pregnant women with anemia and children with anemia, postpartum care and reproductive health care needs of post-menopausal women.
- Review PHC programs to expand non-communicable and cancer prevention awareness.
- Strengthen prevention programs for home and road accidents.
- Encourage new approaches to understand the underlying risk factors. and management interventions associated with congenital diseases and genetic disorders[19].
- Support implementation of legislation through drafting and adopting executive procedures for the existing public health law.

[18] Strengthening the Palestinian Health System, Rand Corporation; page 55.

[19] .(National strategic health plan – page 38 & 39).

- Support research activities such as collecting data and comparing the effectiveness of different interventions within the MoH system of care...
- Review and strengthen approaches to provide regular and ongoing supportive supervision to staff at PHCs including recognition of excellent performance by the facility and staff.
- Encourage the use of supervisory assessment tools by both the supervisor and the staff to identify problems and assistance to resolve the problems through formal and OJT training, brainstorming, peer to peer exchange, and support from the supervisor.
- Strengthen the medical record to ensure the accuracy and completeness of the data.
- Strengthen the monitoring and evaluation system to improve data collection, analysis, communication and dissemination of results for informed decision-making.
- Strengthen HIS to collect accurate data that is reviewed in a timely manner at different levels of the system for informative decision-making.
- Strengthen and improve functioning of medical waste management system and personal safety procedures and practices.
- Renovation (minor upgrade and extension of clinics to meet the needs of the growing population and provide quality services at each level). This should be dependent upon linkages with other projects and donors who can support this needed area of improvement.
- Develop and reprint health education materials.
- Develop and institutionalize a process to improve the quality of services provided by PHCs that includes the voice of the community, providers, and district supervisors

Strengthening Hospital Service Delivery

- Draft and approve a “Master Plan” for hospitals as required to improve the rational use of budgetary resources in expansion of existing structures and/or renovation.
- Provide well-trained appropriately qualified staff, essential medical equipment including lab and diagnostic equipment and furniture according to the needs of the patients seeking care.
- Ensure the existence of clear job descriptions for all cadres of staff.
- Provision of current protocols, guidelines, and job aids and training of different cadres of all staff (both formal and through OJT).
- Respond to training needs to include all types of staff providing hospital services (including doctors, nurses, midwives, and laboratory technicians, and others).
- Provision of equipment and strengthening the system to use and maintain the proper functioning of the equipment including staff training on how to use the equipment, when to perform routine maintenance, order spare parts, and replace outdated equipment.
- Ensure continuous pharmaceutical supplies to hospitals.
- Establish and implement a strengthened referral and discharge follow-up systems for better continuity of care.

- Improve referral and follow up systems between Hospitals and PHCs.
- Review and strengthen approaches to provide regular and ongoing supportive supervision to staff at hospitals including recognition of excellent performance by the facility and staff.
- Encourage the use of supervisory assessment tools by both the supervisor and the staff to identify problems and assistance to resolve the problems through formal and OJT training, brainstorming, peer to peer exchange, and support from the supervisor.
- Strengthen the medical record to ensure the accuracy and completeness of the data.
- Develop and install a computerized information system with linkages inside and between hospitals and with the central management units at the MoH. The goal is to manage patients' admissions, records, appointments and referrals from and to external hospital clinics and primary health clinics.
- Strengthen and improve functioning of medical waste management system and personal safety procedures and practices.
- Support construction and renovation priorities (dependent upon linkages with other projects and donors who can support this needed area of improvement).
- Develop and reprint health education materials.
- Re-rationalization of bed distribution according to population needs.
- Develop and institutionalize a process to improve the quality of services provided by hospitals that include the community, providers, and supervisors.

Strengthen Integration and Coordination among all Service Providers

- Strengthen integration and coordination among the MoH, NGOs, UNRWA, and private sector service providers
- Strengthen MoH capabilities to provide oversight of roles and responsibilities of NGOs through:
    1. Establishing and developing a comprehensive health care system and assure accessibility and affordability of services based on integration to avoid overlapping.
    2. Enhancing community participation and encourage community involvement by identifying resources, brainstorming solutions, and advocacy for improved services.
    3. Rationalizing the use of resources and support primary health care as strategic choice.
    4. Cooperating and working in partnership according to health sector objectives and priorities, in order to:
- Ensure consistency with national health policies and strategies.
- Contribute and feed data to the national health information system;
- Upgrade the skills of human resources in the health sector.
- Assure quality standards of the health services provided.

- Consider client satisfaction and improve health services accordingly.

Improve Quality of Services at both PHC and Hospitals

- Integrate services at primary health care: promote the utilization of staff and availability of services for clients seeking care during the same visit by review of services and promoting efficient use of resources.
- Establish an integrated quality improvement program including updated legislation, a line-item in the budget for staff and logistical needs to support the continuous review of performance at PHC and Hospital facilities and the use of innovative strategies (e.g. facility assessment, medical chart review, and patient feedback) to review facility performance by staff at the facilities and maximize the use of financial and human resources.
- Explore with MoH the structure of the QI Unit to include functions of 1) standards review and updating, 2) monitoring and improvement of facility performance; and 3) recognition of facility performance through a revitalized accreditation program that recognizes staff and facility performance.
- Review and implement updated standards for initial licensure of all cadres of health professionals and certification of specialists.
- Review and expand opportunities for continuous education of all cadres of health professionals in order to assure current practice according to best practice (re-licensure)
- Review and update standards for licensure of facilities and develop an accreditation program of facilities to indicate a process of continuous review and achievement

D. Human Resources

This section covers four topics under the human resources (HR) module of the assessment tool with each topic covering a group of indicators as outlined in the assessment tool. The discussion includes two parts. The first will outline the current status and the other will present, when applicable, priority areas for future institutional development interventions. The priority areas were checked, as far as possible, by comparing them with those outlined in the MoH strategic plan, presentation made by our counterparts at the MoH[20] and other available past assessments of the health sector in the West Bank and Gaza.

D1. Assessment Findings for Human Resources: Current Status

There are approximately 40,000 persons working in the health sector. The ratio per 1000 capita for physicians 2.07; dentists 0.52, pharmacists 0.99; nurses 1.71; midwives 0.12; paramedical 2.71; administrative staff 1.93. The MoH is the major employer of health professionals with 13,057 as employed health workers (39 percent administrative staff, 26 percent Nurses, 18 percent physicians and 17 percent other categories)[21].

[20] Presentation made by General Directorate of Higher and Continuing Health Education staff at the Health System Assessment meeting dated Oct 29, 2008.
[21] MoH National Strategic Health Plan 2008-2010.

Table 4: Distribution of Palestinian health sector human resources

Group	WB	GS	Total
Physicians	4401	3759	8160
Dentist	1355	680	2035
Pharmacists	2242	1600	3842
Nurses	2452	4200	6652
Midwifes	475	204	679
Para medicals	7421	3100	10521
Administrative	4263	3257	7520

Unplanned growth of human resources is one of the main challenges facing the health sector. There are shortages in many specialties, such as nurses, midwives, nutritionists, and dieticians, and surpluses in others, such as dentists and pharmacists. In addition to shortages and surpluses in professional staff, the insufficient geographic distribution of human resources has a profound effect on availability and accessibility of health services for the public. For example, in comparison with other countries in the region and Europe, the ratio of doctors per capita in the West Bank and Gaza is relatively adequate. However doctors tend to be concentrated in urban centers and hospitals (see Health Service Delivery). There is also a high rate of qualified and trained staff moving from the governmental sector to work in the private sector, NGOs and / or to outside the Palestinian territories; consequently the "brain drain" has an effect on the quality of service provided by the governmental health services.

Planning

This assessment looked at the HR planning practices of the Palestinian health system. The team examined four key areas related to HR planning: distribution of health care professionals in urban and rural areas, presence and use of an HR data system, presence and use of an HR planning system, and HR budgeting practices. A fundamental issue that needs to be addressed is human resource data. According to the MoH HR working group team, the HR data that were reported in the MoH statistical reports do not necessarily reflect actual figures due to lack of a centralized MIS or other data system to provide accurate data and the fact that conflicting figures are issued by different organizations. Other critical issues related to HR planning are presented below:

Indicator area	**Status/critical issues**
Distribution of health care professionals in urban and rural areas	While data exists on HR distribution, the reliability and validity of the data is not guaranteed. In addition, the available data lacks coverage of important demographic and geographic parameters such as urban-rural distribution, refugee camp distribution, and the new realities created by the roadblocks and closures.
HR data system	The Personnel Department at the MoH has information about MoH personnel. The database however is not being updated on a timely manner and is not maintained using modern information management systems. As indicated above the MoH does not have a management information system that is capable of providing accessible, accurate and timely data which constitutes a prerequisite for efficient and effective planning.
HR planning system	As outlined in the MoH strategic plan, informed HR planning remains a priority need

	for the MoH. The plan noted that unplanned growth in HR continues to impact describe the functioning of the MoH where shortages are noted in many specialties and surplus in others. In addition, there is a lack of an informed planning process for the distribution of health care professionals.
HR budget	There is a lack of a well planned budgeting system for the HR function at MoH. In addition, there is a shortage of staff at the General Directorate of Higher and Continuing Health Education which was recently mandated with the HR function at the MoH[22].

Policies

A review of HR policies revealed that while key HR systems are theoretically in place, they are in need of upgrading and revision, and lack actual implementation. For example, while the Civil Service Law and its by-laws provide a form process for recruitment, hiring, transfers, and promotion, the processes and procedures need to be updated in order to promote lawful and transparent implementation. Furthermore, the job classification system is in need of updating and implementation. In addition, MoH documentation on conditions governing employment requires upgrading as well as compilation into a human resources manual which should be made available to all MoH staff.

The compensation and benefits system is also highlighted by the MoH as a priority area for reform. The civil service law governs this aspect and it assigned the Civil Service Bureau (Diwan) with this function. The system exists in theory but it is not used in an efficient manner. According to the proposed mandate of the General Directorate of Higher and Continuing Health Education, they are looking forward to establish an incentive system to help in retaining the skilled workers and recruit new ones.

Of critical importance to the MoH are certification and licensing policies and practices. All staff of different professions must be affiliated to and registered in the relevant syndicates (association) which necessitates sitting for enrollment exams. Membership is annually renewed (without further exams). This is a pre-condition for licensing from the MoH so that one can practice his/her career. Unfortunately, due to the prevalent political and security conditions as well as economic and financial difficulties, this is not fully imposed on all health professionals at the present time.

In terms of accreditation, rules for health facilities are present and are regulated by law, with bylaws and regulations that must be fulfilled before licensing such facilities. Again, for the same reasons, this is not fully enforced. Monitoring of medical practice is the responsibility of the MoH with the cooperation of the relevant associations particularly the medical syndicate.

Salaries are currently paid on time, regularly and in full. Due to the economic conditions however, the employees consider their salaries low and through their syndicates are seeking increases through certain allowances and merits, such as inflation allowance, overtime allowance and others. Moonlighting is a problem, as is lack of professional supervision.

[22] The MoH has recently established this directorate. Counterparts reported that the directorate has the mandate, yet the Personnel Department at the Finance and Administration Directorate is actually still carrying out the HR function. This is an issue that could be raised in the governance module.

Performance Management

Performance management is fundamental to ensuring high quality health services. As with other policies and procedures, the human resource system lacks implementation of performance management tools such as job descriptions, specifications, and appraisals.

There is no formal process for clinical supervision; therefore it is conducted in a variety of ways. Forms have been developed in the past to standardize the clinical supervision processes; however they have not been put into use. Supervision is highly impacted by availability of personnel, transportation, and physical access to clinics which are often impeded by checkpoints and closures.

The civil service law provides a mechanism for individual performance planning and review. During the first year of employment, the employee is technically under probation, and his/her performance is to be reviewed. In actuality, most employees are employed until retirement, irrespective of performance or merit.

In addition, there are no methods to reward or encourage employee performance. This constitutes a major obstacle which contributes to low motivation and performance and moonlighting.

Training and Education

The MoH recognizes the need to improve the quality of health professionals through systematic, continuous, long-term training and education. However, there is a lack of formal in-service training, management and leadership development programs; most training is done on an ad hoc basis and usually initiated from outside agencies and/or donors.

The General Directorate of Higher and Continuing Health Education has proposed a comprehensive professional development program for development of potential leaders in the health sector. A proposal on this initiative is available and was submitted by the Center for Continuing Education at Birzeit University.

At present, there exist some modest initiatives to cooperate and coordinate with existing educational institutions and the Ministry of Education and Higher Education. The recently established General Directorate of Higher and Continuing Health Education is mandated to link organizations and pre-service training institutions in order to ensure the right cadres of people are entering the health sector workforce. In addition, at present there exist some modest initiatives to cooperate and coordinate with existing educational institutions and the Ministry of Education and Higher Education.

D2. Possible Options for Strengthening Human Resources

Strengthen Human Resource Planning Capacity by:

- Developing and maintaining a modern HR database at the MoH.
- Developing the human resources planning and management process through specification of the exact number, specialty and the place of work for the available

health human resources; and identification of the shortage and the surplus in the various fields and developing a plan to overcome this.

Improve Human Resource Policies by:

- Reviewing the compensation and benefits system to allow for motivation and retention of qualified health staff.
- Updating recruitment, hiring, transfer, promotion and placement regulations and procedures.
- Updating Palestinian standards for licensing and accreditation of human resources.

Improve Performance Management by:

- Reviewing and updating job descriptions.
- Improving placement and orientation systems.
- Providing supervisors with training on supportive supervision and managing staff performance.
- Developing a performance based incentives system to motivate qualified human resources to work in the Palestinian health system.

Improve Training and Education by:

- Developing continuous education programs (including residency programs) and encourage the health staff to participate in it and reward them[23].
- Initiating ongoing leadership training for managers in the health sectors[24].
- Ensuring that the new and existing educational institutions and programs are accredited, using appropriate international standards[25].
- Initiating formal coordination modalities with Ministry of Education and Higher Education (an area that could be covered under governance too)

[23] Ditto.
[24] Ditto.
[25] Ditto

E. Pharmaceutical Management

Pharmaceutical management is fundamental to a country's ability to address public health concerns. Pharmaceutical management is described as the "set of practices aimed at ensuring the timely availability and appropriate use of safe, effective, quality medicines and related health products and services in any health care setting." (USAID Health System Assessment Tool). Pharmaceutical management systems involve the selection of products, procurement, distribution, and use.

This assessment investigated the following components of pharmaceutical management: (1) policy, laws, and regulations; (2) selection of pharmaceuticals; (3) procurement; (4) storage and distribution; (5) appropriate use, availability, access to and financing of quality products and services. The sections discussed below are the issues deemed critical by the MoH pharmaceutical and procurement departments and in immediate need for attention.

E1. Assessment Findings for Pharmaceutical Management: Current Status

Pharmaceutical and Procurement Policy, Laws, and Regulations

The existence of a comprehensive pharmaceutical law demonstrates commitment to a transparent and fair pharmaceutical and procurement management system. A comprehensive law would include a regulatory framework, principles for selecting medicines, strategies for supply and procurement, promotion of rational use of pharmaceuticals, economic and financing mechanisms, the role of health professionals, and monitoring and evaluation mechanisms.

In the Palestinian health system, the procurement unit at the Ministry of Health is responsible for the procurement of medicines and medical supplies. Procurement of medicines and medical supplies is done annually through national competitive bidding and on the basis of quantification and requirements from health clinics and hospitals that have been consolidated by their respective central drug stores. The procurement process is governed by the Palestinian General Supplies Procurement Law and the pharmaceutical practice by-law issued in 2006. The General Supplies Procurement Law regulates procurement for all ministries. It gives very little authority to line ministries to procure items based on their needs. Under the General Supplies Procurement Law, health commodities are dealt with in the same manner as non-medical supplies. As a result, there is no public procurement entity, no single entity for arbitration, no standard bidding documents, no law for regulating consultancies services, no consistent record keeping and archiving of procurement documentation. Obstacles related to the General Supplies Procurement Law include limited and inflexible procurement budget ceilings, and delays emergency response, and high prices due to lack of competition and prohibitions of international bidding.

Having a Unified Procurement Law (UPL) would solve most of the problems resulting from the current law. A Unified Procurement Law allows greater authority for line ministries in procurement and it will reduce many obstacles in methods of procurement. While draft texts of a UPL have been prepared, it has not been approved by the PLC due to the current political situation.

Selection of Pharmaceuticals

Selection of pharmaceuticals is controlled by the Pharmaceutical and Therapeutic Committee at the MoH, and selection is typically according to the Essential Drug List (EDL). The Ministry of Health has adopted the Palestinian Drug Formulary and Essential Drug List (EDL). The EDL is the list of pharmaceuticals approved and used by the MoH and includes categories, sub-categories, generic names, strengths, and dosage forms. The Drug Formulary, which includes the EDL, provides detailed information on the medication, including indications, dosages and administration, contraindications, side effects and toxicity, drug interactions and precautions. The EDL was updated recently in 2008. However, the Drug Formulary has not been updated since 2002.

The first Palestinian Drug Formulary was issued in March, 2002, funded by the World Bank. The achievement of introducing and distributing the Drug Formulary to every doctor and pharmacist in West Bank and Gaza was a source of technical assistance and motivation for all health services providers to abide by the Essential Drug List (EDL). Furthermore, the MoH is hoping that this Palestinian Drug Formulary will form the first step towards developing and adopting diagnosis and treatment protocols for the most prevalent diseases in the West Bank and Gaza in order to score a real success in providing the best, most cost-effective drug treatment. Updating the Palestinian Drug Formulary will impact positively on the efficiency of the health services and the health sector as a whole.
The Palestinian health sector would benefit from using pharmacoeconomic analysis to ensure rational and effective selection of pharmaceuticals. Capacity building and intensive training is needed to enable the members and staff of the drug policy department in the General Directorate of Pharmacy to conduct proper Pharmacoeconomic analysis, including the capacity to critique, apply and conduct pharmacoeconomic research, such as cost-benefit analysis to make decisions on adding or deleting drugs from the Essential Drug List (EDL).

Storage and Distribution

The MoH Pharmaceutical Department and the central warehouses face challenges related to storage and distribution. The current central and peripheral warehouse lack space and physical infrastructure. This affects good storage practices (GSP). In addition, transportation vehicles available at the central warehouses are old and below the distribution capacity.

There is a commitment from the French government to build a central store for drugs, disposable and supplies with all equipment needed.

Appropriate use, availability, access to and financing of quality products and services
Due to the current payment system, most of the suppliers failed to meet their commitment which leads to delays in delivery; this also affects forecasting for future orders and estimation of needs.

A drug information department has been established recently. The main objective of this department is to follow up and monitor the availability and expiry dates of drugs in the central drug store, primary health care departments and hospitals and is mandated with the following responsibilities:

- Updating and reviewing the Essential Drug List (EDL) and the Drug Formulary

- Establishing drug and therapeutic committees in all the national hospitals and monitoring their performance
- Participating in the evaluation process for the clinical aspects of products before the registration process and introduction of new products to the Palestinian markets
- Following up on reports and complaints of side effects of drugs (Pharmacovigilance)
- Following up the reports of drug shortages in hospitals and districts

Policies and capacity building for good pharmacy practice, including inspection of private pharmacies are necessary to ensure quality and safe medicines are dispensed to patients. The Ministry of Health lacks resources for carrying out consistent monitoring of good pharmaceutical practice. Security of inspectors is not always guaranteed and movements are restricted due to the current political situation. As a result, the prevalence of counterfeit and substandard products has become an issue of concern for the Ministry of Health.

In addition, the control of herbals in the Palestinian market has become a problem. There are criteria and guidelines for the registration of herbal medicine; however it is critical that the MoH develop and adhere to a similar set of regulations for herbal medicine as exists for pharmaceuticals, including staff training and conducting frequent supervisory visits.

E2. Possible Options for Strengthening Pharmaceutical Management

- Establishing new pharmaceutical procurement policies and procedures (SOPs) for more efficiency that is not contradictory to the Palestinian law in order to increase the ability to respond to emergencies
- Strengthen institutional capacity building of the procurement department
- Strengthen human resource technical capacity for the drug information department to ensure optimal performance and efficiency
- Procure of new computers for monitoring and evaluation
- Pharmaceutical inspection and supervision training programs and observational study tours abroad for relevant staff.
- Train new staff working in central, district, and hospital drug stores on Good Storage Practice (GSP), and Good Distribution Practices (GDP).
- Introduce the computerization of drug dispensing system for inventory control and safety for patients (unit dose system).
- Arrange for Pharmacoeconomics course in neighboring counties for the purpose of understanding the process of updating/revising the MoH EDL.
- Train health staff on registration, quality and control of herbal medicine in the Palestinian market.
- Update and Review the old Palestinian Drug Formulary since the EDL was updated in 2008.
- Provide technical consultancy for this update and review.

- Print and distribute the updated Palestinian Drug Formulary to doctors and pharmacists.
- Strengthen the pharmaceutical information system including inventory and consumption data for pharmaceuticals, links between different hospitals, primary health directorates and central stores, drug – drug interaction, dispensing, and medical administration records.

Suggested training for MoH staff on pharmaceutical management.

MoH staff highlighted the following trainings as important to strengthening the capacity of the pharmaceutical management team:

- Bioequivalence and stability studies
- Training in registration file evaluation
- Training in computerized registration department system in order to develop the Palestinian National Drug Database, Management Information System, Archiving Systems, Access Control and Security Systems at the Registration Department in Pharmacy Directorate
- Establish guidelines for registration of vaccines, biological and blood products, and train the relevant staff
- Guidelines to register medical devices/ consumables
- Operational manuals and protocols including SOPs for GMP inspection, registration, pharmacy and wholesalers inspection

F. Health Information Systems

Health information systems (HIS) involves "a set of components and procedures organized with the objective of generating information that will improve health care management decisions at all levels of the health system." As such, this assessment investigated the structure and performance of the Palestinian HIS by taking a look at four topical areas: (1) resources, policies, and regulation, (2) data collection and quality, (3) data analysis, and (4) use of information for management, policy making, governance and accountability.

F1. Assessment Findings for Health Information Systems: Current Status

There are various ways in which data is collected in the Palestinian health system. The Palestinian Health Information Centre (PHIC) collects health related data that include vital statistics and clinic- based data, and publishes an annual report "Health Status in Palestine." The Palestinian Central Bureau of Statistics (PCBS) collects and compiles demographic data and conducts health surveys.

The Palestinian health information system collects data on a regular basis from primary health care centers (all levels) through standardized forms. These forms cover MCH, morbidity, dental health, vaccination, communicable diseases and non-communicable diseases. In the health care centers the staff responsible for filling these forms copy information from the patient records to the standardized statistical forms on a daily basis.

These forms are sent on a monthly basis to the district health directorate. Some of the forms are entered using various data bases in different health directorates and some forms are sent to the health information center at MoH to be entered centrally. After the data is entered at the district health directorate, they are sent to the Health Information Center (HIC) at the MoH to be integrated and produce a national data set. Below is a description of some of the weaknesses of the current health information system:

- Data is not stored at the case level (patient record). It is aggregated at the facility level and at the level of visits. This weakens the ability of the Palestinian HIC personnel to do further analysis of the data; moreover it limits the indicators that can be produced out of the data. When data collection and data storage is done at the patient record level, data access and confidentiality protocols will be developed. That is personal information will not be published, data users can utilize raw data for statistical analysis purposes only without reference or use of personal information.

- No correlation analysis is possible among the various variables due to the current methodology in collecting and storing data at the facility level.

- Vital statistics such as death notifications are collected from the various health directorates. The death notifications suffer from deficiencies in terms of completeness of reported information about both the incidence and cause of death. For example, sometimes for children who die under 5 years of age and were not registered at birth, their families might not notify the health authorities about the death—thus neither the death nor its cause are reported. This is most likely to happen in marginalized rural areas. However, the MoH has the most accurate database of death notifications; it is more comprehensive than the one available at the Ministry of Interior (MoI). Another issue that makes it harder for health information center to estimate maternal mortality is the lack of reporting on whether the deceased woman was pregnant or gave birth within 40 days of her death.

- Birth certificates go to the MoH database through the MoI. The MoI is the one responsible for issuing birth certificates. Sometimes birth notifications are delayed at the MoI prior to reaching the MoH; however, in general the level of cooperation between the two ministries is acceptable.

- Establishment of information databases in different MoH departments causes incompatibility between the different databases and ineffectiveness in analyzing the data. The computerized health information system used in the Ministry of Health is fragmented and differs from one department to another. Standardization and integration is necessary.

- Poor technical expertise in different MoH departments in managing databases, school health is one example.

- The demographic and health survey (DHS) is conducted by the Palestinian Central of Statistics by law. It is usually conducted every four years. The HIC and Palestinian Central Bureau of Statistics coordinate their efforts in designing the various indicators to be collected at the DHS. The DHS is based on a sample survey that enables analysts to get reliable results at the district level.

- The population census is conducted by the Palestinian Central Bureau of Statistics every 10 years. The first Palestinian census was conducted in 1997 and the second one was conducted in 2007. Major problems in data collection faced the teams of the Palestinian central bureau of statistics while doing the data collection in Gaza due to the political turmoil between the major political factions in the West Bank and Gaza. The census data was completed successfully in the West Bank and the Gaza data is still under negotiations to be released.

- The availability of accurate population estimates through the population census is vital for producing various indicators especially those related to immunization coverage in various areas in the West Bank and Gaza.

Resources, Policies, and Regulations

The current budget of the Ministry of Health does not include any support for development of the health information system. All the budget items related to the health information system are mainly salaries for full time employees. Most activities geared towards development of the health information system were donor driven. Donor activities, however, have been irregular and inconsistent, making planning very difficult for executing a systematic health information system development plan. Currently some developmental work is being done on the health information system in cooperation with Spanish aid. They are trying to create a local area network (LAN) in the health directorate centers. This will help the health directorate centers improve their IT related infrastructure which will eventually help enhance data entry processes and utilization of network resources by a larger number of employees.

There are laws that require private health facilities in the West Bank and Gaza to provide the Health Information Center with data about morbidity and mortality as well as data about financial issues related to the provided services. But so far the MoH does not have the mechanism that encourages private sector health care facilities to provide reliable data for MoH. Therefore, the reporting on health activities is limited to the governmental and NGO health facilities.

There are no well-defined regulations and protocols for data management and storage. There are verbal regulations and agreements on how to manage data flow to the health information center at MoH. There is lack of adequate ways of communication between the central and statistics/information units at the peripheral level. Special protocols and regulations must be defined to take into account confidentiality of data and patient's privacy, especially at the patient record level.

Data Collection and Quality

The assessment reviewed the data collection process by determining whether guidelines for data collection exist, if data quality is verifiable, where the data comes from, burden of data collection on health facilitates, and if national summary HIS reports are compiled.

It was found that there are no written guidelines for data collection process. All the protocols are done through verbal communication without documentation and without proper training for data collectors (nurses or other administrative staff at the health care facilities).

As reported by the staff in the health information center, data quality suffers from serious problems due to lack of training of the staff responsible for filling the standardized statistical forms distributed to the health care facilities by the health information center. Sometimes some of the nurses that are responsible for filling the forms at the health facility level get overloaded with work and this is usually at the expense of reporting data in the required forms. No mechanism is defined by the health information system for quality control and data audits. There are other reasons that could contribute to the lack of quality of reported data such as:

- The Health Information Center manages information through various systems and programs including Access, Excel, Oracle, etc. The inconsistency and variety make it difficult for staff to manage and process data.
- Some MoH departments and health care centers do not share data with the center.
- Lack of resources (equipment and human resource) within hospitals and other departments to compile and report data.

The staff of the health information system at MoH is comprised of 50 employees where 37 of them are based in Gaza and 13 are based in Nablus in the West Bank. Due to the current political situation, the staff based in Gaza are not contributing to the work being implemented, which sheds serious doubts on the quality of data produced in Gaza. Moreover, it overloads the staff working in the West Bank for producing the yearly report and managing the data flow.

Data Analysis and Use for Management, Policy Making, Governance, and Accountability

The health information center has an experienced team in statistical data analysis. The team are experienced in analyzing data using various statistical software such as SPSS, excel and Epi-info. The way data is being collected and stored limits the ability of the team at the Health Information Center to conduct sophisticated data analysis. This is due to the fact that the data is being stored at the health facility level and not at the patient record level.
There is still no culture for data utilization for decision making process at various levels at MoH. After Palestinian universities started their programs to supply qualified human resource in the area of public health, things started to change regarding this issue. Many doctors/physicians/administrators who are currently working at MoH were enrolled in the master programs of public health in the various Palestinian universities, and hence the culture of information utilization is picking up momentum.

F2. Possible Options for Strengthening Health Information Services

General

- Conduct training workshops for the staff responsible for filling the statistical forms (data collection) on a periodic basis

- Design a manual that contains protocols needed for standardizing the data collection process. This manual will help new staff, who join the data collection process follow the required protocols for filling the statistical forms in the health care facilities.

- Supply the health care facilities (primary health care centers, district health care centers, hospitals) with computers, necessary software, and installing local area networks.

- Design a system for data entry auditing that will be managed by the health information center at MoH. This can be done through conducting double entry for a sample of the records to check if the data is being entered without errors or with minimal number of errors.

- Standardizing the software necessary for data entry at the various health care facilities such as Oracle, Access, Epi-Info, etc.

- Enhancing the forms used by hospitals for reporting their activities. The forms still lack important information about patients and treatments.

Rules, Regulations and Policies

- Design new regulations that ensure that private sector clinics/hospitals that reported data about their activities in hospitals and private clinics will not be used by the tax authority and it would be used for statistical purposes only.

- Design new regulations that set the standards for information management and information flow within the various departments at the Ministry of Health and the Health Information Center.

- Ensure that the MoH budget contains a developmental component for the MoH Health Information Center.

- Support the HIC with proper human resource especially in the area of epidemiology and biostatistics.

- Support the various health care facilities (primary health care facilities and hospitals) with computers and networks.

- Set up a set of procedures for allocating resources and planning based on information products of HIS.

- Set up regulations for information flow from various departments at MoH to the health information center, including tracking information flow

- Enhance linkages between the health information center and the various departments within the Ministry of Health in terms information flow. This can be done through producing a set of regulations that allows the health information center to standardize databases and to get access to information.

- Enhance linkages between the health information system and other governmental and nongovernmental organizations, such as the Ministry of Interior, Palestinian Central Bureau of Statistics, Medical Relief Committee, etc.

Data Analysis and Use for Management, Policy Making, Governance, and Accountability

- Support the HIC at MoH with proper human resources, especially in the area of bio-statistics, epidemiology, and statistics.
- Train current staff on data analysis and reporting
- Supply the HIC at the MoH with new computers especially laptops.
- Arrange educational tours for top management staff at MoH to go and visit other countries and educate them on how health information system data are being utilized for decision making and health planning.
- Sponsor scholarships for existing staff to go and pursue their higher education in bio-statistics or epidemiology.
- Establish new integrated hospital information system and strengthen the existing ones: include Admissions, medical records management, discharge and health insurance, and the hospital cost accounting and billing system.
- Standardize and strengthen existing clinic information system: appointments and registration, health insurance, medical records management, immunization tracking, and growth charts.
- Establish health manpower registries, national registry systems for licensing, certification, and continuing education of health professionals
- Strengthen pharmaceutical information system including inventory and consumption data for pharmaceuticals, links between different hospitals, primary health directorates and central stores, drug – drug interaction, dispensing, and medical administration records.
- Establish laboratory and radiology health information system: lab workflow management, results reporting, inventory and consumption, and link between different hospitals, primary health directorates and central stores.

SECTION 4: SUMMARY AND ANALYSIS OF HEALTH SYSTEM ASSESSMENT FINDINGS

This section summarizes the assessment findings according to health system performance, which is measured according to equity, access, efficiency, quality, and sustainability. It then presents the key areas for reform highlighted by the MoH for immediate action and support.

A. Health System Performance

The chart below presents a summary of the Palestinian health system according to five health system performance indicators: equity, access, efficiency, quality, and sustainability.

System elements	Health System Performance Indicators				
	Equity	**Access**	**Efficiency**	**Quality**	**Sustainability**
Governance	• The MoH has recently begun emphasizing the need for an overall strategic approach to the health sector • Enforcement problems exist in terms of applying regulations	• Increased tendency to widen/broaden participation in planning • Local community participation in planning and policy making is still inadequate • More efforts are needed to systematize rules and procedures for transparency • Establish rules governing publishing health sector information.	• Regulations are not being implemented • Licensure of entry-level professionals and certification of health professionals as specialists is inadequate. • Need to implement enforcement of prescribing practices. • Need to strengthen the coordination and integration between different health care providers and levels of care (primary, secondary, and tertiary)	• More efforts need to be directed to enforce licensing and relicensing of health professionals. • Accreditation of academic health programs needs to be enforced. • Palestinian standards for licensing of both health care providers and facilities in the health sector should be updated, standardized and enforced. • Process for accreditation of facilities (review of performance after licensure) should be strengthened.	• Continues to be largely dependent on personalities • Recent efforts to establish streamlined and strengthened systems should be encouraged
Financing	• Insurance premiums are largely equitable; however the poor spend a higher percentage of their income on co-payments • Not all poor people are exempt from paying health insurance premiums • Referrals to hospitals abroad are selectively provided	• Two thirds of the population do not seek health care due to the high cost • The poorest segments/quintiles of the population spend40% of their total income on health	• 49% of public health finances is allocated to hospitals and only 30% devoted to primary health car • Staff are not paid regularly • Suppliers are not paid regularly • MoH pays much higher prices for pharmaceuticals in comparison to UNRWA and international market • Most of The public	• The resources allocated to salaries are greater than resources allocated for operation and maintenance. • Government budget allocations to capital investment are minimal. • No specific line items for human resource development, equipment maintenance, purchase of	• Extreme reliance on donors impact availability and quality of services • Donor funding is not reliable • Government funding is not reliable • Lack of funds for human resources development

System elements	Health System Performance Indicators				
	Equity	**Access**	**Efficiency**	**Quality**	**Sustainability**
			spending is dominated by salaries payments	pharmaceuticals, or review of facility • performance.	
• **Service delivery**	• Horizontal equity: - - PHC clinics located throughout 11 governorates of the West Bank. • Need to upgrade and strengthen clinics to meet the needs of the growing population. • Secondary care provided in major cities. • Tertiary care provided on a limited basis by private sector and NGOs. • Vertical equity: People treated equally with limited way to determine if care is differentiated based on personal characteristics or risk factors.	Financial: • - Reported that 68% of population does not seek care due to high cost of care. • Health insurance coverage increasing; Poor spend 40% of income on health care • Physical: clients face challenges accessing the appropriate place of care due to physical barriers (separation wall, checkpoints)	• Difficult to determine efficiency- Good examples: immunization program; antenatal care • Medicalized system favored over programs supporting behavioral change, counseling, • support groups	• Legislation, structural unit and experience of demonstration projects to improve quality of care exist at the MoH. • New priorities: • Strengthen existing unit with capacity building of staff and resources; • Fill gaps in service protocols, • Revise, disseminate, and monitor staff performance of standards; • Introducing applicable measures of quality (client satisfaction, facility assessment & medical chart review)	• Health insurance system needs reform to improve cost recovery • Special medical treatment referrals use disproportionate amount of • available resources • A stable political and economic environment are pre-requisites for sustainable • Institutional development. • Institutional capacity for quality assurance is needed
• **Human Resources**	• Employment policies are politically interfered with. • Employment policies are used as a welfare mechanism to solve unemployment.	• Health personnel often unable to reach facilities because of physical barriers • Health professionals usually concentrated in urban centers • Doctors are more concentrated in hospitals	• No human resource planning • Weak evaluation system • Performance feedback is weak • Lack of incentives system to retain qualified health professionals in the public health sector.	• Differences in skills and competencies among professionals. • No review of performance after initial licensure • No continuing medical education programs • Standards for licensing and certifying different types of health professionals are weak.	• Lack of management training • Lack of sufficient funds to pay for staff training and human resource development
• **Pharmaceutical management**	• Co-payments are fixed amongst population	• Pharmaceuticals are largely accessible to	• Not all medications are available to the	• MoH is establishing a department to improve	• Reliance on donor funding and

System elements	Health System Performance Indicators				
	Equity	**Access**	**Efficiency**	**Quality**	**Sustainability**
	segments and disproportionately affect the poor.	most segments of the population. • Obstacles encountered in accessing pharmaceuticals during non-peak service hours (holidays, days of religious observance)	population. • Procurement procedures (lack of procurement legislation) lead to inefficiencies. • - Inefficient storage systems and facilities. • Essential drugs list is updated regularly.	manufacturing quality • Weak inventory system	donations • High cost of local medicines
• **Health information systems**	• Current system measures geographic equity, but it does not have other measures of equity to aid in decision-making. This is due to lack of storing information at the patient record level. Therefore, no profiles can be produced about the health care recipients.	• Current system measures only infrastructure access. However, the demographic and health survey conducted by Palestinian Central Bureau of statistics measures access to all segments. However, this survey is not done routinely.	• No parallel systems exist. There is a complimentary relationship between HIS and the Palestinian central bureau of statistics. The HIS is not exploited at lower levels. It's only exploited sometimes by research centers and donors.	• No routine measures of quality of care are included at HIS. This can be by agreeing on a set of standardized indicators that can be used to measure quality, part of which can obtained through conducting regular employee and patients surveys.	• The Ministry approved the organizational structure for the HIS. More staff is needed to fill in the various boxes in the new organizational structure. More staff and resources are needed
• **Private sector & NGOs**	• Private sector services are expensive and largely target "well to do" segments/quintiles of the population • NGOs support areas where government services are unavailable. • NGOs provide rehabilitation services	• The health system is not designed to cover the whole country; therefore, opportunity exists for private sector and NGOs.	• Government may contract the private and NGO sector to provide needed services. • Some overlap between public and NGOs services. • Claims that NGOs services more efficient	• The quality of care is acceptable; but providers need to adhere to quality "best practice" standards. • Need to adhere to standards for initial licensing of providers and facilities and periodic review of performance through accreditation. • Claims that NGOs services have better quality	• NGOs are dependent on donor funding. • Government started taking on more of the oversight function • The government should provide a conducive environment for private sector investment and share in providing health services.

B. Priority Areas for Reform and Recommendations

As discussed in previous sections, the health system assessment revealed several priority areas for reform by the Ministry of Health. During a workshop chaired by the Minister and Deputy Minister of Health, the MoH assessment team discussed the health system's needs and priorities as a whole, identified areas of mutual concern, and developed a more targeted list of priority areas for reform (see Annex 5 for entire list). During the discussion and of that list, key areas for reform were highlighted by the MoH assessment team:

Create a Center of Excellence at the Palestine Medical Complex

The Palestinian Authority and Ministry of Health is in the process of establishing the Palestine Medical Complex in Ramallah. The complex represents four hospitals that will provide specialized services to the Palestinian people. The complex will provide emergency care (Sheikh Zayyed Hospital, financed by the United Arab Emirates), specialized surgery (Kuwaiti Hospital), pediatrics (Bahraini Hospital), tertiary care at Ramallah hospital, and a blood bank.

The longer-term objective of the Palestine Medical Complex is to serve as a Center of Excellence in the West Bank that will inspire the rest of the Palestinian health system to provide the highest quality service in a complementary fashion. Therefore, the MoH has expressed that one of its chief priorities is to operationalize the Palestine Medical Complex in a manner that promotes good governance and transparency in health, equitable and quality services in care, social participation, and cost-effectiveness.

The Flagship Project views the Palestine Medical Health Complex as a critical opportunity to bring international best practices in governance, health finance, service delivery, human resource management, pharmaceutical management, and health information systems. By providing technical assistance and capacity building support to the Complex in these areas, the MoH can then guarantee improvements in equity, access, efficiency, quality, and sustainability, which can then be emulated across the West Bank and Gaza.

Develop a Comprehensive and Integrated Health Information System

Developing a comprehensive health information system was highlighted as essential by all MoH staff participants, as it is a cross-cutting issue that affects the entire health system. However, developing a health information system goes beyond just the procurement and installation of software and equipment. MoH staff stressed the importance of building its capacity to utilize data for management, planning and informed policy formulation. Establishing a comprehensive and integrated health information system will allow this to happen.

Implement the New Health Insurance Program

Health finance—specifically the operationalization of the new compulsory health insurance program—was also highlighted as an area of critical importance to the Minister and all departments. Developing a system that not only improves Palestinians financial access to medical care, but also generates sufficient revenue to ensure the sustainability of the health system, is critical. Costing and pricing of services to determine package of services, cost of services, and pricing of services if contracted to NGO and private sector.

Create a Relicensing System of Medical Professionals

Licensing and relicensing of medical professionals was raised as a fundamental to ensuring the highest quality of care in the Palestinian health sector.

- Design a medical facility accreditation program. Accreditation represents a commitment to quality care by medical facilities. By implementing medical facility accreditation programs, the MoH would in fact raise the bar for quality medical care.
- Design a Continuing Medical Education program to support relicensing of medical professionals. In addition, designing a fellowship abroad program that meets the emerging needs of the reform system.
- Strengthen service delivery and clinical guidelines. Clinical guidelines serve as the basis for quality service delivery. The need to review, adapt and update clinical guidelines was apparent during the assessment. The MoH staff highlighted the need to simplify existing clinical guidelines practical use, ensure dissemination, and train staff on their use.
- Coordination of stakeholders in order to ensure that long-term priorities are addressed and that there is greater predictability of resources to finance MoH development goals.
- Support implementation of the procurement law. Successful implementation of the procurement law is fundamental to having a sound, transparent, and equitable pharmaceutical management system. The MoH expressed its desire for support from the Flagship Project in implementing the procurement law and coinciding regulations.

SECTION 5: NEXT STEPS AND CONCLUSION

Next Steps

As such, the USAID Flagship team will support the MoH in developing institutional development plans that will turn their goals into reality. The development plans will allow the MoH to specify how they aim to achieve their priority goals, and to solicit technical assistance and procurement support from the USAID Flagship team. In addition, a similar assessment and corresponding institutional development plans will be conducted for NGO health service providers. The assessment and development of the plans will also be coordinated closely with the MoH. The Flagship team looks forward to working closely with the MoH to strengthening the Palestinian health sector.

Conclusion

The health system assessment exemplified genuine cooperation between the MoH, USAID, and all stakeholders involved in the health system. The assessment process also promoted openness, transparency, and accountability within the MoH. Staff identified strengths and weaknesses in the system, and also to come up with realistic solutions to overcome the challenges. One of the greatest achievements of the assessment was the ownership promoted and commitment demonstrated by the MoH to reform the health sector. As expressed by the Minister of Health to his staff at the first assessment-related workshop: “If this project is a success, it is because of you. If it fails, it is also because of you.”

ANNEX A: ASSESSMENT TIMELINE

Deliverable	Deadline
Presentation of assessment tool to USAID	October 17, 2008
Review Assessment Tool	October 22, 2008
Form Module Teams	October 27, 2008
Adapt tool to Palestinian needs	October 30, 2008
Collect Relevant Data	November 6, 2008
Interview informed observers	November 12, 2008
Analysis of findings/ MoH-USAID Flagship staff workshop to discuss findings	November 25, 2008
First draft of report	December 1, 2008
Comments on report	December 11, 2008
Final report	December 20, 2008
Stakeholders' meeting	January 14, 2008

ANNEX B: BACKGROUND DOCUMENTS — DESK REVIEW FOR HEALTH SYSTEM ASSESSMENT

USAID/USG Documents

USAID Country Health Statistical Report (May 2007); available online at: http://pdf.usaid.gov/pdf_docs/PNADJ065.pdf

USAID Palestinian Health Sector Reform and Development Program RFP

World Bank Documents

West Bank and Gaza Public Expenditure Review: Volumes 1 and 2 (2007) (available online at: http://domino.un.org/unispal.nsf/1ce874ab1832a53e852570bb006dfaf6/6024011fa484837c8525729700548f66!OpenDocument)

WHO/UN

Health Sector Review 2007—conducted by WHO, DfID, EC, MoH, Italian Cooperation, and World Bank http://www.emro.who.int/Palestine/reports/health_policy_planning/Health_Sector_Review Report_2007.pdf

Comprehensive Food Security and Vulnerability Assessment (CFSVA) – January 2007 - conducted by the United Nations World Food Program (WFP) and the Food and Agriculture Organization (FAO) (available on-line at http://www.wfp.org/policies/Introduction/other/Documents/pdf/CJFSVA_21_Feb.pdf

WHO Country Cooperation Strategy 2006-2008 (available online at http://www.emro.who.int/palestine/reports/health_policy_planning/WHO_Country %20Cooperation_Strategy_(2006-2008)oPt.pdf)

Palestinian Ministry of Health/Government

National Health Strategic Plan 2008-2010, Ministry of Health

Palestinian Reform and Development Plan 2008-2010

Palestinian Family Health Survey, 2006, Preliminary Report," published in April 2007 by the Palestinian Central Bureau of Statistics (available on-line at http://www.pcbs.gov.ps/Portals/_pcbs/PressRelease/English_Report.pdf

National Strategic Health Plan – Medium Term Development Plan, 2008 – 2010" published by the Palestinian National Authority, January, 2008 (http://www.palestine-pmc.com/pdf/6-2- 08.pdf)

Health Status in Palestine 2005," published by the Ministry of Health in October 2006 (available on-line at

http://www.MoH.gov.ps/index.asp?deptid=5&pranchid=184&action=details&serial=3661)

Public Health Law

Palestinian NGO/Educational/Professional Institutions

Center for Continuing Education at Birzeit University and Palestinian Health Policy Forum, Palestine Country Study: Identification of Priority Research Questions Related to Health Financing, Human Resources for Health and the Role of the Non-State Sector in Palestine (2007).

Palestine Economic Policy Research Institute (MAS), Public Policies to Enhance Private-Sector Investment and Competitiveness in Tertiary Health Care in the Occupied Palestinian Territory (2008)

Other

RAND Corporation, Strengthening the Palestinian Health System (2005) http://wwwcgi.rand.org/pubs/monographs/2005/RAND_MG311-1.pdf

DfID, West Bank and Gaza Health Sector Expenditure Review (2006)

Proceedings of Rome Health Conference: Health Care in the Palestinian Territories (2004)

ANNEX C: HEALTH SYSTEM ASSESSMENT WORKING GROUPS

Technical Committee
Dr. Naem Sabra, DG of Hospitals
Dr. Asad Rimlawi, DG of Primary Health
Dr. Ghaleb Abu Bakr, DG of Planning

Module 2: Governance
Dr. Anan Masri, Deputy Minister of Health

Module 3: Health Finance
Mr. Mohammad Atyani, Finance Director
Mr. Samer Jabr, Director of Health Economics Department

Module 4: Health Service Delivery
Dr. Naem Sabra, DG of Hospitals
Dr. Asad Rimlawi, DG of Primary Health
Dr. Souzan Abdo, DG of Women's Health
Dr. Bassam Madi, Director of Salfeet PHC

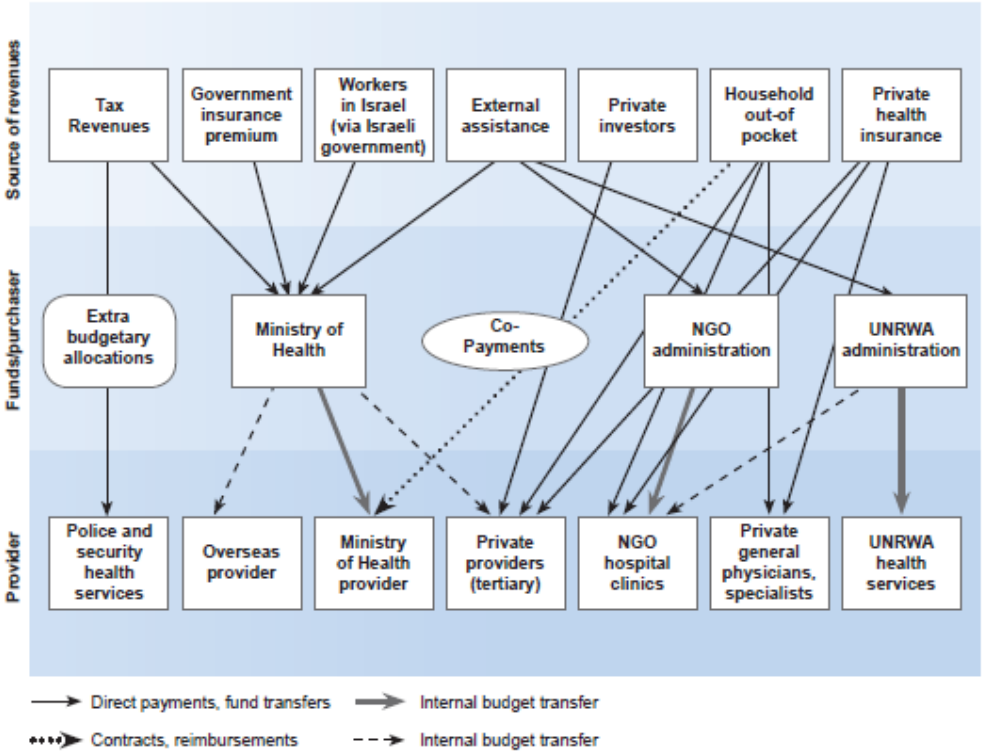
Module 5: Human Resources
Dr. Said Hammouz, DG Higher and Continuing Education
Dr. Khaled Masri, Manager of Human Resource Department
Dr. Nader Bakamin, Licensing and Accreditation Unit
Mr. Mouheb Abu Zant, Licensing and Accreditation Unit

Module 6: Pharmaceutical Management
Ms. Rania Shahin, Director General of Pharmaceuticals
Mr. Ibrahim Ellayaan, Director of Biomedical Equipment Unit
Mr. Rezeq Othman, MoH Procurement Director
Mr. Yousef Srour , Director of Drugstore
Mr. MoHammed Abu Ajamieh, General Director of Central Stores
Ms. Huda Lahham, MoH Pharmacist

Module 7: Health Information Systems
Mr. Omar Abu Arqoub, Public Health Information Center Director

ANNEX D: FLOW OF FUNDS: HEALTH FINANCING SYSTEM

Figure 5.2
Flow of Funds in Palestinian Health System



Source: World Bank,1998,p.24 Also appears in Barnea and Husseini, 2002,p.184.

Note: Several set of arrows are missing from this figure. For instance, arrows should run from the MOH to NGOs and the private sector. As discribed below, government health benefits do cover some care from such providers when patients are referred because a covered service is not available in the government system. Also, an arrow should run from UNRWA to the MOH. As also described below, UNRWA pays government insurance premiums for some UNRWA beneficiaries.

ANNEX E: PRIORITY REFORMS AND INTERVENTIONS

PRIORITY REFORMS AND INTERVENTIONS	
Overall	• To establish and maintain a fully functional Palestine Medical Complex in Ramallah. The complex will be receiving strong priority attention from the Ministry of Health. The Flagship project will provide the Ministry of health with needed assistance to ensure that this complex will be transformed into a center of excellence. The center will serve as the major national health services facility and a catalyst to emulate best practices in management and provision of quality health services.
Governance	• Finalize and issue the Public Health Law corresponding rules and regulations. • Raise the MoH capacity to utilize data in management, planning and informed policy formulation by developing and maintaining a modern information system. • Strengthen the capacity of the National Health Policy and Strategic Planning Council (NHPSPC) as a mechanism to enhance the MoH capacity to engage and integrate NGOs and private sector partners and stakeholders in policy formulation, planning and service provision. • Establish mechanisms to engage and solicit citizens' participation in health policy formulation and decision-making. • See relevant sections on the health insurance law and the pharmaceutical procurement laws.
Finance	• To issue and implement the proposed government health insurance law. • The MoH needs to design a careful plan to finance the non-salary operating and maintenance costs of the recurrent budget to ensure quality service provision. • Initiate a dialogue with national and international stakeholders to agree on a minimum set of dependable resources over the next five years to make effective use of the available limited resources. • The MoH needs to adopt and implement an efficient accounting system to monitor and track outstanding revenues and payments. • Increase revenues through fines on health threatening products and from hazardous behaviors to finance preventive care program. • Allocate more resources to preventive care and primary health care to reduce late diagnosis and future high treatment costs of diseases. • Encourage dialogue and support initiatives demonstrating corporate social responsibility or public/private partnerships. • Implement rigorous criteria and guidelines for prioritizing referral treatment including means and modes of purchase of services outside MoH, avoid duplication and carryout cost effective analysis. • Develop capacity within the MoH to be strategic in procurement of drugs, equipment, and supplies.
Health Service Delivery	• Foster coordination of service quality provided by NGOs, private sector, and UNRWA. • Standardized administrative and operational policies and procedures for MoH hospitals and clinics which respond to new patient's emerging needs. • Establish mechanisms to receive and process feedback from patients about quality of care received. • Upgrade primary health care clinics by shifting certain PHC clinics from Level 1 to Level II in accordance with Palestinian MoH criteria. Moreover, shifting certain Level II clinics to Level III and improvement of Level III clinics. • Review PHC professionals' job descriptions and consider the feasibility of task shifting of staff responsibilities to increase the quality of PHC services provided at each level. • Establishment and implementation of strengthened referral and discharge follow-up systems for better continuity of care between primary health care and secondary health care. • Encourage new approaches to understand the underlying risk factors and management interventions associated with congenital diseases and genetic disorders. • Review PHC programs to focus on pregnant women with anemia and children with anemia, postpartum care and reproductive health care needs of post-menopausal women.

PRIORITY REFORMS AND INTERVENTIONS	
	• Review PHC programs to expand non-communicable and cancer prevention awareness. • Provide training programs in hospital management and administration. • Installation of medical waste management systems and personnel safety procedures and practices. • Installation of a computerized information system with networking inside and between hospitals and with the central management units at the MoH. • Installation of computerized systems to manage patients' admission, records, appointments, external clinics, etc. • Establishment of an integrated Quality Improvement Program for delivery of hospital services.
Human Resources	• Update, standardize and enforce Palestinian standards for licensing, certification and accreditation of human resources and facilities in the health sector. • Develop and maintain a modern HR database at the MoH. • Improve and modernize the archiving and retrieval of documents systems at the MoH. • Update recruitment, hiring, transfer, promotion and placement regulations and procedures at the MoH. • Provide supervisors with training on supportive supervision and managing staff performance. • Develop continuous education programs including residency schemes and encourage the health staff to participate in and reward them for it. • Initiate ongoing leadership training for managers in the health sectors.
Pharmaceutical Management	• To issue the pharmaceuticals procurement law, write, and implement corresponding regulations. • Adopt and implement a drug procurement plan that includes efficient mechanisms for drug pricing, quality assurance and distribution. The plan should encourage national pharmaceutical production.
Health Information Systems	• Developing a comprehensive health information system. All MoH staff participants highlighted this as essential, as it is a crosscutting issue that affects the entire health system. However, developing a health information system goes beyond just the procurement and installation of software and equipment. MoH staff stressed the importance of building its capacity to utilize data for management, planning, informed policy formulation and decision-making. Establishing a comprehensive and integrated health information system.