

Healthcare Challenges

Under the current COVID - 19

Pandemic, Tax clearance Crisis and Weak Government Health Insurance

Report No. 173



2020

AMAN
Transparency Palestine



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(under the current COVID-19 pandemic, tax clearance crisis and weak government health insurance)

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AMAN Coalition wishes to extend deep gratitude to Researcher Baker Shtayeh for preparing this report and to Dr. Azmi Shu'aibi and AMAN's crew for their supervision, review and editing of the report

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To quote this publication: Coalition for Integrity Accountability (AMAN), 2020. Healthcare Challenges (under the current COVID-19 pandemic, tax clearance crisis and weak government health insurance) Ramallah - Palestine.

Introduction:

The Palestinian Basic Law guarantees to all Palestinians the right to health care, as stipulated in Article (22): 1. Social, health, disability and retirement insurance shall be regulated by law. 2. Maintaining the welfare of families of martyrs, prisoners of war, the injured and the disabled is a duty that shall be regulated by law. The National Authority shall guarantee these persons education, health and social insurance¹.

Other laws regulate healthcare in Palestine include the Public Health Law (2004), the Labor Law, which guarantees workers the right to health care and insurance and safety in workplace. This is consistent with the Universal Declaration on Human Rights, which states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services”. The International Covenant on Economic, Social and Cultural Rights includes a more comprehensive article on the right to health in the International Human Rights Law, and stipulates that “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health².”

The Palestinian people lives under occupation and siege while the Palestinian National Authority does not have sufficient or regular financial resources. However, healthcare in Palestine recorded improvement in the past years. The expected life expectancy of individuals in the West Bank and Gaza Strip reached 73.3 years, while the global average is 72.2 years³. Child vaccine coverage reached a hundred percent⁴ (100%), while mortality rates per 1000 of infants and children below 5 years dropped from (36 and 45 to 17.9 and 20.9 respectively)⁵.

Nonetheless, these indicators do not mean that the Palestinian healthcare system is fully prepared. Studies actually found that the system lacks sufficient hospital beds, inclusive health insurance and qualified human resources to deal with complicated cases. As a result, the allocations of the Ministry of Health were depleted to pay for medical transfers, mostly to Israeli hospitals (till end 2019).

¹ Palestinian Basic Law, as amended 2003

² <http://hrlibrary.umn.edu/arabic/cescr-gc14.html>

³ World Bank Open Data, 2019. <https://data.worldbank.org/>

⁴ Palestinian Ministry of Health, Annual Health Report 2020

⁵ World Bank Open Data, 2019. <https://data.worldbank.org/>

On 5th March 2020, a state of emergency was declared in the Palestinian Territories to respond to the spread of COVID-19 pandemic. A three-level management structure was created to make decisions at national and local levels:

1. Policy level, with the President, Prime Minister and political leadership
2. National Emergency Committee, chaired by the Prime Minister and comprising political leaders and ministers of line ministries
3. Executive level, englobing civil and security government agencies with specialized units to implement the government action plan to confront the crisis. Membership at this third level include the Ministry of Health, Ministry of National Economy, Ministry of Agriculture, Ministry of Labor, Ministry of Social Development and Ministry of Transportation and Communication.⁶

The state of emergency declaration was followed by an announcement by the Prime Minister, Dr. Mohammad Ishtiyeh, regarding a 137 million Dollar emergency plan to equip the health sector and provide medicines to confront the epidemic in the West Bank, Gaza Strip and in Jerusalem.

The state of emergency enables the government to apply exceptional measures to achieve the purpose of this state of emergency. These measures include purchase of medicines without the necessity to abide by the Public Procurement Law or the Public Budget Law . Consequently, a high level of transparency is required to maintain citizens' trust on the one hand and to prevent abuse of these exceptional measures by corrupted agents on the other.

It is henceforth important to shed light on the spending of the Ministry of Health during the pandemic and to monitor compliance of officials and stakeholders with the transparency standards of expenditure and assess their respect of the values of integrity and accountability.

⁶ Ghanem, Amjad. 2020. Management of Emergency during COVID-19 Pandemic in Palestine. (in Arabic). <http://www.palestinecabinet.gov.ps/portal/news/details/51401>

⁷ Article 9.13 of Decree Law No 8 for the Year 2020 on 2020 Contingency Budget stipulates that, "If the emergency triggered expense was not considered upon promulgation of this decree law, or if it represents a special type, it may be covered from the financial reserve allocations upon resolution from the Council of Minister following recommendation by the Minister of Finance upon request from the competent minister and recommendation of the Director General of Budget after review of the application for spending. The approved expenses shall be accounted for on the budget of the competent government body or shall be spent from the central MOF budget.

Goals and Methodology:

The present study aims to shed light on the transparency of government spending in general, and MOH's spending in particular on health needs since the declaration of the state of emergency until now. It also assesses the preparedness of the Palestinian health system in times of crises, taking the COVID-19 pandemic as an example that can be used to identify and address the needs. On another level, the pandemic coincided with freezing of transfer of fiscal clearance money by the Israeli side, which deprived the Palestinian treasury from essential resources to allocate to the health insurance fund. The assessment in the study focused on the following aspects:

- Tracking healthcare spending in previous years.
- Diagnosing the problems that emerged during the crisis.
- Studying the MOH's budget, spending mechanisms, sources of funding and expenditure priorities in 2020.
- Evaluating MOH's compliance with the standards of transparency in budgeting, and disclosure of sources of funding and expenditure mechanisms, as well as in its tendering processes and new recruitments.

To achieve these goals, the researcher used a number of secondary data including health accounts published by the Palestinian Central Bureau of Statistics (PCBS), comparison of data on MINISTRY OF HEALTH budget as published by the Ministry of Finance and the Ministry of Health. Other sources included comparison of health care indicators during and before COVID-19 based on data from the Health Information Center at the Ministry of Health. Furthermore, interviews were held with representatives of the health sector to collect primary data.

1. Healthcare Spending in Palestine before the Pandemic

1 - 1 Current Spending on Healthcare:

First, we need to differentiate spending on health as an allocation to a center of responsibility in the state budget (i.e. allocations to the Ministry of Health), and the overall spending on health as a component of the total value added of the gross domestic product (GDP). State budget allocations to Ministry of Health may include non-health expenditure, while allocations to other centers of responsibility may include spending on health⁸. Furthermore, healthcare expenditure systems (as part of the GDP) are not limited to direct government spending. They also include the mandator (governmental) and non-mandatory (private sector) and nongovernmental organizations' insurance programs, as well as households' spending (while seeing a doctor in his/her clinic). This means that tracking the Ministry of Health allocations in the public budget represents a part of the system of healthcare funding. The overall system (central government, insurance companies, households and not-for-profit organizations) represents the total spending on health care as part of the GDP and a key item on the expenditure side.

It should be noted that the overall spending of the GDP includes government, family and investment spending (total capital formation) and the net exports. We can therefore differentiate current spending on healthcare by families and governments and track each share of the overall spending. We add to this total capital spending (overall capital formation) on the health sector and track this share. Comparisons use the nominal GDP (at current prices) as a baseline and not the actual GDP since all healthcare spending indicators are calculated on the basis of current prices.

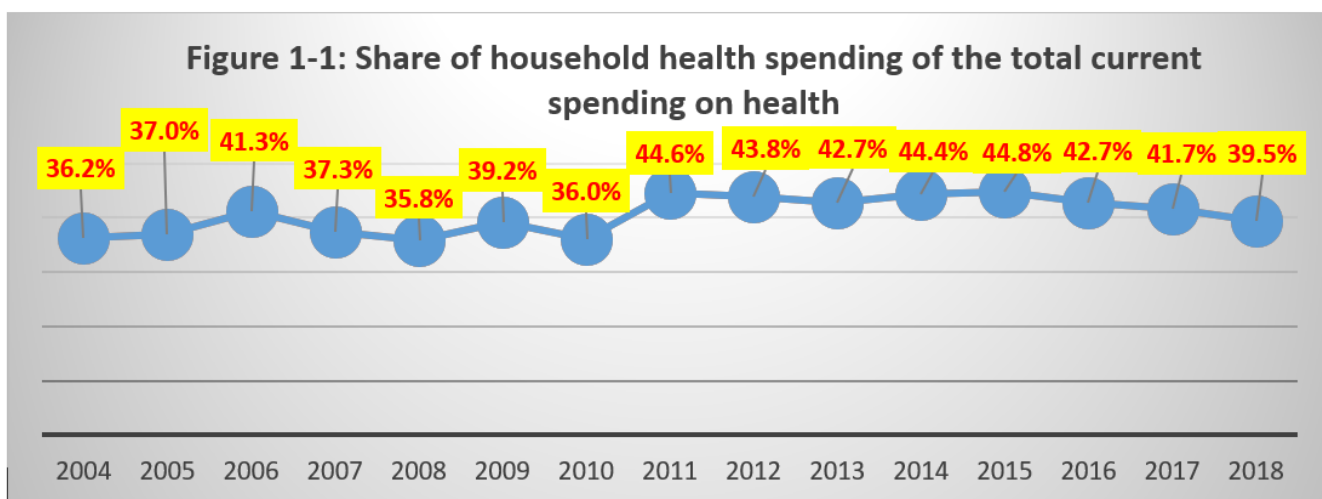
1 - 1 - 1 Households spending on healthcare (extra- insurance system)

Palestinian health accounts data⁹ show a stable share of households spending (an average of 40%, see Figure 11-) on health in the period (2004 – 2018) of the total spending on the health system (financing agents), The international average for the same period reached ca. 35%.¹⁰ This is an additional burden to the households with low and middle income.

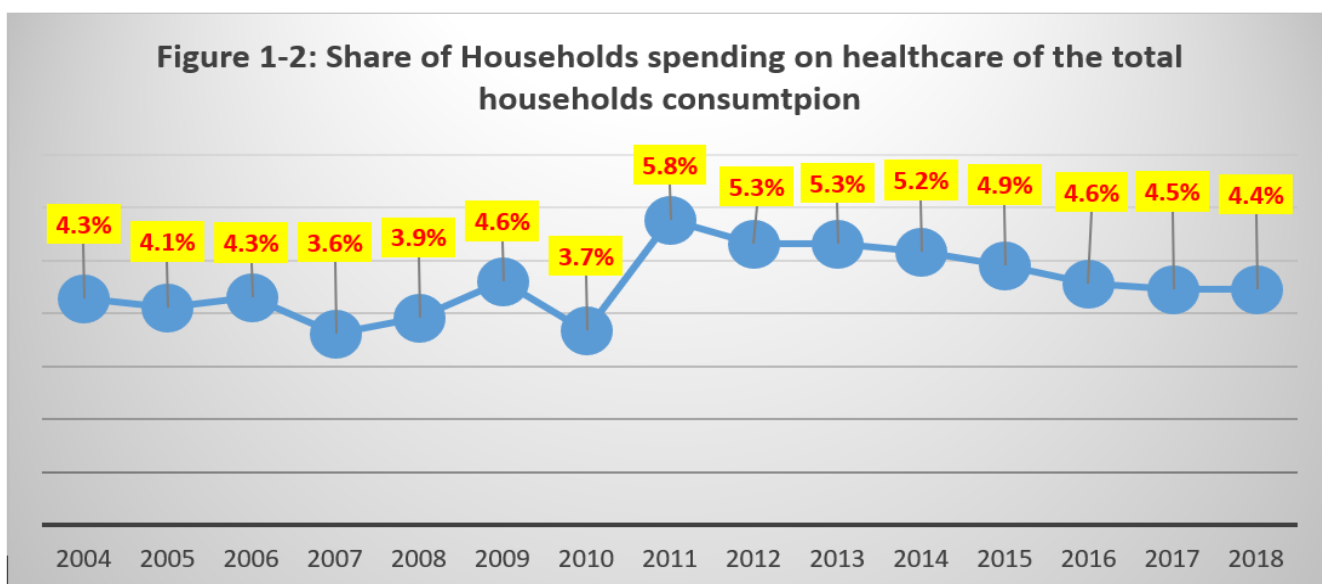
⁸ Examples of the allocations to the overall budget of the Ministry of Health include allocations to educational establishments (like Ibn Sina Nursing College); they do not represent part of healthcare. Furthermore, allocations to other ministries (like the Ministry of Education) for school health programs are computed as part of spending on health care.

⁹ MoH, PCBS, 2020, Palestinian Health Accounts 20002018- (edited series)

¹⁰ World Health Organization. 2019. <https://www.who.int/ar/news-room/detail/202019-02-countries-are-spending-more-on-health-but-people-are-still-paying-too-much-out-of-their-own-pockets>



The share of health spending of the overall households' consumption remained at 4% to 5%, as shown in Figure (1 - 2)¹¹



1 - 1 - 2 Government Spending on Healthcare

The global average government spending on health represents 51% of the global spending on healthcare¹²; according to Palestinian Health Accounts, this rate remained at 42.5% for the periods (2004 - 2018), as shown in Table (1 - 1) here-below¹³.

¹¹ Calculated by researcher using the National Accounts Series published by PCBS and Health Accounts published by MOH.

¹² WHO. Idem.

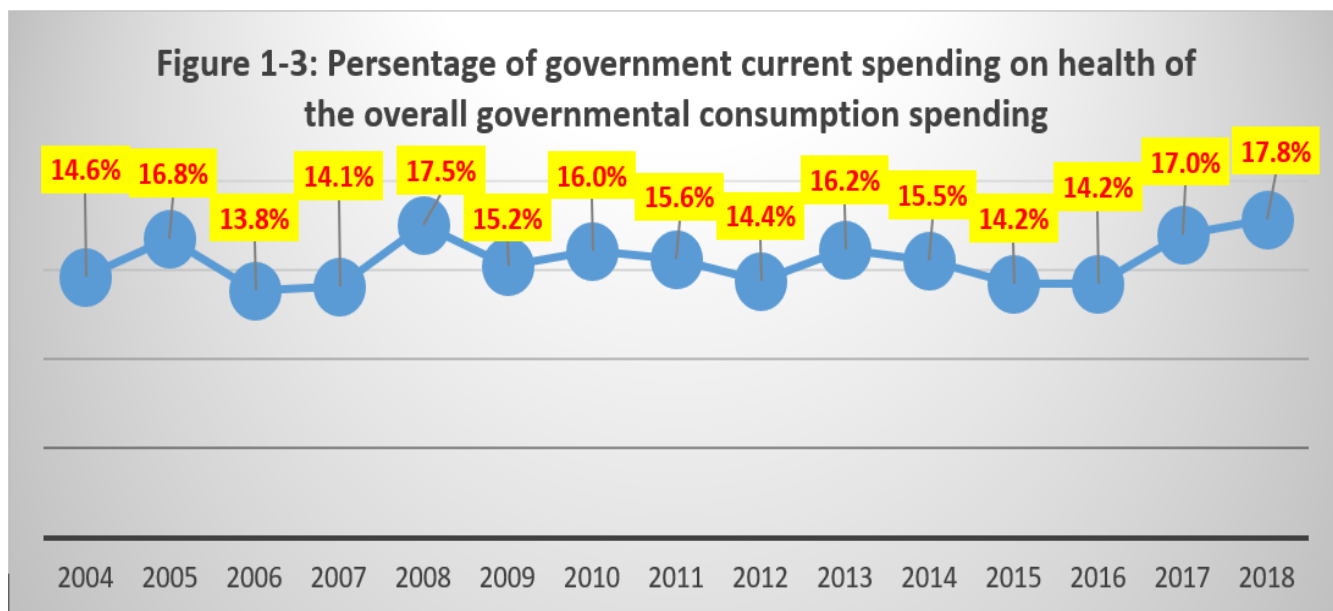
¹³ MOH, PCBS, 2020. Palestinian Health Accounts 20002018- (edited series)

Year	Current spending on health (government + households+ civil society + international)	Central government systems and programs	Mandatory governmental health insurance systems and programs	Total (ratio of government to overall spending)
2004	523.8	34.70%	5.8%	40.50%
2005	563.6	41.20%	5.3%	46.50%
2006	561.7	34.50%	5.4%	39.90%
2007	557.6	41.40%	4.9%	46.30%
2008	769.5	41.80%	3.7%	45.50%
2009	870.4	41%	3.4%	44.40%
2010	881.5	45.50%	2.2%	47.70%
2011	1269.2	35.60%	2.4%	38.00%
2012	1257.6	35.70%	2.1%	37.80%
2013	1412.2	38.70%	2.0%	40.70%
2014	1387.8	39.40%	3.1%	42.50%
2015	1297.3	38.30%	3.3%	41.60%
2016	1387.1	37.20%	2.8%	40.00%
2017	1471.3	38.70%	4.0%	42.70%
2018	1571.7	40.60%	4.2%	44.80%

The above table shows the limited capacity of the mandatory governmental health insurance to fund healthcare programs. In 2018, government contribution to current health expenses amounted to \$ 638 million including the public budget allocations and \$ 66 million through the mandatory health insurance program. This means that this program represents only 9.4% of the total governmental expenditure on healthcare. As a result, the public budget is strained especially in contingency situations, like COVID-19 outbreak and disruption of transfer of fiscal clearance money.

These contribution rates align with AMAN's recommendations from previous years relating to increasing the capacity of the health insurance programs (including the government program) to establish a comprehensive mandatory health insurance system. This effort may halt the fiscal waste on medical transfers abroad, mainly to the occupation state.

Figure (1 - 3) shows the burden borne by the Palestinian government on health care by calculating central government's current spending on healthcare (outside mandatory health insurance system) as a ratio to the overall government consumption spending for all centers of responsibility. The ratio ranged from 14 – 17.8% in the period (2004 - 2018).¹⁴

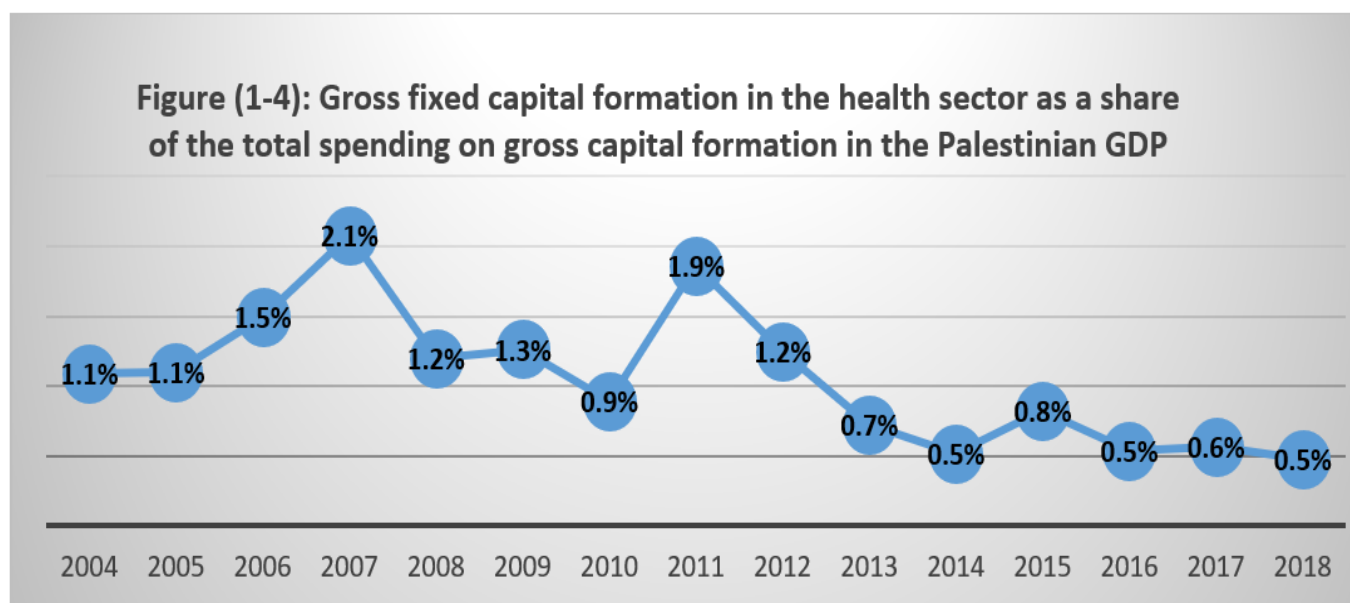


The figures are alarming since they reveal the central government's inability to meet its healthcare obligations under the current fiscal clearance crisis and weak insurance system (lack of any comprehensive insurance system that guarantees financial sustainability and health services development). The study will analyze the effects of the health and financial crisis on different healthcare services. It will assess the government's ability to mobilize foreign financial aid to the health sector. It further compares the public budget allocations to the Ministry of Health during the pandemic with the same months in previous years. The analysis focuses then on the importance of transparency in expenditure and officials' compliance with the values of integrity and non-abuse of their positions. Government officials must avoid nepotism and wastah in making their decisions and should review the national insurance system.

¹⁴ Calculated by researcher using the National Accounts Series published by PCBS and Health Accounts published by MOH.

2. Capital spending on healthcare (gross fixed capital formation)

The gross fixed capital formation of the health sector is the total value of healthcare providers (hospitals, clinics and healthcare facilities) acquisitions less disposal of fixed assets during a given year.



The above figure shows a decrease in the share of the health sector of the total gross capital formation in Palestine. It reflects that capital expenditure on the health sector is not concordant with the increasing needs for health care services from one year to another as a result of natural demographic growth. An indicator of the number of hospitals and hospital beds may be used to assess the adequacy of capital expenditure to respond to healthcare needs.

1 - 2 - 1 Number of hospitals, beds and equipped ICU's

The indicator implies that hospital bed is the key component of a hospital equity shares whereby performance of other assets revolve around its performance. However, continued use of “the number of beds” fails to assess other investment cycles in the health system. Although using the number of beds is an easy method, it is increasingly recognized that this indicator has core limitations¹⁵. It remains however the indicator most globally used.

¹⁵ WHO. Hospitals Capacity Plans. <https://www.who.int/bulletin/volumes/88/7/10/09/8//ar/>

	West Bank	Gaza Strip	Palestine
Number of hospitals	52	34	87
Number of beds	3,990	3,049	7,039
Number of beds per (1000) population ¹⁷	1.3	1.49	1.38
Number of beds in ICU (general and intermediate)	110	102	212

Comparing the beds per 1000 population indicator with a selected number of countries, we find that the indicator marked 5.9 beds in advanced countries and 2.3 beds¹⁸ in middle-income countries. In Palestine, it stays at 1.38 beds per 1000 population, which explains the limited capacity and preparedness of the Palestinian health system in the West Bank and Gaza Strip to face pandemics and other natural, man-made or war-related disasters.

The number of ICU beds is also a sign of weak capabilities (see Table 1 - 2). It is therefore necessary to increase capital spending on the health sector to empower the system to confront critical situations. This is especially true in the Gaza Strip, which suffers a sharp lack in ICU and other hospital beds compared to the health risks related to recurrent wars and COVID-19 outbreak.

1 - 3 Medical workforce

Health workforce requirements for universal health coverage recommended by the World Health Organization (WHO) provide for at least one doctor and three nurses per 1000 population.

Table (1 - 3) shows that the ratio of doctors per 1000 population in Palestine is consistent with the minimum universal requirements, and is higher in the Gaza strip compared to the West Bank (noting that the number is 3.9 in the Euro-countries and 3.9 in Israel, 2.8 in Egypt and 2.6 in Jordan). However, there is a clear lack in nursing and midwifery staffing in the West Bank and the Gaza Strip as the ratio does not reach 3 staff members per 1000 population (the ratio in Israel is 4.9, in Egypt 3.5 and in Jordan 4).

¹⁶ MOH, Health Information Center, Palestine

¹⁷ Humeidan, Mohamed. 2019. The Health Sector Journey is still Long (in Arabic). Qalb Al-Urdun Newsletter.

¹⁸ In 2020, Dora Government Hospital and COVID Military Hospital in Nablus were opened, but no statistics were obtained regarding the number of their hospital beds.

Medial workforce	West Bank	Gaza Strip	Palestine
Doctors	2,807	2,490	5,297
Per 1000 population	0.98	1.3	1.1
Nursing and midwifery	5,441	3,869	9,310
Per 1000 population	1.86	2.06	1.93

Source: Palestinian National Institute of Public Health

Strikingly, as the PNA expanded its institutions and recruited further human resources, the health sector did not benefit from this increase. However, investment in human resources in this sector would have enabled the PNA to rank better on the human development index on the long run not to mention the savings secured by local provision of health services rather than medical transfers abroad.

2. Impact of the Government's Financial Situation on the Ministry of Health's Spending Efficiency During COVID-19

The outbreak of COVID-19 coincided with a suffocating financial crisis due to decrease of foreign funding of PNA budget over the past five years. Furthermore, deductions were made by the occupation authorities on the fiscal clearance transfers in 2019 up to complete seizure of these funds as of May 2020.

In addition to the additional financial burden related to the pandemic, the freezing of transfer of fiscal clearance money obstructed the ability of the PNA to use any financial policy tools. As a result of this situation, the Ministry of Health could not fulfill its duties in providing primary, secondary and tertiary healthcare. Furthermore, it could not secure sufficient medications or medical supplies. This part of the study analyzes this situation.

2 - 1 COVID effect on citizens' access to governmental health services

The analysis will cover citizens (in the West Bank) access to government health services in the first months following the outbreak of the pandemic, compared to the same months in 2019. Health services include:

- Primary health care (visits to general practitioners and specialized clinics as well as family planning, prenatal and post-natal reproductive health centers)
- Secondary and tertiary healthcare (bed occupancy and admission rates in hospitals, surgeries, outpatient clinics and emergency rooms).

2 - 1 - 1 Primary Healthcare

Primary healthcare addresses the broader determinants of health and focuses on the comprehensive and interrelated physical, mental and social wellbeing. It provides whole-person care for health needs throughout the life span, not just for a set of specific diseases. Primary healthcare ensures people receive comprehensive care ranging from promotion and prevention to treatment.

The following tables¹⁹ show accessibility to governmental primary healthcare clinics and centers (in the West Bank) during the first months of the pandemic (March, April and May), with comparison to this accessibility in the same months in 2019. The tables are based on data from the Health Information Center at the Palestinian Ministry of Health.

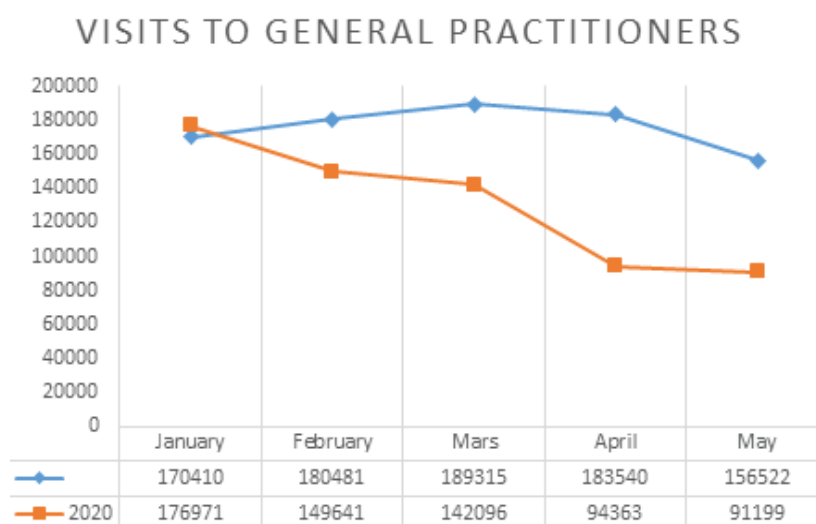


Figure 2 - 1 Visits To General Practitioners

¹⁹ MOH, Health Information Center, unpublished data.

VISITS TO SPECIALIZED DOCTORS

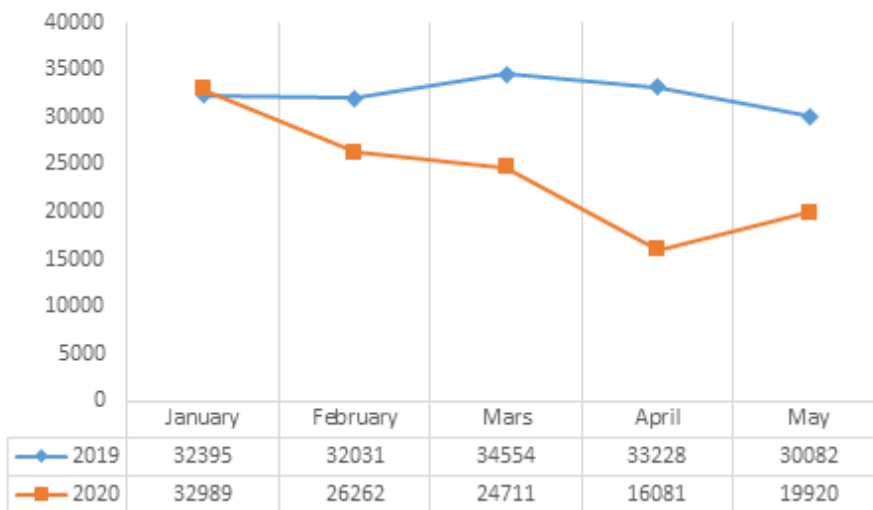


Figure 2 - 2 Visits To Specialized Doctors
ACCESS TO FAMILY PLANNING SERVICES

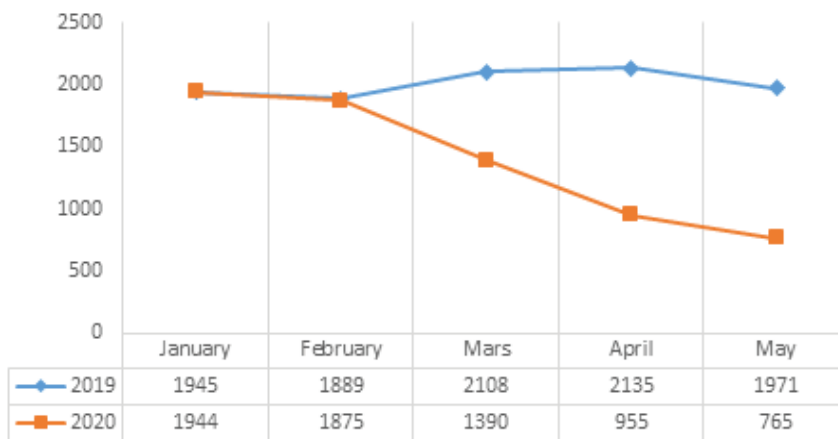


Figure 2 - 3 Access To Family Planning Services

ACCESS TO PRENATAL CARE BY DOCTORS

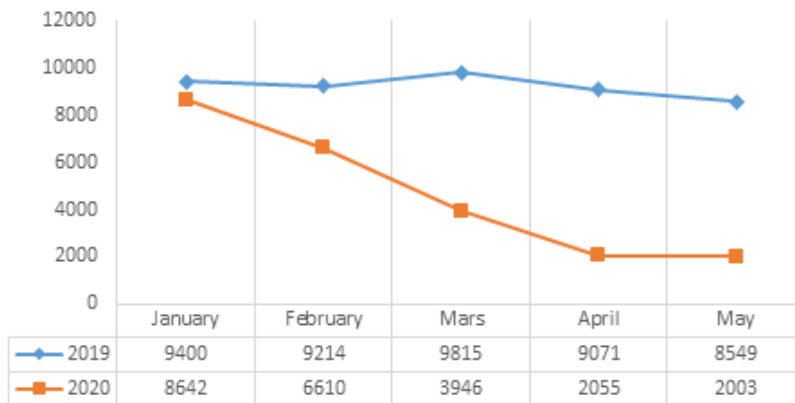


Figure 2 - 4 Access To Prenatal Care By Doctors

VISITS OF HIGH-RISK PRGNANCY CASES TO DOCTORS

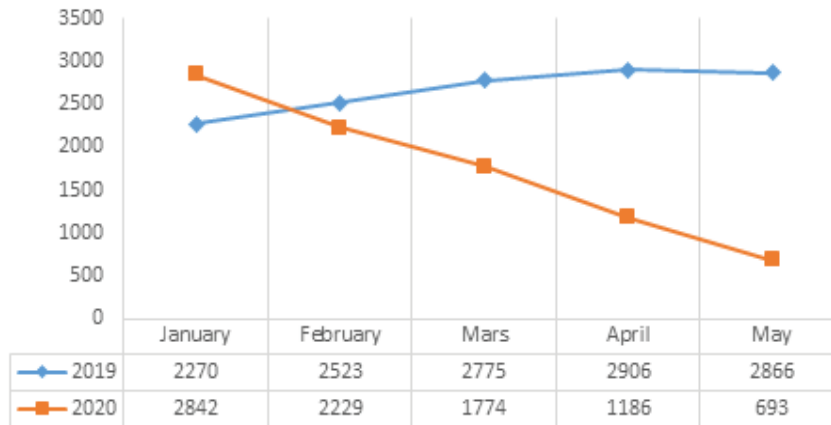


Figure 2 - 5 Visits Of High - Risk Prgnancy Cases To Doctors

ACCESS TO DOCTOR'S POST-NATAL CARE

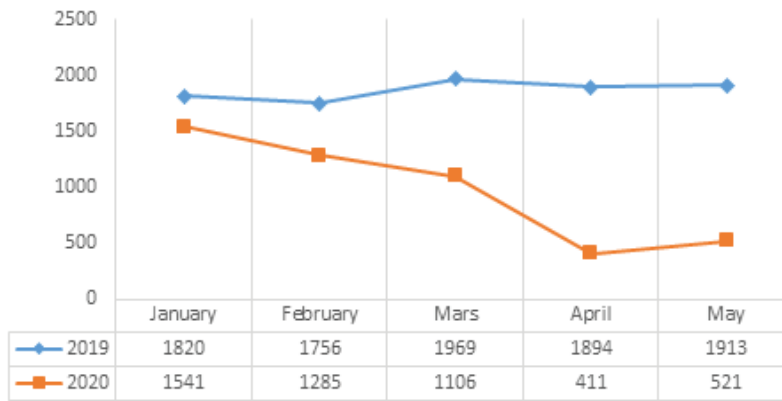


Figure 2 - 7 Access To Doctor's Post - Natal Care

Indicators in all of the above charts show deteriorating accessibility to primary health care for the following reasons:

1. Confusion in the health system obstructed any effective communication with citizens. Since early April till end June, many citizens were unable to access different health services because of closure of many health centers and clinics. Information about clinics shifts was not smoothly communicated while MOH could not handle this unprecedented situation.
2. Total and partial lockdowns hindered citizens' accessibility and mobility.
3. Public panic in the first months following the pandemic outbreak deterred many citizens from visiting primary healthcare centers.
4. Drop in seasonal diseases and associated symptoms due to social distancing and decreased contagions.

2 - 1 - 2 secondary and tertiary healthcare

Hospital healthcare indicators may be divided into the following:

- Month occupancy rate of hospital beds (number of occupancy days of patients over a month period/number of beds *30) * 100
- Number of monthly admissions.
- Number of surgeries
- Visits to outpatient clinics
- Visits to ER.

The following graphs show the variances in hospital healthcare indicators in the West Bank during the pandemic and partial and total lockdown compared to the same period in 2019.

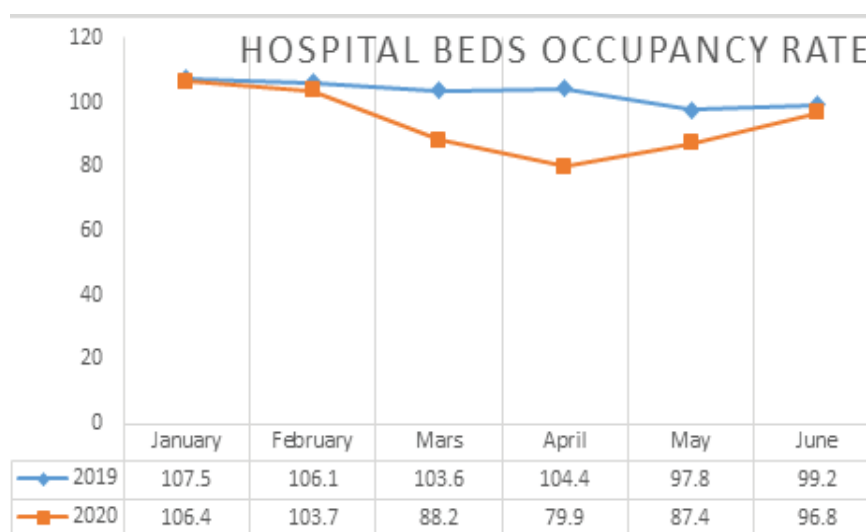


Figure 2 - 8 Hospital Beds Occupancy Rate

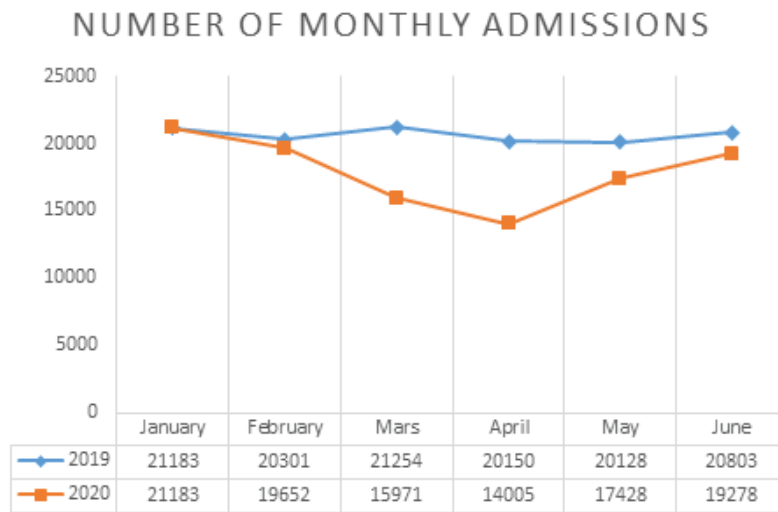


Figure 2 - 9 Number Of Monthly Admissions

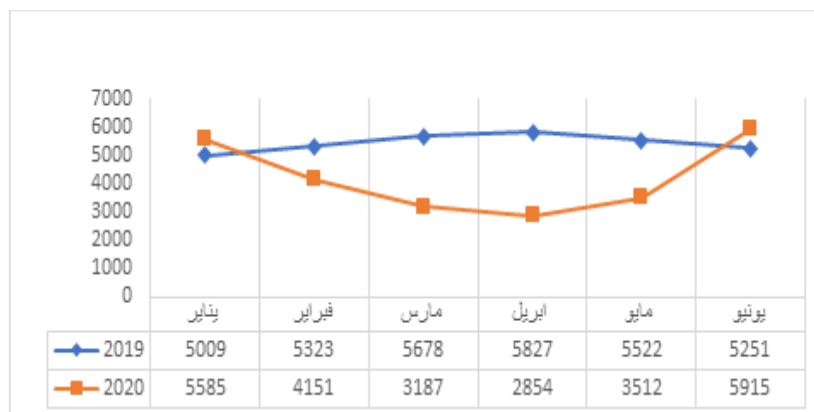


Figure 2 - 10 Number of surgery operations

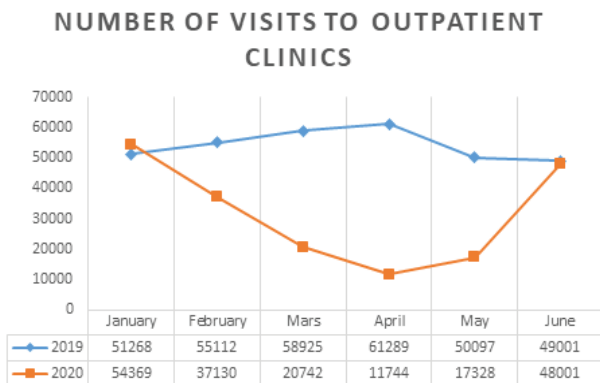


Figure 2 - 11 Number Of Visits OutPatient Clinics

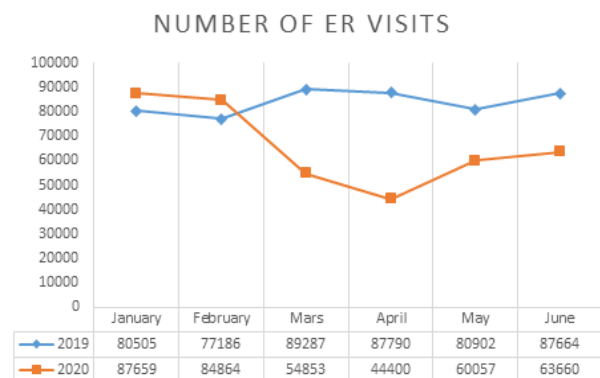


Figure 2 - 12 Number Of ER Visits

Data show an increase in bed occupancy rate in government hospitals in the West Bank from 88% in 2015 to 103.4% in 2019. As a result, there is a long waiting list whereby patients may need to wait for over 6 months before admission. Additionally, this gap forced MOH to purchase medical services (medical transfers) of some cases to local and foreign medical establishments outside its own system. This confirms our previous statement that health sector capital spending does not match the annual increase in needs to health care due to natural demographic growth. Contingency funding from the government and other partner local and international organizations is needed to raise MOH's capital allocations. The Civil Society Coalition to Promote Public Budget Transparency had previously addressed the negative effect of inadequate capital spending on health due to funds depletion by medical transfers.

Figure 2 - 7 shows a drop in beds occupancy rate during the pandemic because of delay of non-contingency admissions and surgeries. The drop resulted prevention procedures to mitigate the spread of COVID and not from enhanced equipment in governmental hospitals (as shown in figures 2 - 8 and 2 - 9).

Figures 2 - 10 and 2 - 11 show the impact of lockdowns, restrictions on mobility and public panic on the number of visits to outpatient and emergency clinics in government hospitals.

2 - 2 MOH spending and public treasury response during the pandemic

MOH public budget allocations remained unchanged over the past years at an average of \$ 1.7 billion. The allocations did not account for the natural demographic growth and increased demand on health services. They do not suffice to implement the government's four-year plan to provide medical services locally and end dependency on the state of occupation. Moreover, no radical changes were introduced to the expenditure items while salaries and wages continued to use about half of the budget.

However, a review of MOH monthly reports (on actual revenues and expenses) during the second quarter of 2020 (the pandemic period), as compared to the same quarter in the last three years showed the following (Table 2 - 1):

Table (2 - 1): Health sector revenues and expenses based on MOF monthly reports (second quarter of the current year)/accrual basis (NIS million)

2nd quarter / year	Health services fees	Health insurance fees	Total revenues	Total expenses	Salaries and wages	Social contributions	Operational cost	Capital expenses	Developmental expenses
2017	21.2	58.7	79.9	331	188.24	17.26	122.27	0	3.1
2018	23.7	42.1	65.8	446.7	148.47	13.5	266.55	1.04	17.12
2019	25.3	46.2	71.5	459.4	169.68	10.27	256.86	2.6	20.01
2020	17.6	24.4	42	404.85	163.24	15.27	189.7	20.8	15.85

1. Sharp drop in MOH revenues from health services fees during the second quarter of 2020 (by 30% compared to previous year) while insurance fees decreased by 47% compared to past year. This drop in revenues may be seen as part of MOH response to the financial hardships of Palestinian households due to the lockdown and loss of livelihoods. See figure (2 - 12) below:

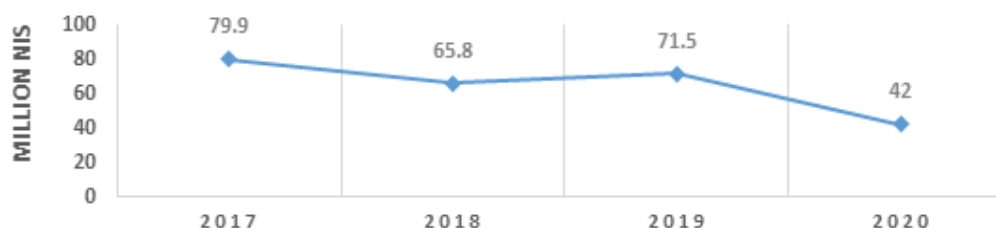
Health services fees were adversely impacted by the following measures ²⁰:

- Full closure of many health centers (clinics) in villages.
- Utilization of entire health centers for quarantine (Hugues Chavez Hospital)
- Closure of hospitals' outpatient clinics
- Lockdown of governorates and restrictions on public mobility.
- Public fear of the spread of the contagion.
- Closure of borders and travel ban, which lead to drop in the number of vaccines to perform umrah (semi-pilgrimage in Mekkeh) and other destinations.
- Closure of dental clinics in health district centers.

The drop in revenue from health insurance premiums may be explained as follows:

- Workers inside the Green Line (around 33% of subscribers to government health insurance) are no longer able to pay instalments as they lost access to their workplaces;
- A large segment of workers is outside the mandatory insurance system during the pandemic after tens of thousands of them lost their jobs and source of income due to partial or total lockdown.
- Many checks issued by subscribers to voluntary insurance were pounced.

FIGURE 2-12: MOH REVENUES IN THE SECOND QUARTER IN SEVERAL YEARS



- Table (2 - 1) above shows that MOH responded quickly to capital expenses (equipment, medical devices, vehicles, capital transfers to developmental projects and costs, etc.). the level of spending rose from NIS 1 million to NIS 2.6 for the second quarter in 2018 and 2019 respectively, and to 20.8 million in the same quarter of 2020.
- Operational costs (medical consumables and medical transfers and medicine) decreased from NIS 77 million in the second quarter 2018 to 67 million in the second quarter 2019. Developmental expenses also fell slightly. It seems that this spending structure resulted from the contingency funds mobilized by MOH during the pandemic in 2020 and from other emergency external assistance to promote the capacity of the health sector in confronting the adverse effects of COVID-19. Grants covered drugs and medical supplies and equipment. Table (2- 2) shows the level of funding provided during the first three months following the pandemic outbreak, disaggregated by source. It also shows the tender awards in US Dollars and NIS as well as MOF measures to confront the lack of funding.

Funding from	Grant value/\$	Bids awards/\$	Bids awards/NIS	Total awards (\$)
World Bank	3,500,000	2,495,363	276,140	2,576,581
Taawon (Welfare Association)	1,400,000	1,249,477	25,200	1,256,889
Qatari grant	10,000,000	7,389,576	2,263,140	8,055,205
Waqfat Ezz Fund	1,000,000	835,632	-	835,632
Corona Contingency Budget	Based on emergency need	6,335,180	10,312,918	9,368,391
Total		18,305,228	12,877,398	22,092,698

It should be noted that the items presented in the table above are not part of the public budget. They do not appear on MOF monthly reports. The Palestinian government opened a contingency account for the Ministry of Health on 9 April 2020, with a ceiling of USD 137 million to purchase medications and other equipment needed to confront the pandemic in Palestine, including in Jerusalem and the Gaza Strip.

4. Generally speaking, the fiscal clearance crisis had a visible effect on the allocations of the Ministry of Health and Palestinian treasury as a whole. The draft budget law for 2020 responded to MOH actual needs and allocated it 13% of the total budget (compared to 11% in previous years). However, the contingency health and financial challenges obstructed the enforcement of this law.

On another level, MOH has revolving arrears (unpaid entitlements to suppliers and service providers and cost of medical referrals to Palestinian nongovernmental hospitals). The arrears reached a peak of NIS 956 million in 2017 and decreased to NIS 840 million in 2018. Consequently, MOH remains unable to continue its purchase of referral services or other medical supplies and drugs.

3 - 2 Spending on medical referrals (service outside government hospitals)

Medical referrals in (2019 – 2019) constituted 25% of the overall MOH budget and over 50% of the total arrears, representing thus a heavy burden for MOH and Palestinian nongovernmental hospitals. Arrears due to these hospitals reached NIS 470 million in 2018, which represents a decrease from NIS 516 million in 2017²². Figure (2 - 13) shows the trend of medical referrals in (2011 - 2019), while Figure (2 - 14)²³ shows the distribution of purchase of medical referrals from non MOH facilities in (2014 - 2019).

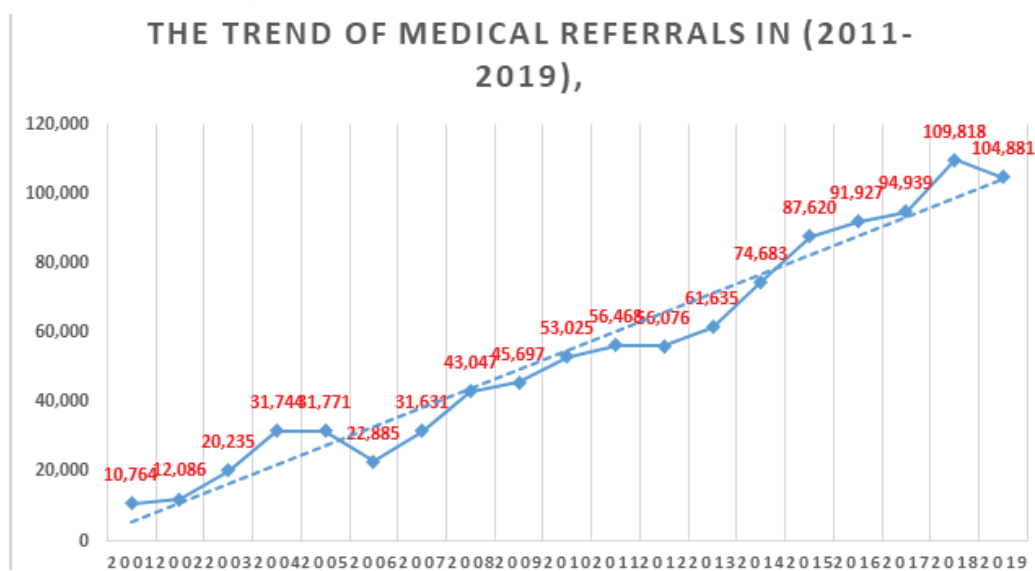


Figure 2 - 11 The Trend Of Medical Referrals in (2011 - 2019)

22 Economic Policy Research Institute (MAS). 2020. Analysis of the Palestinian Health Sector. Macrolevel analysis. Ramallah, Palestine.

23 MOH, annual reports from different years.

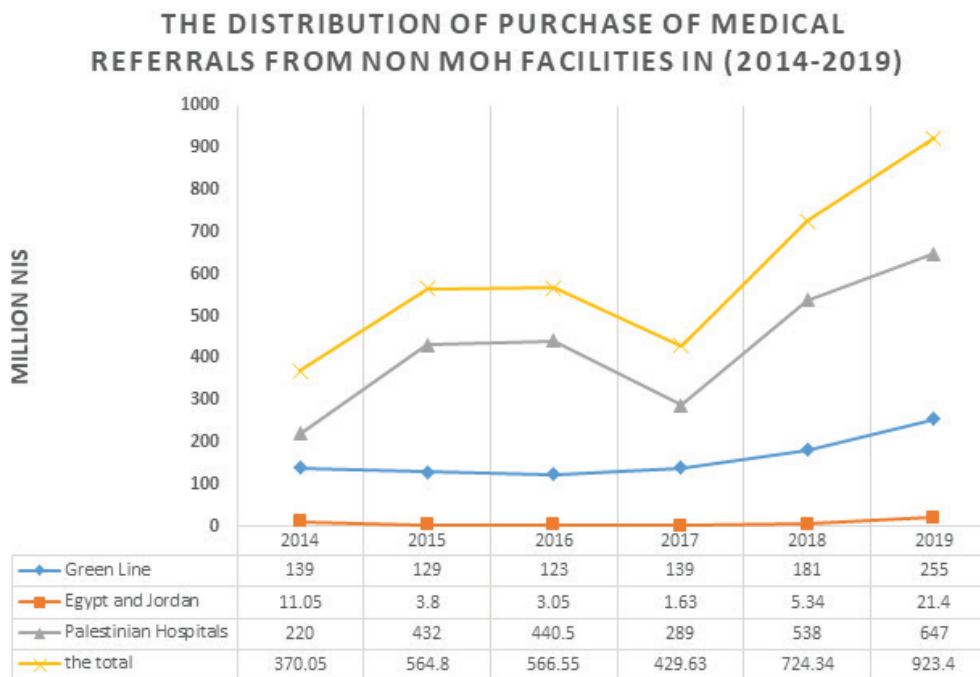


Figure 2 - 12 the distribution of purchase of medical referrals from non MOH facilities in (2014 - 2019)

On 26 March 2019, the Palestinian government decided to stop medical transfers to Israeli hospitals; however, Figure (2 - 14) shows a rise by 41% in these transfers in 2019, compared to 2018. This can be explained as follows:

1. Referral of cases approved before the decision was taken continued;
2. The Palestinian government started to locate alternative solutions in Arab countries (Jordan and Egypt) and needed time to conclude relevant agreements. Actually, Figure (2 - 14) shows an increase by 300% in medical transfers to Jordan and Egypt in 2019 compared to 2018. This is a sign of serious Palestinian efforts to put an end to health dependency on Israel. However, it should be noted that referral to Jordan and Egypt requires fastidious logistics and signature of agreements with hospitals in these countries. There is also the problem of security vetting, which deprives a certain segment of Palestinians from access to these countries. Other problems relate to the high cost of patients' companions due to travel and accommodation expenses as well as partial disruption of work.
3. Insufficient absorption capacities in Palestinian hospitals.
4. Lack of specialized medical services for certain diseases, mainly cancers and marrow transplant.
5. Weak medical infrastructure and inadequate equipment to diagnose certain cases.

The constant increase in medical referrals in general (by 27.5% in 2019 compared to 2018) shows that MOH lost the ability to control this file. It needs structural reform to audit referrals with an electronic system in addition to filling in the medication gap in the Gaza Strip²⁴. Furthermore, MOH needs to apply its referral instructions more rigorously.

Feasibility analysis of further investment in primary, secondary and tertiary health services needs to be conducted to address the absorption capacity problems and lack of expertise and technology. Government, private and nongovernmental hospitals also need to consolidate efforts and distribute roles among them. Most medical referrals relate to specialized tertiary services (cancers, marrow transplants and urology system related diseases). Government hospitals are not attractive for qualified human resources compared to the private sector. Thus, the government needs to facilitate broader investment by the private and nongovernmental sectors in tertiary health services with sufficient guarantees (long-term government plan) to shift these services to local hospitals. The government sector needs to expand its primary and secondary medical services, as statistics show a visible improvement at this level.

With the Palestinian leadership's decision on 19 May 2020 to stop all forms of coordination with the Israeli side, humanitarian interventions in the West Bank and Gaza strip have been compromised. The situation has also affected MOH preparedness to respond to the pandemic. Since early June, humanitarian agencies were no longer able to import basic supplies, which harmed the activity of key organizations including World Health Organization, UNICEF and UNDP not to mention NGOs²⁵.

As for medical referrals to Israeli hospitals, the research could not access MOH information following the decision.

²⁴ MAS, idem

²⁵ OCHA, <https://www.ochaopt.org/ar/content/end-palestinian-authority-coordination-israel-response-annexation-threat-decision-already-0>

2 - 4 Spending on medical supplies and medicines

The main goals of the national pharmaceutical policy (as updated by MOH in 2019) focuses on justice and sustainable pharmaceutical sector via assurance of safety, quality and effectiveness of medicines, medical herbs, nutritional supplements, medical instruments and cosmetics. The policy also focuses on fair distribution and rationalization of use of medicines and promotion of the national pharmaceutical industry²⁶.

The Palestinian governmental health sector suffers from accumulation of arrears to local medical and pharmaceutical companies and suppliers. Medicines represented 18% of the MOH budget over the past three years, but this figure rises to 37% when adding up the arrears. By end 2018, the arrears reached NIS 336 million not to mention arrears on medicines supplied by private sector hospitals since payment thereof is accounted for under medical referrals. Consequently, optimal cost-effective procurement is hindered; it is not possible to have best prices, standards and timely delivery of medicines.

The annual MOH report for 2019 shows NIS 356.4 million expenses on medical supplies and medicines, split into NIS 318.9 million for medicines, vaccines and lab supplies and NIS 37.5 million for medical consumables.

The Palestinian treasury endures a double-folded crisis with fiscal clearance transfer freezing and deteriorated public capacity to purchase medicines under the resulting economic crisis. These are signs of potential collapse of the government pharmaceutical sector if the crisis continues till end November 2020.

MOH reports annual bids for pharmaceuticals and vaccines with lists of 500 – 550 types. The top 50 items consume around 65% of the total tender value. According to MOH, the shortages in some pharmaceutical item is not only the result of the recent COVID-19 pandemic. Indeed, with the accumulation of arrears over many years, MOH warehouses started to endure shortages in 20 to 40 items.

The pandemic outbreak caused additional medicines supply-related problems due to the lockdowns and restrictions on mobility as well as government's inability to repay its debts to national suppliers and pharmaceutical producers. Another complication relates to the bureaucratic procedures for assessment and award of bids and financial allocations. This particular problem is discussed in the third section of the present study.

Participation with nongovernmental and private sector health organizations during the pandemic

Since the declaration of the state of emergency in Palestine, MOH formed a cell to combat the pandemic with the participation of nongovernmental and private health organizations. Periodic meetings were held with the National Epidemics Committee and COVID National Committee.

In addition to working in cities and villages, NGOs focus on serving deprived and marginalized communities in the camps, Jordan Valley, Jerusalem and Bedouin communities through their fixed and mobile clinics. Private sector hospitals provide advanced therapeutic services.

However, the ability of these NGOs and private sector hospitals to complement the services of the government health sector in confronting the pandemic retreated tangible for many reasons:

- 1. Drop in revenues of health nongovernmental services because of the closure of some of these centers during the pandemic.**
- 2. Long-due arrears from the Palestinian government to these centers. The peak of the crisis appeared at Al-Maqased and St. Augusta hospitals in Jerusalem. Both hospitals accepted referrals from the West Bank and Gaza Strip and ended up in heavy debt to their drugs and food suppliers. They could not cover their running costs and were compelled to borrow from banks and other financial institutions to sustain their humanitarian activity.**
- 3. Additional financial burdens incurred during the pandemic for both the civil and private sector health centers and clinics.**

These factors undermined the participation between the government and nongovernmental health organizations. The latter call for resumption of their historical role in the sector of health in order to promote MOH efforts to deal with the pandemic at a more comprehensive national level, not only as a government effort.

3. Integrity, Transparency and Accountability in the Palestinian Governmental Health Sector during the Pandemic

This section presents an assessment of the integrity, transparency and accountability in a number of issues related to the health sector and its efforts to confront COVID-19:

3 - 1 Purchase of Services (Medical Transfers)

Palestinian Council of Ministers' Resolution 11 for the year 2006 regulates purchase of services from hospitals and outside healthcare centers, like health insurance and treatment. Article 17 of the Resolution stipulates for the tasks of the service procurement unit (medical transfers department). The organization and rationalization of purchase of services is important due to lack of specialized medical staff and equipment and buildings apt to absorb the increasing number of health services demanders.

To purchase a service, as per applicable MOH procedures, the patient is first admitted to a government hospital where he/she is examined by a specialized doctor or the emergency doctor in case a specialized doctor is not available²⁷. At this stage, the patient is classified either as an emergency case or a non-emergency case.

- When it is not an emergency case, the specialized or resident doctor refers the patient to another government hospital that provides the service. The patient's file may also be referred to an MOH medical committee to examine the possibility of referring the patient to a nongovernmental hospital in Palestine or to a private hospital outside Palestine.
- When it is an emergency case, the specialized or resident doctor refers the patient to another government hospital that provides the needed service or directly (without a medical committee) to the service procurement unit for potential transfer to a private hospital inside or outside Palestine, or at times to another government hospital that provides the service.

²⁷ The rule is to have a specialized doctor 24 / 7.

This referral system broadened the purchase of service to include cases that did not need such a service. Consequently, government debt to private hospitals grew and arrears accumulated because:

1. The diagnosis is limited to two categories (emergency and non-emergency), leading to classification of mild cases as emergency cases.
2. Lack of medical equipment and device for accurate diagnosis place the specialized doctor in a dilemma and subsequently opts to refer the patient to avoid any medical error or responsibility.
3. In many cases, the specialized doctor or medical committees face social, partisan or family pressure to consent referral of some cases for which treatment is available in government hospitals. This is an act of financial or administrative corruption, which is exacerbated by a weak security and/or judicial system to counter such pressures.
4. In some cases, favoritism and *wastah* play a role or influential officials may interfere in the decision-making process.

To promote transparency and put an end to the deviations of this mechanism, the following steps are needed:

1. Apply multi-tiered eligibility criteria for medical referrals instead of the current two-category system (emergency and non-emergency cases). The changes may be introduced gradually with three categories first up to five later.
2. Reinforce security measures in hospitals to protect medical staff against any threats to their lives or otherwise when making their decisions regarding referral to services outside government hospitals.
3. Increase MOH internal control on referral of cases by hospitals and rotation of staff members to different committees to avoid potential corruption or *wastah* or personal gains.
4. Increase the number of beds in government hospitals to avoid referrals due to over crowdedness and insufficient beds.
5. The exceptions granted to certain cases, including those relating to the President's Office and the offices of the Prime Minister and the Minister of Health, must also be regulated and transparently explained to the public.

3 - 2 Referral and award of bids for purchase of medicines and medical consumables

MOH purchases medicines and medical consumables through its supply unit, focusing on cost effective purchases (best quality for lower cost), as stipulated by Public Procurement Law No 8 for the year 2014 and Council of Ministers' Resolution 5 for the year 2014 on public procurement regulations.

The applicable procurement procedures²⁸ start with needs assessment by government hospitals and primary care centers. Following the identification of needs, central medical warehouses, medical engineering unit and Engineering and Construction Department prepare lists of medical needs and estimated cost. The Minister of Health approves the lists and refers them to the Medical Supply Units for procurement.

Procurement may be made by one of the following measures²⁹ :

1. **Direct Procurement:** through the Purchase Division at the Medical Supply Unit, for purchases with a financial ceiling of \$ 3000 for supplies or small services and \$ 5000 for works. The procedure involves three special committees representing the General Supplies (presided by the Head of the Supplies Unit), and Public Works (presided by MOH Engineering Unit) and Medical Supplies (Presided by the Director General of Pharmaceuticals).
2. **Request for Price Offers:** The Purchase Division sends requests for price quotations to relevant suppliers with a financial ceiling of \$ 20,000 for medicines and consumables, and of \$20,000 to 50,000 for other supplies as well as \$5,000 to 50,000 for works.
3. **Tenders (bids):** The Tender Division at the Supplies Unit launches a bid if the purchases are expected to exceed \$ 50,000. In which case, the request is referred to the Public Purchases Department at the Ministry of Finance, with the exception of purchase of medicines. Actually, Council of Ministers' Resolution 5 for the year 2014 on Public Procurement Regulation grants the Minister of Health with the power to purchase medicines for any cost through MOH procurement committees. The same Resolution provides that the Deputy Minister of Health shall preside over these committees, which will include membership of the Head of the Supplies Unit, Director of the Warehouses Unit and two representatives of the Council of Ministers, the Ministry of Finance and Planning, Ministry of National Economy, Palestinian Standards Institute, and the State Administrative Audit and Control Bureau.

²⁸ UNDP, ACC, MOH, 2018, Management of Corruption Risks in the Health Sector

²⁹ IBID

However, the eighteenth government annulled the exception relating to purchase of medicines without ceilings. It established special committees within the Council of Ministers to assess referral, approval and award of bids. The objective was to tighten control and avoid abuse by local pharmaceutical companies and suppliers. As a result of this new measure, delivery of pharmaceutical products to MOH warehouses is sometimes delayed.

Generally speaking, the tendering processes and award of bids are highly transparent and subject to internal and external audit:

- MOH internal control unit ensures compliance of different MOH departments and divisions with applicable laws and regulations. It should however be noted that this unit needs capacity building to handle the huge number of files that need financial and medical auditing.
- SAACB
- Anti-Corruption Commission
- Higher Procurement Council
- MOF (through ten staff members deployed in MOH procurement committees, who audit procurement-related financial transactions).

Bureaucracy represents a burden in the process in addition to the arrears due to pharmaceutical products and medical consumables suppliers. Furthermore, gaps in purchase implementation mechanism hinder continuing availability of supplies in MOH warehouses and generate a potential for violations.

1. Tender allocations from MOF require a long time, up to a month in some cases;
2. In the request for quotations and tenders, an evaluation committee is established to examine different offers, but the law does not provide for a time framework. As a result of this legal lacuna, referrals and award of bids are delayed in many cases.
3. The committee created by the Council of Ministers after annulment of the exception for purchase of pharmaceuticals is slow. In the previous arrangement, a bid would be awarded to a certain company. The other companies would be able to object to this decision within five workdays prior to final award and approval by the Minister. With the new arrangements, approval of the Council of Ministers is required, which lead to longer bureaucracy and consequently delays.
4. The special regulation governing MOH purchase committee allows for discarding the recommendations of the tender's technical evaluation committee without justifications. This creates a potential for favoritism and personal gains for any of the committee's members. The regulation must be changed to compel the purchase committee to submit a reasoned rejection of the evaluation committee's recommendations.

3 - 2 - 1 integrity and transparency in tendering during the recent pandemic

Article 28 of the Decree Law on Public Procurement 2014 states that, Subject to the controls set forth by the Regulation, the purchasing party, Public Supplies Department, or Central Tenders Department is entitled to follow the direct purchase method in any of the following cases: (...)

D. In cases of utmost necessity and natural disasters.

Transparency International provided for a number of criteria to regulation public procurement and spending during emergencies to confront COVID-19. The criteria were disseminated by the Palestinian ACC to MOH and MOF; they include:

1. Establish or dedicate a government website to disseminate information on public procurement and tenders, with information on the needed commodities and services as well as the contracting mechanisms. The website should also post the terms of reference and prices submitted.
2. Publish a summary of purchase contracts signed with different companies, specifying the financial sums and quantity of goods to be delivered or services to be performed. This chapter should also specify of the cost of the purchase will be paid from the Public Budget or the Contingency Budget or from any other allocations announced by the Head of State or Government or through donation funds.
3. Disseminate complete data on companies and individuals contracted and the reasons for exceptional direct contracting. The names of companies' owners, beneficiaries and shareholders must also be published to avoid any conflict of interest and comply with the principles of good governance.
4. Specify the control and monitoring mechanism applied in conformity with the terms of tender and quality control measures.
5. Identify the government agency responsible for overseeing performance and quality of services and for publishing periodic reports, as per the principles of transparency and good governance.
6. Live broadcast bids opening online, or under the current circumstances at least in presence of all tender bidders and other contractors working in the same sector.
7. Provide for a mechanism to file complaints and appeals against any malfunction in any of the procedures.

The key question: Have procurements of pharmaceutical and other medical supplies during the emergency situation (especially the direct purchase orders) complied with the controls specified in the Public Procurement Law? Or, does the Emergency Law allow MOF and MOH to overcome these controls to serve public interest? Have purchases during the pandemic been guided by the criteria of public procurement issued by Transparency International?

It may be too early to fully assess the level of integrity, transparency and accountability in the entire tendering and purchases of medical supplies and consumables during the emergency situation because of insufficient data and experience. However, a number of observations may be presented following interviews with officials at ACC, SAACB, MOH Supplies Unit and the Public Procurement Council, as follows³⁰:

1. Procurements follow the legal controls via a direct purchase committee established by the Council of Minister and chaired by the Deputy Minister of Health, with membership of representatives of the Prime Minister Office and SAACB.
2. Direct purchase and tenders during the emergency aim to meet expected needs during the pandemic.
3. ACC has not observed any breaches in the purchase processes during the emergency.
4. SAACB integrity requirements were fully observed in terms of compliance and transparency with reference – when possible – to Transparency International criteria.

The challenges included:

1. MOH has not complied with the invitation to bid practice during the emergency and has rather opted to direct calls to companies for the sake of time and faster supply.
2. Certain contingency supplies fell behind actual needs during the pandemic because of insufficient cash through Waqfat Ezz Fudn, local or foreign grants. This situation may also have resulted from rising global demand on the same supplies due to the pandemic in addition to increased prices with increased demand.
3. MOH technical committees faced problems relating to matching contingency purchase requirements with the standards needed to confront the pandemic. An example to this relates to masks, breathing devices (respirators) and disinfectants.

³⁰ Phone interviews on 1 November 2020 with Ms. Rasha Amareneh, Advisor to the President of the Anticorruption Commission), Mr. Jaffal Khalil Jaffal, Director General of the State Administrative Audit and Control Bureau, Engineer Faeq Al-Diek, President of the Higher Council of Public Purchase Policies.

3 - 3 COVID Lab testing

The official COVID-19 e-platform reported (326469) COVID tests by the Palestinian MOH till 10 September 2020. The same platform explained that there were 7 approved labs for the said test distributed in six governorates in the West Bank and one lab in the Gaza Strip.

However, in spite of these efforts, the Independent Human Rights Commission document a number of violations³¹:

- **Locations of tests:** Most locations were overcrowded as entry of citizens was not organized with previous appointments. This was particularly the case in Hebron, Ramallah and Albireh and Nablus. Such crowdedness violates international and even national standards of social distancing and improved ventilation for prevention.
- **Announcement of test results:** MOH created an e-application that enable citizens to find out their test results through their ID card number and region only. However, IHRC recorded cases where citizens were not informed of their test results prior to the creation of the app in August 2020. Information about these citizens was circulated through social media with lists of names of tested citizens and the results of their tests. Such a practice represents a violation of the privacy of citizens, which is guaranteed by Article (17) of the International Covenant on Civil and Political Rights³². Furthermore, citizens who arrived through Al-Karama border bridge were informed that if they do not receive any call from the Ministry, this means that they tested negative for Corona.
- **Cost of tests:** the prices of COVID-19 test reports for voluntary testing were very high. IHRC reported that voluntary testing included citizens within the surrounding of infected persons or suspected of contact with infected persons. However, these citizens were not tested properly but had a simple complete blood count that would cost 10% of the price demanded.
- **Recovery test:** IHRC also reported that no further lab test was conducted upon end of quarantine of infected or contacting persons who returned from abroad. MOH relied only on elapse of the prescribed quarantine period and non-exhibition of symptoms for the infected persons.

³¹ D'is Maan. 2020. Draft report on: Preparedness of the State of Palestine to Enforce the Right to Health during Corona Pandemic: a Human Rights Perspective. Independent Human Rights Commission. Ramallah, Palestine.

³² For more information, refer to: General Comment No 16 for the year 1988 on Article 17 on the Right to Respect of Private Life, issued by the United Nations Committee on Civil and Political Rights, published on Minnesota University Library website: <http://hrlibrary.umn.edu/arabic/hrc.html>

3 - 4 Reporting:

MOH showed a certain level of accountability and transparency by producing periodic performance reports:

- Publication of monthly reports on MOH performance as of August 2020 on MOH website, in addition to continuing efforts to publish the annual health report as per MOH commitments since 2014.
- The Minister of Health joined a number of press conferences and TV interviews to answer questions from the media.

3 - 5 Dissemination of COVID information:

Since the outbreak of the pandemic, MOH and the 18th government closely monitored COVID-19 related data via:

- Establishment of MOH website based COVID-19 e-observatory to monitor the spread of the pandemic in Palestinian areas and efforts made to mitigate contagion.
- Daily updates on the situation through the website, medias, social media in addition to a daily report on the pandemic
- Publication of data on cash and in-kind donations and grants received by MOH.
- Daily press conference during the first months with MOH media spokesperson to provide citizens with updates on the situation.

3 - 6 Contingency appointments:

Appointment of administrative and medical staff at MOH must observe a number of administrative and oversight procedures including: advertisement of vacancies with the required qualifications, admission tests and interviews, and oversight by SAACB and the General Personnel Council.

The Minister of Health and Prime Minister were informed of tests and interviews with 280 medical staff during the pandemic to fill in urgent MOH needs. One hundred medical staff have been recruited in July 2020 and the process started to employ another 400 staff members in October 2020³³. However, due to the declaration of the state of emergency, MOH could not fully comply with appointment requirements and opted for alternative mechanisms that may need further evaluation, including:

³³ <https://www.maannews.net/news/2020316.html>

1. The appointments were not controlled by SAACB:
2. Certain appointment requirements were not observed, including:
 - Reduced advertisement period through the media;
 - The advertisement for various position did not specify the exact position.
 - Recourse to previous waiting lists for some contract-based (temporary) administrative and nursing positions without any advertisements or interviews. These appointments were made with extra-budgetary funding from the World Bank.

Recommendations

The recommendations are summarized in the following matrix:

Area	Target	Proposed interventions
Government spending	Current expenditure	<ul style="list-style-type: none"> Promote the efficiency of medical insurance programs, which currently cover only 10% of government health care programs funding. The solution would be to adopt a mandatory all-in health insurance to ensure sustainability of funding and improvement of health services. Reduce fiscal waste and leakage in medical transfers, mainly outside Palestine and more specifically to the occupation state. Policies for repatriation of health services in government, civil and private hospitals need to be drafted accounting for their competitive edge
	Capital expenditure	<ul style="list-style-type: none"> Adopt a long-term strategic plan (in cooperation with the civil and private sectors) to increase the number of beds in Palestinian hospitals from 1.38 to 2.5 beds per 1000 population during the coming five years. Such a practice may promote the ability to confront health pandemics and effects of natural disasters, accidents or wars. The government has proven quick response to contingent capital needs in the health sector, and has shown competence in mobilizing diversified funds from donors. It can build on this practice after the pandemic to address the structural flaws of the Palestinian health expenditure system.
	Medical staff	<ul style="list-style-type: none"> Increase nursing staff to reach the global average (4 per 1000 population at minimum) Increase scholarships and contracts with doctors with rare medical specializations for diseases that require medical referral abroad, such as cancer and marrow transplants. The longer-term objective will be to provide the service locally.
	Absorption capacity	<ul style="list-style-type: none"> Most medical referrals are made for specialized tertiary health services (cancer, marrow transplants and urology). The government cannot recruit qualified medical resources, compared with the private sector. Therefore, the government needs to remove barriers to private and civil sectors' investment in tertiary services. Proposed policies include giving sufficient guarantees (in the government's long-term plan) to use the services locally to ensure investment feasibility. In the meantime, the government sector may expand primary and secondary health services especially when health data show that it is efficient and effective in this sector.

Area	Target	Proposed interventions
Finance and healthy adaptation to the pandemic	Access to health services	<ul style="list-style-type: none"> • Adopt a permanent emergency plan and communication channels to inform the public on the distribution of services during the emergency situation. • Continue efforts to remedy the weaknesses of the primary health care systems in normal and contingent situations.
	Financial resources	<ul style="list-style-type: none"> • Control financial resources for medical services and insurance fees following sharp decline during the pandemic. It is necessary to restructure fees and insurance instalments in accordance to income levels. Medical insurance deductions on government servants' pay must be abolished, since the maximum (NIS 75) is deducted while the legal deduction of 5% must be applied regardless of the wage paid. The same should apply to health services' fees.
	Arrears for medical supplies and referrals	<ul style="list-style-type: none"> • Reschedule repayment of arrears to civil and private hospitals, with compliance. • Control medical referrals and introduce further reforms, mainly in revision and use of the e-referral system; solve the problem of shortages of pharmaceuticals supply to the Gaza Strip; address weaknesses in the medical referral system. • Apply a multi-layered classification of medical cases for referral purposes instead of the current two-category system. The current system may be phased out through the introduction first of a third category up to five categories later on. • Increase the number of beds in government hospitals to avoid referrals due to insufficient hospital beds. • Secure further funding from donors and international health organizations and for the allocations for pharmaceuticals and medical supplies on the public budget, in order to reschedule repayment of arrears to supplies. This will lead to a better and more cost-effective procurement process.

Area	Target	Proposed interventions
Transparency and oversight	Purchase of services (referrals)	<ul style="list-style-type: none"> Tighten security procedures in hospitals and guard of medical staff against any security threats when making decisions on referral to services outside government hospitals. Tighten internal control on referrals issued by government hospitals with rotation of members of control committees to avoid corruption and personal gains. Regulate exceptions allowable to the Minister of Health for referral outside government hospital through dissemination of reasoned information to the public.
	Award of tenders and bids	<ul style="list-style-type: none"> Address the delay for granting of financial allocations for tenders by MOF; the delay may exceed a full month in some tenders. Specify a timeframe to review bids submitted to the evaluation committee for request for quotations and tenders. Revisit the abolition of the exception granted to MOH procurement committees to purchase pharmaceuticals without specific ceilings; assess the performance of the committee designated by the Council of Ministers, the reason for which the exception was annulled. Previous procedures allowed for award to the bid to one of the bidders while allowing a delay of 5 days for challenges and appeals by the other bidders prior to final award and signature of the Minister. The current procedures require approval by the Council of Ministers, which lead to heavier bureaucracy and longer delays. The special purchase regulations applicable at MOH allow the procurement committee to overturn the recommendation of the technical evaluation committee without justification. Such a practice may entail favoritism and personal gains for any of the members of the committee. The regulations need to be amended to prescribe for reasoned rejection of recommendations.
	Contingency appointments	<ul style="list-style-type: none"> Revisit the emergency appointments made by MOH during the pandemic to ensure they comply with legal controls applicable to contingent recruitment.
Participatory approach	Civil and private sectors	<ul style="list-style-type: none"> Be aware of the importance of promoting the preparedness of the civil and private sectors by dedicating fully equipped and isolated floors or buildings to respond to any further demands following the spread of the contagion. ICU beds in the West Bank and Gaza in private and civil society hospitals are barely 212 beds with 100% occupancy in government hospitals. Assist civil and private centers and hospitals with disinfectants, equipment and test kits to alleviate their additional financial burden. Promote the role of the private and civil sectors in national pandemics and COVID committees to consolidate national efforts to confront this situation.

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Interviews:

- Interview with Attorney Rasha Amarneh, Advisor to the President of the Anti Corruption Commission, on 1 November 2020
- Interview with Mr. Jaffal Khalil Jaffal, Director General of the State Audit and Administrative Control Bureau.
- Interview with Engineer Faek Al-Deek, President of the Higher Council of Public Procurement Policies

AMAN
Transparency Palestine



The Coalition for Integrity and Accountability (AMAN), the Palestinian institution accredited by Transparency International since 2006,

It was founded in the year 2000 from a group of civil institutions active in the field of democracy, good governance and human rights,

In pursuit of his vision of a «Palestinian society free of corruption.»

The coalition is currently seeking to create and lead a community movement across sectors fighting corruption, and to contribute to the production, transfer and localization of knowledge of corruption and its struggle at the national, regional and international levels. AMAN Coalition is keen to perform its watchdog oversight role on the National System of Integrity by focusing on community participation and activating the role of civil society organizations and the media in monitoring and accountability, creating a fortified environment and contributing to uncovering corruption crimes and limiting its spread.

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