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Towards a Comprehensive Health Insurance Scheme

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Executive Summary

This report stresses the significance of achieving universal health coverage, which has a favourable bearing on equity and equality in the provision of public health service to all people. A health insurance scheme needs to be developed and be capable of providing universal health coverage, including high-quality and affordable health services. Such a health insurance scheme should not impoverish low income households. The report diagnoses the current context of the applicable government health insurance scheme, highlighting relevant caseload and impact on the right to health. To be discussed with stakeholders, the report analyses the health insurance scheme, with a particular focus on subscribers, coverage, required budget allocations, and challenges.

The report provides a review of the Health Insurance Fund and identifies the root causes of its failure to achieve intended goals. The cost of the Health Insurance Fund has turned into an onerous financial burden on the Ministry of Health (MoH) budget, obstructing the implementation of development policies within the public health sector. Most partial solutions devised to develop this sector have failed. Earlier, an attempt was made to introduce a new health insurance scheme. However, this attempt failed due to disagreement between relevant stakeholders, disrupting the latest reform effort and resulting in further deterioration of the Health Insurance Fund. Consequently, efforts now need to be made once again to develop a clear vision of providing universal health coverage. A national and social health insurance scheme needs to be established and be capable of ensuring that all citizens have a readily available, equitable and equal access to the public health services they need. The report is underpinned by a review of an extensive body of relevant literature, including reports, research papers, studies, laws and decisions of local, regional and international institutions engaged in health systems, good quality health services, and universal health coverage.

The review shows that the MoH, and broader Palestinian government, are committed to work towards providing universal health coverage to all citizens and promoting good quality health services delivered by the MoH facilities and partner health providers, including the private sector and civil society actors.

Commitments have been articulated by relevant laws, regulations and strategic plans. The latest and most comprehensive of these is the National Health Strategy 2017-22, which reflects health goals of the National Policy Agenda (NPA) 2017-22. As a national obligation, the Palestinian government developed the NPA in response to the United Nations call for all Member States and governments to adopt the 2030 Agenda for Sustainable Development and create the conditions and mechanisms conducive to the achievement of this Agenda.

A review demonstrates that the 2018 Public Budget Law and 2018 MoH budget allocation do not reflect the aforesaid commitments. Both do not provide the groundwork or infrastructure needed to ensure universal health coverage. Budget line items do not help promote and ensure sustainable provision of good quality primary, secondary and tertiary health care services.

All development budgets are mediocre. They do not reflect a forward-looking vision to ensure a tangible development of the level and quality of service provision. The MoH income generated from the current health insurance scheme, patient contributions to treatment and other fees represents just 10 percent of the overall MoH budget. Health sector service and infrastructure development, including buildings, equipment and human resources, need significant allocations, which reflect the vision set by the National Health Strategy 2017-22.

The report also shows that the current government health insurance scheme is compulsory to national and local government staff, but is optional to other citizens. Contrary to the principles of equity, equality and risk sharing, uninsured citizens can subscribed to health insurance when needed only. According to the risk sharing principle, everybody will be committed to pay for health service coverage of all patients, ensuring the provision of necessary funding to deliver good quality and sustainable health services.

Covering all citizens, compulsory health insurance is essential for creating an equitable health system, which provides health care services to all beneficiaries. It secures a universal and affordable health coverage for the entire population without discrimination. Poorer households will not be disproportionately burdened with health expenses, resulting in their impoverishment.

A good health system is capable of providing comprehensive, affordable and good quality health services to all the population. Health services fulfil public needs, maintain equity and equality among the population, and ensure equitable and sustainable access to the same health services.

Achieving the desired goal of introducing a good health system requires a broad community participation in a nationwide dialogue, which involves all health institutions and actors concerned with providing comprehensive, equitable and high quality health services to people. A law for compulsory health insurance, with multiple funds, needs to be developed to govern the working relationship between all government, community, international and private health service providers.

Preface

Development of human society and progress of states are measured by the use of specific, quantifiable and comparable development indicators. In this context, the UN has published a Human Development Report on an annual basis.[1] In this report, the ranking of countries is informed by a set of indicators. These do not only reflect the development achieved by a certain country, but also show how equitable, equal and advanced the distribution of rights and services is. In her foreword to the Human Development Report 2016, Helen Clark, Administrator of the United Nations Development Programme (UNDP), stated: "Human development has to be sustained and sustainable and has to enrich every human life so that we have a world where all people can enjoy peace and prosperity."

Health and the standard of health services is a key indicator of development in any human society. Since its inception in 1948, the World Health Organisation (WHO) has aimed at establishing the principle that all people should be enabled to avail themselves of their right to the highest attainable standard of health. As a culmination of its efforts, the WHO announced, on its 70th anniversary in April 2018, "the impetus behind the current organisation-wide drive to support countries in moving towards Universal Health Coverage (UHC). The Organisation has also maintained a high-profile focus on UHC via a series of events through 2018, starting on World Health Day on 7 April with global and local conversations about ways to achieve health for all."[2]

According to Article 25(1) of the Universal Declaration of Human Rights (UDHR),[3] "[e]veryone 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, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[4] provides: "(1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

In the Palestinian context, Article 22 of the Amended Basic Law[5] prescribes that "[s]ocial, health, disability and retirement insurance shall be regulated by law." In accordance with Article 29 of the Law, "[m]aternal and childhood welfare are national duties. Children shall have the right to […] comprehensive protection and welfare."

1 UNDP, Human Development Report 2016.
2 WHO, Campaign essentials for World Health Day 2018, http://www.who.int/campaigns/world-health-day/2018/campaign-essentials/en/.
3 Universal Declaration of Human Rights, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).
4 International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976.
5 Palestinian Official Gazette, Extraordinary Issue, March 2003.

Unlike clear and definitive provisions on the right to education, the Basic Law does not explicitly provide that health is a fundamental right of citizens.[6] However, the Basic Law entitles the legislature to regulate social and health insurance services by law. Hence, the scope of health services, provision mechanisms, and free health service delivery are delineated in line with the available means of the State and in accordance with obligations under relevant international conventions.

It is noted that the Palestinian National Authority (PNA) has adopted and expressed its commitment to international conventions, including the UDHR, International Covenant on Civil and Political Rights, and WHO Constitution. Accordingly, health is deemed to be a right in Palestine. This right should be manifestly articulated under all relevant Palestinian laws and regulations, particularly the Public Health Law and Health Insurance Law. The right to health should also be translated into available, good quality and accessible health services.

Article 2(5) of the Public Health Law[7] provides that the MoH is committed to providing health insurance to citizens within the available means. Article 4 of the Law also prescribes that the Ministry is bound to prioritise mother and child health care, stressing that it "shall be regarded as an integral part of the development strategy of the Palestinian National Authority."

In line with National Priority 9: Quality Health Care for All, the NPA 2017-22 ensures better health care services through a set of interventions, first and foremost by reforming the public health insurance scheme. This national priority is consistent with the State of Palestine's obligations under the ICESCR. Article 12 of the ICESCR provides that "[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The States Parties will take steps to achieve the full realisation of this right. They will create conditions that would assure to all medical service and medical attention in the event of sickness."

The National Health Strategy 2017-22 includes a set of principles, which reflect the national commitment to provide universal health coverage. According to Strategic Objective 1, the MoH will "[e]nsure the provision of comprehensive health care services for all citizens and work towards nationalising health services in Palestine."

Against this background, every citizen has the right to health. To ensure enjoyment of this right, the State should regulate by law the provision of needed health services. The law should ensure equitable, equal and accessible good quality health services for all. It will guard against impoverishing or preventing households from accessing needed health care services.

6 The Basic Law was promulgated in Ramallah on 18 March 2003.
7 Public Health Law No. 20 of 2004, promulgated in Gaza city on 27 December 2004.

Demographic, Economic and Social Background

According to the 2017 Preliminary Results of the Population, Housing and Establishments Census of the Palestinian Central Bureau of Statistics (PCBS), the estimated population of the State of Palestine was 4,780,978, including 2,881,687 in the West Bank and 1,899,291 in the Gaza Strip.[8] According to age groups, 47 percent of the population were under the age of 17; 24.3 percent aged 18 to 29; 23.5 percent aged 30 to 60; and 5.2 over 60 years.

Distribution shows that the population in Palestine is young. The productive group of the Palestinian society comprises 35 percent of the entire population. It is also noted that there are approximately 250,000 university students, who have not yet entered the labour market and participated in the production process.

The PCBS Census shows that the average size of households nationally is 5.1 persons (4.8 in the West Bank and 5.6 in the Gaza Strip).

In Palestine, unemployment stands at 27.2 percent (13.2 percent in the West Bank and 48.2 in the Gaza Strip). Compared 24.2 percent among males, unemployment is as high as 40.1 percent among females. (This data does not include East Jerusalem, which the Israeli occupying authorities forcibly annexed to Israel following occupation of the West Bank in 1967).

Health Determinants

Social and economic conditions that affect health, but can nevertheless be influenced and altered, include poverty, social exclusion, shortage of adequate housing, and poor health systems. These are key determinants, which impact the ability of individuals to enjoy their right to health and are leading causes of ill health and premature death.

In October 2011, the World Conference on Social Determinants of Health was held in Rio de Janeiro, Brazil.[9] The conference was organised in response to the Sixty-Second World Health Assembly Resolution A62/14. It furnished a global opportunity to discuss how to reduce health inequities and share national experiences and technical knowledge on addressing social determinants of health.

More than 1,000 participants attended the conference, including delegates from 125 Member States (with delegations from health, social development or other sectors), representatives from other organisations in the UN system and civil society, and technical experts. At the end of the meeting, the Rio Political Declaration on Social Determinants of Health was adopted. The Declaration stresses, inter alia, the following key points:

- Expressing the determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach. Health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.

8 PCBS, Preliminary Results of the Population, Housing and Establishments Census, 2017, February 2018.
9 http://www.who.int/social_determinants/en/

- Underscoring the principles and provisions set out in the World Health Organisation Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognised that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". The conference participants also recognised that governments have a responsibility for the health of their peoples. They reaffirmed that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.
- Reaffirming that good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies.

Health System

As a concept, a health system is the combination of institutions, activities, human resources and available technical resources of any people, which are employed to provide health services that meet the needs of these people.

Health systems differ from one place and country to another around the world. The structure and composition of a health system also vary according to historical, political, environmental and social factors. All nations seek to reform, improve and develop their health systems with a view to realising the right of access to good quality health services for all, both equitably and equally. Nations also strive for coping with social determinants of health.

The WHO resolves that the goal of health systems is to provide good quality health, which is responsive to the population expectations and in line with a fair-share financing system. A health system is assessed in light of the quality standards it achieves, including effective and efficient provision, easy access, equitable distribution, and sustainability of health services.

A good health system is capable to provide comprehensive, affordable and good quality health services to the entire population. On a sustainable basis, it meets people's needs and ensures equitable and equal access for all to the same health services.

Palestinian Health System

The primary responsibility for the overall performance of the national health system rests with the government. Favourably, however, health partners from nongovernmental sectors enhance the efficiency and capacity of the government health sector to further develop and promote health service provision.

The health system is a universal expression, which describes many services, agencies, and human resources, who provide all types of health services in society. It involves physicians, primary health care centres, hospitals, public health services, community health, and the environment.

The Palestinian health system consists of a number of health service providers. In the first place, the MoH is the main provider of various forms and levels of health services. Through two independent departments operating in the West Bank and Gaza Strip, the United Nations Relief and Works Agency (UNRWA) provides health services to Palestinian refugees in refugee camps in both areas. Several nongovernmental organisations and non-profit associations provide primary, secondary and tertiary health services. Through the Military Medical Services, these are also involved in delivering health services to Palestinian military personnel. The Palestine Red Crescent Society (PRCS), a nongovernmental organisation that reports administratively to the Palestine Liberation Organisation, provides prehospital trauma care and manages a number of health care and rehabilitation centres. The for-profit private sector plays an important role in providing health services at different levels. The private health sector has been rapidly growing over the past few years.

The Current Context of Health Services in Palestine

The Israeli occupying authorities[10] used to manage the Palestinian territory in the West Bank and Gaza Strip through Regional District Coordination Offices of the Israeli Civil Administration. These were part of the so-called Israeli Defence Forces and security apparatus.

Some sectors, including health and education, were not given the proper attention and had low budget allocations. In the education sector, the curriculum was Jordanian and Egyptian. Before 1967, in the West Bank, schools had already been built by the Jordanian government. The appointment of teachers was subject to security considerations. Any teachers with national sentiments were dismissed from service immediately. Late during the Intifada, education witnessed serious setbacks and was effectively discredited by Arab and international universities. Due to strikes and closures, university students had to spend twice the time required for graduation.

The health sector was in no better position than education. Very few hospitals and health care centres were in operation. Support was hardly adequate. Then, there were no programmes with a particular focus on maternal and child health care, vaccination, and nutrition.

10 Salameh, Abdul Ghani, "Before and After the Authority", Al-Ayyam, 23 January 2017.

After it was established, the PNA took over the management of the Palestinian health system in the West Bank and Gaza Strip.[11] The PNA received from the Israeli Civil Administration a number of health care centres that were so poorly equipped to provide comprehensive, good quality health services. These provided rudimentary services, including vaccination for children against communicable diseases, some maternal and child health care, and other substandard diagnostic and therapeutic services. It is worth noting that all health care centres handed over the PNA had already been in place when Israel occupied the West Bank and Gaza Strip in June 1967.

This was also the case of hospitals. The number of governmental hospitals that had been in operation before 1967 was larger than those handed over to the PNA. Compared to 14 before 1967, only nine governmental hospitals were functional. In the Gaza Strip, the number of governmental hospitals dropped from six to five.[12] When they were transferred to PNA, these hospitals were in an exceptionally bad condition in terms of buildings, equipment, and cadres of medical and nursing professionals. The Israeli occupying authorities implemented a policy of transferring patients, who needed specialised interventions, to Israeli hospitals.

Hospital beds totalled 1,925, including 1.8 per 1,000 inhabitants. In 1990, the number of hospital beds dropped to 1,872 – 1.2 beds per 1,000 inhabitants.

On 17 May 1994, the Palestinian MoH took over the powers and management of the health sector, first in the Gaza Strip and Jericho, and in the rest of the West Bank governorates by the end of that year. The Ministry undertook an assessment study of health facilities in place at the time, covering primary and secondary health services. Technical support was provided to this assessment by UN agencies, including the UNDP and WHO, as well as by the donor community, including Italy.

The first Palestinian health plan was developed in 1994, before the MoH took up its responsibility. With support from various international bodies, the health planning process was supervised by the Palestinian Health Council, which included PRCS staff and health practitioners. Later, the National Health Strategy 1999-2003 was developed by the MoH with wide participation from civil society organisations and with technical and financial support from the World Bank and WHO.[13]

The implementation of these plans resulted in a major development of quality health services, enhanced capacity of health workers, and an improved network of government services. Meantime, health services delivered by civil society organisations, particularly in primary health care sector, decreased in view of the declining sources of finance. Increased funding was channelled to the official health establishment, namely, the MoH.

Following the outbreak of the second Intifada in 2000, the Israeli army made a military incursion into the PNA-controlled territory under the Oslo Agreements. The Israeli army reoccupied all areas of the West Bank. The incursion was compounded by severe measures, including military checkpoints and construction of the Separation Wall. Combined, these conditions caused an outright decline in Palestinian citizens' ability to access health services. The Separation Wall isolated many Palestinian villages and communities, which have

11 Interview with Munther al-Sharif, MoH Undersecretary, 1996-2004.
12 Al-Haq, An Ailing System: Military Government Health Insurance in the Occupied Palestinian Territories, http://www.alhaq.org/publications/publications-index/item/an-ailing-system
13 Abu Mughli, Fathi, Health System Development Project 1999-2004.

no longer been capable of accessing health services. These events, and consequent security and social instability, obstructed the implementation of a significant number of the projects and activities envisioned by the National Health Strategy 1999-2003.

In 2006, after Hamas won the legislative elections, comprehensive economic sanctions were imposed on the PNA. These greatly impacted the PNA capability of providing health services. Health facilities, including hospitals and clinics, faced significant resource shortfalls, including in medicines, medical supplies, and equipment. Maternal and child health care were particularly impacted. The most notable manifestations of the impact of sanctions featured a sharp rise in malnutrition and anaemia.

After Hamas took control of the Gaza Strip in June 2007, a deep internal Palestinian political divide has had a significant impact on the lives of Palestinians and Palestinian relations with countries around the world. The blockade was further tightened on Gaza – now completely governed by Hamas. Although it no longer has control over the situation in Gaza, the PNA's role is limited to administering the payroll, paying other liabilities, including electricity, fuel and medicines, and approving patient transfers. The Gaza Strip has ended up relying entirely on relief aid and development projects have come to a complete halt. Unlike the Gaza Strip, the situation in the West Bank has been clearly improving. The government managed to develop sector and cross-cutting development plans, which were well received by the donor community. These significantly contributed to enhancing living conditions, plummeting unemployment, and improving health services. Economic performance continued to perform better until mid 2010.

Relative stability across the West Bank has encouraged the government to launch a development planning process, particularly in the health sector (National Health Strategies of 2008-10, 2011-13, and 2017-22 respectively). The government has also enacted laws, which would help to scale up services, particularly in the social development sector. To this avail, the Draft Compulsory Health Insurance Law was developed, but never saw the light of day for different considerations. Due to inaction of the Palestinian Legislative Council (PLC), the draft law was not considered to be an urgent law. Objections to the law[14] questioned how the government would deal with Palestinian refugees and UNRWA responsibilities for providing health services to registered refugees in the West Bank and Gaza Strip. In addition, the draft law did not clearly address the exemption of Gaza residents from health insurance fees and taxes.[15] The draft law dealt with the internal Palestinian political divide as a temporary issue, including all consequent rights and duties. Lastly, the draft law did not provide how fees owed by released prisoners would be covered. In this context, the Law on Prisoners and Released Prisoners provides that "[e]very released prisoner who served in the prisons of the occupation a term of not less of than five years, and every female prisoner who served a term of not less than three years, shall be exempted from the health insurance fees."[16]

14 Independent Commission for Human Rights (ICHR), A Legal Review of the Draft National Health Insurance Law, Ramallah, August 2009.

15 On 26 June 2007, the PNA President promulgated Decree No. 18 of 2007, providing for exempting the Gaza Strip inhabitants from applicable taxes and financial fees under national legislation.

16 Article 5 of the Law on Prisoners and Released Prisoners No. 19 of 2004.

Available Health Services [17]

- **Primary health care and public health**

In Palestine, primary health care services are provided to citizens by 739 primary health care centres, including 587 in the West Bank and 152 in the Gaza Strip. Primary health care centres mainly provide maternal and child health care as well as chronic disease management services. 466 primary health care centres belong to the Palestinian MoH, representing 63 percent of the total number of primary health care centres. The number of primary health care centres managed by NGOs is 189, or 25.6 percent of all primary health care facilitates. The UNRWA runs 64 primary health care centres. 20 military medical centres are also in operation.

The population rate per health centre is 6,159 persons. Primary health care centres vary in terms of area, type and volume of services delivered, depending on the number of inhabitants in the geographical area served by relevant centres. Some health care centres serve communities with less than 1,000 inhabitants. These are managed by a female health worker, who monitors births and deaths, administers vaccination campaigns in the area, and organises medical staff visits. Other health centres serve communities with less than 5,000 inhabitants. Considered as secondary health care centres, these are supervised by a physician who works on a part-time basis (3-5 days a week), as well as one or two staff nurse(s). While all provide maternal and child health care services, some centres include small medical laboratories. Serving communities with 5,000-12,000 inhabitants, tertiary health care centres are run by one or more general practitioner(s) as well as visiting medical specialists. These centres are equipped with laboratories and X-ray machines. Level-IV clinics, namely Health Directorates, provide maternal and child health care as well as chronic disease management services. These are properly equipped by cadres of medical and nursing professionals. Managed by the Director of the MoH Directorate in the respective governorate, these centres accommodate a number of medical specialists, including paediatricians, gynaecologists, obstetricians, orthopaedists, and psychiatrists. They also provide health education and supervise school and environmental health. In addition to managing all primary health care centres in their governorates, health directorates are in charge of all public health services, school health management, and oversight of the licensing and functions of nongovernmental health institutions across governorates.

Due to the high population density in the Gaza Strip, primary health care centres are considered as Level III and Level IV clinics and services.

- **Secondary and tertiary health care**

In 2016, there were 81 functional hospitals in Palestine. Of the total hospitals, 51 (or 63 percent) were in West Bank, including East Jerusalem, and 30 in the Gaza Strip. The total number of hospital beds in Palestine (including psychiatric and neurological hospitals as well as hospitals in East Jerusalem) was 6,146, with a rate of 784 people per bed (783 in the West Bank and 784 in the Gaza Strip).

Of all hospitals, 27 are owned and operated by the MoH. Bed capacity in these hospitals is 3,325, or 54.1

17 MoH, Palestinian Health Information Centre, Health Annual Report 2016, July 2017.

percent of the total number of beds in Palestine. There are 14 MoH hospitals in the West Bank, with a capacity of 1,661 beds. In the Gaza Strip, there are 13 MoH hospitals, with a capacity of 1,664 beds.

The number of nongovernmental hospitals, including community and private hospitals, is 54, with a total capacity of 2,821 beds. The private sector owns and manages 16 hospitals with a capacity of 536 beds. Nongovernmental organisations operate 34 hospitals, with a total capacity of 2,061 beds. UNRWA runs one hospital in the Qalqiliya governorate in West Bank, with a capacity of 62 beds. An-Najah University manages the An-Najah National University Hospital, with a capacity of 123 beds.

The Department for Quality of Government Services issued the 2017-18 Assessment Report of Governmental Hospitals and Primary Health Care Directorates in the West Bank.[18] According to this assessment, a key challenge that could impede the improvement of quality health services lies in a significant shortfall of medical and administrative staff. Some health directorates cannot provide direct monitoring because management premises are separate from clinics, where medical services are delivered (Tubas, Hebron, Northern Hebron, Southern Hebron, and Yatta). These directorates are also affected by poor hygiene standards. Emergency rooms of governmental hospitals are under enormous pressure due to high demand. Medical specialisations are inadequate across health directorates. It is also noted that marginalised communities, border areas and Area C do not receive proper health services. Additionally, solid waste disposal is inadequately managed. This is one of the most serious causes of environmental pollution and hazards on a national level. Some buildings that house health care centres and hospitals are old and cannot be expanded either horizontally or vertically.

Particular problems that affect some centres and hospitals require immediate interventions.

Human Resources in the Health Sector

According to the MoH Health Annual Report 2017, there were 29,479 health professionals registered by various health associations in Palestine. These included 22,201 health professionals in the West Bank (75.3 percent) and 7,278 in the Gaza Strip (24.7 percent) of the total cadres of medical and nursing professionals. These figures are inaccurate, of course. Rather, they reflect the number of health workers registered by professional health associations only. A large number of health professionals surely work outside Palestine, particularly in the Arabian Gulf countries. In the Gaza Strip, data released in a statistical report similar to that of the PNA MoH indicates that health workers in the Gaza-based health sector totalled 13,180, including 9,536 in the MoH facilities, 2,963 in nongovernmental organisations, and 681 in health services.

Health Expenditure

In February 2018, the PCBS and MoH published the Palestinian Health Accounts Report 2016, which reflects the status of spending on the health sector in Palestine.[19] Health expenditure totalled NIS 1,419.5 billion in 2016, marking a rise of 4.7 percent compared to NIS 1,321.3 billion in 2015. The report shows that central

18 Department for Quality of Government Services, 2017-18 Assessment Report of Governmental Hospitals and Primary Health Care Directorates in the West Bank.
19 PCBS and MoH, Palestinian Health Accounts 2016, February 2018.

government spending accounted for 38.2 percent of the total health expenditure.[20] Expenditure by financing agents shows that households managed and paid 45.5 percent of health spending. Also, the percentage contribution of non-profit institutions serving households as financing agents was 8 percent of the overall health expenditure. The rest of the world, including UNRWA, contributed 5.6 percent to health expenditure.

The PCBS and MoH report indicates that the percentage of health expenditure to the gross domestic product (GDP) in Palestine at current prices represented 10.7 percent in 2015 and 2016.

According to the MoH Health Annual Report 2016, according to type of revenue, MoH general revenue registered NIS 121,316,838. The general revenue collected from primary health care centres scored the highest percentage of revenues (46.2 percent), followed by general revenues from health insurance (27.6 percent). General revenues collected from government hospitals were 24.1 percent. Revenues accrued from administrative centres were the lowest (2.1 percent).

These figures show that MoH revenues were marginal in comparison to the volume of health expenditure. In 2016, MoH expenditure was as high as NIS 1,711,900.00. The Ministry's budgeted allocations in 2018 totalled NIS 1,765,483.478. Of this, 46 percent is earmarked for salaries, 48 percent for operating expenses, and 0.6 percent for capital expenses. This appropriation does not reflect in any way the ambitious goals set for implementation in 2018, nor does it articulate the aspirations expressed in the NPA 2017-22. According to National Priority 9: Quality Health Care for All, the NPA looks for better health care services and well-being.[21]

In 2010, the Palestinian government announced a shift from a line item budget to a programme (performance-based) budget structure. This transformation was in line with the development planning process across sectors, marking a paradigmatic shift and distinct development that is also responsive to Palestinian development planning needs. This strategic approach necessitates that adequate budgets be earmarked to implement ambitious health, preventive and therapeutic development projects. These include, first and foremost, chronic disease prevention programmes. Chronic diseases have been a concern worldwide, particularly in third world countries which have not yet been relieved of the burden of communicable diseases. This burden has been twice as much with the increased incidence of chronic diseases, which are in a way or another associated with modern lifestyle. These include diabetes, cardiovascular diseases, and cancer. The health system needs to make even greater efforts to develop the maternal and child health care programme and, consequently, reduce maternal and infant mortality rates. In short, over the past eight years, the government has not reflected this strategic approach in its programme budget structure.

In addition, patient transfers outside Palestine have been a major drain on the already low MoH budget. To fulfil the slogan of nationalising health services, needed budget allocations should be provided to improve health institutional infrastructure, develop continuing medical education programmes, and provide capacity building to health professionals or attract immigrating competent Palestinian health professionals. This requires more substantial budgets than those currently allocated. Adequate budget allocations need to be designated for the MoH. To this avail, at least 12-15 percent of the GDP should be appropriated to strengthen the capacity of Ministry to implement necessary health programmes, which are essentially linked to sustainable development.

20 Data presented by the Palestinian Health Accounts Report does not cover the part of the Jerusalem governorate annexed by Israel following the West Bank occupation in 1967.

21 National Policy Agenda 2017-22, December 2016.

Universal Health Coverage

Universal health coverage[22] has been defined as the desired outcome of health system performance, whereby all people who need health services (promotion, prevention, treatment, rehabilitation and palliation[23]) receive them, without undue financial hardship.

Universal health coverage encompasses two interrelated components: the full spectrum of good-quality essential health services according to need, and protection from financial hardship, including possible impoverishment, due to out-of-pocket payments for health services. Both components should benefit the entire population.

On 25 September 2015, the UN General Assembly adopted Resolution A/RES/70/1, Transforming our world: the 2030 Agenda for Sustainable Development.[24] According to this resolution, the General Assembly adopted the outcome document of the UN summit for the adoption of the post-2015 development agenda. The document comprises 17 Sustainable Development Goals (SDGs) and 169 targets. Paragraph 26 of the General Assembly Resolution provides: "To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing anti-microbial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development."

The WHO has adopted the UN document, Transforming our world: the 2030 Agenda for Sustainable Development. In May 2016, the Sixty-ninth World Health Assembly also adopted resolution WHA69.11, Health in the 2030 Agenda for Sustainable Development.[25] In January 2017, the Executive Board of the World Health Assembly, at its 140th session, took note of a report on progress in the implementation of the 2030 Agenda, in which the Secretariat proposed six main lines of action, presented as instruments of change, in order to help Member States achieve the SDGs. Those lines of action were endorsed by Member States at that session.

According to the WHO Resolution A69/A/CONF./10 Rev.1, the WHO urges Member States: (1) to scale up comprehensive action at the national, regional and global levels, to achieve the goals and targets of the 2030 Agenda for Sustainable Development relating to health by 2030; (2) to prioritise health system strengthening, including ensuring an adequately skilled and compensated health workforce, in order to achieve

22 WHO and World Bank, Monitoring Progress towards Universal Health Coverage at Country and Global Levels: Framework, Measures and Targets, May 2014.

23 Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

24 United Nations General Assembly Resolution A/RES/70/1, September 2015, http://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf

25 WHO, Strengthening essential public health functions in support of the achievement of universal health coverage, Document WHA69.1.

and sustain universal health coverage, defined as universal access to quality promotion, prevention, treatment, rehabilitation and palliation services, including access to safe, effective, quality and affordable essential medicines and vaccines for all, ensuring financial risk protection for all with a special emphasis on the poor, vulnerable, and marginalised segments of the population as fundamental to the achievement of the 2030 Agenda for Sustainable Development; (3) to emphasise the need for cooperative action at the national, regional, and global level across and within all government sectors to tackle social, environmental and economic determinants of health, to reduce health inequities, in particular through the empowerment of women and girls, and contribute to sustainable development, including "health in all policies" as appropriate; (4) to appropriately prioritise investments in health and strengthen the mobilisation and effective use of domestic and international resources for health in accordance with the broad multisectoral impact that health investments can have on economies and communities; and (5) to support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use the full provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all. The Declaration provides additional flexibility to Member States to receive compulsory licences. Since it is excluded from the procedures and restrictions set by manufacturing companies and laboratories in the pharmaceutical sector on patent protection, the Declaration allows to export medicines to Member States with insufficient or no manufacturing capacities in the pharmaceutical sector to face pandemics and epidemics. It also aims to provide affordable medicines to patients, commensurate with their income levels. These particularly include medicines for deadly epidemics, such as HIV/AIDS, tuberculosis, malaria, and hepatitis.

Additionally, the WHO urged Member States to strengthen the dialogue between medical, veterinary, and environmental communities with a special attention to emerging and re-emerging diseases, along with the emergence of antimicrobial resistant pathogens in a way that fosters strengthened and improved surveillance, research, preventive measures and training to ensure or to build capacities to address and manage these threats.

In compliance with the UN resolutions on the implementation of SDGs, the Palestinian government launched the NPA 2017-22 in December 2016. In his Foreword, the Palestinian Prime Minister states that the NPA "draws on past achievements and extensive consultations across Palestine to create a plan that clearly does put citizens first. [… The Agenda will] strengthen the resilience of all Palestinians, while providing concerted support to citizens in Area C, the Gaza Strip and East Jerusalem, the capital of the independent State of Palestine […]. The government's reform and development strategy, outlined in this Agenda, aims to provide all Palestinians with an improved standard of living, better services accessible to all and responsive, accountable, transparent public institutions that put citizens' interests and needs first each and every day." Quality Health Care for All is National Priority 9 in the NPA.[26] Accordingly, the government policy focuses on better health care services for all. To this effect, health care is a collaborative venture between the government, non-governmental organisations, private providers and UNRWA. Looking ahead, focus will increasingly be placed on governance, quality, access, modernisation and affordability. The public health insurance scheme will be reviewed. Preventive health care, chronic disease management and family and maternal health care will be strengthened.

26 National Priority 9: Quality Health Care for All, National Policy Agenda 2017-22, p. 42.

Meantime, the Palestinian Council of Ministers issued a decision, providing for establishing a national team to develop national sustainable development priorities. The team will integrate SDGs into, and provide needed mechanisms to implement, national plans.

On 21 November 2016, the PCBS launched activities of the national team for coordinating and leading national efforts to implement the UN 2030 Agenda for Sustainable Development. The process is part of the tasks of the National Team on the Statistical Monitoring System for Integration of SDG Indicators. The team will provide data in partnership with national institutions and in collaboration with the UNDP. In this context, the PCBS Chair confirmed that work has already been underway to implement the 2030 Agenda for Sustainable Development since January 2016. "This outcome document of the UN summit of September 2015 was adopted by world leaders," the PCBS Chair stated.

Health Insurance

In any country, the provision of public health insurance is a key component of social protection systems. Its philosophy settles on securing necessary funds in line with the principle of risk sharing. This principles prescribes that the risk of illness posed to the community or a particular group in that community is shared equally between individuals. Needed funds are collected to address this shared risk on an equal footing. These are then distributed to individuals on the basis of their treatment needs, alleviating burdens and costs associated with the treatment of pathological cases covered by the health insurance scheme. It ensures that all people in need can access health care in consideration of a small, but regular, amount paid by all health insurance subscribers.

The Goals of Health Insurance

In general, health insurance aims to provide health care to individuals and groups, cover costs associated with health care provided to individual and groups, and distribute health care costs among individuals so that everybody pays an equal share. Accordingly, healthy persons cover the cost of patient treatment. Individuals will be protected from short health care as a result of poverty or unaffordable treatment costs, so they can receive medical attention and avoid deteriorating health conditions. Health insurance financial resources are managed in a manner that ensures continuity for future generations. These resources can be invested in projects that enhance national development planning processes or health systems. Health insurance seeks to improve medical service provision by maintaining stable and regular financial resources. It also encourages further diversification and competition in the delivery of health services.

The Elements of Health Insurance

Health insurance consists of four key components:

1. The insurer (insurance institution, fund or company) can be a government body, private sector firm, civil society organisation, or international actor (e.g. UNRWA).
2. The beneficiary (an individual or individual and his/her family).

3. The insurance contract makes clear the nature of insurance contractual relationship between the insurer and beneficiary. It sets the insurance fees, coverage, diseases covered or excluded by coverage, percentage of covered or excluded diseases, and beneficiary's contribution to the cost of service (medical examinations, medicines, hospitalisation, etc.).

4. The medical service provider can be a government, community, private or international institution, or a combination of all these. In other words, insurance can cover treatment at government health care centres only, decided according to the patient's own choice and need, or limited to services provided by the insurer (e.g. UNRWA services).

Health Insurance Scheme Financing

As mentioned above, health insurance is a means to cover health care costs. It requires that governments that wish to provide health services ensure that citizens are not impoverished. Cost will be affordable, allowing patients to access needed health care services. The health insurance scheme will be financed by tax leverage or a risk sharing system. This means that funds earmarked for health care will be prepaid and managed in a manner that ensure all members of the population afford health care costs in case of illness. This way, individuals will not afford all costs alone. In this system, healthy individuals, who only need limited health care, finance the patients who rely more on available health resources.

Two systems are used to provide needed funds and cover public health care service costs.

Firstly, taxes are levied to finance health care service provision. Ensuring universal health coverage, this system allows all citizens to benefit from health services.

Secondly, social health insurance depends on collecting health care contributions from all employees, including in the public and private sectors. Funds are collected in a fund(s). In this financing system, universal health coverage can only achieved when the entire population pay their due compulsory contributions on the basis of health insurance contribution and an individual's capacity for payment. In this system, the government pays contributions for persons who are incapable of satisfying theirs.

The first system relies on the government, which covers health service costs by tax leverage. Health services are provided by government health facilities, including clinics and hospitals. Otherwise, the government purchases unavailable health services from private health establishments. According to the second system, citizens pay contributions to a government or private health insurance fund. Some funds are run by insurance companies.

Importantly, both systems should ensure that health coverage is universal, and ensures high quality, equitable and equal access to health services.

In the Palestinian context, the UNRWA provides a package of primary and secondary health care services to registered Palestinian refugees. The Agency receives needed funds through international grants and aid.

According to the 2018 Public Budget Law,[27] as an institution of the State of Palestine, the MoH is committed to the principle of joint action with all partners to improve the health of citizens and society and enhance performance of the Palestinian health sector. To this end, the Ministry ensures the provision of integrated, high quality health services to all citizens, promotes public health in society, leads and manages the health sector both effectively and efficiently, develops and monitors the implementation of policies, laws and regulations that govern functions of the health sector.

Reality of the Current Health Insurance Scheme

The current health insurance scheme has been in place since the PNA was established. It is an extension of the system imposed by the Israeli occupying authorities on the West Bank and Gaza Strip in 1974. Then, subscription to health insurance was optional and limited. Serving only a third of the Palestinian population, health insurance revenues covered 41 percent of Israel's health expenditure in the occupied Palestinian territory (West Bank and Gaza Strip). Low subscription was attributed to the high cost of health insurance under the Israeli occupation.

The Health Insurance Regulations No. 11 of 2004 and 11 of 20016, respectively, serve as remedial steps to identify the health service basket and essential medicines approved. Both regulations make clear many aspects of health insurance subscription, outline how health services can accessed at government health care facilities, and ensure that health care services may be purchased from the nongovernmental sector to the benefit of the government health insurance scheme.

Publicly available data and indicators show the health situation of Palestinian citizens continues to be impaired by many challenges. More efforts need to be made in order to realise announced goals of the health sector. The health insurance scheme is still incomprehensive. According to the MoH 2016 Health Annual Report, households covered by health insurance totalled 218,658, or just 26 percent, of 814,056 households. While 49.3 percent benefit from free health insurance, 50.7 percent of households were covered by the official health insurance service. Health insurance cash revenues totalled NIS 9.3 million. MoH exemptions of health insurance fees were as high as NIS 98 million.

In relation to fees and financial burdens, the MoH 2016 Health Annual Report indicates that the Ministry collected NIS 31,040,001 in revenues. Operating expenses were NIS 635,672,165, with a deficit of almost NIS 605 million. Combined with capital expenses of NIS 2,833,697, the MoH deficit and debt are doubled. This situation unveils significant challenges. Most importantly, rather than ensuring self-sufficiency, the MoH budget is overloaded with excessive operating expenses, effectively debilitating the Ministry's development budget, improved performance, and enhanced quality services. Patient transfers outside the government health sector need to be reduced as they consume a major portion of the MoH budget.

Should the MoH continue to operate the current health insurance scheme will exhaust the Ministry's budget. Health subscription fees do not cover health expenditure. According to the 2016 MoH Health Annual Report, revenues contribute only 29.8 percent to the Health Insurance Fund.

27 Public Budget Law of 2018.

The currently applicable health insurance scheme faces several challenges, impacting quality, easy access and equitable benefits from health service delivery. These include:

1. In the best case scenario, health insurance revenues cover up to 10 percent of health service costs. Because the system is not compulsory, voluntary subscription base is not as wide as possible.
2. Many groups are exempted from health insurance fees in accordance with decisions and laws. The latter do not outline a mechanism to compensate the health system or Health Insurance Fund for these exemptions.
3. The MoH itself manages the health insurance scheme, while at the same time it delivers basic health services to the insured. Therefore, any budget deficit or deficient policies of the MoH negatively affect the quality of, and access to, health services.
4. Purchase of health services from the nongovernmental sector or outside Palestine (patient transfers) is costly. Patient transfers are not regulated by clearly defined controls. Often, these were associated with political or community pressure.
5. The over 11-year internal Palestinian political divide and decision to exempt Gaza inhabitants of health insurance fees have undermined expenditure control capability, and at the same time dispossessed the health system of significant revenues.

What Suitable Model for Palestine?

Social health protection and universal health coverage systems differ from one country to another. Nevertheless, as mentioned above, the common denominator between all these systems is the risk sharing principle. This allows as many people as possible to share risks of illnesses and avoid recourse to costly health care. Risk sharing means that funds earmarked for health care will be prepaid and managed in a manner that ensure all members of the population afford health care costs in case of illness. This way, individuals will not afford all costs alone.

Many countries demonstrate successful health insurance models. For example, reference can be made to the models of France, United Kingdom, Canada, or Switzerland. However, the system of a particular country may not be appropriate for another. Each country needs to develop its own specific health insurance paradigm, taking account of the number of the population, applicable health system, and prevalent political, economic and social conditions in that country.

An Example of a Successful Health Insurance scheme

According to WHO 2010 Health system financing: The path to universal coverage, promoting and protecting health is essential to human welfare and sustained economic and social development. WHO Member States are committed to develop their health financing systems so that all people have access to services and do not suffer from financial hardship paying for them.

The WHO ranked countries according the quality of, and easy access to health services at minimum cost. In this context, France ranked first, followed by Italy, San Marino, Honduras, Malta, Singapore, Spain, Oman, Austria, and Japan, respectively. The UK ranked 18, Switzerland 20, and USA 37.

The fact that the WHO views the French health system as the best in the world is attributed to the applicable health insurance scheme. In France, the health insurance scheme is managed by the government through the Social Security Administration. Reporting administratively to the Ministry of Health, the Administration reports to the Ministry of Social Affairs in financing issues.

The French compulsory health insurance scheme is based on three principles: (1) universal coverage, whereby the scheme covers all risks and compensations; (2) patient's freedom of choice; and (3) government-private sector cooperation in hospitals and financing health services.

Most notably, the French system givens the beneficiary the freedom to choose, without restriction, to visit a variety of physicians, including acupuncture specialists, psychiatrists, obstetricians, and dentists. A beneficiary can even visit private doctors without a patient transfer. The government also owns 64 percent of hospital beds.

In this scheme, patients pays health insurance fees, but are compensated by social security. Patients also contribute 11 percent to the health insurance scheme. Some insurance companies provide a supplementary health insurance; that is, these companies cover 12 percent of the health service cost. 87 percent of the population benefit from this supplementary insurance service. The government covers all public health service and preventive medicine costs. The government also partially covers the fees of health care provided by private clinics, which offer specialist care. The Social Security Administration pays for medicines.

The French national compulsory health insurance scheme is financed by employers, public social contributions, and limited salary cuts. The health systems covers the entire population. The government sector accounts for 78 percent of the health system financing.

In my opinion, in line with the principle of risk sharing, the optimal model for Palestine is a system that deducts a certain percentage from the income of government, civil society and private employees. Employers would contribute the same percentage. The system should be binding on all. Accordingly, every citizen or expatriate in Palestine would enjoy health insurance coverage, regardless of their workplace or income. A limit for deduction percentages would be set on the basis of an actuarial study of the national health insurance cost, which should achieve universal health coverage.

At the same time, the government would afford the cost of services provided by the current health insurance service basket, including public service, preventive medicine, environmental health, maternal and child health.

I propose this model for several reasons. Firstly, this model is partially applicable in the current health insurance scheme, which is compulsory to government staff but optional for other citizens and expatriates. Secondly, compulsory insurance maintains equity among the entire population. Hence, for households, the social system will ensure the right to health at minimum cost and without undue financial hardship. Foreign grants and assistance will not be needed to develop the health system and improve the quality of health services. In my understanding, compulsoriness does not mean that the health insurance scheme be run by the government. It would include multiple funds or insurers. This would help insurance companies develop

their working mechanisms, reduce prices and probably invest in consolidating the health system infrastructure. Multiple funds would also help promote and make clear the role the UNRWA plays as a key partners in providing comprehensive health services to a large segment of the population in partnership with either the government or private insurance companies.

The proposed health insurance scheme comprises several steps:

1. Enacting a binding law or decree on compulsory health insurance, and developing needed mechanisms to bind the entire population to receive appropriate insurance coverage.
2. Establishing a national health insurance institution, which provides insurance coverage to government staff and purchases needed health services from government and nongovernment health care centres. This institution will be open to the entire population in line with standards that ensure continued subscription.
3. Encouraging private insurance companies to build partnerships or develop mechanisms for further investments in the health insurance sector. The can deliver services to persons who do not wish to purchase services from the national insurance institution.
4. Agreeing with the UNRWA to setting the health service basket, which the Agency can provide to beneficiary refugees, and allowing an opportunity to the insured to purchase supplementary services from private insurance companies or from the national insurance institution.

As a Member State of the WHO, Palestine is committed to provide universal health coverage in line with the 2030 Agenda for Sustainable Development. To be able to do so, the government needs to double its efforts to provide necessary financing and ensure universal health coverage. This can only be achieved when all citizens are committed to subscribe to a health insurance scheme. Premised on the principle of risk sharing, this scheme will provide high quality, equitable and equal health services to all.

Recommendations

Beyond doubt, ambitious plans have been devised to develop the quality and efficiency of health services provided to citizens in Palestine, ensuring equitable and equal distribution of these services. Implementation of these plans ensures that households are not impoverished by access to health services. National projects, plans and agendas are responsive to UN and WHO resolutions. However, these are not guided by a clearly defined national vision, which is informed by a self-assessment of needs and capacities, service provision, and high quality and sustainable services. This national efforts does not need to be dependent on unpredictable and politically motivated foreign funding.

Against this background, mechanisms, budget allocations and infrastructure do not help implement any plans, agendas or policies. Seminars, conferences, conferences or encounters need to be organised, bringing together government representatives, service providers, service beneficiaries, research centres, and think tanks. These will jointly examine weaknesses in the Palestinian health system and shortfalls in the current financing system. Successful global examples will be promoted, highlighting experiences of poor or low income countries in providing good quality and affordable health services. In these countries, households have not been impoverished nor discouraged from accessing health services by reason of exorbitant cost.

A number of basic principles should be satisfied in any future planning activity, most notably:

- Highlight that the principle of universal health coverage based on risk sharing requires the enactment of a health insurance law, which prescribes compulsory subscription to an existing health insurance fund(s). Such a fund(s) does not have to be run by the government.
- Develop an actuarial financial study on the cost of required health services, and set government or nongovernment health insurance fees in line with that cost and citizens' payment capacity.
- Compile a study on the distribution of health care centres, including public, primary, secondary and tertiary health care facilities (public and specialist hospitals). In addition to examining safe and easy access, the study will assess the capacity and efficiency of these centres to provide high quality health services.
- Develop more comprehensive studies on human resources in government and nongovernment health sectors. These will provide the geographical distribution of health professionals to areas and communities.
- Ensure that health coverage is universal, high-quality and sustainable.
- Revisit working hours of government primary health care facilities and support double-shift work schedules.
- Improve work conditions at emergency wards of government and nongovernment hospitals, with a particular focus on equipment and human resources.
- Support continuing medical education programmes and set relicensing controls and criteria.

- Set prices of medical services and procedures at nongovernment clinics and hospitals, taking account of the level of service provision. Minimum and maximum prices and wages can be set. To this effect, a memorandum of understanding can be reached with representatives of the MoH, Medical Association, Federation of Private Hospitals, and insurance companies.

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الائتلاف من أجل النزاهة والمساءلة
aman أمان
Transparency Palestine

The Coalition for Accountability & Integrity (AMAN)- which was accredited by Transparency International (TI) as a national chapter in Palestine since 2006 - established in 2000 by an initiative of number of CSOs working in the field of democracy, human rights and good governance towards reaching its vision of Palestine free of Corruption.

The Coalition is keen to create and lead a social movement against corruption and to contribute in the production, transferring and localization of the necessary knowledge in anti-corruption at the local, regional and international level.

The Coalition is also keen to play its monitoring/watchdog role on the National Integrity System through focusing on community participation, activating the role of civil society institutions and media in monitoring management of public money and affairs, and creating a work environment that contributes to unclose corruption crimes and restrict its spread.

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