Understanding the private health sector
in the occupied Palestinian territory

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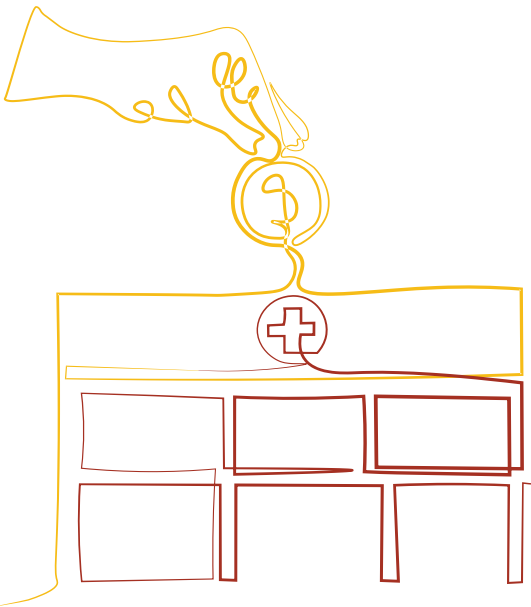
Comprehensive, reliable data on the private health sector, particularly the for-profit sector, are still lacking in the occupied Palestinian territory. Views and perspectives of the different health stakeholders, collected from a set of structured interviews, were thus very helpful in clarifying several key issues related to the role of the private health sector in promoting universal health coverage (UHC) in the context of the occupied Palestinian territory. These views relate to the challenges facing the implementation of UHC, the potential role of the private health sector, and the needed reforms. Hence, the author extends his gratitude to all individuals and organizations who participated in the interviews and contributed so valuably to the research with their expertise, and whose observations enhanced the recommendations of the report, in particular the Palestinian Ministry of Health for their cooperation and facilitation of interviews. Lastly, the author extends his gratitude to the WHO Regional Office for the Eastern Mediterranean and the PNIPH for their guidance and support in conducting this study.



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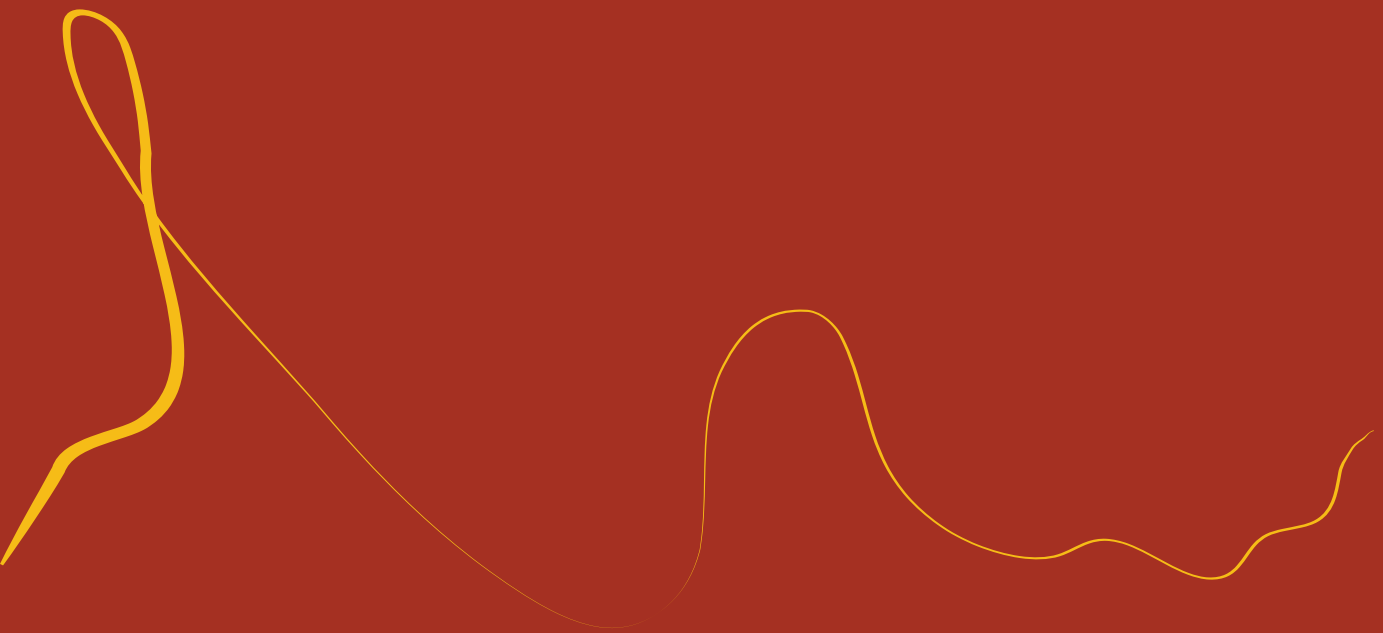
Executive summary

This study aims to contribute to policy formulation and planning for universal health coverage (UHC) in the occupied Palestinian territory. Its primary purpose is to assess the involvement of the private sector in health care (both for-profit and not-for-profit) and its engagement in current efforts to attain UHC. This is done through a systematic examination of the health status of the Palestinian population and the development of the health system over the past two decades. This has been done by compiling all relevant data and information, as well as the views and perspectives of key stakeholders.



Several interesting findings and key implications are worth highlighting

Several interesting findings and key implications are worth highlighting. First, there is a consensus in favour of UHC among all health sector stakeholders. Importantly, all stakeholders agreed that achievement of UHC can only be made possible through effective collaboration between the four major health care providers in the occupied Palestinian territory, namely: the Palestinian Ministry of Health and the Palestinian Military Medical Services Agency; nongovernmental organizations; the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA); and the private for-profit health sector. While this reflects the widespread political support and social acceptability of UHC, the readiness of the current health system for achieving UHC appears to be inadequate. Secondly, while mobilizing additional resources is certainly required, most stakeholders emphasized that financial resources alone will not be enough to close the provision gaps – which are expected to rise significantly given the expansion of coverage and the demographic and epidemiological transition. The overall health system has to be organized in a way that can ensure the effective participation of all stakeholders in the design and implementation process. Moving towards UHC and enhancing engagement of the private sector requires, according to stakeholders, a comprehensive, participatory and stepwise approach – rather than piecemeal and ad hoc procedures – to reform the current health system and health insurance in view of UHC. Thirdly, there is a broad consensus among the main stakeholders that a gradual – rather than ad hoc – transition is required for the successful implementation of UHC. This a fortiori necessitates enhancing and upgrading the supply-side capacities, not only in terms of provision and financing, but also the administrative and monitoring capacities (including accreditation, contractual and purchasing arrangements) which are all viewed by the majority stakeholders to be unfavourable and inadequate. Addressing and redressing the current frameworks and mechanisms is a vital area for better engagement with the private health sector. An attempt should be made to outline the future role of the private health sector and lay the foundations for an effective complementarity-based public–private partnership within the perspective of achieving UHC, through side-by-side cooperative planning, design and implementation of a national health care strategy between private and public health care stakeholders, as well as other key players.

1
Country context

1.1 Geopolitical and socioeconomic context

The occupied Palestinian territory is split into three geographically and administratively separate areas: the West Bank; east Jerusalem (a total area of 5640 km2); and the Gaza Strip (a total area of 365 km^2). The West Bank is further split into three areas, namely A, B and C.[1] Areas A and B are, respectively, under full civil and security control and partial security control of the Palestinian Authority. The Gaza Strip is under full Palestinian internal control, although borders and access to the sea and airspace remain under full Israeli military control. Area C in the West Bank, which constitutes about 61% of the West Bank territory, also remains under full Israeli control. Israel's construction of the separation barrier (with a total length of 708 km) inside the West Bank cuts off about 16.8% of the total West Bank territory (943 km2 of land located between the wall and the 1967 Green Line border *(1)*. The separation barrier has entirely parted east Jerusalem and split agglomerations located in Area C from other localities in the West Bank *(2,3)*. The impact of such geographical dismemberment on the living conditions of Palestinians (including access to minimum essential services) has recently been subject to empirical assessment based on nationally representative surveys *(4–6)*.

Globally, the occupied Palestinian territory is classified as a lower-middle income country *(7)*. In 2016, the gross domestic product (GDP) is estimated at US$ 13 269.7 million (in constant prices 2015) as compared with US$ 0 051.2 million in 2010, resulting in a GDP per capita of US$ 2864.8 in 2016 compared with US$ 2331.3 in 2010 (8). Macroeconomic indicators show a slight improvement in the overall performance of the economy of the occupied Palestinian territory in 2010–2016 (an average growth rate of 5.3) as compared with 2000–2010 (an average growth rate of 4.1) *(8)*. However, a number of recent reports commenting on the overall performance of the Palestinian economy showed that such growth has mainly been driven by government services, real estate and other non-tradable sectors, while manufacturing and agriculture have dropped significantly *(7)*. The unemployment rate has remained high, at about 27% of the total labour force in 2018 as compared with 24% in 2010 and 13.5% in 2000 *(8)*.

Similarly, estimates indicate the persistence of high poverty rates, with almost a quarter of the Palestinian population living below the poverty line. The poverty headcount ratio at the equivalent national poverty line (of US$ 6.7 per day) is estimated at 23% of the total population in 2017 as compared with 26.2% in 2005[2] *(8)*. Nonetheless, the continuous heavy reliance of the Palestinian economy on Israel and on foreign aid has been shown to have serious consequences on the living conditions of Palestinians *(7)*. The World Bank 2018 Economic Monitoring Report

1 The current geopolitical division of the occupied Palestinian territory is due to Oslo Agreement, signed on 13 September 1993 by the Palestinian Liberation Organisation (PLO) and the Government of Israel. Such split was initially supposed to last for a 5-year interim phase (until end of May 1999) – a period during which negotiations leading to a permanent settlement based on Security Council Resolutions 242 and 338 was supposed to take place. Since then, however, negotiations towards a permanent settlement have broken down entirely. Source: Bauck P, Omer M. The Oslo Accords: a critical assessment. Cairo: American University in Cairo Press; 2017.

2 Author's calculations based on the Palestinian Household Expenditure and Consumption surveys (2004–2017). Note that poverty lines are typically measured at the household level for a typical household size. However, given that the varying size of households, we use the Oxford (old OECD) equivalent scale method to calculate adjusted poverty lines and to calculate equivalent household consumption expenditure (Source: OECD list of social indicators. Paris: Organisation for Economic Co-operation and Development; 1982). This assigns a weight of 1 to the head of household, 0.7 to adult and 0.5 for children aged 15 years and younger. Thus, the equivalent scale is measured as 1+0.7×N_a+0.5×N_cwhere N_a and N_c are the number of non-head adults and children in the household, respectively.

highlights the increasing vulnerability of the Palestinian economy, as economic growth – mostly consumption-driven – has largely been fuelled by international aid from donors *(7)*. The latter source was shown to fall significantly in 2017–2018, particularly in the Gaza Strip where about 79% of Gazans report receiving some aid from governmental or nongovernmental sources in 2017 (compared to 15% in the West Bank).[3]

1.2 Sociodemographic characteristics of the population

The 2017 Population, Housing and Establishments Census *(9)* counts 2.88 million Palestinians living in the West Bank, including east Jerusalem, and 1.89 million Palestinians in the Gaza Strip (about 40% of the total population of the occupied Palestinian territory) at the end of 2017. About two thirds of Palestinians living in the Gaza Strip and one third of Palestinians living in the West Bank are registered refugees *(10)*. Demographically, the Palestinian population living in the occupied Palestinian territory is undergoing a rapid demographic transition characterized by significant shifts in size and structure (see Table 1). In 2015, approximately 27.7% of the population are aged below 10 years and young people (aged 10–24 years) represent about 33.3% of the total population. Adults (aged 25–59 years) represent about 34.5% of the total population, while people aged 60 years and above account for 4.5% of the population (see Fig. 1).

Fig. 1 shows population projections for the occupied Palestinian territory for the year 2030. Overall, the average age of the population in 2030 is older than in 2015. The population structure indicates that, as fertility rates decline over time, the youngest proportion of the population (children and young people) will shrink while the proportion of adults and the elderly rises, resulting in a more rectangular-shaped age pyramid. The shift in demographics (high but declining rates of population growth coupled with longer life expectancy) means that the occupied Palestinian territory will have significant increases in population in all age ranges (in absolute terms), particularly the elderly range (60 years and above). As a result, the proportion of elderly population (who are retired, earn less and are more susceptible to chronic diseases) will increase, while higher numbers of individuals will enter the workforce. Consequently, although the dependency ratios are expected to fall, the overall economic burden of diseases is expected to increase due to the higher proportion of elderly people *(15)*.

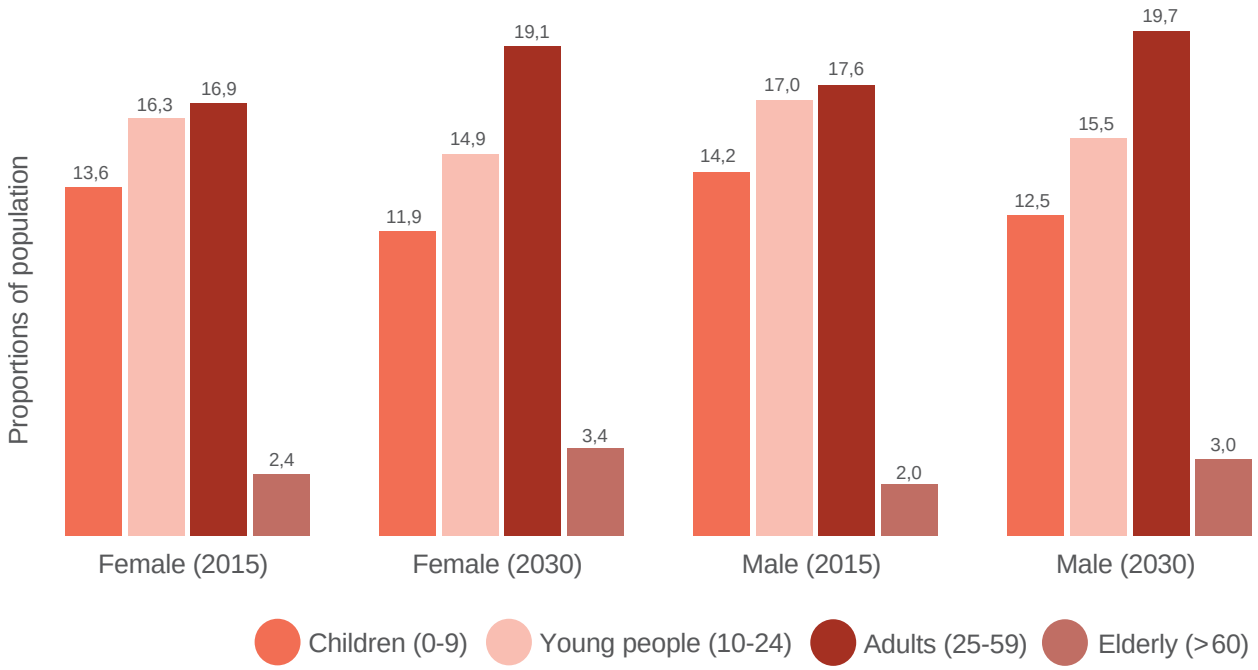
3 The 2017–2018 decline in foreign aid to the occupied Palestinian territory is mainly due to abrupt changes in the Government of the United States aid policy to the Palestinian Authority. This includes the cuts of a payment of US$ 30 million per month to Palestinian Authority in 2018, US$ 50–60 million per year cuts in United States aid operations, and the cuts made in the UNRWA programme. Source: Zanotti J. U.S. foreign aid to the Palestinians: updated December 12, 2018. CRS report RS22967. Congressional Research Service; 2018 (https://fas.org/sgp/crs/mideast/RS22967.pdf, accessed 10 April 2022).

Table 1. Demographic and socioeconomic characteristics of the Palestinian population living in the occupied Palestinian territory

Indicators	West Bank	Gaza Strip	Total occupied Palestinian territory
Total population[a]	2 881 957	1 899,291	4 781 248
Males	1 470 293	962 903	2 433 196
Females	1 411 664	936 388	2 348 052
Male-to-female ratio (2015)[b]	104.15	102.80	103,60
Total fertility rate[c]	3.7	4.5	4.1
Natural growth rate[c]	2.5%	3.3%	2.8%
Proportion of registered Palestinian refugees (number)[c]	26.0	66.7	41.9 (2.05 million)
Percentage of population aged under 17 years[a]	47.5	48.0	47.0
Percentage of population aged 18–29 years[a]	25.0	23.2	24.3
Percentage of population aged above 60 years[a]	5.9	4.3	5.2
Average household size[a]	4.8	5.6	5.1
Median age (years)[b]	21.4	19.1	20.5
Population density (person/km2)[d]	510	5204	794
Poverty (percentage)[e]	13.9	53.0	29.2
Deep poverty (percentage)[e]	5.8	33.8	16.8
Unemployment (percentage)[a]	13.2	48.2	27.2

a Population, Housing and Establishments Census (Summary of census results), 2017 (9).
b Palestinian Central Bureau of Statistics, 2018 (11).
c Series of Health Annual Reports, Palestinian Ministry of Health (12).
d Palestinian Central Bureau of Statistics, 2017 (13).
e Palestinian Central Bureau of Statistics, 2017 (14).

Fig. 1. Population structure in the occupied Palestinian territory, 2015 and projections for 2030



Source: Author, based on the 2015 Demographic Survey (16) and United Nations predictions for 2030 (15).

Life expectancy at birth is estimated at 71.8 years for the year 2016 (70.3 for males and 73.4 for females) and the population growth rate is estimated at 2.65%. As shown in Fig. 2, the average life expectancy at birth has improved in both regions of the occupied Palestinian territory over the last two decades by almost 2.5 years.

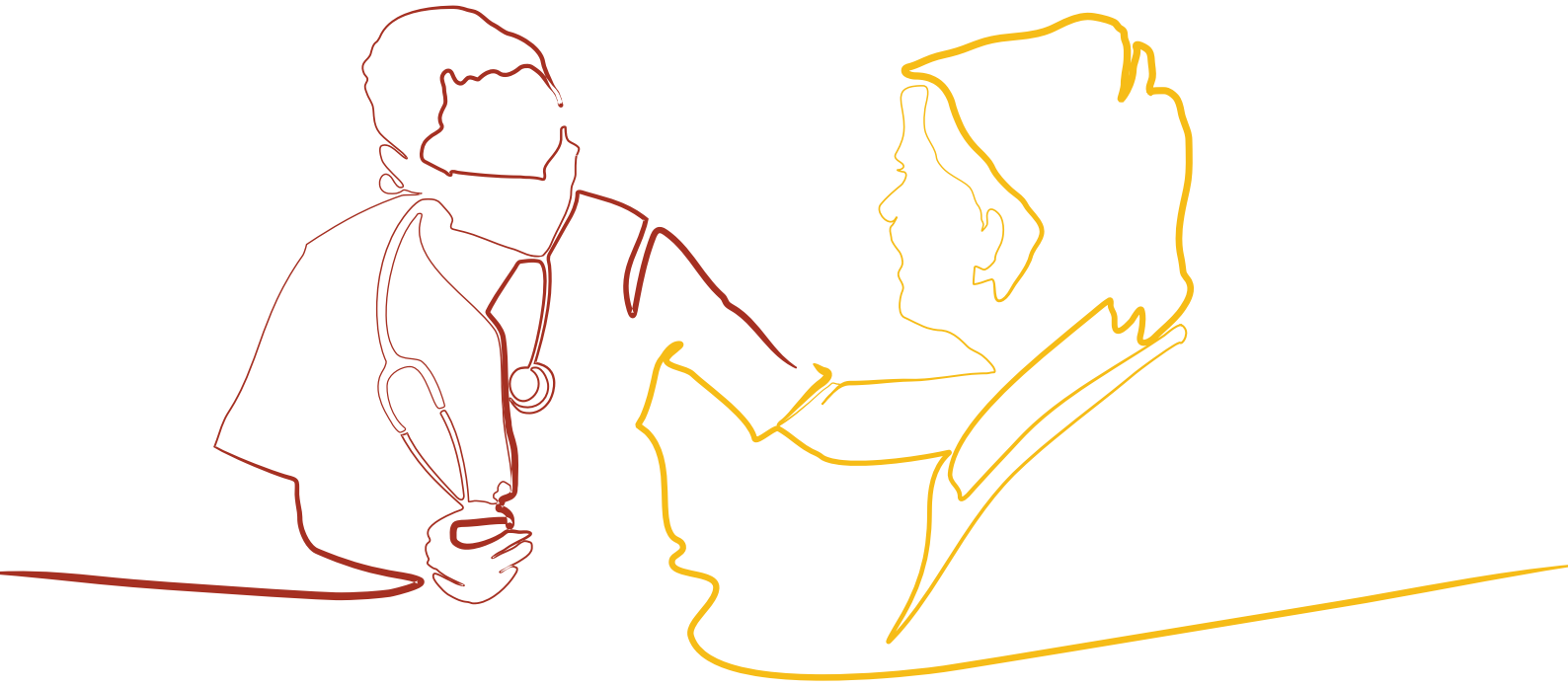
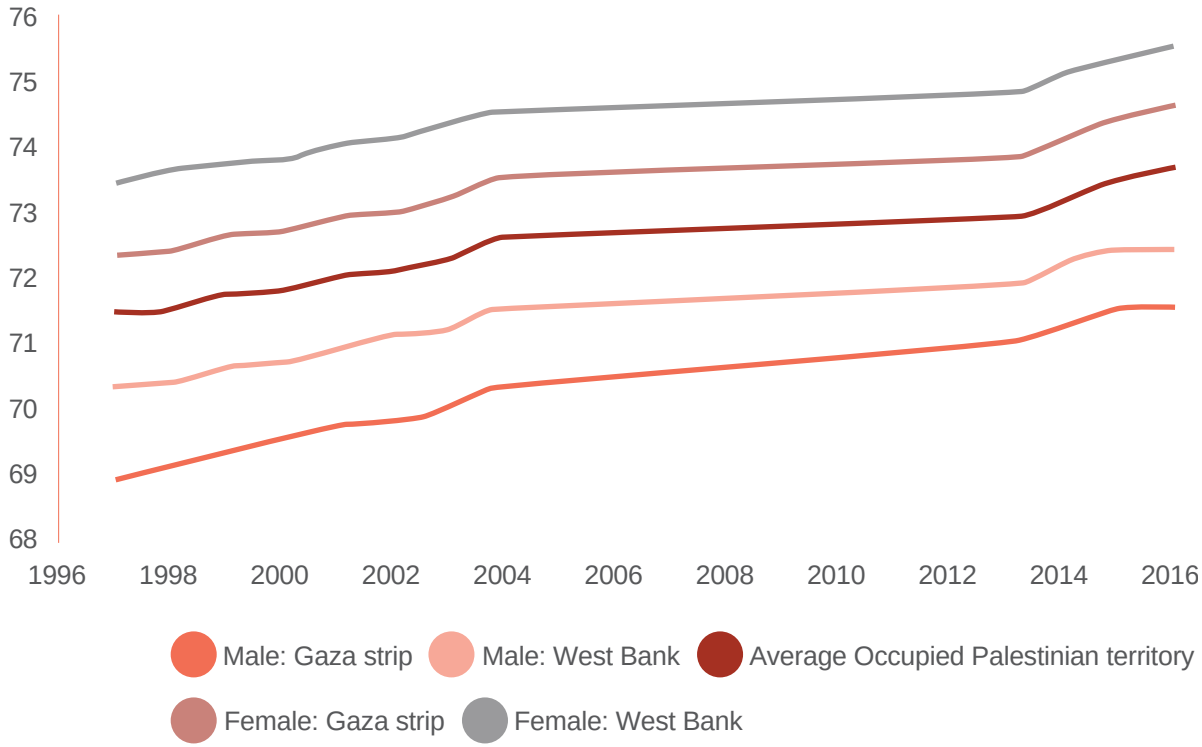


Fig. 2. Life expectancy at birth in the occupied Palestinian territory (male versus female), 1996–2016



Source: Author, based on the Demographic Surveys 1996–2014 *(17)*.

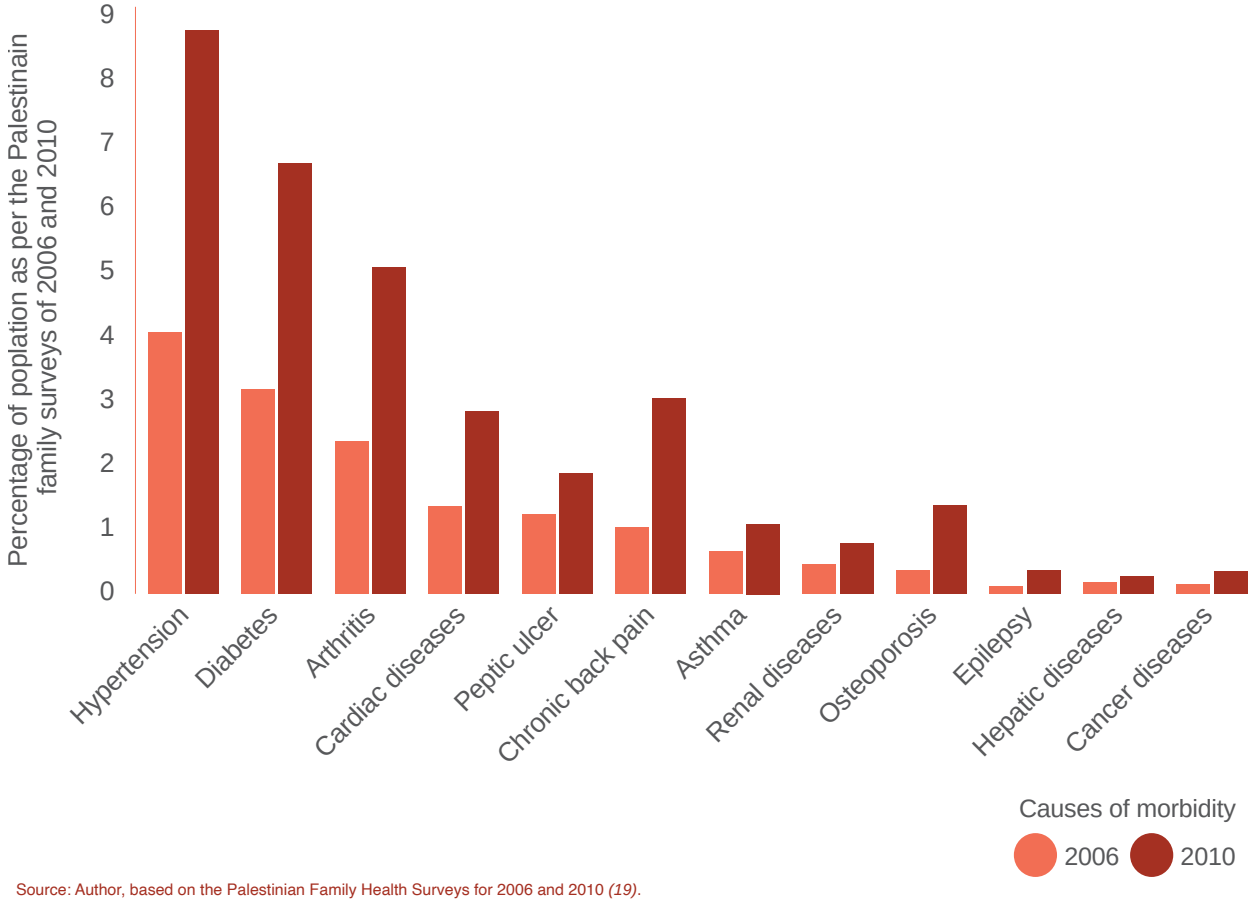
1.3 Overall health status of the population

A review of the available health status indicators over the last two decades reveals that the Palestinian population is progressing through a health transition to longer life expectancy (Fig. 2) and lower fertility rates, coupled with a shift toward noncommunicable diseases (Fig. 3). Information is available on infant mortality rates, under-5 mortality rates and maternal mortality ratio *(17)*. The infant mortality rate has gradually declined from an estimated rate of 29 deaths per 1000 live births in 1991 to 11 deaths per 1000 live births in 2017, while the under-5 mortality rate has rapidly declined from about 43 deaths per 1000 live births in 1991 to 12 deaths per 1000 live births in 2017. The occupied Palestinian territory has also observed a rapid decline in maternal mortality ratio since 1990, from 11 per 1000 in 1991 compared to about 4 per 1000 in 2017. Similarly, the adult mortality rates show that the probability of dying between ages 15 and 60 has decreased for both males and females, from 19.8 to 13.5 and from 15.4 to 9.4, respectively, during 1990–2016. Overall this indicates that, on average, 176 out of 1000 adults would die before they reach their sixtieth birthday in 1990 and only 114 would die before they reach their sixtieth birthday in 2016 *(18)*.

The epidemiological transition in the occupied Palestinian territory is characterized by a shift in the major causes of morbidity and mortality from communicable diseases and maternal and childhood causes to noncommunicable diseases and injuries. We use data from the

Palestinian Family Health Surveys – conducted by the Palestinian Central Bureau of Statistics in 2006 and 2010 – to analyse the patterns of disease in the occupied Palestinian territory. The main results, which are shown in Fig. 3, indicate that hypertension, diabetes and arthritis are the major three causes of morbidity in the occupied Palestinian territory among adults aged 18 years and above. While the incidence of almost all diseases has sharply increased in 2010 as compared to 2006 for all groups, the increase is particularly noticeable among the elderly (60 years and above) *(19)*. For instance, the incidence of hypertension among the elderly has increased from about 18% in 2006 to 43% in 2010.

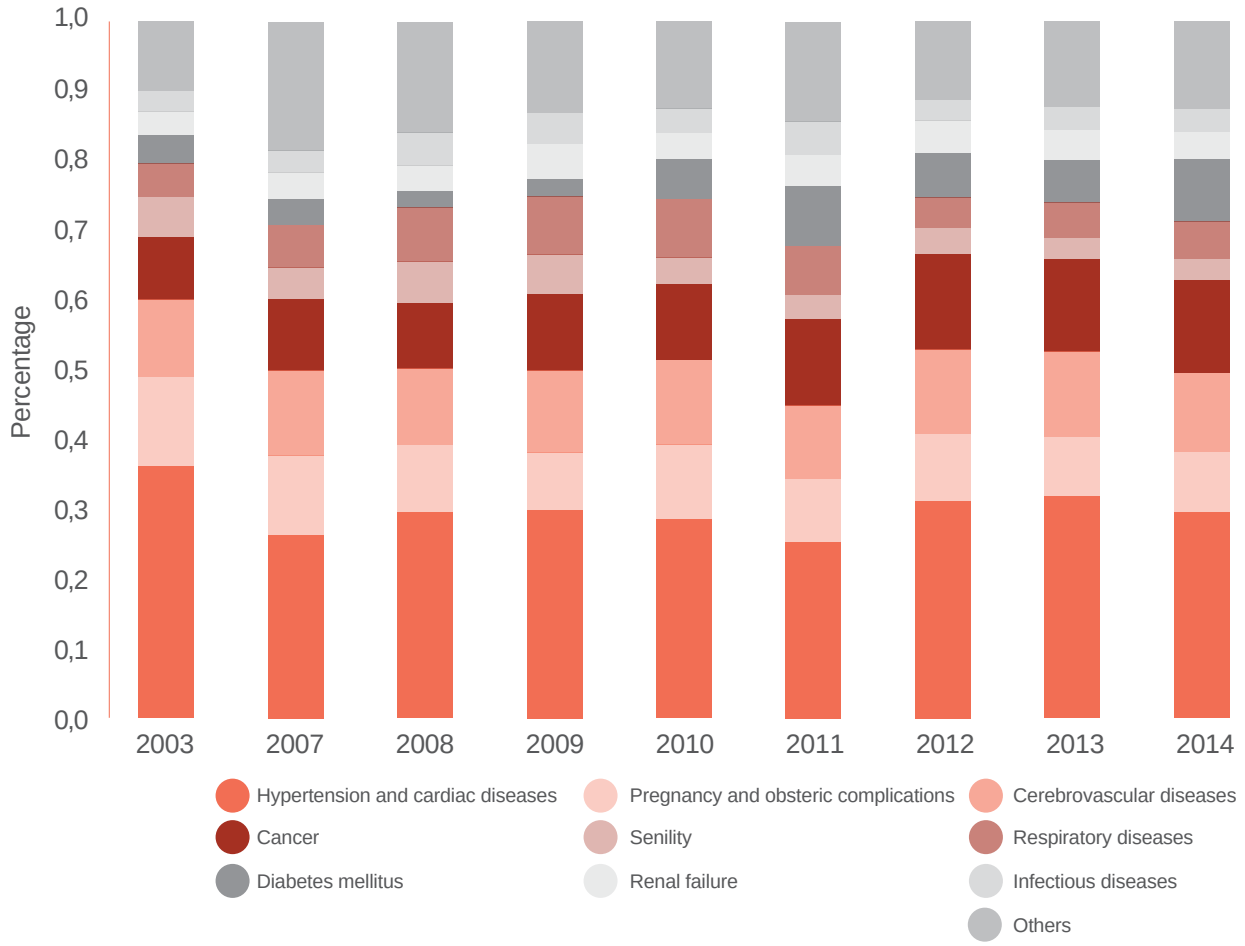
Fig. 3. Major causes of morbidity for adults aged above 18 years (% of total population), 2006 and 2010



Source: Author, based on the Palestinian Family Health Surveys for 2006 and 2010 *(19)*.

Fig. 4 shows that the major causes of mortality are hypertension, cardiac diseases, pregnancy complications, cancer and cerebrovascular diseases. These diseases are responsible for about 69% of mortality in 2003 and 63% of mortality in 2014.

Fig. 4. Major causes of mortality in the occupied Palestinian territory, 2003–2014



Source: Author, based on a series of Annual Health Reports 2003–2014, Palestinian Ministry of Health *(12)*.

The leading causes of death in the occupied Palestinian territory in 2017, according to the Health Status Annual Report *(20)* of the Palestinian Ministry of Health, are given below.

1. Cardiovascular diseases: 30.3% of deaths.
2. Cancers: 14.7% of deaths.
3. Cerebrovascular diseases: 11.7% of deaths.
4. Perinatal conditions: 9.3% of deaths.
5. Diabetes mellitus: 9.0%.
6. Respiratory diseases: 5.6%.
7. Accidents of all kinds: 4.5% of deaths.
8. Infectious diseases, especially septicaemia: 2.9%.
9. Congenital anomalies: 2.8%.
10. Digestive diseases: 2.2% of total reported deaths.

2

The health system in the occupied Palestinian territory

2.1 Organization and delivery of health care services

The institutional and organizational features of the occupied Palestinian territory's health system have been subject to several assessments by researchers in the field and by international organizations *(21–30)*. These assessments highlight the complexity of the organizational structure of the Palestinian health system, with fragmentation in health finance and delivery being its main characteristic *(21,26,31)*. As elsewhere in the world, the evolution of the health system has largely been shaped by a complex political history *(29)*. The two territories of the occupied Palestinian territory – the West Bank, including east Jerusalem, and the Gaza Strip – have been continuously subject to different organizational structures imposed by their diverse geopolitical and historical contexts *(32)*.

Following the establishment of the Palestinian Ministry of Health in 1994, several institutional and organizational reforms have been undertaken with the aim of regulating, restructuring and unifying the fragmented structure of the pre-1994 system *(33)*. Attempts have been made in the last two decades to enhance the provision capacity of the health system and to synchronize the activities of the four main health care providers: the Palestinian Ministry of Health and the Palestinian Military Medical Services Agency; nongovernmental organizations; the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA); and the private sector *(26)*. Despite the progress made – particularly in improving population health and increasing the provision capacity of the public health sector – two and a half decades later, fragmentation of the current financing and delivery arrangements remains one of the key institutional and organizational challenges to the health system in the occupied Palestinian territory *(34)*.

To date, the Palestinian Ministry of Health has developed and produced five detailed National Strategic Health Plans for health sector development and reform:[4] the first plan was prepared in 1998 to cover five years from 1999 to 2003, the second covered 2008–2010 *(35)*, the third covered 2011–2013 *(36)*, the fourth covered 2014–2016 *(37)*, and the latest covers six years from 2017 to 2022 *(38)*.[5] The constitutional status of health in the occupied Palestinian territory is explicitly recognized in the Palestinian Constitution of 2003 and the Public Health Law No. 20-2004 *(39)*. The latter assigns stewardship responsibilities (oversight and regulations) and the delivery of preventive, diagnostic, curative and rehabilitative services to the Palestinian Ministry of Health. Accordingly, the Ministry of Health is responsible for the provision of equitable and affordable quality health services for all Palestinians and for integrating the activities of the different service providers *(22,38)*.

The Palestinian Ministry of Health, however, has a limited amount of resources. Its share of the overall Palestinian Authority's budget is determined by the Ministry of Finance and Planning. The latter provides

4 It is worth noting that national health planning and policy development was initiated prior to the establishment of the Palestinian Ministry of Health in 1994. The first National Health Plan was developed by the Palestinian Council of Health (1994).

5 Other health sector plans have also been developed by the Ministry of Health; for example, the Human Resource Development Plan, and the Palestinian National Strategy on Cancer Prevention and Control. Other development plans have been formulated by the Palestinian Ministry of Planning, such as the Medium Term Development Plan 2006–2008.

financial support to the health sector and paid the accumulated debt of the Ministry of Health to the private sector *(38)*. In recent years, the Ministry of Health budget has constituted about 12% of the overall Palestinian Authority's budget. In 2017, the operating budget of the Ministry of Health was 1.72 billion Israeli shekels (NIS) (about US$ 454 413 947) of which a slightly more than half (51%) was paid for wage bills (compared with 47% in 2015), while 25% was paid to purchase services from outside the public health facilities (compared with 34.2% in 2015) *(38)*. The inadequate budget for the Ministry of Health can be inferred from its accumulated debts, where carried-over debts from 2014 and before are NIS 542 million, of which 44.7% is due to the purchase of health services from outside the Ministry of Health and 46% is due to medical consumables *(38)*. A World Bank review of the public expenditure of the Palestinian Authority raises serious concerns about the fiscal stance of the health sector, which is heavily constrained by the uncertain foreign aid flows and the increasing costs of medical referrals, inefficiencies and duplication of services, and an excessive focus on tertiary care *(21)*. The review also points to the fragile sustainability of the Government Health Insurance (GHI) scheme, where the costs of GHI health expenditures have tripled during the 2000s (representing 15% of total health expenditure in 2010 versus 5% in 2000). The increasing costs of the GHI have been attributed to the increasing numbers of GHI non-contributing enrolees *(21,25)*.

As regards the delivery of health services, the Palestinian Ministry of Health remains the largest health care provider and employer, particularly at the primary and secondary health care levels.[6] In addition, the private not-for-profit sector – represented by a network of Palestinian nongovernmental organizations and UNRWA, funded by international donations – continues to play an active role in the provision of health care at all levels, particularly to hard-to-reach communities and Palestinian refugees. Lastly, a private for-profit health sector – including speciality hospitals, diagnostic centres and self-employed physicians and group clinics – is gradually developing throughout Palestinian urban centres, and participate in the provision of health services particularly at the secondary and tertiary health care *(22,25)*.

Regular assessment of whether and to what extent the stated objectives in the successive national health plans have been achieved is still lacking. However, previous studies of the health sector in the occupied Palestinian territory point to the lack of involvement of non-ministry stakeholders in the planning process of the first and second national plans, the lack of target completion times, the absence of adequate budget and prioritization, and lack of provider-specific development policies *(26,28,40)*. The later national health plans have, however, attempted to overcome some of the aforementioned drawbacks. For instance, in its latest National Health Strategy 2017–2022, the Palestinian Ministry of Health has highlighted the active involvement of other health sector stakeholders and providers (including the private sector and international organizations) in the development process of the national plan *(38)*. The 2017–2022 plan has six national strategic objectives, with specific indicators for monitoring and evaluation of

6 For more details on the organizational structure of the public health system, see: *Health System Profile: Occupied Palestinian Territory 2012*. WHO Regional Office for the Eastern Mediterranean; 2014 *(22)*.

each. These include: the provision of comprehensive health services to all Palestinians; enhancing the health financing system and protection of citizens against the financial hardships of paying health care costs; institutionalizing quality systems in all aspects of health services; strengthening health governance, including effective health sector management, laws and legislation development and enforcement, cross-sectoral coordination, intrasectoral coordination and integration towards achieving the localization of services and UHC *(38,41)*. The 2017–2022 National Health Plan has also emphasized the need to develop long-term partnerships between the public and private health sectors in order to achieve UHC and localization of health services as a key objective of health policy *(38,41)*.

The following subsections provide an up-to-date assessment of the relative size and contribution of each health care provider, including the volume of services provided according to level of services and the distribution of health resources.

2.2 Health sector resources and the private sector

The number of primary health care services and the relative share by different health care providers is shown in Fig. 5 for selected years (2000–2018). Overall, the number of primary health care centres in the occupied Palestinian territory has increased from 595 in 2000 to 743 in 2018 (an increase of 25%). The public (Ministry of Health) sector continues to provide the bulk of primary health care centres, at about 60% of the total number of centres in 2000 and 65% in 2018. Private not-for-profit providers constitute the second largest provider of primary health care, although its share of the total number of primary health care centres has fallen from 31% in 2000 to 26% in 2018. The share of UNRWA primary health care centres has stagnated at 9% during the same period.

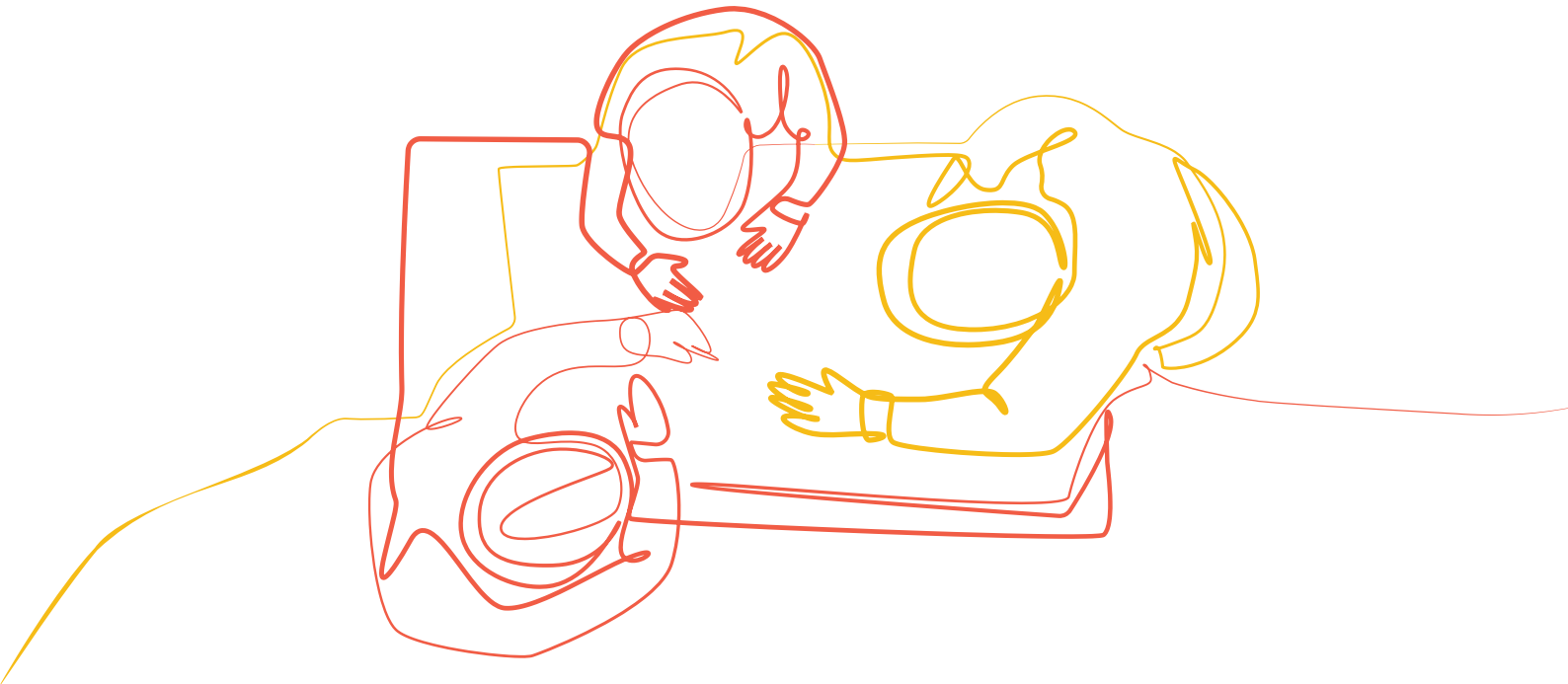
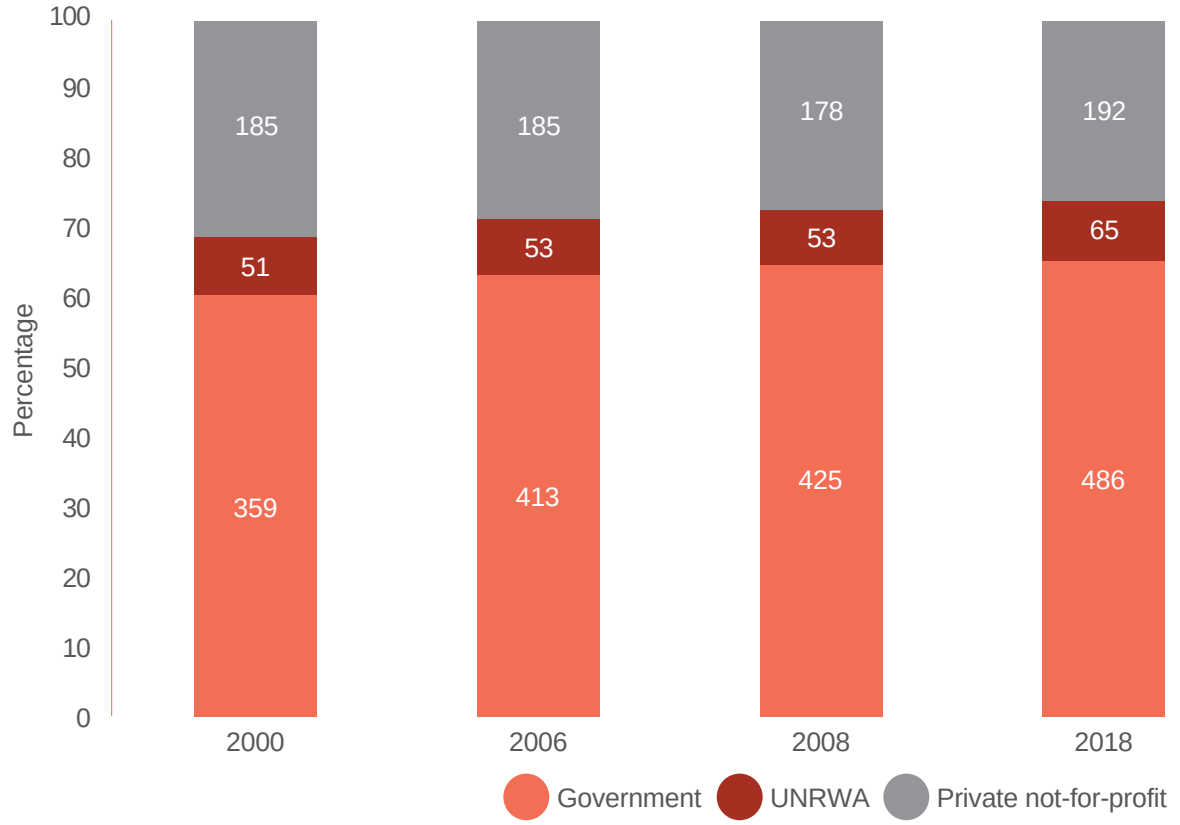


Fig. 5. Number of primary health care centres by health care provider in the occupied Palestinian territory, 2000–2018



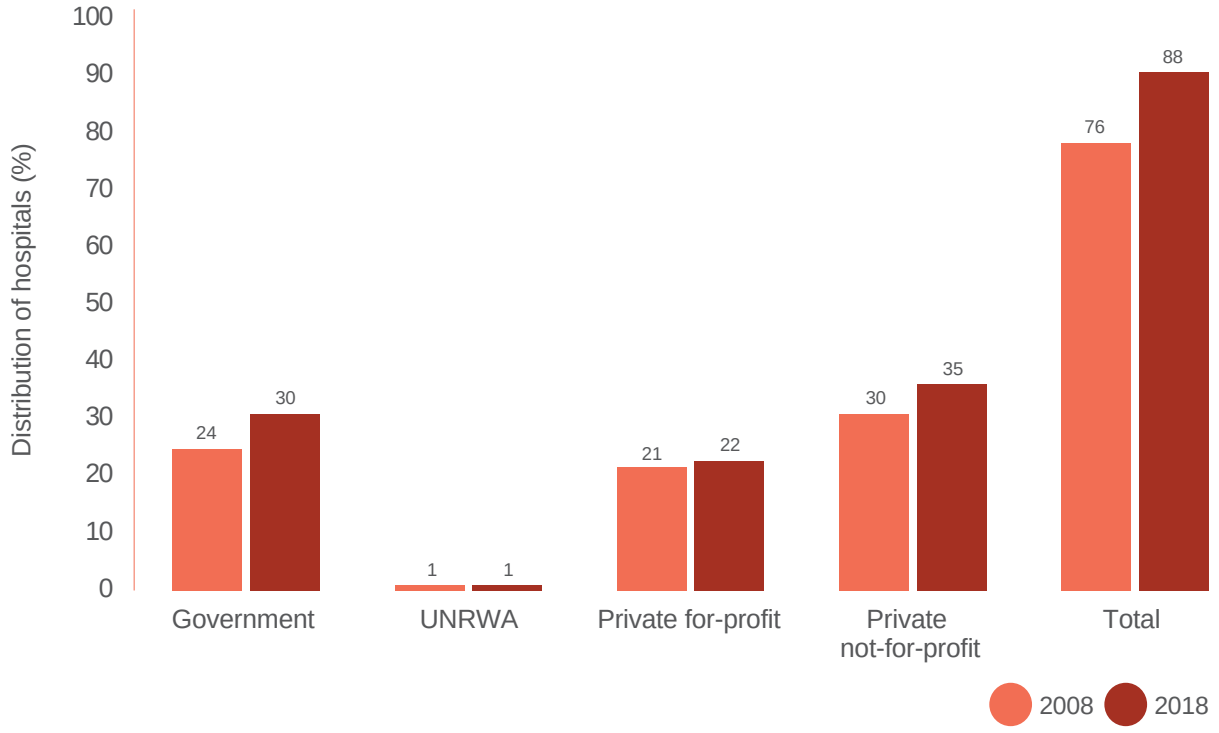
Source: Author, based on a series of Annual Health Reports 2000–2018, Palestinian Ministry of Health *(12)*.

Fig. 6 shows the total number of hospitals by health care provider in 2008 and 2018. The total number of hospitals has increased by 12 hospitals (an increase of 16%) (Fig. 6), with an increase in the number of total hospital beds of about 42% (see Fig. 7). However, at the population level, the number of beds per 10 000 population has only increased from 12.8 in 2000 to 14.3 beds in 2018. Unlike primary health care, the private not-for-profit sector appears to provide the bulk of secondary health care services, with 40% of the total number of hospitals and 2492 beds (representing 36% of total hospital beds). However, the public sector, which operates 34% of the total number of hospitals, has the largest share of hospital beds: a total of 3967 beds (57% of hospital beds). The private for-profit sector runs about 25% of the total number of hospitals, with 404 beds (6% of total hospital beds).

Paradoxically, while the number of hospitals run by the private for-profit sector has increased by only one hospital during the last decade, the number of private hospital beds has fallen by about 3 percentage points. The ratio of beds to hospitals in the public sector has increased from 119 beds per hospital in 2008 to 132 beds per hospital in 2018. In contrast, this ratio is relatively small in the private for-profit sector and has decreased from 21 to 18 beds per hospital in the last decade, despite the increase in the number of hospitals run by the private for-profit sector (see Figs. 6 and 7). While there is no global norm for the density of hospital beds *(42)*, these figures reveal the relatively high density of public hospital beds compared to private hospital beds, in relation

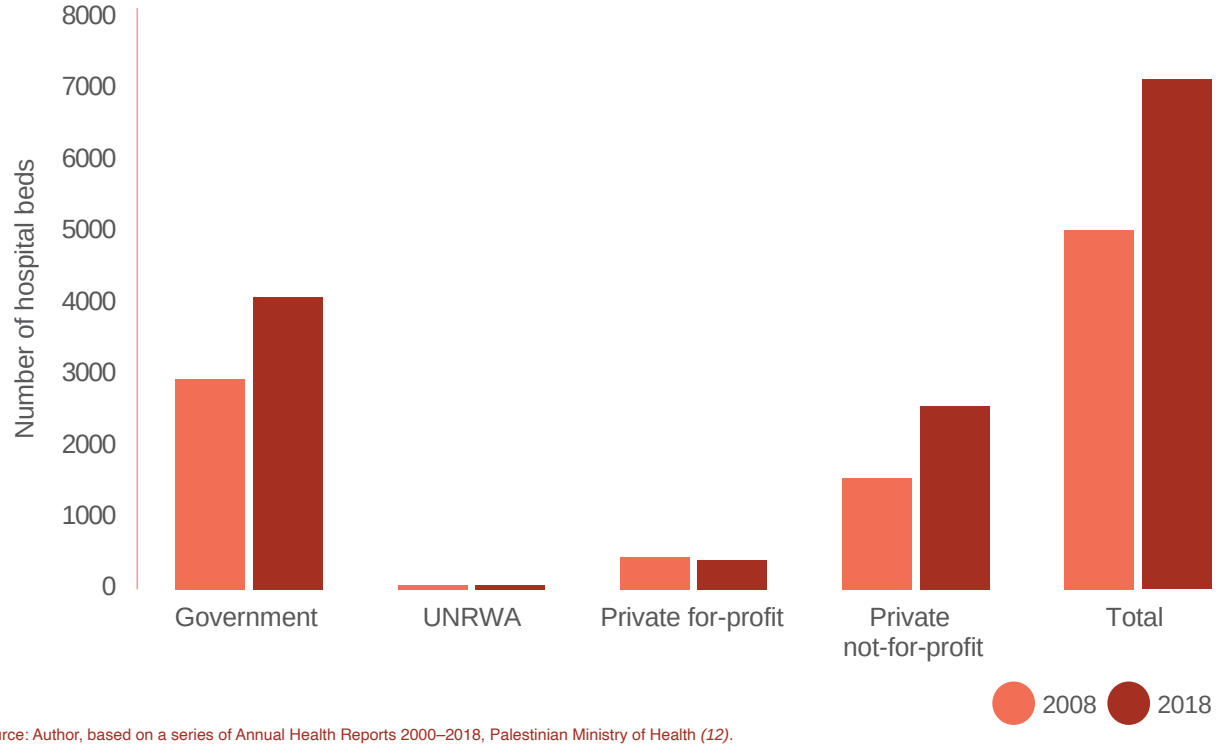
to total population. In 2017, the total number of visits to primary health physicians in the West Bank was 2 383 661; out of the total, 1 977 131 visits were for general clinics. The number of visits to primary health care nurses was 2 371 198 visits *(43)*.

Fig. 6. Percentage of hospitals by health care provider in the occupied Palestinian territory, 2008 and 2018



Source: Author, based on a series of Annual Health Reports 2000–2018, Palestinian Ministry of Health *(12)*.

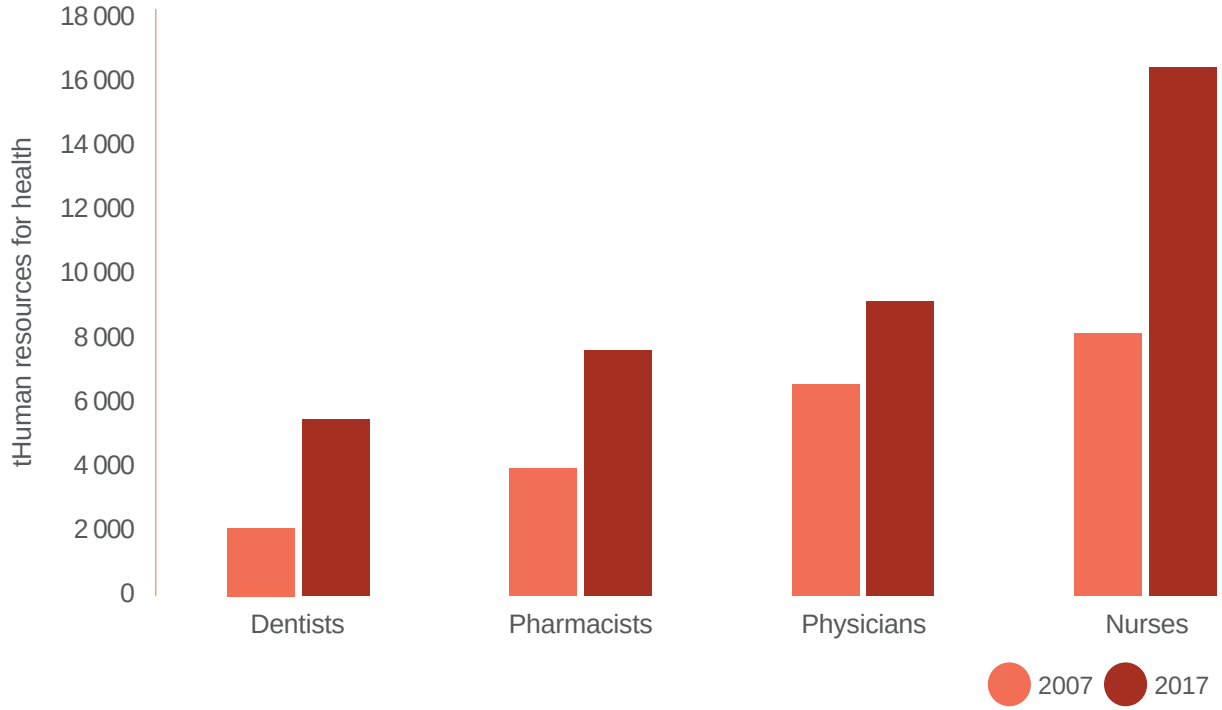
Fig. 7. Number of beds by health care provider in the occupied Palestinian territory, 2008 and 2018



Source: Author, based on a series of Annual Health Reports 2000–2018, Palestinian Ministry of Health *(12)*.

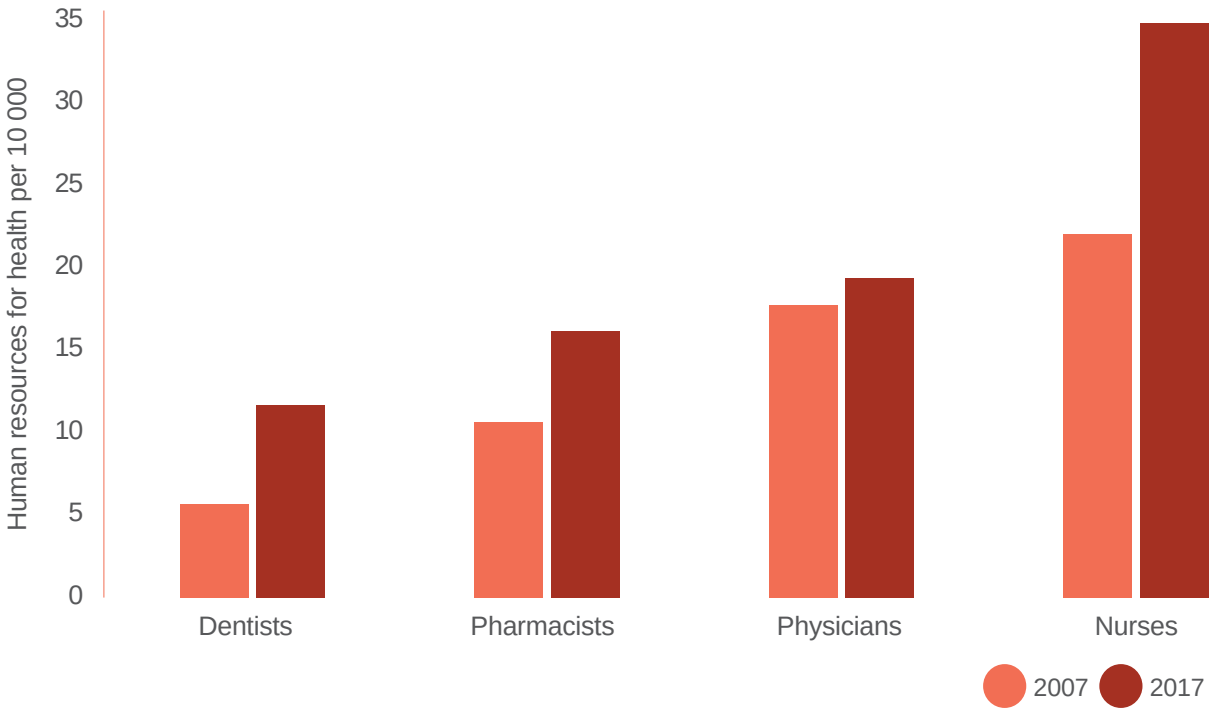
Regarding the availability of human resources for health, Figs. 8 and 9 show that the size of the health workforce has grown in absolute and relative terms in the occupied Palestinian territory over the last decade. A remarkable increase is observed for dentists (160%) and nurses (101%). The total number of physicians has also increased by 39%. The number of human resources for health per 10 000 population has consequently increased: the number of dentists per 10 000 population has more than doubled (106%), however, the number of physicians per 10 000 population has only slightly increased (by less than 10%). In general, there are about 19 physicians, 11 dentists, 16 pharmacists and 34 nurses per 10 000 population. Data on the distribution of human resources for health by provider and by density are still lacking. However, previous studies indicate a high concentration of human resources for health, particularly for secondary and tertiary health care services in the large urban areas, suggesting wide spatial inequalities in the distribution of health care resources *(22)*.

Fig. 8. Total number of human resources for health in the occupied Palestinian territory, 2007 and 2017



Source: Author, based on a series of Annual Health Reports 2000–2018, Palestinian Ministry of Health *(12)*.

Fig. 9. Number of human resources for health per 10 000 population in the occupied Palestinian territory, 2007 and 2017



Source: Author, based on a series of Annual Health Reports 2000–2018, Palestinian Ministry of Health *(12)*.

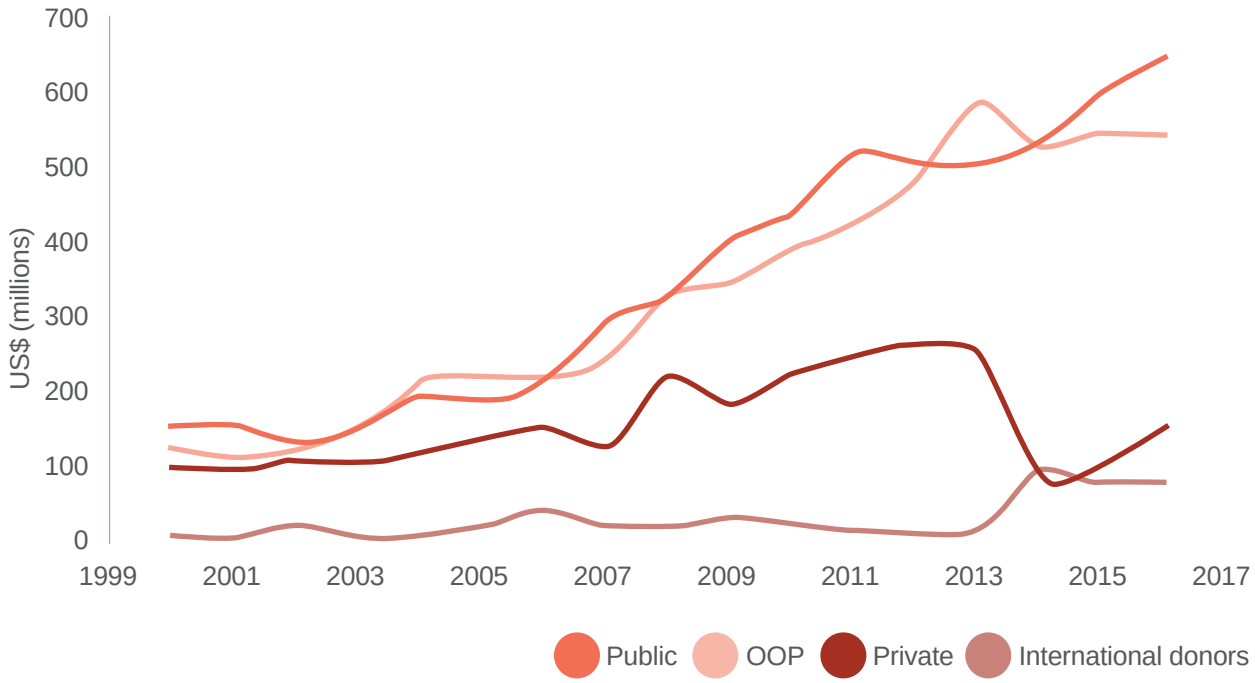
2.3 Health care finance and expenditure

In 2017, the occupied Palestinian territory spent about US$ 1466.7 million on health (about 10.3% of its GDP), compared to health spending of about US$ 384.3 million in the year 2000 (9.0% of GDP). Although the share of GDP allocated to health decreased in 2016, it remains slightly higher than the global average of 10%, and more than twice the average of the Arab world (about 5%) *(18)*. Nonetheless, total health expenditure per capita falls short of the global average of about US$ 1000 per capita *(18)*.

Figs. 10 and 11 trace the evolution of the composition of the health financing-mix in the occupied Palestinian territory over 2000–2017. In 2017, the share of total health expenditure funded by the public sector (Ministry of Health) was about 42.4%, while 41.8% was funded by direct out-of-pocket (OOP) payments, 12.4% from private (for-profit and not-for-profit) institutions, and 3.5% from international donors. Interestingly, although the share of public health spending has increased, this rise was not associated with a fall in direct OOP payments. On the contrary, both public and private sector OOP payments appear to move in the same direction over time. This indicates the low contribution of private risk-pooling mechanisms to health financing. Not having such a national health insurance system forces many people to pay directly OOP when they need health care. Examples of such OOP payments include co-payments for treatment, medicines and diagnostics, purchasing medications directly from private pharmacies, and visiting private physicians and health centres.

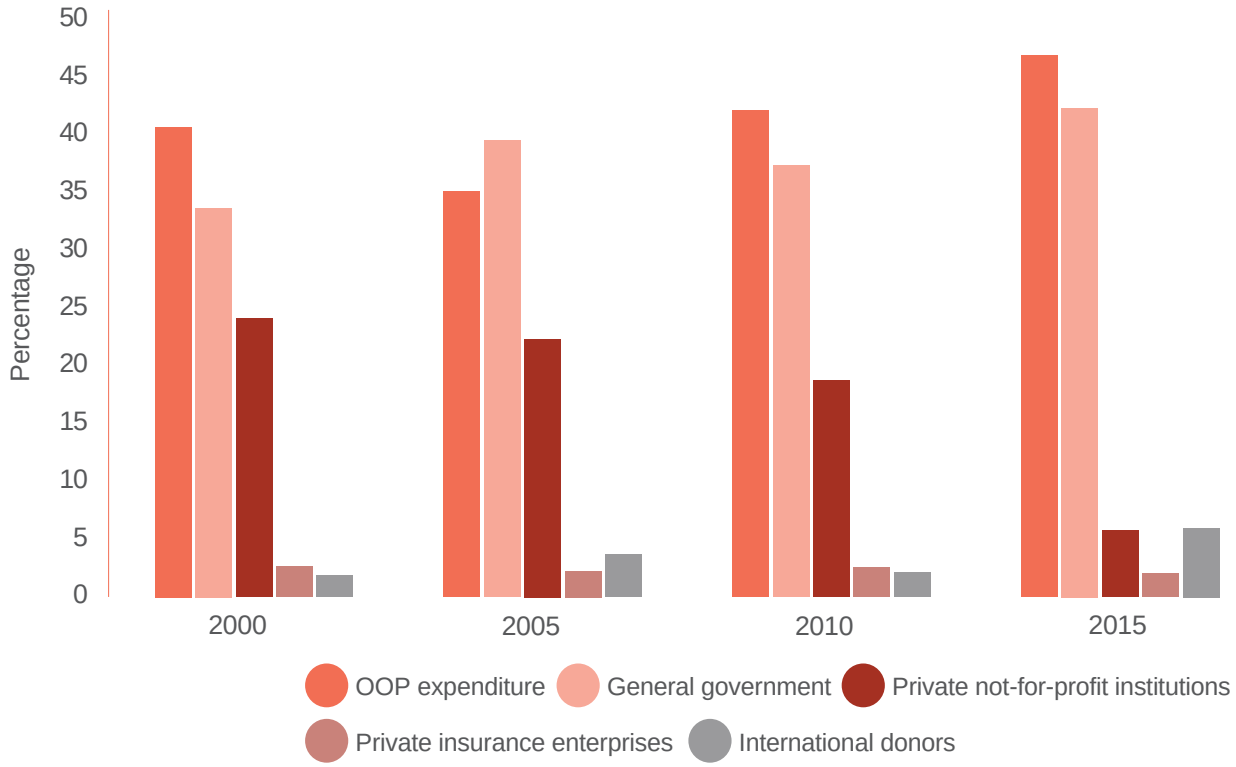
Fig. 11 shows that both the shares of public and private OOP payments of total health expenditure have increased from about 32.7% and 39.5% in 2000 to 42.3% and 41.8% in 2017, respectively. However, the share of private not-for-profit health expenditure has decreased from 23.4% in 2000 to 12.4% in 2017, while private for-profit health expenditure has increased from 2.6% to 3.4%. Up until 2013, the share of total health expenditure of external funding from international donors did not significantly change (representing 2–3%); however, the share of international donors showed a significant increase in 2014, reaching 7.4% of total health expenditure, but then later declined to its previous range.

Fig. 10. Trends in health expenditure (in US$ million) by source of finance in the occupied Palestinian territory, 2000–2016



Source: Author, based on National Health Accounts, Palestinian Central Bureau of Statistics and the Palestinian Ministry of Health (2000–2016).

Fig. 11. Sources of health financing in the occupied Palestinian territory, 2000–2015

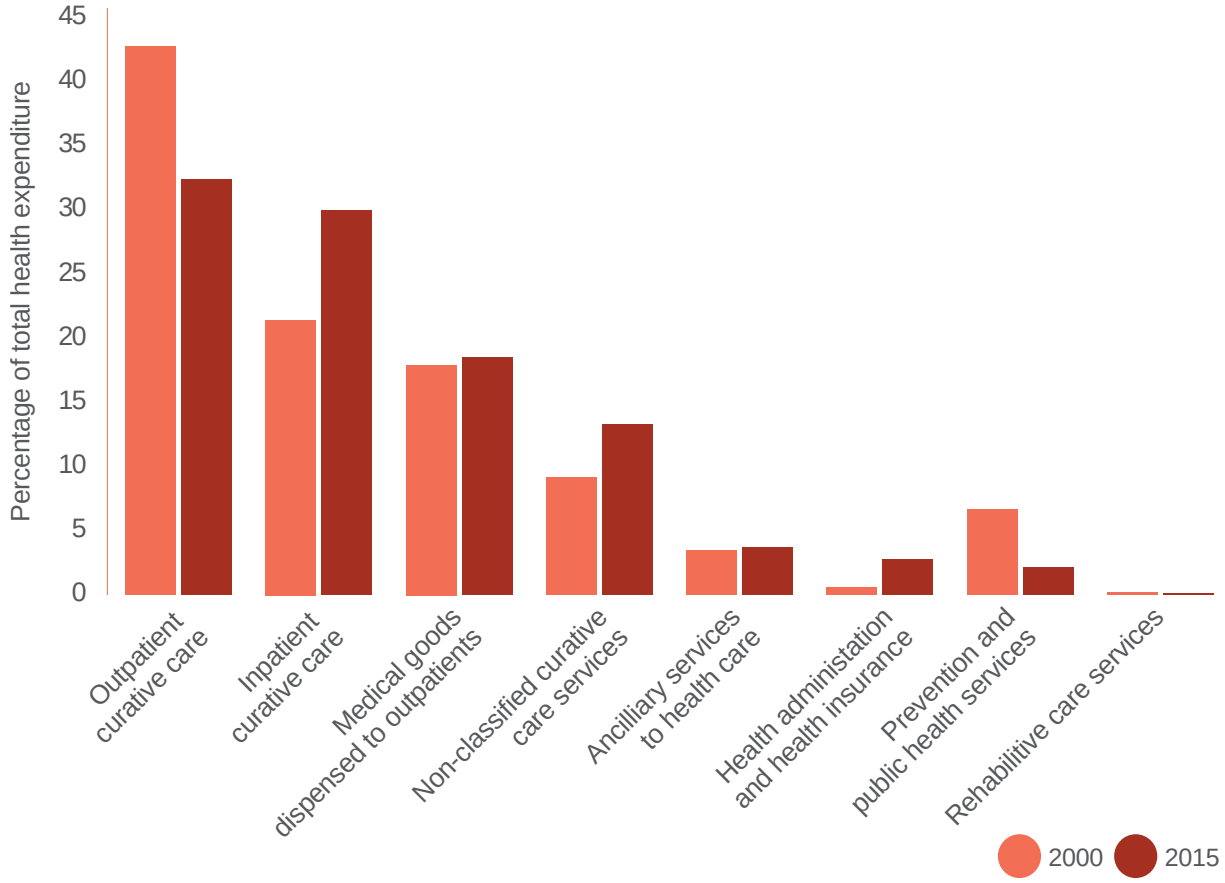


Source: Author, based on National Health Accounts, Palestinian Central Bureau of Statistics and the Palestinian Ministry of Health (2000–2016).

Fig. 12 depicts the main components of total health expenditure by function of health care in 2000 and 2015. Three striking trends can be observed. The first is the dominance of spending on private outpatient and inpatient curative care, representing about 31.5% and 29.1%, respectively, in 2015. The relatively high spending on inpatient care is largely explained by the way health system is structured in the occupied Palestinian territory, with a hospital-centred urban-based system. The contribution of hospitals (including general, specialized and mental health services) to total health expenditure is about 41.6% in 2015 (8,38). The second trend is the importance of spending on medical goods[7] (about 18% in 2015) which may be due, among other factors, to weak coverage of medications in current health insurance schemes. The third is the relatively low ranking of spending on health insurance and on prevention and public health services, which represent only 2.7% and 2.1% of total health expenditure in 2015, respectively. Lastly, although expenditure on outpatient curative care fell by about 10 percentage points in 2015, expenditure on inpatient curative care increased by 8 percentage points. The share of expenditure on medical goods remains almost the same (18%). Nonetheless, expenditure on public health administration and governmental health insurance has increased from less than 1% in 2000 to about 3% in 2015.

7 In the Palestinian National Health Accounts, medical goods include pharmaceuticals and other medical non-durables and therapeutic appliances and other medical goods that are consumed by beneficiaries due to a medical prescription or as self-prescription.

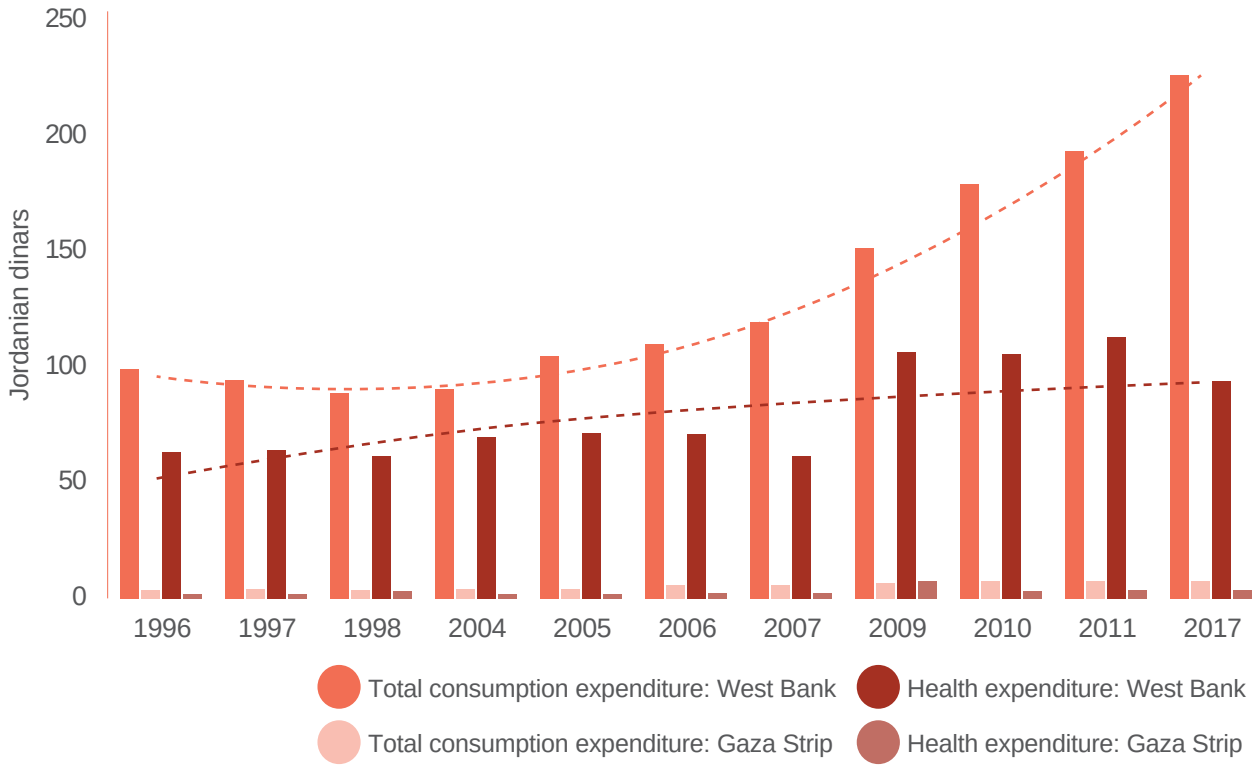
Fig. 12. Distribution of total health expenditure by function of care in the occupied Palestinian territory, 2000 and 2015



Source: Author, based on National Health Accounts, Palestinian Central Bureau of Statistics and the Palestinian Ministry of Health (2000–2016).

At the household level, health expenditure constitutes about 3.4% and 4.1% of total household consumption expenditure in the West Bank and the Gaza Strip, respectively, in 2017. Fig. 13 shows that although household health expenditure increased by about 61% in both the West Bank and the Gaza Strip over the last two decades, its share of total household consumption expenditure has not changed in the West Bank; however, in the Gaza Strip the share of health expenditure has increased by about 1.5 percentage points.

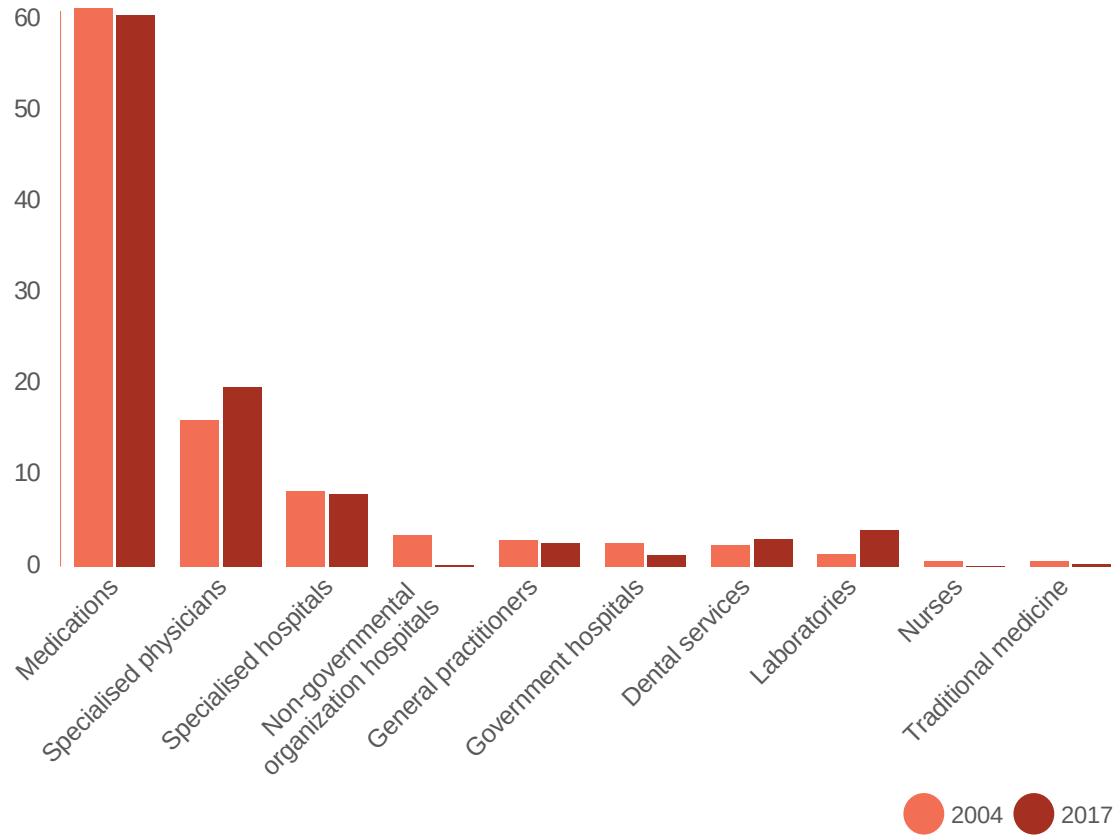
Fig. 13. Total household expenditure versus health expenditure (in Jordanian dinars) per capita per month in the West Bank and Gaza Strip, 1996–2017



Source: Author, based on data from the Palestinian Central Bureau of Statistics (1996–2017).

We use microdata from the Palestinian Household Expenditure and Consumption surveys for 2004 and 2017 to analyse the patterns of household medical expenditure as per specific medical items *(44,45)*. The survey collects detailed expenditure data on 27 medical items, and we grouped these into 10 main items. Results show that the majority share of household medical expenditure is on medications (purchase of drugs and supplies), at 61.5% and 60.7% of total household medical expenditure in 2004 and 2017, respectively (Fig. 14). Also of note is the relatively high ranking of spending on special practitioners' services and specialized hospitals. This confirms the earlier observations on the shallow coverage of medications and problems in the referral system. As far as household medical expenditure on private health sector services is concerned, available data do not allow a breakdown of medical expenditure as per private-for-profit and not-for-profit services. However, for the latter, the only available figure is for medical expenditures in nongovernmental organization hospitals, which appear to fall from about 3.5% of total household medical expenditure in 2004 to 0.14% in 2017.

Fig. 14. Composition of total household medical expenditure: shares of medical items, 2004 and 2017



Source: Author, based on data from the Palestinian Household Expenditure and Consumption surveys (2004 and 2017).

2.4 Equity and accessibility

We use microdata from the Palestinian Household Expenditure and Consumption surveys (2004 and 2017) to give snapshots on inequality patterns in the utilization of and expenditure on different types of health care services in the occupied Palestinian territory *(44,45)*. Total medical expenditure per equivalent adult is computed for the main types of medical expenditures: medication; general practitioners; specialist physicians; and hospitalization. The overall picture (as shown in Table 2) is rather discouraging. Results show quite a high degree of inequality in the distribution of equivalent consumption expenditure: the richest quintile appear to receive 44% of the total consumption expenditure, while the poorest quintile receives only 6% of total consumption expenditure. This is reflected by an increase in the Gini index of inequality from 0.34 in 2004 to 0.43 in 2017 *(44,45)*.

Overall, a Palestinian household in the occupied Palestinian territory spends, on average, about 3% of its total consumption expenditure on health care services. In absolute terms, the richest 20% of the population spent six times more than the poorest 20% of the population (NIS 92.3 versus NIS 15.1 per month, respectively, in 2017). Table 2 presents the shares of the main types of medical expenditures. Reported results clearly confirm that the richest quintile

spends much more on all types of health care under consideration than the poorest quintile. Pro-rich inequality appears to be highest for inpatient hospitalization, with the share of the richest quintile being 60% of total hospitalization versus only 5% for the poorest quintile. These trends did not change much in 2017. With the exception of medication, inequalities in the distributions of the main types of medical expenditures have increased: the most inegalitarian distribution being that of hospitalization (with a Gini index of 0.50).

Table 2. Distribution of equivalent total and medical expenditure across socioeconomic status quintiles in the occupied Palestinian territory, 2004 and 2017

Socioeconomic status	Quantile share of medical expenditure of total consumption expenditure	Total medical expenditure (NIS per month)	Quantile share				
			Total consumption expenditure	Medication	General practitioner	Specialist practitioner	Hospitals
2004							
1 (poorest 20%)	2.79	8.01	6.50	7.80	9.07	8.39	4.64
2	3.24	15.39	11.03	14.03	15.80	15.13	6.46
3	3.15	20.81	15.57	17.66	25.18	18.22	9.89
4	3.30	31.46	22.28	22.27	26.98	20.70	18.63
5 (richest 20%)	3.96	83.23	44.61	38.23	22.98	37.56	60.37
Total			100	100	100	100	100
Gini	0.06	0.42	0.35	0.28	0.16	0.26	0.49
2017							
1 (poorest 20%)	3.27	15.09	5.85	9.92	5.78	6.46	0.33
2	3.43	28.93	11.05	15.24	17.79	14.40	6.86
3	3.32	41.59	16.33	19.77	24.03	21.31	5.10
4	3.36	59.40	23.34	24.70	26.60	21.70	41.78
5 (richest 20%)	2.93	92.25	43.43	30.38	25.79	36.12	45.94
Total			100	100	100	100	100
Gini	0.03	0.31	0.43	0.20	0.20	0.27	0.50

Source: Author, based on data from the Palestinian Household Expenditure and Consumption surveys (2004 and 2017).

2.5 Health insurance coverage

To date, the draft of the Palestinian Health Insurance Law, which stipulates the creation of a new national health insurance programme to be administered by an independent agency to meet the health needs of all Palestinians in the occupied Palestinian territory, has not yet been passed. The Government Health Insurance (GHI) – run by the Ministry of Health – remains, therefore, the main health insurance scheme in the occupied Palestinian territory, although by no means the only one (see Fig. 18). The functioning of the current GHI is regulated by Palestinian Government Decree No.113 for the year 2004 *(46)*.

Initially, the GHI was designed to cater to public sector employees and Palestinians workers in Israel who are compulsorily enrolled. However, since late 1999, the Palestinian Ministry of Health has undertaken several policies that aim to expand the breadth of GHI coverage to uncovered segments of the population, particularly the poor and the unemployed – referred to as "hardship cases" *(47,48)*. These policies[9] succeeded in expanding the nominal coverage of GHI enrolees from less than 20% of the total population of the occupied Palestinian territory to more than 50% in 2000 *(44,49)* and nearly 60% in 2018 *(43,50)*.[10]

Figs. 15 and 16 trace the evolution of the five types of enrolment in the GHI and the corresponding GHI revenues over the last decade in the West Bank.[11] As shown in Fig. 15, the GHI has realized a significant increase in the percentage of enrolees under all types of enrolment. The category labelled "mandatory" includes public sector employees who contribute a flat rate of 5% of their basic monthly salaries – deducted and transferred from the Ministry of Finance to the GHI account.[12] This category constituted the majority of enrolment in the GHI and its funding in 2007 (53.5% of all insured families, resulting in 42.5 % of total GHI revenues). However, these shares have witnessed a dramatic decrease in the last decade, reaching only 24.7% of all insured families and 23.0% of total GHI revenues (Figs. 15 and 16).

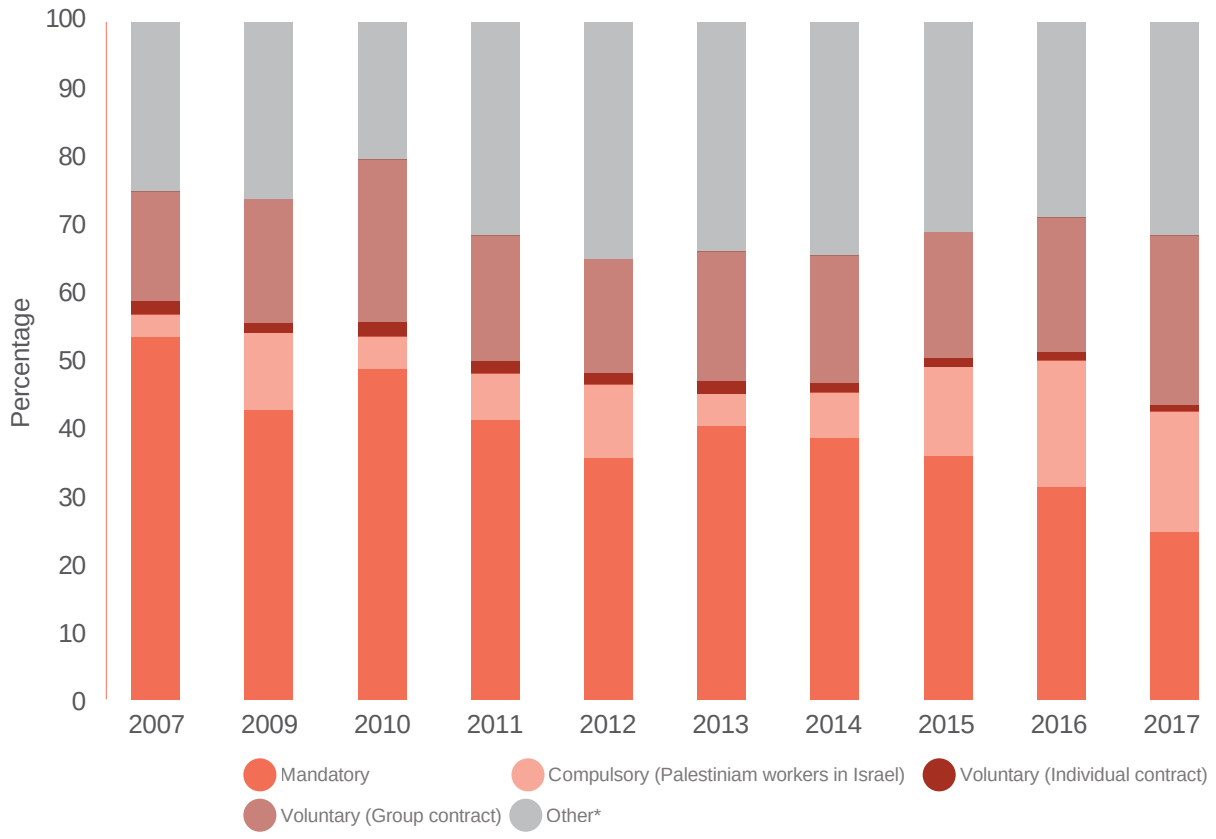
"Compulsory" enrolment concerns Palestinian workers in Israel, whose contributions to the GHI (a lump sum of NIS 75 per month) are deducted by Israeli employers and transferred to the Palestinian Ministry of Finance. The affiliation of this group has increased since 2007 from 3.34% of all GHI enrolees (resulting in 24.5% of total GHI revenues) to 17.80% in 2017 (resulting in 26.6% of total GHI revenue). This category was the second largest type of GHI enrolees before it drastically declined due to the Israeli-imposed closure of borders in 2000 – from 22% of all GHI participants (with about 25.3% of its total revenue) to 2% of all GHI participants (8% of total GHI revenue in 2005) *(22)*. Despite the decrease in the share of GHI total enrolment of this category as compared with 2005, it still constitutes the major source of GHI revenues in 2017.

9 For a detailed description of Ministry of Health policies to expand GHI coverage, see the report *Health system profile: occupied Palestinian territory 2012.* Cairo: WHO Regional Office for the Eastern Mediterranean; 2014 *(22)*.
10 It is worth noting that eligibility for GHI coverage was estimated to be around 80% of the population in 2005 *(35)*. However, effective enrolment was 60% of the population *(48)*. This indicates that not everyone who is eligible for GHI coverage has actually enrolled; as soon as premiums are required, the percentage of effective enrolment peaked at 56.8% of total households in the occupied Palestinian territory *(22,48)*.
11 No data were available for the Gaza Strip.
12 For each additional dependent, a lump sum of NIS 5 (≈US$ 1.40) is added to the monthly premium for all types of enrollments. The minimum and maximum contributions are in the range of NIS 50–100.

The third and fourth categories are voluntary enrolment, referred to as “group and individual contracts”. Affiliation to group contracts is undertaken by the formal private sector employers/ organizations. Their monthly contributions are similar to those of the mandatory group (5% of the wage bill). Enrolment in this category has witnessed a significant rise from 16.1% of the total number insured in 2007 to 25% in 2017 (with an increase in corresponding revenues from 8.6% in 2007 to 17.0% in 2017). Affiliation to the GHI can also be undertaken by individuals or families, with monthly contributions ranging between NIS 50 and NIS 80.[13] In 2007, this category represented 2.0% of all GHI enrolees and 2.7% of total GHI revenues. In 2017, this category represented less than 1% of all GHI enrolees and 1.1% of total GHI revenues.

The last category, labelled “others”, includes GHI non-contributing enrolees (political ex-detainees, the unemployed and indigent families – referred to as social hardship cases).[14] The share of “non-contributing enrolees” showed an increase from 25.0% in 2007 to 31.6% in 2017, hence constituting the bulk of GHI enrolees. Revenues for the GHI from payments made on behalf of this category amounted to 6.6% of total GHI revenues in 2007 and 12.2% in 2017. Lastly, another source of GHI revenues is co-payments, the share of which in GHI revenues has increased from 15.2% in 2007 to 20.2% in 2017.

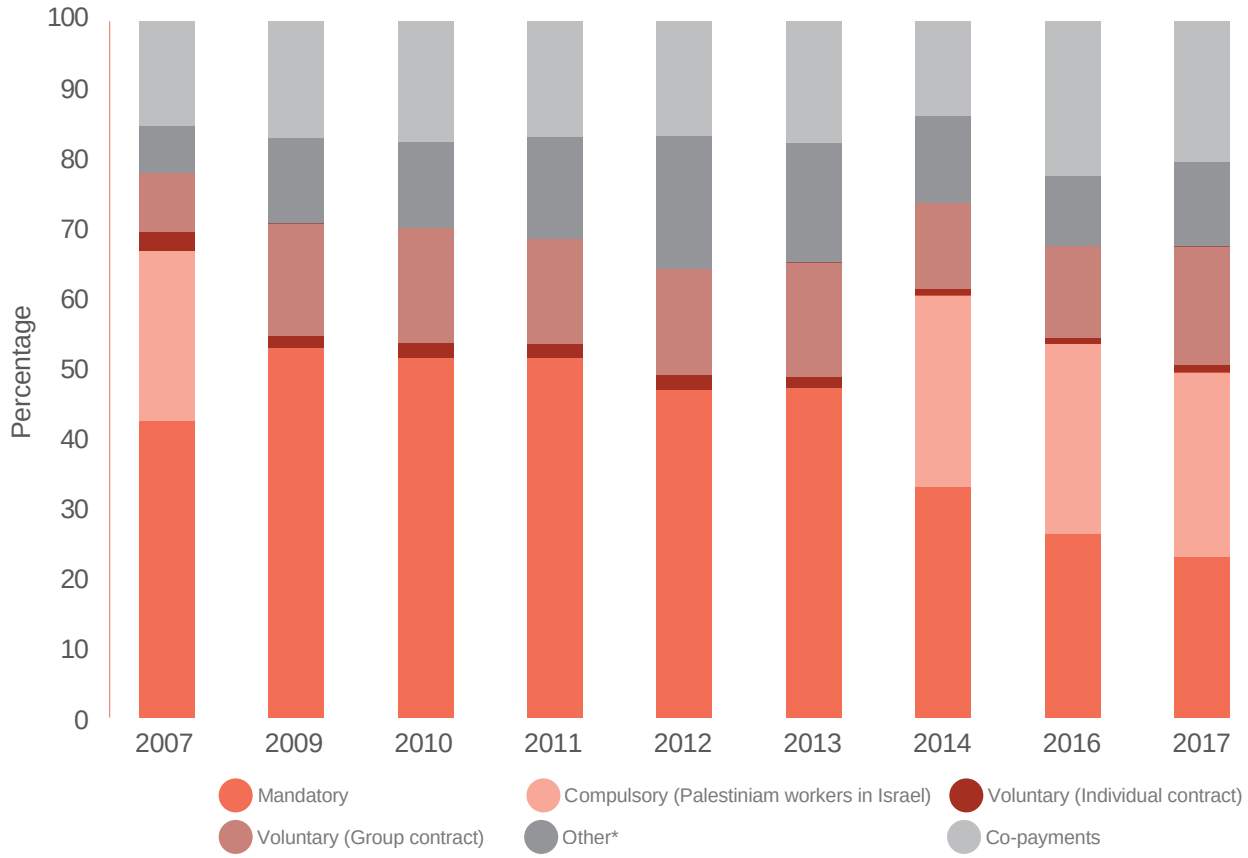
Fig. 15. Distribution of insured families by type of GHI enrolment in the West Bank, 2007–2017



Source: Author, based on a series of Annual Health Reports, Palestinian Ministry of Health (2007–2017).
*Includes the Commission of Detainees and Ex-detainees’ Affairs, the Ministry of Social Development, and unemployed and indigent families.

13 The contributions in this category depend on whether the insurance is undertaken by an individual or a household. For individuals, a lump of NIS 50 is required while NIS 80 is required for a household. Enrollment in this category also includes members of professional unions and worker’s unions who contribute NIS 80 and NIS 50, respectively.
14 The Ministry of Finance transfers payments (a monthly contribution NIS 45 per household) from the budget of the Ministry of Social Affairs to the Ministry of Health-GHI account for all beneficiaries in this category.

Fig. 16. Distribution of GHI revenues (in NIS million) by type of enrolment in the West Bank, 2007–2017



*Includes the Commission of Detainees and Ex-detainees' Affairs, the Ministry of Social Development, and unemployed and indigent families.

Some key issues related to the functioning of the current GHI are worth highlighting. First, the GHI offers its enrolees coverage for a wide range of services: its benefit package is often described to be "comprehensive", covering maternal and child health services, prescribed medications, primary, secondary and tertiary health care services, which are provided by Ministry of Health facilities or purchased from other non-Ministry of Health providers, particularly east Jerusalem hospitals or even abroad (referred to as treatment/referrals aboard).[15] In practice, however, the GHI benefit package includes a negative list of services – that is, a benefit package that covers all health care services except for a number of specified services.[16] A varying co-payment rate is required for a number of specified services and for medications, but no expenditure cap is imposed. Although the GHI benefit package appears to be generous, it is less clear which criteria have been used to define its content (the included and excluded items), nor is it clear whether these have been subject to any revision and rationalization. By the same token, it is not clear whether the list of covered medications include generic or brand-name drugs and whether the list was established using a cost-effectiveness

15 The GHI benefit package covers some services free of charge such as vaccinations, treatment for communicable diseases (e.g. tuberculosis), maternal and child health services, school health programmes in public schools, casualty care for all man-made and natural disasters including war, mental health services, and any other services approved by the Ministerial Cabinet and recommended by the Minister of Health (53).

16 These include medical durable devices, prostheses, contact lenses and other optical items, hearing aids, cosmetic dentistry, cosmetic plastic surgery, infertility services, organ transplantation and hormone drugs, and any other drugs that are not part of the drug formulary. The GHI also does not cover road accidents, work accidents and cases where someone is harmed by others (53).

criterion. This is particularly important given that expenditure on medications appears to represent a large share of household health expenditure in the occupied Palestinian territory (see Fig. 14).

Second, the current GHI plays a passive purchasing role, merely collecting contributions from enrolees while the Ministry of Health transfers the pooled funds to service providers on behalf of the GHI. However, there is growing evidence favouring an active purchasing function for the insurance scheme through purchasing, setting of payment mechanisms and remuneration rates, and contracting and commissioning of services from other providers (such as the private for-profit and not-for profit sectors) *(51)*. An active purchasing function can help foster efficiency and cost containment. This is particularly relevant in a context where the costs of referrals aboard represent an important strain, exacerbating the already constrained fiscal stance of the GHI and the Ministry of Health budget, and where an active private sector already exists and the use of its services comprises a fairly large share of health care expenditure (see Figs. 11 and 14).

Third, although the GHI has succeeded in expanding the breadth of coverage to about 60% of the population, such expansion has failed to reduce OOP payments which remain a major source of health funding in the occupied Palestinian territory (see Figs. 10 and 11). This source of funding has often been shown to push households into poverty and to further increase inequity in health and in access to health care *(23,27)*. This again indicates rather shallow coverage in terms of both the depth and breadth of health care services.[17] Indeed, previous assessments of the Palestinian health system indicated that successive expansions in the entitlements to GHI have been ad hoc, with no simultaneous expansion in the provision capacity of the system and resulting in a significant increase in Ministry of Health debts and compromised quality of services *(23,27,29).* In addition, it has been shown that individual contributions to the GHI are weakly linked to an ability to pay, resulting in a mildly progressive scheme with no significant redistribution (cross-subsidizing) role *(53)*.[18]

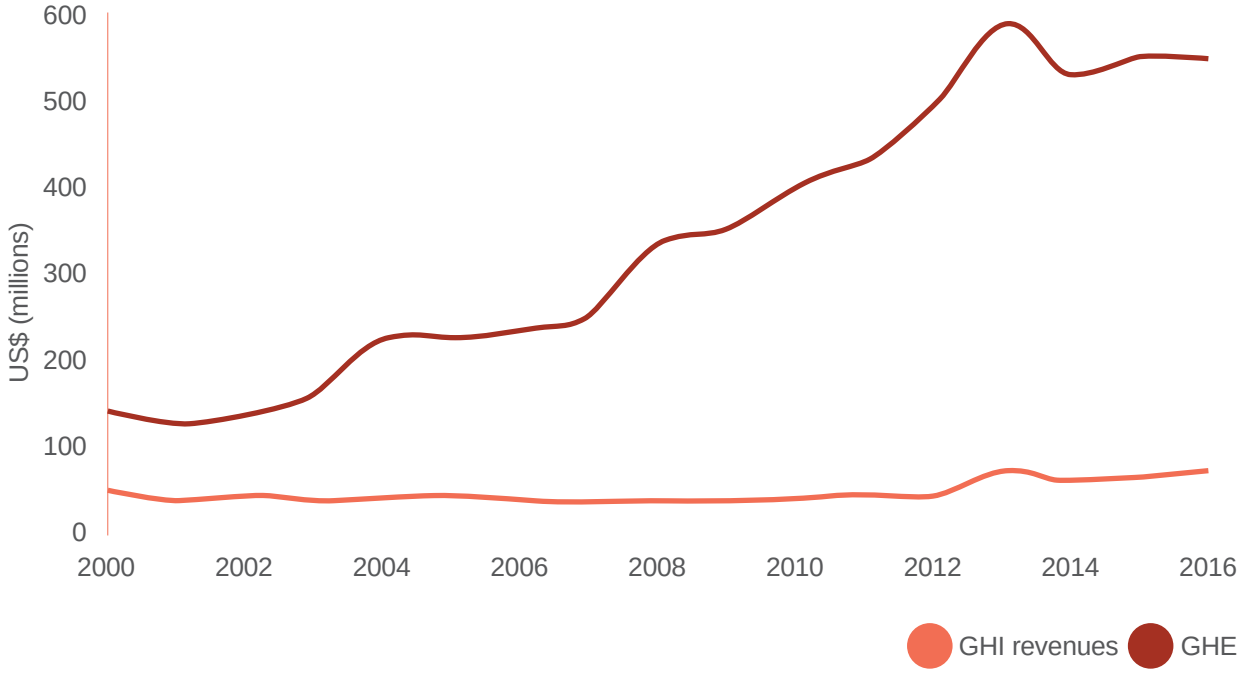
Fourth, the large increases in the number of non-contributing enrolees (about 31.6% of total GHI enrolees), regardless of any income-related criteria or a means-tested benefit, can jeopardize the fiscal sustainability of the GHI (see Figs. 15 and 16). Fifth, the presence of five different types of enrolment in the GHI, with different collection mechanisms, results in fragmented fund pools. This compromises the collection and management capacity of financial resources. Sixth, the GHI contribution to government health expenditure (GHE) appears to be trivial. Fig. 17 shows a striking and increasing gap between GHI revenues and GHE, with the GHI-GHE gap standing four times higher in 2016 as compared to 2000. This clearly indicates the limited role of the current GHI in funding public expenditure on health and the increasing reliance on other sources of funding, mainly general tax revenues.[19]

17 It is worth noting that GHI premium-exempted insured are required to pay some charges and co-payments. For instance, individuals who are referred by a private provider to public services are charged US$ 4 per referral.

18 This is mainly due to the presence of a ceiling on the contributions of mandatory enrolees, the lump sum contributions required from the voluntary affiliations while eligibility to the free of charge – the "subsidized" health insurance category – is rarely a means-tested benefit. All of which makes GHI contributions mildly progressive or even regressive.

19 No information was made available on the contribution of general tax revenues in health finance.

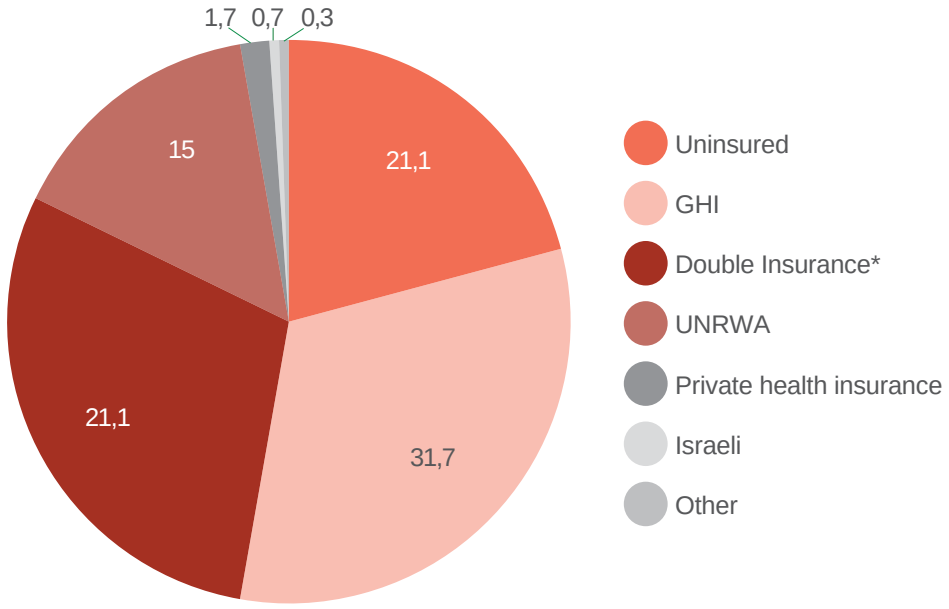
Fig. 17. GHI-GHE gap (in US$ million) in the West Bank, 2000–2016



Source: Author, based on National Health Accounts and Annual Health Reports (Palestinian Central Bureau of Statistics and Ministry of Health).

Lastly, as mentioned above, there are other types of health insurance coverage in the occupied Palestinian territory. According to the 2017 population census (9), the GHI only covers about two thirds of the Palestinian population (60.1%). UNRWA is the second largest insurer with a population coverage rate of about 43.9%, while private health insurance covers 2.6% of the population. This leaves about 21% of the population without any coverage (Fig. 18).

Fig. 18. Distribution of insured persons by type of health insurance coverage, 2017



Source: Author calculations, based on the 2017 population census *(9)*.
* Includes those who have double insurance such as GHI + UNRWA or UNRWA + private health insurance or GHI + private health insurance.

Currently, there are nine private-for-profit insurance companies, seven of which provide various forms of employment-based health insurance plan (Table 3). However, as shown in Table 3, private health insurance written premiums represent a tiny proportion of these companies' total written premiums (from 5% to 22%). Contributions to private health insurance schemes are made by both employers and employees; however, these schemes continue to cater for a tiny proportion of Palestinians at 2.6% of the population in 2017 (compared to about 5% in 2004) (44,454). This is mainly due to the relatively high premiums, which are an average of US$ 2000 per annum compared to an average GHI premium of US$ 250 (for an average-sized family) (Table 4). Another reason for people not taking up private health insurance is their deteriorating purchasing power, due to the fragile economic and political situation (22). In addition, the private benefit packages exclude many pre-existing conditions and chronic illnesses, while other services such as pre- and postnatal care are only covered upon payment of additional premiums. Nonetheless, a maximum ceiling for claims is imposed. Overall, the contribution of private health insurance schemes to the health care financing-mix in the occupied Palestinian territory remains trivial, at about 2.5% of total health expenditure (see Fig. 11).

Table 3. Insurance portfolio per company, from 1 January 2017 to 31 December 2017

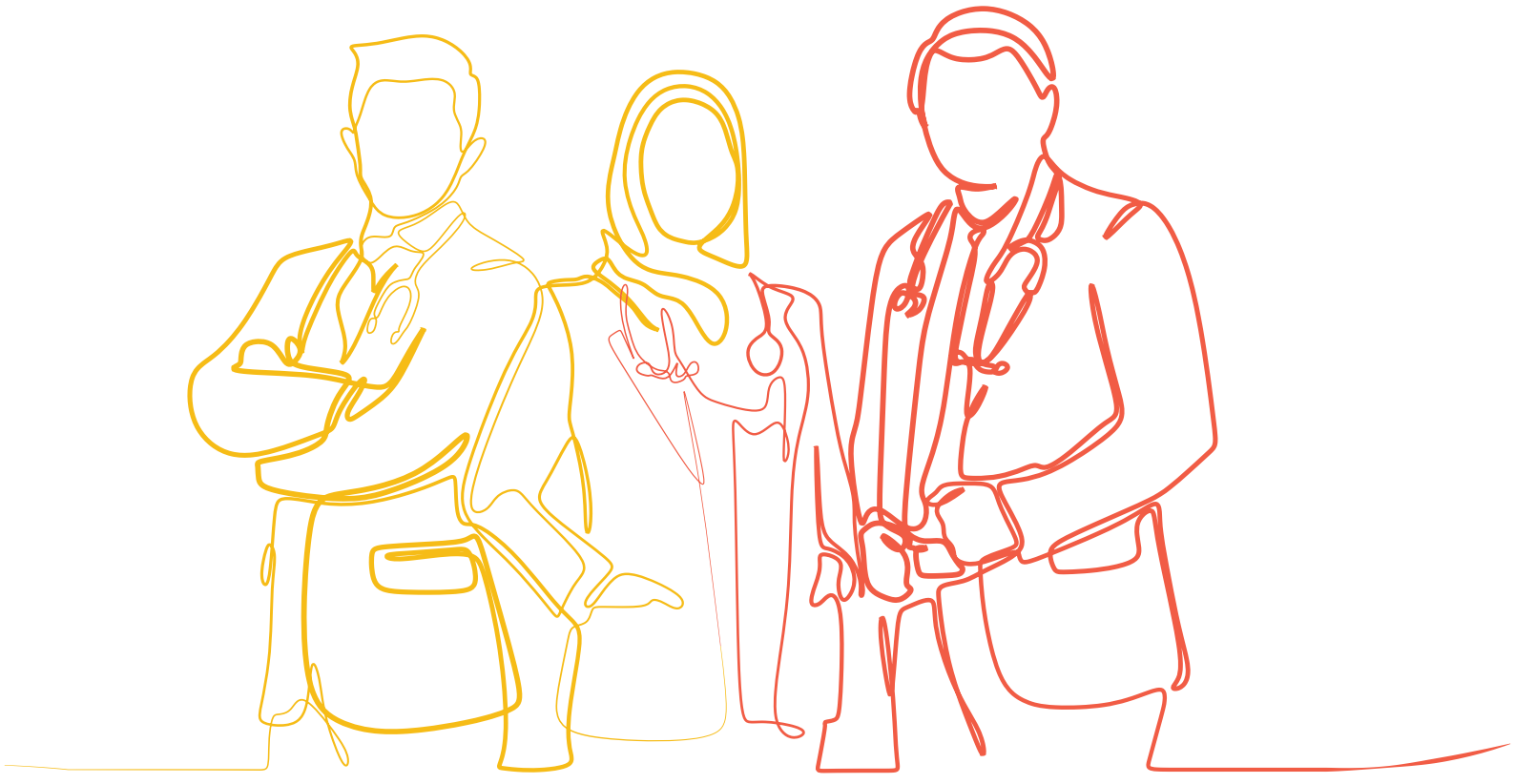
Insurance company	Health insurance written premiums as % of total company's written premiums
Al Mashreq insurance	0.114
Al-Ahleia insurance group	0.053
National insurance	0.222
Palestine insurance	0.069
Al-Takaful insurance	0.104
Trust International insurance	0.048
Global United insurance	0.155
American Life Insurance-ALICO	0.000
Palestine mortgage insurance fund	0.000

Source: Author calculations, based on Health Insurance Companies Operational and Financial Data Report for 2017 and 2018.

Table 4. Comparison of GHI and private health insurance[a]

	2017		2018	
	GHI	PHI	GHI	PHI
Insured population[a]	1 390 557	75 529	–	–
Insured (%) a	31.5%	1.70%	–	–
Total health insurance premiums (in US$)	61 100 625	29 783 673	–	29 024 836
Health insurance premiums of total premiums (%)[b]		12%		13%
Annual average insurance premium (in US$)[c]	40.72	370.13	–	–
Number of private insurance companies		9		10
Number of branches private insurance companies		141		147
Number of employees in private insurance companies		1245		1355
Palestine mortgage insurance fund	0.000			

a Population, Housing and Establishments Census, 2017 (9).
b Author calculations, based on data on Private Health Insurance Companies Operational and Financial Report (2017–2018).
c Computed as a ratio of health insurance premiums to the insured population (computed as the percentage of insured population multiplied by the total size of the population).



3

Qualitative analysis of stakeholder perspectives

3.1 Materials and methods

This section presents a synthesized qualitative analysis of the views and perspectives of various health sector stakeholders in relation to the role of the private health sector and its potential engagement in current efforts towards attaining UHC in the occupied Palestinian territory. For the purpose of this assessment and in order to fully explore the perspectives of all stakeholders, while allowing new viewpoints to freely emerge, a set of in-depth semi-structured interviews were held (between 18 December 2018 and 13 February 2019) with a sample of 36 individuals representing the spectrum of health sector stakeholders in the local context of the West Bank and Gaza Strip. All interviews were performed by a well-trained team from the Palestinian National Institute of Public Health (PNIPH) and were recorded on tape and transcribed verbatim. The length of the interviews was between 60 and 90 minutes. The selection of interviewees was based on informed choice (purposive sampling). They include Palestinian Ministry of Health officials, private for-profit and not-profit providers (including the pharmaceutical industry, laboratories and diagnostic centres, private health insurance companies, medical professional association representatives, health academics and experts), donors and beneficiaries (details are provided in the Annex, Table A.1). Consultations were held using checklists of questions/questionnaires for each type of stakeholder, as per the assessment tool developed by the WHO Regional Office for the Eastern Mediterranean in 2018.

The interview checklists involved a set of questions about different aspects related to private health sector finance and delivery, opportunities and challenges facing the health sector (in general) and the private health sector (in particular), and opinions about the future development of the private health sector and its engagement in efforts to develop the health system to attain UHC. Stakeholders were questioned about past experiences, and their thoughts about policy interventions that would help promote public–private partnership in health care finance and delivery. Interview questions gathered detailed information on the main determinants of private sector growth, major achievements and shortcomings, and reforms needed to address current obstacles and challenges. The feasibility of private sector investment in health care services in the Palestinian context was also addressed and assessed. All information reported in the interviews was carefully analysed with the aim of revealing the current obstacles in the path towards achieving UHC and engaging all stakeholders in the future development of UHC, with a particular focus on role of the private – for-profit and not-for profit – health sector.

3.2 Analysis and findings

3.2.1 Private health sector growth and determinants

In analysing private health sector involvement and growth in the occupied Palestinian territory, it is necessary to first distinguish between *private for-profit and private not-for profit* health care providers. Although common factors – mainly context-specific – are found to affect both types of providers, their diverse inherent characteristics (goals, roles, clientele, direct and indirect resources, and so on) imply

that some of the context-specific factors can have a varying and sometimes opposite effect on the extent of their involvement in health care provision and finance, as well as their current and potential growth. The conflict-affected and fragile setting within which the two sectors have grown over the years, coupled with a relatively high degree of political and economic instability and insecurity, remain by far the prime determinants of the growth of both sectors. However, as is to be expected, the consequences of such a context-specific factor on the involvement and growth of the two sectors appears to vary: while the private non-profit sector grows faster than the for-profit sector in times of emergencies (as was the case during the first and second popular uprisings in 1987–1994 and 2000–2006), subsequent periods have given way to sluggish growth of non-profit sector and marked a cautious recovery of the for-profit sector.

Although not unrelated, there are other sector-specific factors at play deriving mainly from the inherent features of each sector. The most salient characteristic appears to be the continuous reliance of the not-for-profit sector on foreign – rather than domestic – resources *(19)* (WHO 2014). Even if involvement of the not-for-profit sector in health care provision is mainly driven by benevolence and altruistic commitment towards local communities, the extent of their role and growth are greatly affected by donor-driven priorities and practices. These include, inter alia, the diverse modalities of aid-giving, the unpredictability and inflexibility of aid in dealing with rapidly changing circumstances, and the sudden withdrawal of donors due to political reasons. Such practices threaten the sustainability of many not-for-profit programmes and services (for example, sector representatives highlighted the financial crises of UNRWA and many other not-for-profit providers working mainly in east Jerusalem and the Gaza Strip as a result of the United States aid cut, which represented about 30% of UNRWA operations funding in the region). Nonetheless, the fragile economic situation coupled with the budgetary constraints of the Ministry of Health – the main purchaser of secondary and territory services provided by the private health sector – has led to increased demand for not-for-profit services by low-income groups and the Ministry of Health. However, given the lack of dedicated budget and financial resources to pay for services purchased from the private not-for-profit sector, such increased demand has often culminated in severe financial crises, with striking cases reported such as the frequent deferrals in payments for services purchased from the not-for-profit hospitals in east Jerusalem.

The Ministry of Health remains the predominant health care provider in the occupied Palestinian territory. Its functions, mandated by Public Health Law No. 20 (2004), entail directly providing services (including preventive, diagnostic, curative and rehabilitative services) to the population, besides regulating, licensing and monitoring several related activities (including nongovernmental health institutions, businesses, medical and auxiliary medical professions, drug industries, and so on), and providing health insurance to citizens *(39)*. Despite notable achievements, the budgetary and fiscal constraints of the Ministry of Health have, however, hindered the public sector's capacity to expand coverage to all services and populations. These supply-side shortages, coupled with the rising demand for health care by the population, have further fuelled the growth of indigenous investment by the private for-profit health sector in the occupied Palestinian territory. Involvement

of the private for-profit sector in health care covers almost the whole spectrum of medical services including speciality hospitals, laboratories and diagnostic centres, in addition to self-employed physicians, pharmacies and group clinics.[20]

Health sector stakeholders participating in this study indicated that approximately 15% of the population of the Gaza Strip seek health care from the private sector (compared with an estimated 60% in the West Bank) and that about 20% of health care services in the Gaza Strip are provided by the private (both for profit and not-for profit) sector; while in the West Bank, some stakeholders indicated that nongovernmental organizations cover about 52% of primary health care services (in terms of the number of clinics).[21] Nonetheless, the private sector share of secondary and tertiary health care services was said to vary significantly according to the volume of referrals by the Ministry of Health. Accordingly, the private health sector appears to be predominant in some areas and in some services. For instance, the private (not-for profit) sector is said to be predominant in the provision of some primary health care services in Area C in the West Bank and in the Gaza Strip[22], and in provision of specialized (secondary and tertiary) services, mainly in east Jerusalem, the Gaza Strip and the main urban areas of the West Bank. The private not-for-profit sector is also attributed the leading role in medical education and scientific research, with the majority of medical colleges, schools and training institutions (including medicine, dentistry, pharmacy, nursing and health professions) run by the not-for-profit sector in collaboration with the Ministry of Higher Education.

In contrast, the private for-profit sector is deemed predominant in some specific areas, including specialized surgeries, laboratories and diagnostic facilities, dental services and the pharmaceutical industry. Despite its active involvement, the growth of the private for-profit sector has been subject to several critiques from health policy-makers, experts and representatives of other not-for-profit sectors. These critiques include several issues related to its role and practices. We first focus on those critiques that are mainly related to the nature of growth of the private for-profit sector, and discuss other critiques that are related to its practices in the following subsection. The growth of the private for-profit sector is often viewed as a “by default auto-growth” – which is often not well aligned with the country-specific health needs, economic and institutional capacities, and cultural characteristics. For instance, some interviewees argued that the growth of the sector has been ad hoc, often resulting in a mere increase in the number of establishments, beds and infrastructures without provision of new specialities. Others pointed out that the growth of the private for-profit sector may have resulted in some new services being offered. However, the lack of specialized human resources for health leads to insufficient and unsustainable provision of these services (as indicated by one key stakeholder: “private provision often relies on short/part-time contracts and task-shifting to practical nurses”). Such ad hoc growth can be attributed, according to many participants, to two main factors: 1) the profit-seeking behaviours that drive much of private investment in health; and 2) the lack of effective legal and regulatory systems, planning and oversight of the private

20 No official statistics are available on the market share of the private (for-profit and not-for-profit) sector and the proportion of population seeking private care.
21 Given the lack of accurate data, these figures should be interpreted with caution.
22 Stakeholders referred mainly to maternal and child health care services, mental and physiological support, as well as health education and awareness.

sector. Although some participants alluded to the emergence of some sort of public–private partnership, that being said, such intersection is a source of concern due to conflicts of interest ("the goal of the government is to serve the citizens, while the goal of private sector is to maximize profits") and resultant task-shifting from the public sector to the private sector. Nonetheless, although many have argued that the growth of the private sector was intended to fill the gaps in the health care market, which may have enhanced complementarity in some areas of health care provision, much of this growth has led to service duplication and rivalry between sectors. Table 5 gives a summary of the relative importance of the determinants (direct and indirect) for private (for-profit) sector growth, and the possible benefits and negative consequences of growth as viewed by the key health sector stakeholders. As shown in Table 5, political stability and overall macroeconomic performance, and the weak capacity and low quality of the public health sector appear to be the most important reasons for private sector growth. Complementarity and reduction in the burden on public health facilities and the involvement in secondary and tertiary health care services, as well as quality improvement, are among the main cited benefits of private sector growth. Duplication (i.e., covering the same services as the public sector) and profit-oriented and irrational behaviour (namely dual practice and supplier-induced demand) are viewed as the main negative consequences of private for-profit sector growth.

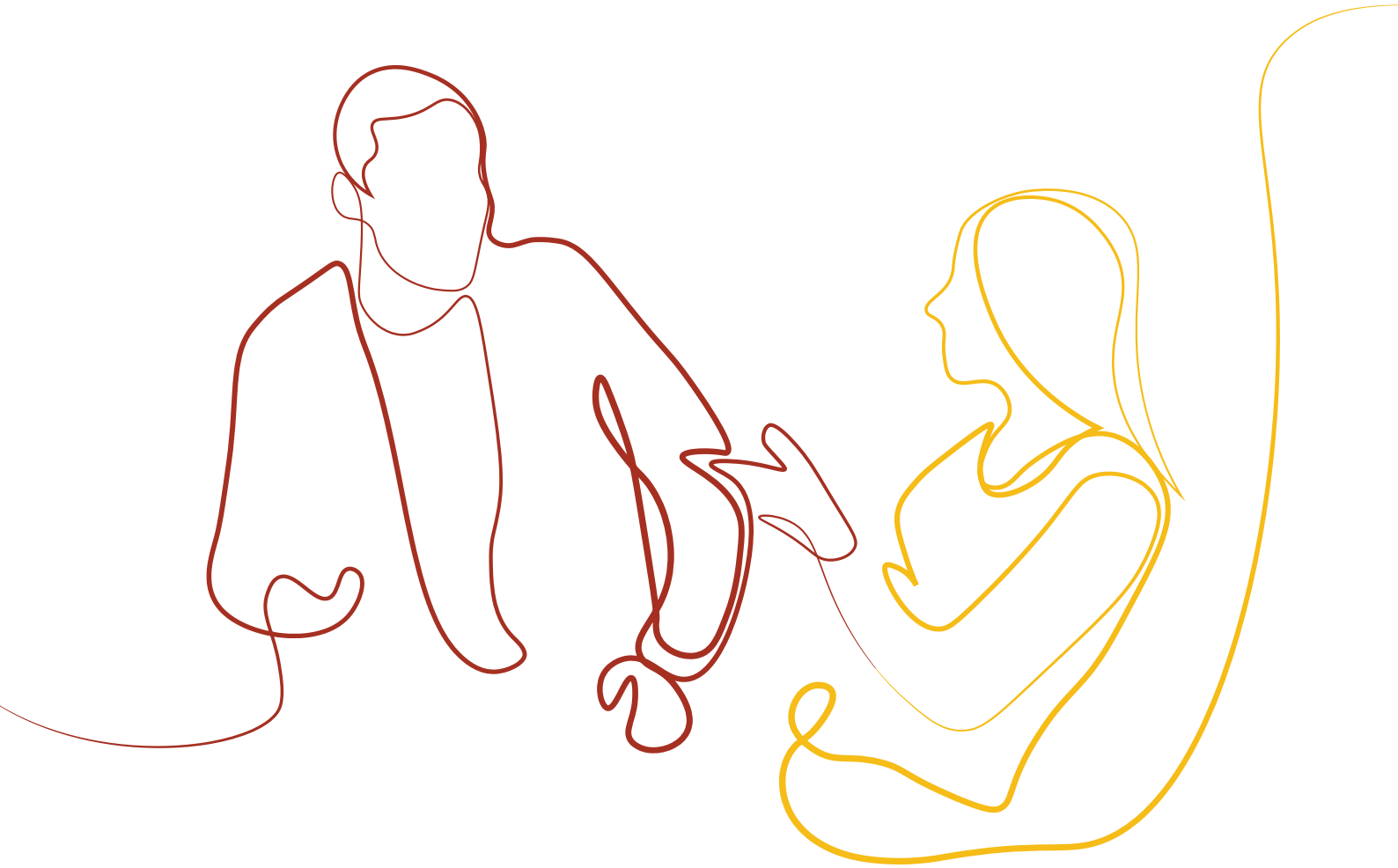


Table 5. Key determinants and consequences of private for-profit sector growth in the occupied Palestinian territory, based on perspectives of key stakeholders

	Scope of services	Rank[a]
Reasons for growth	Political stability and overall macroeconomic performance	1
	Weak capacity of public sector to deliver services/steady decline in capacity of public sector	2
	Perceived low quality of the public sector	3
	Weak regulation of the private health sector (lax administration)	4
	Public–private partnership	5
Benefits of growth	Complementarity	1
	Reducing the burden on public health facilities	2
	Involved in secondary and tertiary care services	3
	Quality improvement	3
	Responsiveness	4
	Client satisfaction	4
	Increasing patient choice	5
Negative consequences of growth	**Duplication** (covering the same services or benefits as the public sector)	1
	Profit-oriented and irrational behaviour (dual practices and supplier-induced demand)	2
	High costs (unaffordability)	2
	Higher risk of inequality in access and catastrophic expenditure	3
	Lack of coordination with the public sector	3
	Lack of information, low monitoring/lack of quality control	3
	Lack of interest in primary care services	4
	Not accepting insurance	5
	Lack of interest towards public health programmes	5

a The rank measures the relative importance of each attribute, j. This is calculated based on the relative frequency of attribute j relative to total frequency of all attributes.

3.2.2 Characteristics and behaviour of the private health sector

Table 6 presents a tentative ranking of the main characteristics and practices of the private health sector as viewed by key health sector stakeholders. These include the positive (including managerial strengths) and negative attributes, as well as key concerns about the behaviour of the private sector in terms of service delivery, quality, clinical practices, cost, systems abuse, geographical distribution, and so on. Client satisfaction with respect to different attributes of service provision (such as quality, shorter waiting time, ease of access) emerged as the first positive attribute of the private health sector. This is followed by the availability of needed services and the creation of surplus capacity (beds, laboratories and diagnostic centres). As regards the managerial strengths, the private health sector appears to be capable of attracting more competent staff (mainly due to higher compensation and the potential for career development). In addition, cost control (through better supervision) and performance (in terms of optimal utilization of resources and technical and managerial efficiency) are considered among the main managerial strengths of the private health sector.

Turning to the negative attributes of the private health sector, the main concerns expressed by key stakeholders were related to the unaffordability of services and discrimination against poorer patients (for-profit sector only), the duplication of services provided by the public sector and the ad hoc nature of sector growth. Some negative practices in the private for-profit sector that seem to derive from profit-seeking behaviours (such as unnecessary clinical procedures, over-prescription, rivalry with the public sector, dual practice) raise serious concerns on the role that this sector may play in the provision of health care services. However, there is a virtual consensus among the key stakeholders that many of the negative practices of the private for-profit sector are mainly due to a lack of adequate and effective regulation and/or the lack of monitoring and enforcement of regulations.

The main sources of health financing in the private for-profit health sector include direct OOP payments by patients, particularly for services that are not covered by health insurance (whether public or private). Another important source of financing for the private (both for-profit and not-for-profit) sector comes from the purchase of services (referrals) by the Ministry of Health. For the private not-for-profit sector, foreign aid/donations remain the major source of funding in addition to user fees and co-payments paid by patients at the point of consumption. The private health sector is said to have no involvement in any aspect related to the design and functioning of the GHI, which is entirely administered by the Ministry of Health.

Table 6. General perceptions on private health sector providers, including nongovernmental organizations, in the occupied Palestinian territory

	Scope of services	Rank*
Positive	**Client satisfaction** (good quality, less crowded/shorter waiting times, ease of access)	1
	Services available	2
	Created surplus capacity (beds, diagnostic technologies)	3
	Involved in primary care services	4
	Available in remote area (not-for-profit only)	5
	Managerial strengths	
	Capable of attracting more competent staff (higher compensation, career growth)	1
	Cost control through better supervision and monitoring	2
	Performance (optimal utilization of resources, technical and managerial efficiency)	3
Negative (key concerns)	**Unaffordability of services: high cost/discrimination against poor patients** (only for private for-profit)	1
	Duplication of services	2
	Nature of growth (unplanned, buildings and infrastructure only)	2
	Profit-oriented behaviour, irrational/unnecessary clinical procedures and practices, over-prescription, rivalry with the public sector, dual practice (mainly private for-profit)	3
	Lack of coordination with the public sector	3
	Inadequate regulations and lack of enforcement of rules and regulations	3
	Low monitoring/control of quality/poor physical standards	4
	Not available in remote areas/concentrated in main urban areas (for-profit only)	4
	Lack of information-sharing with government	5
	Lack of interest in primary care services	4
	Not accepting insurance	5
	Lack of interest towards public health programmes	5

* The rank measures the relative importance of each attribute, j. This is calculated based on the relative frequency of attribute j relative to total frequency of all attributes.

The current health financing mechanisms in the occupied Palestinian territory are considered to be inadequate and inefficient to meet the growing health care demands. A striking example is the increasing gap between GHI revenues and GHE (see Fig. 17). This is also manifested in the continuing reliance on OOP expenditures paid at private for-profit facilities (see Fig. 11). Three financing mechanisms/arrangements are considered by the key stakeholders to be necessary to better integrate the private sector in the provision of health care services. These include: 1) improving tax collection and increasing the share of general government revenues allocated to health; 2) improving service purchasing arrangements according to the national health insurance regulations and standards; and 3) reforming the current insurance system and increasing the percentage of contributions by the participants. To quote a key stakeholder: *"the higher the direct OOP paid, the higher is the need to create a mechanism to protect the poor from the catastrophic and impoverishing consequences of OOP. The persistence of high OOP also gives evidence on individual's capacity to contribute to the health insurance fund"*.

3.2.3 Legal, regulatory framework and quality standards

According to the Public Health Law of 2004 (Article 56), the Palestinian Ministry of Health, *"has the right to inspect any health institution to ensure its compliance with regulations and internal charters and the health conditions and specifications. [It] has the right to notify the health institution that committed a violation that it has to terminate the cause of the violation in a specific time that the ministry determines … In case of the continuation of the violation after the previously determined date, the minister has the right to close this institution or withdraw its permit" (39)*. The Ministry of Health is thus mandated by law to regulate and monitor quality and standards in the private sector, to provide accreditation and licenses and to maintain the registry of private health care facilities.

Relying on the views of the key stakeholders, we assess whether and to what the extent the current regulations and monitoring procedures are adequate and proper to ensure providers' compliance with regulations and quality standards. The current legal framework for licensing, accreditation, regulation and oversight of the private health sector is deemed inadequate and inefficient. To illustrate, some insights related to licensing and mentoring procedures are worth highlighting. First, when asked about how easy (or difficult) it is to register and obtain a license to establish a new health care facility, the majority of the stakeholders considered that licensing is relatively easy. However, the reason for this, as given by stakeholders, is the absence of any regulations or standards that rely on an assessment of population needs and demands, as well as sound quality standards. Second, although some regulations and standards are in place to ensure quality and safety, the absence of "transparent/objective standards" and "regular inspections" by the Ministry of Health make these ineffective in ensuring compliance with quality and safety standards. Reasons for this are related to the lack of regular coordination and information-sharing between the public and private sector,[23] weak technical and managerial capacities (mainly due to the lack of adequate resources), and the lack of sovereignty of the

23 As noted by the stakeholders, there is no regular reporting to the Ministry of Health, except for reports on morbidity due to communicable diseases, mortality, and some lab reports.

Ministry of Health over some geographical areas (east Jerusalem and Area C). Currently, the Ministry of Health undertakes some corrective measures and actions to reinforce regulatory compliance (such as setting price lists and quality standards procedures).

3.2.4 Stakeholder perspectives on public–private partnership and collaboration

The need to promote and strengthen partnerships between health sector stakeholders in the occupied Palestinian territory is articulated in the National Health Strategy 2017–2022 (objective 5.b) *(38)*. This subsection explores the perceptions and views of key stakeholders on the different aspects of public-private partnership. As far as political commitment is concerned, the majority of stakeholders agree that there is "strong political commitment" towards engaging the private (for-profit and not-for-profit) sector in health care delivery. However, there is broad consensus that rhetoric commitments and political statements on the part of policy-makers are not enough to achieve an effective complementary-based partnership between the heterogeneous health care providers. Indeed, despite the explicit objective and commitments towards building public–private partnership in successive national health plans, to date there has been no practical policy framework and guidelines for engaging the private sector.

Reasons for this are multiple. Perhaps the most frequently cited is the lack of an independent ("not politically oriented") representative body/platform that can gather all stakeholders to explore the nature, shape and areas of possible collaboration. This is despite past experience in forming a successful partnership between all stakeholders through the Palestinian National Health Council, founded in 1994 (however, as pointed out by a key stakeholder, this council no longer exists). It should be noted that a Supreme Palestinian Health Council exists; however, its mission, role and responsibilities are not clear, as we did not find any form of policy statement or document or resolution on this Council. A second possible reason seems to be a lack of administrative capacity and limited financial/budget allocations which may hinder the Ministry of Health from translating the ambitious objectives into real actions, policies and protocols. A third reason derives from the rapidly changing socioeconomic and political situation that can impede strategic development and integration of the private health sector. A last but important reason is related to the absence of a "functioning" Palestinian Legislative Council, since the split between the West Bank and Gaza Strip in 2007.

Given the importance of public–private partnership, all stakeholders emphasized the crucial need to set up a dynamic institutional arrangement, which could take the form of a "social dialog platform" (some highlighted the need to engage in wider societal dialogue, including beneficiaries[24]) and would constitute an "independent representative national body". Some stakeholders highlighted that the presence of a department/cell at the Ministry of Health to deal with the private sector is not enough to build a strategic public–private partnership, while others shed light on the potential role that a representative national body could play in "transforming the current rivalry among health care providers into an integrative and

24 As pointed out by a key stakeholder, there is currently no representative body for patients/consumers.

complementary role". The current relationship/intersection between the public and private sectors is viewed by many participants as "merely a practical or technical relationship", mainly motivated by mutual interests or needs. For instance, the Ministry of Health is the largest purchaser of private sector services and is thus seen as a source of revenues for this sector, while private providers cannot function without accreditation and licensing from the Ministry of Health. Table 7 summarizes the main opportunities and challenges for engaging the private health sector in health care delivery, as viewed by key stakeholders.

Table 7. Priority areas in engaging the private health sector: opportunities and challenges

		Rank[a]
Opportunities	**Shortages in the public sector and increasing demand for specialist and tertiary care services**	1
	Complementarity and enhancing competitiveness	1
	Political commitment and acceptance of a participatory approach	2
	Potential to reduce referrals and treatment abroad	3
	Desire of all to reach UHC	4
	Clinical service delivery through contracting and outsourcing	4
	Financing/purchase options through insurance, vouchers, etc.	5
	Geographical distribution of the private health sector (mainly not-for-profit)	5
Challenges	**Weak regulations and legislation, or weak compliance to existing regulations**	1
	Continuing reliance on foreign aid	2
	Poor/inadequate coordination or lack of transparency and accountability	2
	Deferral of payments for services purchased from the private health sector	3
	Prices and quality monitoring[b]	4
	Political and economic instability (high unemployment and poverty rates)	4
	Limited financial capacity/limited budget of the Ministry of Health and lax management	5

a The rank measures the relative importance of each attribute, j. This is calculated based on the relative frequency of attribute j relative to total frequency of all attributes.
b It should be noted that prices of medical tests, drugs and consultations are set by the corresponding medical syndicates/associations and sent to the Ministry of Health for endorsement and dissemination.

Private sector representatives prioritized the scope of services where public–private partnership is needed (ranked on a scale from 1 to 9). Results, which are reported in Table 8, show that the three main areas where public–private partnership should be prioritized include building new hospitals and managing them over a long-term contract, focusing on specialized clinical services (for example, dialysis, radio diagnostics, surgery), and delivering services through purchase/insurance modalities. Although it is possible to envisage a tentative public–private partnership model for the occupied Palestinian territory using these results, an in-depth analysis should be undertaken with all stakeholders to construct an appropriate public–private partnership model.

Table 8. Scope of services where private sector engagement/public–private partnership is needed (prioritized by rank)

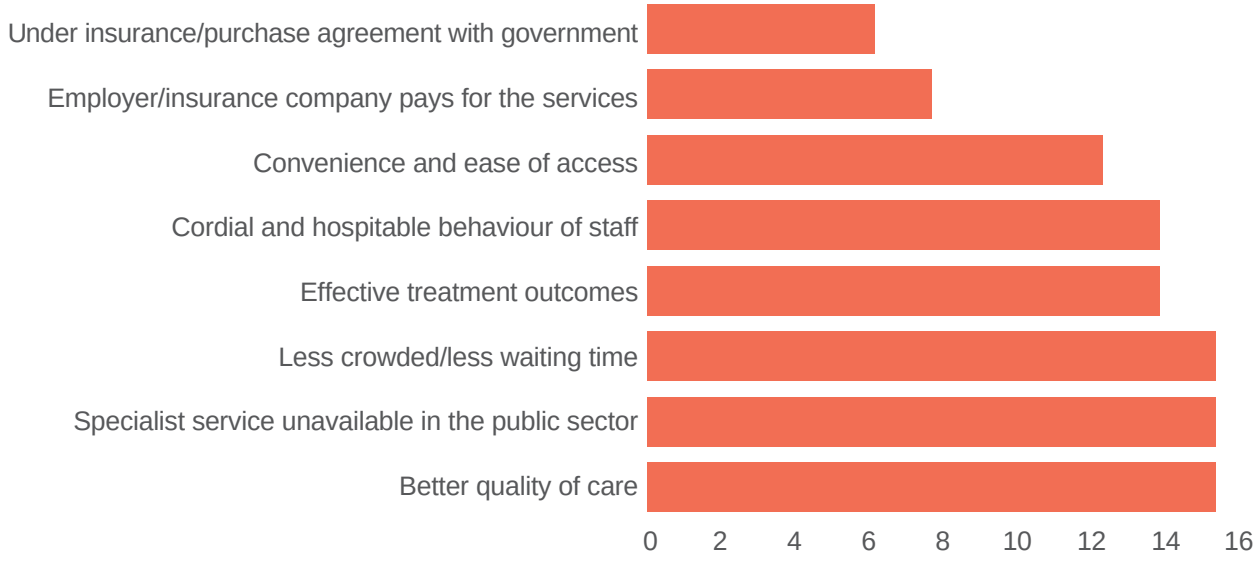
Scope of services	Rank
Building new hospitals and managing them over long-term contracts	1
Specialized clinical services (dialysis, radio diagnostics, surgery, etc.)	2
Delivery of services through purchase/insurance modalities	3
Drug discovery, research and development, and technology development	4
Clinical support services (laboratories, diagnostics, blood banks, ambulances)	5
Managing hospital operations (management of hospitals and public health facilities)	6
Community mobilization for preventive and health promotion activities	7
Primary care services (including maternal and child health)	8
Non-clinical support services (housekeeping, laundry, kitchen, etc.)	9

According to the perceptions and views of private sector representatives, the top three barriers to public–private partnership are: 1) the absence of clear government policy on the private health sector or public–private partnership in the health sector, and the lack of a clear legal framework that supports collaboration; 2) the lack of a dedicated unit within the government to design, negotiate and implement public–private partnerships; and 3) the lack of information on the private sector (services, tariffs, geographical distribution, and so on). Focusing on private not-for profit providers, the main operational challenges for public–private partnership are the frequent delays in payments for services purchased by the Ministry of Health and the reliance on foreign aid, where providers are sometimes required to align their provision with the earmarked funding rather than with the national priorities. However, the private not-for profit providers emphasized their active involvement in the provision of all types of services and programmes of national priority, in addition to their prominent role in health education and awareness.

3.2.5 Beneficiaries' perspectives on the private health sector

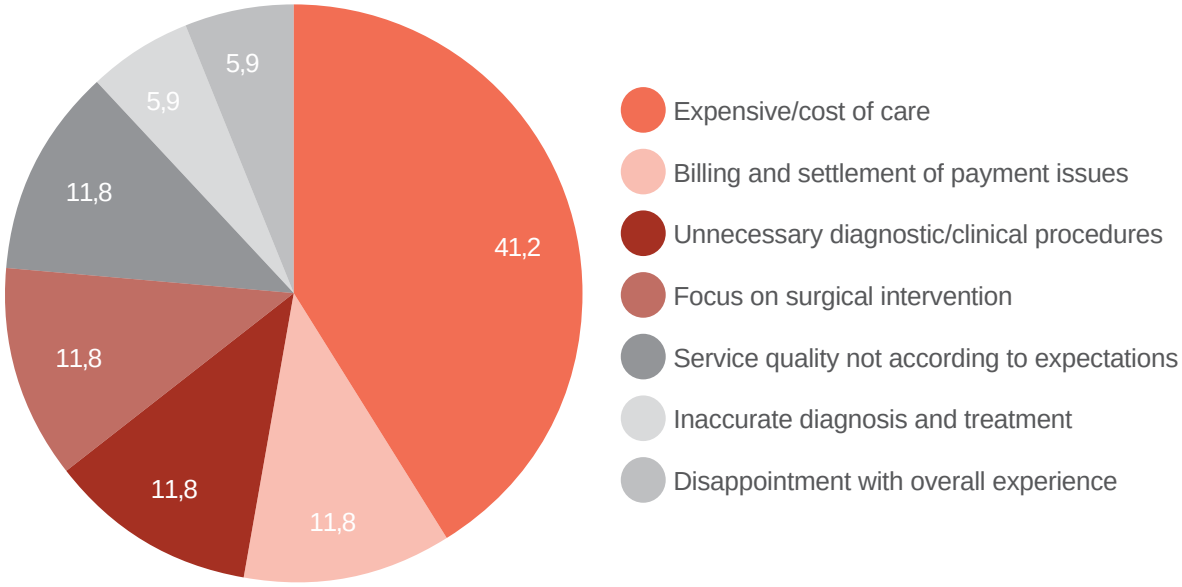
This subsection presents a snapshot of beneficiaries' perspectives on the different aspects of use and quality attributes of health care delivery in the private health sector. Fig. 19 presents a summary of the main reasons for seeking services from the private health sector compared to the public sector. For each attribute, we calculated its relative importance as the relative frequency of attribute relative to the total frequency of all attributes. Overall, the results on beneficiaries' perspectives corroborate those of key stakeholders on the positive attributes of the private health sector (see Table 6). As shown in Fig. 19, better quality of care, availability of specialized services and shorter waiting times are the main reasons for seeking health care at private facilities as opposed to the public sector.

Fig. 19. Reasons for seeking services from the private sector instead of the public sector



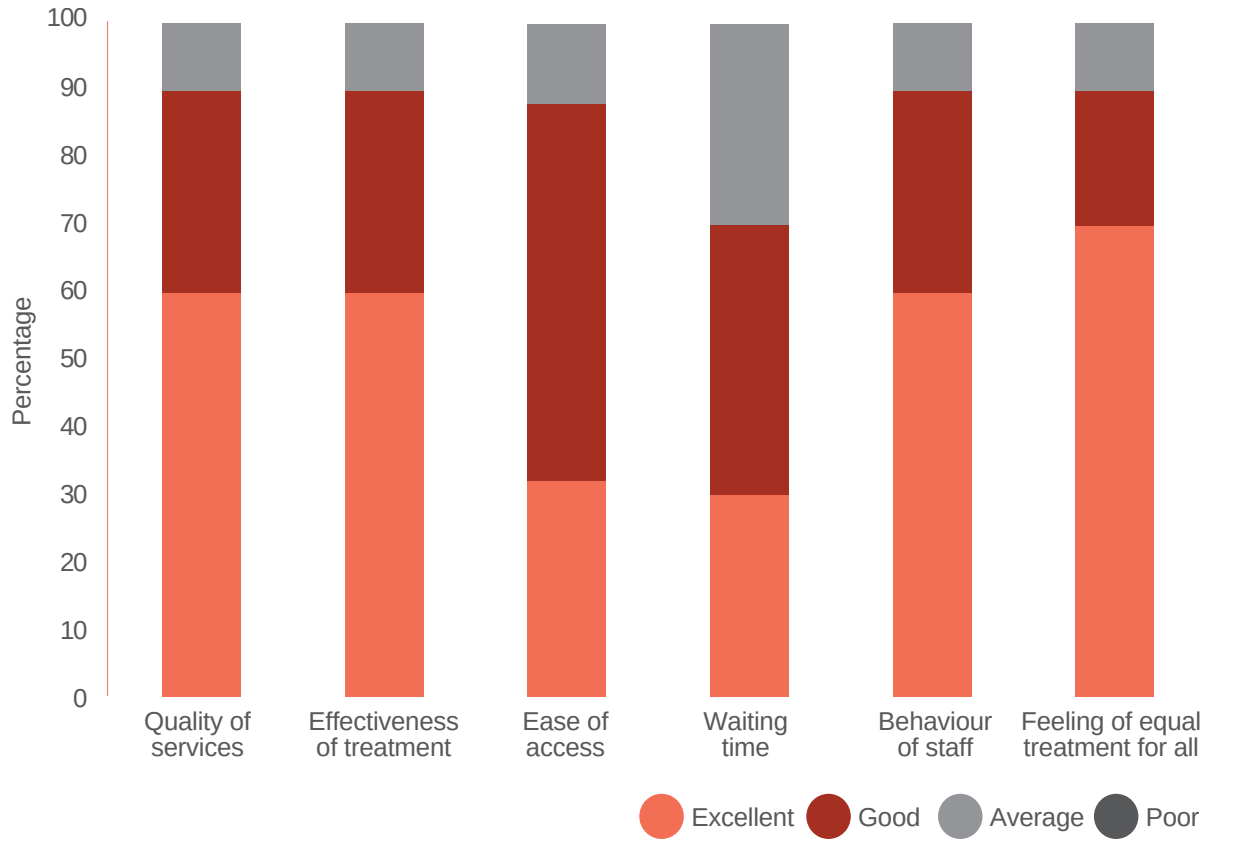
Likewise, reasons reported by beneficiaries on possible dissatisfaction with private health providers appear to confirm the perceptions of stakeholders, as reported above (see Table 6). Fig. 20 shows that high costs, unnecessary diagnostics and the focus on surgical interventions, as well as issues related to billing and settlement of payments, are among the main sources of beneficiaries' dissatisfaction in seeking health care at private health facilities.

Fig. 20. Reasons for dissatisfaction with private health providers



Lastly, beneficiaries were asked to rank specific quality attributes of the private health sector, based on their experience (and in comparison to a public facility). Results, which are reported in Fig. 21, show that the "feeling of equal treatment for all" dominates all other attributes, with about 70% of private sector users reporting having had an excellent experience as per this attribute. This is followed by quality of services, effectiveness of treatment and the cordial behaviour of staff, with about 60% of users rating their experience regarding these attributes as "excellent". Our results, although reliant on a small sample, appear to be in line with previous results from the first (and sole) nationally representative survey: the Palestinian Health Care Provider and Beneficiary Survey *(54)*, which assessed beneficiaries' perceived satisfaction of the availability and quality of health care services in both the public and private sectors. Results from this survey showed that the majority of patients were more satisfied with care provided by the private sector as compared to the public sector in terms of both availability and quality of services.

Fig. 21. Beneficiaries' ranking of quality attributes in the private sector, based on their experience (in comparison to a public facility)



4

Conclusion and policy directions

This study aims to assess the involvement of the private sector in the provision and financing of health care and its engagement in current efforts to attain UHC in the occupied Palestinian territory. A thorough review of the role of the private sector in the health system has been conducted to assess the relative importance of the sector's involvement in health care, its main characteristics, challenges and opportunities, and policy options that can enhance its engagement in UHC. This has been done by compiling all relevant data and information, as well as the views and perspectives of key stakeholders. Several interesting findings and key implications emerged from the analysis and are worth highlighting in light of the current debate on the implementation of UHC and the role and engagement of the private health sector. In what follows, we rely on – and focus on – the views and perspectives of key stakeholders in articulating some useful policy directions, recommendations and concluding remarks.

First, there is a consensus in favour of UHC among all health sector stakeholders and providers. Importantly, however, all agreed that achievement of UHC can only be made possible through effective collaboration and engagement with the four main health care providers. While this reflects the widespread political commitment to and social acceptability of UHC to key stakeholders, it raises critical questions about the readiness and adequacy of the current health system for UHC.

Secondly, while mobilizing additional resources is certainly necessary to move towards UHC, most stakeholders emphasized that financial resources alone will not be enough to close the current and potential "provision gaps", which are expected to significantly increase given the expansion of coverage and the demographic and epidemiological transition. The overall health system has to be run in a way that can ensure the effective participation of all health stakeholders in the design and implementation process of UHC. Moving towards UHC and enhancing engagement of the private sector requires (according to stakeholders) a comprehensive, participatory and stepwise approach, rather than a piecemeal ad hoc approach, to reform the current health system and health insurance in view of UHC.

Thirdly, there is broad consensus among the main stakeholders that a gradual – rather than ad hoc – transition is required for the successful implementation of UHC. This necessitates enhancing and upgrading supply-side capacities – not only in terms of provision and financing, but also in terms of administrative and monitoring capacities. Indeed, the current frameworks and mechanisms for licensing, accreditation, regulation, information-sharing, contractual and purchasing arrangements, costing of services and budgeting, referral, and oversight of quality and safety are all viewed and described by almost all stakeholders to be "unfavourable", "weak", "inadequate" and "ineffective" in terms of both design and implementation. Addressing and redressing the current frameworks/mechanisms appears to be a vital steppingstone for better engaging the private sector and laying the groundwork for a progressive implementation of UHC.

Fourthly, while there appears to be strong political support and commitment towards engaging the private health sector, representatives from this sector view the current relationship with the public sector to be "merely practical" – developing through mutual needs and interests

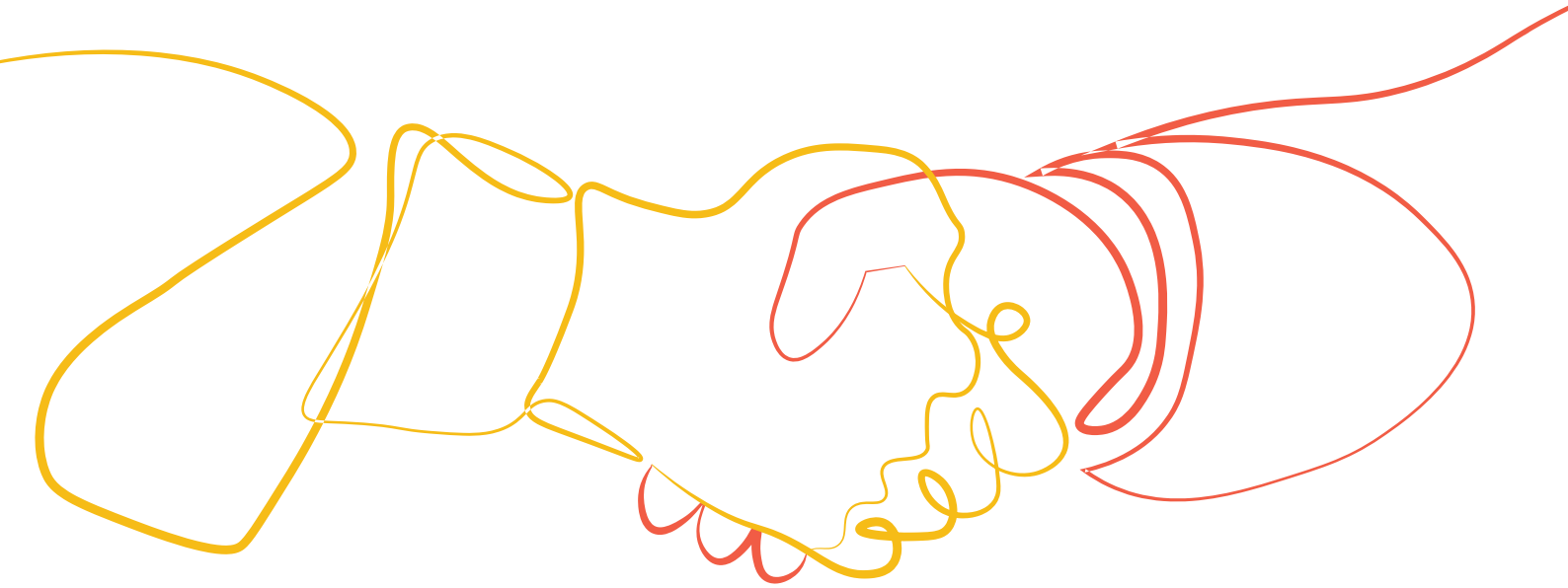
– rather than an “effective partnership” built through shared vision, goals and regular coordination between partners. The need to build a “complementarity-based partnership” thus appears to be another prerequisite to enhancing engagement of the private health sector in efforts to attain UHC.

Fifthly, although, the private health sector can be leveraged to increase service availability and quality, its compliance to national health priorities, regulatory frameworks and rules are deemed “mediocre”. Furthermore, its growth, role and practices appear to be controversial. This is not only because the private for-profit sector tends to cater for the better-off population groups, but also is due to the lack of adequate regulations that can limit the negative consequences of its growth and certain practices that are considered to be “irrational, inefficient and inequitable”.

Lastly, the participatory approach used to prepare the most recent National Health Plan for 2017–2022 is viewed as promising but, as yet, inadequate. Appropriate institutional and organizational reforms of the health system based on a stepwise action plan with timelines seem to be in order to enhance the engagement, capacity and performance of all stakeholders, and in particular the private health sector. Despite their practical limitations (mainly the lack of detailed micro-level data on private health sector activities and reliance on a small sample of key stakeholders), the results reported in this study can be used to formulate tentative stepwise action plans for the occupied Palestinian territory. However, further in-depth analysis should be undertaken with all stakeholders to construct an appropriate public–private partnership model capable of accommodating the context-specific factors of the occupied Palestinian territory, as well as the sector-specific characteristics of all health sector stakeholders.

5
The way forward

As mentioned above, moving towards UHC requires developing a stepwise action plan that can enable a more active role for the private sector in the provision and financing of health care services in the occupied Palestinian territory. Delegating effective regulatory and monitoring powers to an independent body, such as the former Palestinian National Health Council, can play a significant role in establishing an effective partnership between the key health care providers, defining their roles and responsibilities within the UHC system. Making substantial progress towards UHC also requires a comprehensive health care needs assessment. This will help to identify the gaps in health care provision, projecting future health care needs and forecasting demographic and epidemiological trends that can influence the demand for health care. Efforts to reform the current structure of the health system should start with the institutionalization of a genuine social insurance system, with a view towards effective UHC. This will entail establishing an independent and dedicated legal entity for the social health insurance system that can ensure rational decision-making as regards the mobilization and allocation of resources. This would enable the efficient purchasing of services from other health care providers and suppliers and allow for better formulation of policies and regulations that can enhance private investments in the health system, particularly in secondary and tertiary health care services where there is considerable scope for private investment.



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Annex

Table A.1. Number of interviews with health sector stakeholders by checklist

Checklist	Interview/questionnaire	West Bank	Gaza Strip	Total
1	Interview with senior policy-makers/national health authorities/health sector experts	5	3	8
2	Questionnaire for private health sector representatives	3	1	4
3	Interview with private sector laboratories/ pharmacies/diagnostic centres	2	–	2
4	Interview with not-for-profit private sector organizations (nongovernmental organizations)	3	3	6
5	Interview with private professional associations/ syndicates/business councils	2	–	2
6	Interview with private health insurance organizations	1	–	1
7	Interview with donors (development partners)	3	–	3
8	Exit interview questionnaire with patients at private health facility	10	–	10
Total		29	7	36