# A Palestinian Health Strategy

## The Challenges Ahead


Prepared

By

Ziad Abdeen,Ph.D., MPH

Al-Quds University



Jerusalem 1997

## TABLE OF CONTENTS


| | |
|---|---|
| **Background:** | **4** |
| **1. Population.** | **4** |
| **2. Vital Statistics:** | **5** |
| a. Life expectancy. | 5 |
| b. Births. | 5 |
| c. Death rates ( per one hundred thousand residents ). | 5 |
| **3. Utilization of health services - selected data:** | **6** |
| a. Hospitalization. | 6 |
| b. Preventive Medicine. | 6 |
| **4. Resources:** | **6** |
| a. Manpower. | 6 |
| b. Beds. | 6 |
| **5. The National Expenditure on Health.** | **7** |
| **Health and Development:** | |
| **1. Principals for a long-term national health policy.** | **7** |
| **Requirements:** | **9** |
| **1. The Approach.** | **10** |
| **2. The Benefits.** | **11** |
| **The Strategic Frameworks for Health Care:** | **12** |
| **1. Frameworks for Primary Care and Community Outreach Care.** | **12** |
| **Benefits of the Proposed Approach.** | **14** |
| **Conclusion and Recommendations.** | **15** |
| **References** | **17** |
| **Appendix I** | **18** |
| **Appendix II** | **19** |

**Appendix III** **20**

**Appendix IV** **17**

**Appendix V** **18**

**A Palestinian health strategy: The challenges Ahead.** **19**

**A Palestinian Health Strategy**

## Background

The West Bank and Gaza Strip have a sensitively balanced, post-war third world economy. Unemployment is estimated at 45 percent, reflecting a high refugee population. The area's infrastructure is weak, with contaminated water supplies, poor sewage disposal and solid waste management, representing key areas of environmental health risks. Not surprisingly, there are relatively low levels of life expectancy, arising from a high prevalence of communicable diseases, maternal and childhood mortality rates as well as poor chronic disease management.

The Palestinian Ministry of Health has done a great deal to improve the health services through doubling the number of health personnel, installing new beds and purchasing new facilities. However, the health status of the Palestinians did not improve much because of the deteriorating economic situation, the most important determinant of health.

In addition to coping with the environmental health challenges, the Palestinian Ministry of Health has the formidable task of:

♦ Turning the existing fragmented approach to health care into a cohesive, well regulated, properly financed, affordable, safe and effective health service;

♦ In order to coordinate and focus the efforts of donor organizations, strategic planning, health service management and program management disciplines need to be introduced. This should be done in a fashion which will ensure that services are cost-effective, robust, and accurately targeted to meet the health needs of the population.

The West Bank and Gaza Strip - A Brief Profile:

### 1. Population:

The West Bank and Gaza Strip have a combined area of about 6,000 sq. km; a population of 2.44 million (1966); a GNP of $2.2 billion; and, a per capita GNP of $715. The population density in the West Bank is 250/Km$^2$ while in the Gaza Strip it is as high as 3000/Km$^2$. Approximately 47 percent of the population is under 15 years of age while the percentage of the elderly - aged 65 and over - has stabilized today at approximately 3.5 percent. Projections for the year 2000 indicate that this level will be maintained (Appendix I).

This age distribution has direct implications on the Palestinian health system.

## 2. Vital Statistics:

In spite of severe data problems, a fairly broad consensus exists regarding the general outlines of health conditions in the West Bank and the Gaza Strip. Life expectancy, infant mortality and patterns of mortality in the Occupied Territories are believed to be fairly similar to those typical of lower/middle income countries.

### (a) Life expectancy:-

In 1996, life expectancy reached the age of 69 for males and the age of 71 for females. In general, there has been a continuous trend of increasing life expectancy. In the past, this trend was the result of the elimination of a number of infectious diseases. Today, the improvement in life expectancy is primarily associated with a lower infant mortality.

### (b) Births:-

The annual growth rate is 3.7 percent. The total fertility rate, relating to the average number of children expected in one woman's lifetime, was 5.6 in 1996. Furthermore, the percentage of newborns who weigh less than 2500 grams has risen from 6.2 percent in 1977 to 7.5 percent in 1996.

Maternal mortality rates are nearly 29/100,000 births. The rate of stillbirths has decreased from 11/1000 in 1985 to 8.2/1000 in 1996.

### (c) Death rates ( per one hundred thousand residents ):-

Causes of mortality in the West Bank and Gaza Strip have changed over the years. Deaths caused by infectious diseases have decreased significantly, while deaths caused by chronic illnesses have risen. Heart diseases, diseases of the circulatory system as well as malignant tumors account for more than half of the deaths in the West Bank and the Gaza Strip today.

In 1986, the total death rate, per 100,000 residents, was 360. The three main causes of death in 1996 for both males and females were: heart diseases, malignant tumors and, cerebral-vascular diseases (Appendix III). Deaths from malignant tumors and heart diseases have been on the rise among the Palestinian population.

For children and adolescents, 5-19 years of age, the main causes of death were accidents, injury, poisoning and malignant tumors. In 1996, the rate of infant mortality during the first year of life was 17/1000 in the West Bank and 22.7/1000 in the Gaza Strip.

**3. Utilization of health services - selected data:**

**(a) Hospitalization:-**

**General hospitals** - The rate of hospitalization days per one thousand persons has been decreasing. In 1996, the rate was 947/1008 as compared to 1008/1000 in 1985. The average length of stay in general hospitals is also decreasing, falling from 7.9/1000 in 1985 to 4.8/1000 in 1996.

**Hospitals for chronic diseases** - The hospitalization rate in hospitals for chronic diseases has sharply increased from 511 days per thousand in 1985 to 748/1000 in 1996.

**(b) Preventive Medicine:-**

Approximately 85 percent of newborns and 80 percent of pregnant women receive preventive medical services at local health centers throughout the West Bank and the Gaza Strip.

Around 95 percent of children are immunized against diphtheria, tetanus, measles and poliomyelitis.

**4. Resources:**

**(a) Manpower:-**

**Physicians** - The number of practicing physicians is constantly increasing. During the 1990s, there were approximately 4.9 physicians per 10000 residents.

**Dentists** - Nearly 4000 dentists were in practice in 1996. This corresponds to a ratio of about one dentist to 1,100 patients compared to a ratio of about 1 dentist to 1900 patients during the 1980s.

**Nurses** - The number of practicing nurses was about 9.1/10000 in 1996. More than half are registered nurses.

**(b) Beds:-**

**Beds in general hospitals -** There has been a continuous downward trend in the number of the available beds in general hospitals. The rate has decreased from 1.7 beds for every one thousand patients in 1985 to 1.2/1000 in 1996.

**Beds in mental hospitals** - The rate of beds for the mentally ill have also decreased from 1.35 beds for every one thousand patients in 1985 to 1.05/1000 in 1996.

## 5. The National Expenditure on Health:

(a) In the 1996 fiscal year, expenditures on health services reached $230 million, thus representing 13 percent of the national Palestinian expenditure. Expenditures on hospitals rank as the highest health expenditure. In 1996, hospitals required 65 percent of the total expenditure in the West Bank and the Gaza Strip.

(b) In 1996 , 27 percent of the health expenditure was financed by insurance premiums while 12 percent was directly spent by households . The remainder of the expenditure was covered by taxes.

## Health and Development

## 1. PRINCIPLES FOR A LONG-TERM NATIONAL HEALTH POLICY:

As this century nears its end, the global goal of "health for all in the year 2000" is quietly slipping away. The objective of global health equity, as endorsed by the world community at the Alma-Ata Conference on primary health care in 1978, does not seem to have been successful. The substantial progress made during the past decade has recently slowed and in some countries, health indicators have actually worsened.

Meeting this challenge requires an understanding of the dynamic transition in health that is taking place around the world: the evolving epidemiological pattern of disease, the obstacles impeding health action, the impact of the economic recession and, the long-term problems of rapid population growth and environmental sustainability.

Many developing countries, therefore, are simultaneously coping with two stages of epidemiological transition. This double burden is straining the health system capabilities of developing-countries and the resulting pressures may stall progress and further widen health disparities.

**Illustrative health problems of the two phases of epidemiological transition**

| AGE CATEGORY | PRE-TRANSITION | POST-TRANSITION |
|---|---|---|
| **CHILDREN** | Diarrhea<br>Acute respiratory infections<br>Intestinal ailments<br>Micro-nutrient deficiency<br>Malnutrition<br>Malaria | Congenital defects<br>Growth failure<br>Injury<br>Mental Development<br>AIDS<br>Environmental risks |
| **ADULTS** | Tuberculosis<br>Malaria<br>Sexually transmitted diseases<br>Chronic parasites<br>Injury<br>Maternity- related problems | Neurological\psychiatric illness<br>Cardiovascular disease<br>Cancer<br>Injury<br>Pulmonary disease<br>Eye and ear impairment<br>Diabetes\metabolic disorder<br>AIDS<br>Environmental risks<br>Substance abuse |

The mechanism by which the economic squeeze affects health is straightforward. Poor purchasing power among the poor and the middle-class translates into reduced health care expenditures. Furthermore, the rise in food prices and the withdrawal of government subsides reduce essential consumption. Cutbacks in government budgets also result in reduced social services. In many countries, funds for health have been cut by 50 percent or more and there has been a virtual cessation of capital investments in health services. These immediate consequences are quite drastic but, long-term consequences may be even more profound as economic hardship takes its toll on human and institutional capabilities which require decades to build.

Research is necessary and needed to guide and strengthen direct action but, it is an insufficient response to the crisis. What is vital is to document and analyze the nature of the economic crisis and its human consequences, in order to develop socially acceptable and politically supportable national and international policies. Also necessary is a close monitoring of the health status, applying policies to protect the poor; and, using more cost-effective actions catering to the specific health needs and circumstances of various countries.

National development emphasizing growth, equity and sustainability is critical to the health of populations. On the other hand, poorly planned development without ample regard to health can lead to increased health risks and inequities. The strong and positive relationship between a society's economic performance and its health is well documented. Some societies, however, have been able to achieve far better health outcomes than would be expected at their comparatively low income levels. "Good health at low cost" has been achieved through many factors, including political commitment to equitable development, widespread

primary education and literacy, enhancing the status of women, accessible health services and a strong public consciousness regarding health rights. These achievements have been made in Sri Lanka, China, Chile, Cuba, and Costa Rica -- a wide spectrum of political ideologies under diverse social, cultural and historical circumstances.

The health sector possesses many instruments for advancing health which have neither been sufficiently developed nor effectively applied. It is insufficiently recognized, for example, that the primary role in achieving good health is played by the individual and the family. Disseminating health information can enable people to improve their health practices, change their lifestyles and use health services more effectively. The success of personal initiative, however, depends upon a facilitating environment shaped by socioeconomic development as well as specific health actions, especially access to effective health services at affordable cost.

## Requirements

In addition to responding to these health challenges, the Ministry of Health also has to reform the fragmented health care system into a cohesive, well regulated, properly financed, affordable, safe and effective health service. The following issues need to be addressed:

**(a) At the policy-making level:** To help define the role of the Palestinian National Authority in the management and provision of health care by creating an appropriate organizational approach to management and strengthening the basis for local strategic planning, decision making, policy formulation, as well as the development and management of human resources;

**(b) At the planning level:** To develop a management capability for health services; introduce accreditation, licensing and control mechanisms; improve the capacity of management and resource allocations; set priorities; review services; and, introduce sustainable cost recovery and insurance mechanisms;

**(C) At the monetary level:** To help understand the structure and methods needed to ensure that clinically effective, operationally efficient and affordable delivery systems are in place; and, to introduce financial management and cash control mechanisms;

**(D) At the operational level:** To assess working conditions; introduce clinical protocols; organize medical records; standardize forms and general procurement mechanisms; develop multidisciplinary teams; improve data, statistics and cash management procedures; and, provide training in the required areas.

**1. The Approach:**

Future health insurance services and cost recovery mechanisms must not be based on the existing financial model of service provision, which is both unreliable and inefficient. More facts, some economic, others financial, need to be considered within an overall framework which accommodates the:

| | |
|---|---|
| 1 | Required levels of efficiency. |
| 2 | Costs of achieving this level of efficiency. |
| 3 | Timetables. |
| 4 | Impact on overtime unit costs. |
| 5 | The underlying capital depreciation costs involved in the same period. |

To support this process it would be beneficial to develop a balanced framework for strategic planning of the health services aimed at improving operational practices and future management. This should be done in cooperation between the Palestinian Ministry of Health, Non-Governmental Organizations (NGOs), UNRWA and other key players.

To achieve this end, the following should be constructed:

- **Strategic Health Service Frameworks:** Encompassing primary care, community care, secondary care, diagnostic care and other infrastructure services. Each of these frameworks will evaluate needs, assess current provisions, suggest ways to improve efficiency, reduce unit costs and, offer models for future resource allocations. These frameworks will be further supported by the preparation of clinical protocols for the high-priority areas of acute, infectious, chronic and anticipatory care in both primary and secondary care. They will be closely linked with;

- **Operational practice frameworks:** Encompassing the standardization of medical records, forms, financial management procedures as well as data and administrative procedures. This will give the Palestinian health service system an operational and administrative basis which will be both compatible and consensus driven.

The above work will result in a solid basis for economic and financial health-targeted models that will direct the development of *Frameworks for Management*. These models will address issues such as the scope of the Palestinian National Authority's role in the management and delivery of health services; accreditation and licensing; organizational structure; and, the level of performance review mechanisms which are necessary for policy and strategy making; planning; monitoring and control; operational management processes; information and information systems; health insurance; and, cost recovery frameworks needed to reform, fund and manage Palestine's health services effectively.

**2. The Benefits:**

These robust, practical frameworks will bring rapid results as well as provide a solid basis and clear direction for future development of services. They include clearly defined, cost-effective development priorities, in addition to significantly enhanced program management capabilities. This should help maximize the effectiveness of using external resources and it should further ensure that externally funded projects bring real benefits to the Palestinian health system.

Developing strategic frameworks for health services, operational practices and management should bring added benefits by introducing practical mechanisms which could be rapidly implemented -- not just at the top policy-making and management levels, but also at the operational level. To ensure this, a high level support system for program management must be incorporated so that risks can be well managed.

Through this approach, many tangible benefits will be realized. These include:-

- ♦ **A Substantial contribution to health gain:** Once protocols are implemented, there will be a reduction in child mortality, a more effective control of communicable diseases and, an improvement in the average life expectancy of the Palestinian population;

- ♦ **Tangible reductions in the cost-per case of primary care:** The adoption of a Primary Health Care Team development approach would be useful. This feature, when coupled with the use of standardized forms will result in an overall 20 percent reduction or more in Palestine's drug and human resource bill;

- ♦ An efficient and effective administration that provides control over unit costs in both primary and secondary health care;

- ♦ The delivery of a cohesive, performance-oriented management culture;

- ♦ Safe standards in clinical care should be effectively reinforced and, underlying trends in the degeneration of health services should be reversed;

- ♦ A solid and stable cost recovery and insurance model should be introduced, to be supported by robust methods for cost recovery.

## Strategic Frameworks for Health Care

### 1. Frameworks for Primary Care and Community Outreach Care:

The Palestinian National Health Plan accurately identifies primary care as the key to delivering sustainable improvements in population health gain whilst improving efficiency. Key health status observations are:

- **That maternal and child mortality is** abnormally high compared to Israel (but relatively low compared to other Middle Eastern countries). It is set against a background of high unemployment, a high fertility index, and natal and child deliveries in the home. This is mainly due to the fact that the NGOs, UNRWA and the public health system do not provide a structured, systematic approach to maternal and child health care. Maternal health checks are variable and developmental checks of the 0-5 year old children are not performed according to a clear regime and to a set standard;

- **That communicable and infectious diseases are inadequately controlled**: The public health system has a commendable track record of immunization and response to notifications. However the system is constrained by the fact that doctors and nurses lack the necessary training to secure adequate levels of detection. There is a lack of coordination in the approach to immunization and a shortage of well trained community outreach clinical teams;

- **The average life expectancy is abnormally high**: This is partly due to the marked effect of communicable diseases on mortality. However, the problem is largely due to the fact that existing primary care services do not address the chronic and anticipatory care needs of patients with CVS risks, including hypertension, diabetes mellitus, angina, asthma, etc.

- In addition to the exisitng problems with the standard of health care, it is evident that the average cost per contact in primary care varies greatly. Quite often, this happens without any relationship to the quality of the health care being provided. There are many reasons for this:

- Too much emphasis is placed on the role of doctors in the delivery of primary care. Even UNRWA's administration would agree that much could be done to improve the contribution of nurses to lower the overall cost of care and increase the quality of chronic and anticipatory care of patients1;

- There is no formal accreditation and licensing process of doctors, nurses and paramedics;

---

[1]. Particularly whose with CVS, endocrine, renal, respiratory, maternal and child health risks.

- ♦ For historic reasons, primary care has been largely provided on the basis of a clinically-centered model. Lack of coordination between the various health care providers has resulted in an unhappy mixture:

  ** There tend to be too many small-sized clinics, ill-equipped to deal with the wide range of maternal, child health, acute and chronic support services required in the populated areas where these clinics provide health services;

  ** Not enough emphasis is placed on community outreach programs. In other countries, this has proven to be particularly crucial at a time when primary care and secondary care services undergo reorganization.

The Palestinians are highly dispersed in the West Bank and highly concentrated in the Gaza Strip. In such extremes, the safety net features of community outreach primary care services have proven that they can offer value-for-money as well as provide effective methods of reducing the over-reliance on secondary care.

*Not surprisingly, there is a* ***very*** *high level of self referral, or inappropriate referral, to* secondary care.

The general consensus of professionals, the public, researchers and providers of primary care is that:

- ♦ There is a need to implement a unified model for identifying needs, allocating resources and deploying services in primary and community care;

- ♦ The most appropriate strategy for improving the standard of primary care is to introduce protocols which address acute, infectious, chronic and anticipatory care needs of the West Bank and the Gaza Strip and, do a follow-up with training and support in the necessary procedures;

- ♦ A family medical approach to primary health care is crucial to success. To achieve this, a consensus needs to be reached between the NGOs, UNRWA and the public health service;

- ♦ Substantial improvements in primary care can only be achieved if UNRWA, the NGOs and the public health services were to jointly sign-up to the same framework for resource allocation, clinical protocols and procedures.

- ♦ Previous experiences of working with multiple donor and provider agencies in order to secure a unified approach to health care will enable us to :

- ♦ Establish the framework for priority needs and the levels of provisions and resources, as well as the model of resource allocations necessary to meet these needs;

- ♦ Make the most appropriate use of the clinically-centered model and the outreach model;

- ♦ Establish a framework of clinical and community outreach response protocols which will lead to significant improvements in the efficiency, effectiveness and responsiveness of primary health care; developments in communicable disease control; and, reductions in referrals and mortality;

- ♦ Formulate the standards of training, accreditation, licensing and resource allocations to be introduced in the next 2-5 years;

- ♦ Introduce the standards of medical record management which is crucial to obtaining an effective case management.

To achieve this, a team of local doctors, nurses and consultants in Community Care and Social Sciences is required. This team should be supported by overseas consultants in Family Medicine, Primary Care Management, Health Economics and Resource Management.

## The Benefits of the Proposed Approach

The situation in the West Bank and the Gaza Strip is changing rapidly. There is an urgent need to support and develop the management capabilities and capacities of the Ministry of Health. This should by done through: carefully formulating cost-effective strategies, policies and plans; using policy analysis tools; evaluating service development priorities; introducing management performance reviews and sound monitoring and control mechanisms. At the same time, the level of health services should be maintained, making sure that the delivery of health services does not degenerate but is rather more effectively and efficiently provided and managed.

What is needed are robust, practical frameworks that will bring rapid results as well as provide a sound basis and clear direction for the future development of services. There should also be clearly defined and cost-effective development priorities and significantly enhanced program management capabilities, in order to effectively use external resources and ensure that foreign-funded projects bring real benefits to the Palestinian health system.

In developing the Strategic Frameworks for Health Services, Operational Practice and Management, the proposed approach will further introduce practical mechanisms, which could be rapidly implemented, not just at the top policy-

making and management levels but also at the operational level. Easily demonstrated key benefits offered by the suggested approach include:

- **A substantial contribution to health gain:** A rapid reduction in child mortality, more effective control of communicable diseases and, a substantial improvement in the average life expectancy of the population will occur when the recommended protocols have been implemented;

- **Tangible reductions in the cost per case of primary care:** The adoption of a Primary Health Care Team development approach, coupled with the use of standardized forms will result in an overall 20 percent reduction or more in Palestine's drug and human resource bill;

- A smoother administration and more accurate appreciation of the unit costs in primary and secondary care, as well as the factors affecting efficiency and effectiveness;

- The delivery of a cohesive, performance-oriented management culture.

- Effectively reinforcing safe standards of clinical care and, reversing underlying trends in the degeneration of health services.

The suggested approach is *integrated* - ensuring the necessary coordination of many vital components. It takes into account the various interdependancies which need to be carefully managed at a time of major health service reforms.

## Conclusion and Recommendations

- The economic prosperity which started in the West Bank and the Gaza Strip in the 1970s and lasted until the early 1990s enabled many high school graduates to study health and medical sciences, irrespective of the actual need for health professionals in the West Bank and the Gaza Strip. Due to a lack of proper human resource planning, unemployment in certain specialties in the field were expected.

- The population increase is the main factor affecting the quality and quantity of health services. A continued increase in birth rates will ultimately affect the provision of health services if proper resources are not allocated to its development.

**Recommendations:**

- Improving the level of existing health services and maximizing on their benefits before embarking on any expansions. This may include enhancing managerial performance and achieving inter-sector cooperation and coordination in order to avoid duplicity and inefficiency.

- The dependence of health services on medical specialization is both costly and undesirable. Hence, it is imperative that general practitioners act as gate-keepers with a proper referral system, acting as the main axis of this system.
- 
- The provision of health services is very costly because most, if not all, of its components are imported and paid for in hard currency.

The current population increase in the West Bank and the Gaza Strip is one of the highest in the world. A continued population increase will undoubtedly affect any additional resource allocations. Hence, it is vital to lower the current birth rate so that we could avoid any deterioration in the provision of health services.

**References**

1. United Nation Development program (1996), Internal document, Jerusalem.

2. Palestinian Central Bureau of Statistics (1996), Statistical Abstract of Palestine, Ramallah, Central Bureau of Statistics.

3. Israeli Ministry of Health (1996), Health in Judea, Samaria and Gaza 1967 - 1994.

4. Palestinian Ministry of Health (1996), Annual Report, Statistics and Information Department, Palestine.

5. The Palestinian National Health Plan (1994), Planning and Research Center, Jerusalem.

6. KPMG Health Report (1996), Private Correspondence.

## Appendix I: Population Distribution in Palestine

## (by age group and sex), 1996

| AGE GROUP | MALE | | FEMALE | | | TOTAL |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| 0-4 | 224,333 | 19.3 | 207,007 | 18.7 | 431.340 | 19.5 |
| 5-9 | 176,677 | 15.2 | 168.395 | 14.8 | 345,072 | 15.2 |
| 10-14 | 149,943 | 12.9 | 140,645 | 12.7 | 290,588 | 12.8 |
| 15-19 | 139.482 | 12.0 | 119,323 | 10.9 | 258,805 | 11.4 |
| 20-24 | 105,774 | 9.1 | 98,545 | 8.8 | 204,319 | 9.0 |
| 25-29 | 83,683 | 7.2 | 75,226 | 6.9 | 158.915 | 7.0 |
| 30-34 | 67,416 | 5.8 | 64,257 | 5.9 | 131,673 | 5.8 |
| 35-39 | 48,818 | 4.2 | 48.801 | 4.5 | 97,619 | 4.3 |
| 40-44 | 38,358 | 3.3 | 38.829 | 3.5 | 77,187 | 3.4 |
| 45-49 | 29,059 | 2.5 | 32,237 | 3.0 | 61,296 | 2.7 |
| 50-54 | 22,085 | 1.9 | 25,590 | 2.3 | 47,675 | 2.1 |
| 55-59 | 19,760 | 1.7 | 27,915 | 2.4 | 47,675 | 2.1 |
| 60-64 | 18,598 | 1.6 | 2,266 | 2.1 | 40,864 | 1.8 |
| 65-69 | 15,111 | 1,3 | 16,672 | 1.6 | 31,783 | 1.4 |
| 70-74 | 9,299 | 0.8 | 8.863 | 0.8 | 18,162 | 0.8 |
| +57 | 13,948 | 1.2 | 13,295 | 1.1 | 27,243 | 1.2 |
| TOTAL | 1,162,350 | 100.0 | 1,107,86 6 | 100.0 | 2,270,216 | 100.0 |

**Source: Palestinian Bureau of Statistics.**

## Appendix II : Distribution of Referral Cases

## ( by selected causes & provinces)

| Causes | Gaza Trip | | West Bank | |
|---|---|---|---|---|
| | No. | % | No. | % |
| Eye diseases | 166 | 6.1 | 816 | 23.5 |
| Circulatory diseases | 721 | 26.6 | 811 | 23.4 |
| Urinary tracts diseases | 77 | 2.9 | 210 | 6.1 |
| leukemia | 12 | 0.4 | 167 | 4.2 |
| Nervous system disorders | 23 | 0.9 | 146 | 4.2 |
| Malignant tumors and radiotherapy | 41 | 1.5 | 102 | 3.0 |
| Bone and muscle | 15 | 0.6 | 90 | 2.5 |
| Digestive tract | 10 | 0.4 | 69 | 2.0 |
| Ear and hearing disorders | 0 | 0 | 52 | 1.5 |
| others | 1641 | 60.65 | 1005 | 29.0 |
| TOTAL | 2,706 | 100 | 3,468 | 100.0 |

## Appendix III: Reported Deaths (by Provinces and age group), 1996

| **Provinces** | 0-1 | 01-04 | 05-14 | 15-19 | 20-39 | 40-59 | 60-64 | +65 | **Total** |
|---|---|---|---|---|---|---|---|---|---|
| **West Bank Provinces** | 537 | 207 | 118 | 61 | 249 | 591 | 380 | 2,561 | **4,704** |
| Jenin | 108 | 27 | 13 | 10 | 41 | 79 | 60 | 458 | 769 |
| Tulkarem | 43 | 18 | 12 | 6 | 24 | 76 | 41 | 275 | 495 |
| Qalqilyiah | 26 | 5 | 7 | 2 | 12 | 14 | 21 | 108 | 195 |
| Salfit | 13 | 5 | 8 | 0 | 7 | 30 | 14 | 91 | 168 |
| Ramallah | 70 | 30 | 19 | 11 | 47 | 116 | 63 | 449 | 805 |
| Bethlehem | 57 | 13 | 10 | 4 | 20 | 71 | 43 | 257 | 475 |
| Jericho | 2 | 2 | 1 | 2 | 5 | 14 | 7 | 20 | 53 |
| Hebron | 162 | 87 | 34 | 15 | 52 | 102 | 71 | 421 | 944 |
| **Gaza Strip Provinces** | 867 | 200 | 110 | 53 | 179 | 433 | 240 | 1,295 | **377.3** |
| North | 186 | 41 | 21 | 10 | 31 | 60 | 36 | 192 | 577 |
| Gaza City | 344 | 68 | 35 | 19 | 67 | 167 | 91 | 472 | 1,263 |
| Mid-Zone | 125 | 32 | 16 | 11 | 28 | 70 | 33 | 204 | 519 |
| Khan-Yunis | 133 | 35 | 21 | 10 | 32 | 76 | 43 | 282 | 632 |
| Rafah | 79 | 24 | 17 | 3 | 21 | 60 | 37 | 145 | 386 |
| Grand Total | 1,404 | 407 | 228 | 114 | 428 | 1,024 | 620 | 3,856 | **8,081** |

## Appendix IV: Reported Infant Mortality (By selected Causes of Death, Province and Age

| Province | West Bank Provinces | | | | Gaza Strip Provinces | | | | Total | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ageت<br>Cause of Death | 0-6 Days | 7-27 Days | 28-364 Days | Total | 0-6 Days | 7-27 Days | 28-364 Days | Total | 0-6 Days | 7-27 Days | 28-364 Days | Total | % |
| Pneumonia | 2 | 9 | 73 | 84 | 10 | 14 | 91 | 115 | 12 | 23 | 101 | 199 | 14.2 |
| Gastroenteritis & dehydration | 0 | 0 | 10 | 10 | 3 | 2 | 36 | 41 | 3 | 2 | 46 | 51 | 3.6 |
| Premature births | NA | NA | NA | NA | 126 | 47 | 22 | 195 | 126 | 47 | 22 | 195 | 13.9 |
| Resparatory conditions | 1 | 4 | 11 | 16 | 50 | 12 | 10 | 72 | 51 | 16 | 21 | 88 | 6.3 |
| Congenital anomalies | 17 | 19 | 61 | 97 | 27 | 23 | 74 | 124 | 44 | 42 | 135 | 221 | 15.7 |
| Cold injury & hypothermia | 23 | 10 | 6 | 39 | 5 | 6 | 6 | 17 | 28 | 16 | 12 | 56 | 4.0 |
| Septicemia | 9 | 17 | 25 | 51 | 9 | 15 | 25 | 49 | 18 | 32 | 50 | 100 | 7.1 |
| Tetanus neonatorm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Accidents, injury & poisoning | 0 | 1 | 3 | 4 | 2 | 1 | 7 | 10 | 2 | 2 | 10 | 14 | 1.0 |
| Signs, symptoms & ill-defined conditions | 3 | 7 | 9 | 19 | 8 | 5 | 25 | 38 | 11 | 12 | 34 | 57 | 4.1 |
| Sudden death, cause unknown | 1 | 6 | 26 | 3 | 5 | 6 | 44 | 55 | 6 | 12 | 70 | 88 | 6.3 |
| Meningitis | 3 | 1 | 4 | 8 | 4 | 7 | 12 | 23 | 7 | 8 | 16 | 31 | 2.2 |
| Others | 72 | 31 | 73 | 176 | 32 | 17 | 79 | 128 | 104 | 48 | 153 | 304 | 21.7 |
| Total | 131 | 105 | 301 | 537 | 281 | 155 | 431 | 867 | 412 | 260 | 732 | 1404 | 100 |

**Appendix V: Reported Child Mortality 1-5 years (by causes of death, province & age)**

| Provinces | West Bank Provinces | | | Gaza Strip Provinces | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age / Cause of Death | 1 Years | 2-5 Years | Total | 1 Year | 2-5 Years | Total | 1 Year | 2-5 Years | Total | % |
| Pneumonia | 21 | 29 | 50 | 14 | 12 | 26 | 35 | 41 | 76 | 18.7 |
| Other diseases of the resparatory system | 5 | 4 | 9 | 2 | 4 | 6 | 7 | 8 | 15 | 3.8 |
| Gastroentritis & deydration | 3 | 3 | 6 | 5 | 1 | 6 | 8 | 4 | 12 | 2.9 |
| Congenital anomalies | 14 | 12 | 26 | 13 | 9 | 22 | 27 | 21 | 48 | 11.8 |
| Neoplasms | 5 | 6 | 11 | 4 | 9 | 13 | 9 | 15 | 24 | 5.9 |
| Septicemia | 8 | 4 | 12 | 0 | 2 | 2 | 8 | 6 | 14 | 3.5 |
| Meningities | 0 | 0 | 0 | 3 | 4 | 7 | 3 | 4 | 7 | 1.7 |
| Traffic accidents | 4 | 11 | 15 | 8 | 18 | 26 | 12 | 29 | 41 | 10.1 |
| Other accidents, injury & poisoning | 11 | 6 | 17 | 11 | 16 | 27 | 22 | 22 | 44 | 10.8 |
| Signs, symptoms & ill-defined conditions | 5 | 2 | 7 | 3 | 4 | 7 | 8 | 6 | 14 | 3.5 |
| Others | 18 | 36 | 54 | 31 | 26 | 57 | 49 | 62 | 111 | 27.3 |
| Total | 94 | 113 | 207 | 94 | 105 | 200 | 188 | 218 | 406 | 100 |

**<u>Abstract</u>**

## A Palestinian Health Strategy

## The Challenges Ahead

This article deals with the changing situation **<u>in Arab East Jerusalem</u>** as well as the West Bank and the Gaza Strip. There is an urgent need to support and develop the management capabilities and capacities of the Palestinian health system by formulating cost-effective strategies, policies and plans; using policy analysis tools; evaluating service development priorities; introducing management performance reviews and sound monitoring and control mechanisms. At the same time, the level of health services should be maintained, making sure that the delivery of health services does not degenerate but is rather more effectively and efficiently provided and managed.

What is needed are robust, practical frameworks which will bring rapid results. The proposed strategy provides a sound basis and clear direction for the future development of services. It also offers clearly defined, cost-effective development priorities and significantly enhanced program management capabilities, in order to effectively use external resources and ensure that foreign-funded projects bring real benefits to the Palestinian health system.

In developing the Strategic Frameworks for Health Services, Operational Practice and Management, the proposed approach will further introduce practical mechanisms, which could be rapidly implemented, not just at the top policy-making and management levels but also at the operational level. Easily demonstrated key benefits offered by the suggested approach include:

- ♦ **A substantial contribution to health gain:** a rapid reduction in child mortality, more effective control of communicable diseases and, a sustainable improvement in the average life expectancy of the population will occur when the recommended protocols have been implemented;

- ♦ **A tangible reductions in the cost per case of primary care:** The adoption of a Primary Health Care Team development approach, coupled with the use of forms will result in an overall 20 percent reduction or more in Palestine's drug and human resource bill;

- ♦ A smoother administration and more accurate appreciation of the unit costs in primary and secondary care, as well as the factors affecting efficiency and effectiveness;

- ♦ The delivery of a cohesive, performance-oriented management culture.

- ♦ Effectively reinforcing safe standards of clinical care and, reversing underlying trends in the degeneration of health services.

The suggested approach is *integrated* - ensuring the necessary coordination of many vital components. It takes into the various interdependancies which need to be carefully managed at a time of major health service reforms.