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**Development Opportunities in the
Occupied Territories**
(West Bank and Gaza Strip)

Health

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PREFACE

This analysis of the health sector was prepared by Policy Research Incorporated (PRI) as part of an assessment of development opportunities in the Occupied Territories. That assessment, initiated in December, 1991, included a review of eight sectors: agriculture, education, finance and credit, health, industry, infrastructure, trade, and water and sanitation. The process by which the reports were developed included:

- 1) on-site data collection by two American development experts, Dr. Irene Jillson-Boostrom (Senior Technical Advisor) and Dr. Alan Richards (International Consultant);
- 2) the preparation of literature and information syntheses by Palestinian experts in each of the sectors (see attached list);
- 3) review of extensive documents across the sectors (including more than 300 documents from the Occupied Territories, Israel, donor organizations and relevant general development reports);
- 4) preparation of the draft analyses for each sector, with Dr. Jillson-Boostrom preparing those for health, industry, infrastructure and trade and Dr. Richards preparing those for agriculture, education, finance and water;
- 5) follow-up data collection and analysis by Dr. Jillson-Boostrom (to clarify issues and obtain additional data, when possible); and
- 6) preparation of the final development report for each sector and of the cross-sectoral analyses, by Dr. Jillson-Boostrom.

Each of the eight sectoral reports follows a consistent outline, as follows: executive summary of findings, introduction (including a discussion of the importance of the sector for development and key issues, if any), sectoral status and trends, institutions involved in the sector, constraints to development, and development opportunities. Citations for data and information presented in the reports are included at the end of each report; the Executive Summary does not contain specific citations. In addition, each report includes two appendices: 1) *Context of Development in the Occupied Territories* (background relevant to all sectors), and 2) *Visions of a Sustainable Future*, (a discussion of the overall potential for development in the Occupied Territories). In order to contribute to the discussion of sectoral as well as cross-sectoral needs and development opportunities, a particular effort was made to describe the organization and function of each sector in the Occupied Territories insofar as possible.

The sectoral reports are intended to add to the resources available for those involved in development planning in the Occupied Territories. In reviewing these reports, it should be recognized that circumstances have limited the degree to which preparation of these documents has followed standard sector analysis procedures. Data limitations are discussed in each of the documents; such limitations exceed those that pertain in many developing countries. Curfews and strikes hamper data collection. Thus far the final draft documents have not been

reviewed by those involved in development planning and implementation in the Occupied Territories in order to ensure that the documents accurately reflect the reality of each sector. Nor is it possible to ensure that the complete range of opinion and all available data sources have been included, although every effort was made to do so.

The conclusions and recommendations presented in the sector analyses are intended to serve as examples for Palestinians, donors and others involved in development planning for the Occupied Territories. It is recognized that each entity involved in this process will have its own specific world view and development goals to which these recommendations may or may not relate. The goals included in this report (in Appendix II, Table 2), based on general development goals derived from World Bank documents and other sources, are intended to stimulate ideas and discussion.

Acknowledgments

Preparation of this report on health in the Occupied Territories would not have been possible without the contributions of many individuals. Dr. Hisham Awartani facilitated access to important data resources in the West Bank; Mr. Fayez Al Wahaidi facilitated access to data resources in the Gaza Strip and prepared a report on non-governmental organizations in the Gaza Strip. Four Palestinian consultants prepared a report on a particular aspect of health in the Occupied Territories: Dr. Selim Hussein (primary health care), Dr. Mohammad Said Kamai (hospitals), Dr. Jamal Tarazi (health services and health status in the Gaza Strip), and Dr. Ismail Naim Abdul-Jalil (medical education). Ms. Monica Awad provided invaluable assistance with respect to identifying and collecting relevant documents, making logistical arrangements and performing other research and administrative tasks.

Cora Gordon and Christine Baluck, both of Policy Research Incorporated, assisted in compiling information resources available in the United States, reviewed and commented on multiple drafts of the reports and assisted in the production of the document. Dr. Mae Thamer, also of PRI, reviewed and commented on the initial draft prepared by Dr. Jillson-Boostrom. Sara Davidson edited the final draft of the report and designed and executed the desktop published version.

I am also most grateful to the representatives of donor organizations and international private voluntary organizations (PVOs), and to the more than 100 Palestinians who agreed to be interviewed. All provided information and ideas necessary for these analyses and engaged in constructive discussion of development opportunities in the Occupied Territories. I trust that this report will be useful to them and to all those involved in efforts to promote sustainable development in the West Bank and Gaza Strip.

Irene Jillson-Boostrom, Ph.D.
Clarksville, Maryland
October, 1992

ACRONYMS

ACC	Agricultural Coordinating Committee
ACCI	Arab Development and Credit Company
ACDI	Agricultural Cooperative Development Institute
ADCC	Arab Development and Credit Company
AGREXCO	Israeli State-owned Agricultural Marketing Company
AID	Agency for International Development
AIE	Arab Insurance Establishment
AMIDEAST	American Mideast Education & Training Services
ANERA	American Near East Refugee Aid
CBS	Central Bureau of Statistics
CCC	Civilian Conservation Corps
CD	Cooperation for Development
CDP	Cooperative Development Project
CIS	Commonwealth of Independent States
CIVAD	Civil Administration
CRS	Catholic Relief Services
CWA	Communications Workers of America
DOA	Department of Agriculture
DOS	Department of State
EC	European Community
ECWA	Economic Commission for Western Asia
EDG	Economic Development Group
FTA	Free Trade Agreement
GCMHC	Gaza Community Mental Health Committee
GDP	Gross Domestic Product
GFTU	General Federation of Trade Unions
GHS	Government Health Services
GNP	Gross National Product
GOI	Government of Israel
ICARDA	International Center for Agricultural Research in the Dry Areas
ICD-9	International Classification of Diseases
ICS	International Christian Society
IDF	Israeli Defense Force
ILO	International Labour Organization
IMR	Infant Mortality Rate
JCO	Jordanian Cooperative Organization
JD	Jordanian Dinar
JFPP	Jordanian Family Planning Program
MAP	Medical Aid to Palestinians
MCH	Maternal and Child Health
MOI	Ministry of Interior

NGO	Non-Governmental Organization
NHI	National Health Insurance
NICU	Neonatal Intensive Care Unit
NIS	New Israeli Shekel
OECD	Organization for Economic Co-Operation and Development
OT	Occupied Territories
PARC	Palestinian Agricultural Relief Committee
PFS	Patients Friends Societies
PFWAC	Palestinian Federation of Women's Action Committees
PHC	Primary Health Care
PLO	Palestinian Liberation Organization
PRCS	Palestinian Red Crescent Society
PVO	Private Voluntary Organization
SAI	Statistical Abstract of Israel
SCF	Save the Children Federation
SCHC	Society for the Care of Handicapped Children
TDC	Technical Development Center
TDG	Technical Development Group
TDP	Trade and Development Program
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Program
UK	United Kingdom
UNESCO	United Nations Educational, Scientific & Cultural Organization
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNRWA	United Nations Relief and Works Agency
UPMRC	Union of Palestinian Medical Relief Committees
USG	United States Government
VAT	Value Added Tax
WHO	World Health Organization
WUB	Workers' Unity Block

I. EXECUTIVE SUMMARY

Available health status measures indicate a cessation of improvements or a deterioration in the health status of the population in the Occupied Territories over the past five years. They also indicate a level of health significantly poorer than that of the Israelis, but comparable to those of populations of Egypt, Morocco and Jordan. The health status of the refugee population is comparable to that of Palestinian refugees within United Nations Relief and Works Agency's (UNRWA) jurisdiction in other countries. Mortality and morbidity data for the West Bank are more comparable to those of middle-income countries (i.e., with chronic disease beginning to predominate), while the data for the Gaza Strip continue to reflect a status comparable to that of lower-income countries.

More than half of the health services in the Occupied Territories are provided by the private sector, with the Civil Administration (CIVAD) (through the Government Health Services, GHS) and UNRWA providing the remainder, more so in the Gaza Strip than in the West Bank. The private sector provides services directly and contracts with UNRWA for provision of services. Hospital-based care is predominant, although hospital beds are seriously maldistributed, as most hospitals are located in the Jerusalem/Bethlehem area with few located in the Gaza Strip or northwestern area (Jenin/Tulkaram). The Gaza Strip has one of the lowest hospital bed per capita ratios in the world. There is also no rational "system" of care (e.g., regional care with clearly delineated referral networks, centralized regulatory bodies and central mechanisms for pharmaceutical purchase, supply, distribution, utilization and monitoring). Although the GHS, private sector and UNRWA operate primary health clinics, there is a scarcity in some areas, and the range and quality of services is highly variable.

There is no mechanism for planning the training of health care personnel consistent with defined service and managerial needs. Moreover, there is no medical school--in fact no formalized system for medical education--nor is there a formalized system for continuing education of health professionals in general, although a number of schools exist for training of nurses and technicians. There is a severe shortage of nurses and trained technicians, and in some medical specialties there are no practicing physicians.

At the height of the Intifada, donors concentrated on providing medical equipment, especially to secondary and tertiary facilities. The equipment was maldistributed, and physicians and nurses were not adequately trained in its use. Much of the equipment is not functioning now and some of it never functioned. Lack of equipment standardization and of equipment parts are obstacles to the repair and use of equipment.

Rehabilitation services are also poorly distributed; and expensive, facility-based rehabilitation predominates, although there have been recent efforts to expand community-based care. An estimated 15,000 individuals with severe Intifada-related injuries require extensive rehabilitative care. This places a significant additional and continuing cost burden on an already-burdened system. Family planning services do exist, but because of political concerns are provided on request only; no outreach activities are carried out by the few organizations which provide such services. In a positive vein, however, at least two of the

organizations which offer family planning services do so in the broader context of maternal health services, including health education.

While Palestinians can participate in the Israeli national health insurance system, most cannot pay the premiums, and others don't consider the benefits commensurate with the cost. Embryonic efforts to establish private health insurance systems in the Occupied Territories are undermined by the lack of a rational system of care and scarcity of health status data on which to base detailed plans as well as by increasing economic problems which limit the ability of individuals or firms to pay health insurance premiums. This latter factor has also increased the proportion of patients who are classified as social cases and are unable to pay for private sector care.

The total amount of funds expended in the health sector in a given year is an elusive figure. Obtaining accurate estimates of total health expenditures is hampered by the difficulty in obtaining cost data from the GHS, private facilities and donors. It is estimated that in the Gaza Strip between \$36 million and \$45 million were spent on health care by a combination of the GHS, UNRWA and private donors in 1990. In the West Bank, the range for 1990 has been estimated at \$50 million to \$75 million. GHS budget allocations for health actually decreased over the period 1988-1991, in spite of continued population growth. This amounts to total health expenditures of approximately \$67 per capita for the West Bank and \$56 per capita for Gaza for 1990. As a result, health and rehabilitation services in the Occupied Territories became increasingly dependent on donor support, perhaps more than any other sector. Such support has been uncoordinated, even within donor agencies and organizations, resulting in excess or inappropriate distribution of certain types of services and equipment and shortages in others. Also, few Palestinian administrators who work for CIVAD, the private sector and UNRWA have training in health systems management or planning; knowledge and experience in health care financing is particularly lacking.

The Government of Israel (GOI) has proposed that the GHS hospitals be turned over to the Palestinian health sector. However, with no existing tax mechanism within the control of the Palestinians, dependence on donors for more than half of all capital and operating costs and only minimal experience and training in policy-level planning and decision-making, it is not clear how Palestinians can readily assume responsibility for these hospitals, particularly in view of the fact that this system has been underfunded for some time. Assuming responsibility for all public health services (including immunization, for example) would add further substantial costs.

Table 1, found on page 36 of this report, presents a summary of conclusions and recommendations.

II. INTRODUCTION

A. IMPORTANCE OF HEALTH AND NUTRITION FOR DEVELOPMENT IN THE OCCUPIED TERRITORIES

The importance of health and nutrition for development in the Occupied Territories cannot be overemphasized. In addition to the personal, familial and social consequences of poor health status, the relationship between health status of a population and economic productivity has been well documented.¹ Moreover, health systems' costs comprise significant proportions of the gross national product (GNP) of most countries. While it is not possible to estimate the proportion of GNP allocated to the health system in the Occupied Territories, it is clear that the private sector bears a large proportion of the economic burden of health care costs--thus diminishing available investments in the productive private sector. Given the importance of health and nutrition, it is imperative that development efforts be undertaken to ensure, insofar as possible, quality health care and efficiencies throughout the health care system.

B. KEY SECTORAL ISSUES

Three issues are paramount in the health care system in the Occupied Territories. The first is the inadequate economic base from which sufficient resources to support a health care delivery system must be derived. That broad economic issue is addressed in detail in the companion report, Finance and Credit. The two issues which relate to the health care system specifically are quality of care and health care financing. Unfortunately, only minimal data are available with respect to quality of care, making it difficult to determine what the priority needs are in this critical area. The ability of the health care system to sustain its costs is related to quality of service delivery. Since mid-1991, there has been considerable discussion among Palestinian health professionals of the proposals to "privatize" the GOI health services in the West Bank and Gaza Strip. The debate over the proposals was exacerbated by the fact that documents describing and explaining the proposals were not available to Palestinian organizations. In April, 1992, as part of the formal peace discussions in Washington, D.C., it was formally proposed that authority for the GHS hospitals be given to the Palestinian private health sector, although it is not clear whether the proposals would have individual organizations or local "authorities" assume such responsibility.

The ensuing debate centers around the recognition by Palestinian health planners and officials of the cost and financing burdens of the health care sector. Many are thus wary of assuming such responsibility in the absence of the ability to create a rationally-designed system (health care industry) with an appropriate and sustainable public and private sector mix of services and financing. They are also concerned that, in the absence of a fully-functioning tax system and in the face of economic problems, they will be unable to cover basic operating costs. The fact that the GHS system in the Occupied Territories has historically (and in particular since 1987) been underfunded with resulting deterioration in physical infrastructure is of further concern.

III. SECTORAL STATUS AND TRENDS

This part of the health sector report presents population and health status data, followed by a description of health services provided through the mixed public/private system which pertains in the Occupied Territories. Demographic factors related to health status--such as education, employment, access to potable water and income level--are discussed in detail in companion sectoral analysis reports prepared by Policy Research Incorporated (PRI).

A. THE POPULATION

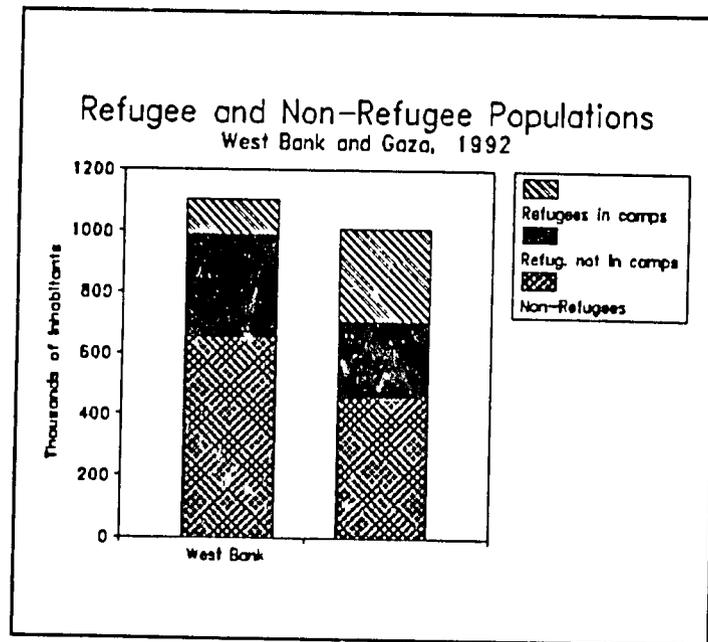
Recent accurate demographic data for the Occupied Territories are virtually impossible to obtain, as the most recent census was conducted in 1967.² Since that time, all population data have been estimated. The three primary sources of information regarding population are the Central Bureau of Statistics (CBS), the Ministry of Interior (MOI) and estimates prepared by the Jordanian Medical Association in 1986.

In the summary of demographic and other data published by Benvenisti and Khayat in 1988, it was noted that the Palestinian population data presented by the CBS and by the MOI for the Occupied Territories differ. For example, the data for 1987 showed CBS estimates for a total Palestinian population of 858,000 for the West Bank, while the MOI estimated the population to be 1,252,000.³ The CBS estimates exclude East Jerusalem; the Palestinian population in East Jerusalem was estimated at 141,000 in 1987.⁴

Using the 1991 Statistical Abstract of Israel, with 1990 data as a basis, and assuming a 3.5% annual growth rate in the West Bank and a 4.5% annual growth rate in Gaza, the following estimates were calculated for 1991: (See Figure 1 on the following page.)⁵

West Bank (including East Jerusalem)	1,104,799
Gaza Strip	<u>1,010,640</u>
Total:	2,115,439

Figure 1



Source: Calculated by Policy Research Inc., Clarksville, MD, using data from Statistical Abstract of Israel; 1991.

This estimate is only 6% less than that published recently by the Center for Engineering and Planning, which used a different basis for population estimates. Given that no census has been taken since 1967, this difference is not significant.

The Palestinian population is a youthful one; nearly half (47.4%) of the Palestinian population in the West Bank is under the age of 15, as is half (49.5%) the population of Gaza.⁶ This age distribution and the high birth rates have important implications for health service delivery, indicating, for example, a need for extensive pediatric and obstetrical/gynecological treatment and preventive care, which are only minimally available.

As of January, 1992, 451,695 individuals (or approximately 40% of the population) in the West Bank were registered as refugees, of whom 119,172 (26%) lived in UNRWA camps. In the Gaza Strip, 549,675 Palestinians were registered refugees (approximately 80% of the population); of these, 302,977 (55%) lived in UNRWA camps.⁷

In spite of the high natural rate of increase, until 1991 the population had a relatively low rate of growth. This resulted from emigration to Jordan, the Gulf States and outside the region, primarily for job opportunities. Even prior to the Gulf War and the influx of Palestinians from the Gulf States, an important population variable in the Occupied Territories, and particularly in Gaza, was the

number of residents who returned from the Gulf States annually for summer vacation. Reportedly, approximately 100,000 were doing so in the Gaza area for 2-3 months each year; no estimates of similar temporary residents were available for the West Bank. Since the Gulf War, an estimated 25,000-35,000 Palestinians have returned to the Occupied Territories; an estimated 40% of them are currently residing in the Gaza Strip.⁸ Most are university graduates but are unemployed or underemployed; however, those who are unemployed are reportedly not eligible for social benefits from the GOI. Some are eligible for services through UNRWA.

B. HEALTH STATUS

Available health status measures indicate a cessation of decades of improvements or even a deterioration in the health status of the population in the Occupied Territories over the past five years. They also indicate a population health status significantly poorer than that of the Israelis, but comparable to those of the populations of Egypt, Jordan and Morocco.

The health status indicators of the Occupied Territories reported by the GOI GHS depend primarily on reporting from government health facilities, which is variable at best. Although private sector facilities often maintain patient utilization records, these data are not aggregated across facilities by the GOI (which does not receive reports from all of the private sector facilities) or by any other organization. Moreover, the reports submitted by the GOI to the World Health Organization (WHO) include no morbidity data, but rather present narrative discussions of selected conditions (e.g., infant mortality, AIDS, brucellosis). The UNRWA makes available annual reports of the health conditions of the refugee population. While no such periodic, comprehensive reports are available from the private sector, individual institutions have produced reports on certain health status conditions (e.g., nutrition) or on regional health status and health services delivery. Nonetheless, to the maximum extent possible, mortality and morbidity data have been collected from published reports and unpublished sources (e.g., interviews at facilities), and are presented in this section as a general indication of health needs of the population.

B.1 Mortality

The statistical bulletins for the West Bank from the GOI indicate that from 1986 through 1991 the leading causes of death did not change appreciably. According to the most recent report,⁹ which includes data based on death records from all sources, the five leading causes of death in 1990 for the West Bank were:

- 1) Diseases of the heart
- 2) Malignant neoplasms
- 3) Respiratory diseases
- 4) Perinatal conditions
- 5) Diseases of the digestive system

These five causes accounted for approximately 60% of the reported deaths in the West Bank in 1990. Reports from hospitals and other sources indicate that there were more than 100 Intifada-related deaths in 1991,¹⁰ a significant decrease from 1988 when nearly 400 such deaths were reported.¹¹

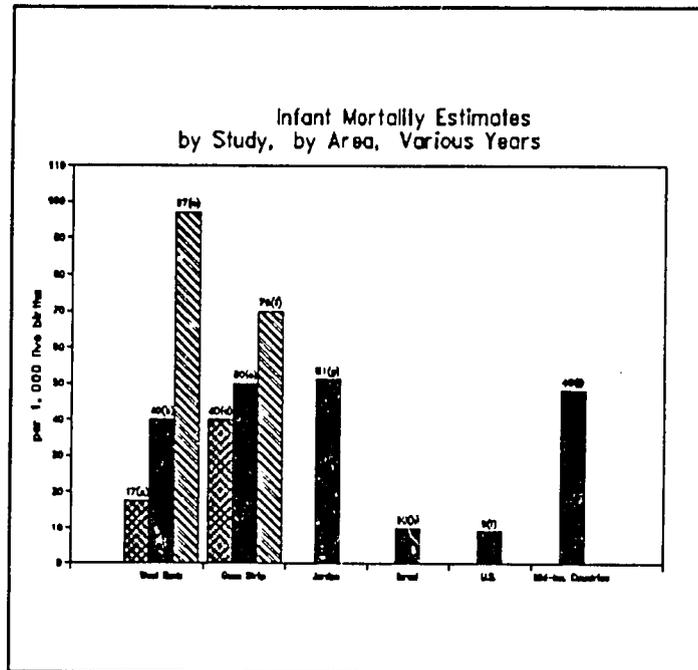
These mortality data follow the patterns for industrialized countries and for developing countries whose patterns have changed in the past decade. By comparison, the leading causes of death in the Gaza Strip in 1990 were much more reflective of developing countries:

- 1) pneumonia and respiratory diseases
- 2) prematurity and birth trauma
- 3) gastroenteritis and dehydration

This would be consistent with the comparative economies and support structures of the West Bank and Gaza Strip, with the West Bank being a middle-income economy and the Gaza Strip ranking with the lower-income countries.

No comprehensive infant mortality study has been conducted in the Occupied Territories; as a consequence, estimates rely on UNRWA statistics and on small population studies. Figure 2 presents a summary of the findings for the most recent years for which data are available, as well as comparisons with Israel, Jordan, the U.S. and middle-income countries. According to GOI reports, the infant mortality rate (IMR) was 22-35/1,000 in the West Bank and 28/1,000 in Gaza in 1991.¹² However, other estimates of infant mortality in the Occupied Territories range widely. For example, in the West Bank the ranges are from 40/1,000 to 97/1,000 (the latter for 20 villages in the Hebron District, based on studies conducted in 1987-1988).¹³ In UNRWA refugee camps in the West Bank--where there is more access to health care than in the general rural population in the West Bank--infant mortality has reportedly decreased from 85.3/1,000 in 1975 to 17.5/1,000 in 1991.¹⁴ The estimated IMR for Gaza range from 50/1,000 to 70/1,000, with the 1991 rate for UNRWA refugees estimated at 40/1,000.¹⁵ For purposes of comparison, it should be noted that the IMR in Jordan in 1990 was 51/1,000 live births; in Israel for the same year it was 10/1,000; in the U.S. 9/1,000 and for middle-income economies 48/1,000.¹⁶

Figure 2



Sources:

- (a) Communication with Dr. Hidmi, UNRWA/WB, 1991.
- (b) Hussein, S. Primary Health Care in the West Bank. Report prepared for Policy Research Inc., Clarksville, MD; 1992.
- (c) Ayed, N. Health. In: Palestine Studies Project. Masterplanning the State of Palestine. Ramallah: Center for Engineering and Planning; 1992.
- (d) UNRWA Headquarters, 1992.
- (e) Tarazi, J. Health Care in the Gaza Strip. Report prepared for Policy Research, Inc., Clarksville, MD; 1992.
- (f) Tarazi, J. Health Care in the Gaza Strip. Report prepared for Policy Research, Inc., Clarksville, MD; 1991.
- (g) Jordan Central Bureau for Statistics; 1991.
- (h) Statistical Abstract of Israel; 1991.
- (i) NCHS. Vital Statistics for the U.S.; 1991.
- (j) International Bank for Reconstruction and Development. World Bank; 1992.

B.2 Morbidity

Morbidity data are scarce; this is particularly important in view of the need to better plan for health service delivery at all levels of care. Presenting diagnoses for inpatient and outpatient hospital care are not included in the GOI statistical reports, although visits to government clinics are shown by standard International Classification of Diseases (ICD-9) codes, and reported incidence rates of infectious diseases are included. However, there have been few systematic studies of health conditions based on hospital or clinic records or community surveys.¹⁷ Moreover, the questionable accuracy of health data could readily distort priority health needs in the Occupied Territories. For example, the 1988 GOI report for the West Bank showed no reported cases of diarrhoea and gastroenteritis, although there were 15 reported deaths due to intestinal infectious diseases (not specified as diarrhoea-related) in that same year, along with 10,196 reported visits to GOI clinics for intestinal infectious diseases.¹⁸ Moreover, the 1989 UNRWA report to the WHO showed 8,239 reported cases of diarrhoeal disease for 1988.¹⁹

The most common conditions among refugee and non-refugee children in 1988 were gastrointestinal and respiratory infections. This is based on presenting conditions at GHS, UNRWA and private health facilities as well an UNRWA household survey.²⁰ In 1988, the five most common presenting conditions reported by GHS clinics for all age groups in the West Bank were: respiratory infections (21%), other diseases of the respiratory system (11%), diseases of the skin and subcutaneous tissue (10%), diseases of the musculo-skeletal system and connective tissue (10%) and diseases of the digestive system (9%) (see Table 2 below). It is of some concern that hypertensive diseases accounted for 4.4% of all reported conditions and may be under reported.²¹

TABLE 2
FIVE MOST COMMON PRESENTING CONDITIONS
AT CLINICS IN THE WEST BANK, 1988

Presenting Condition 1988 Visits	# Visits	% of Total
Diseases of the upper respiratory tract	94,425	21.1%
Other diseases of the respiratory system	48,777	10.9%
Diseases of skin and subcutaneous tissue	46,709	10.4%
Diseases of musculoskeletal system and connective tissue	44,078	9.9%
Diseases of other parts of the digestive system	39,773	8.9%

Source: Ministry of Health, December 1988 Statistical Report
for Judea and Samaria.

The rates of communicable diseases are also a matter of concern, particularly in view of overcrowded conditions among the refugee population. For example, 1991 case rates were 288/100,000 for mumps and 246/100,000 for dysentery (amoebic and bacillary) among the refugee population in the West Bank; in Gaza, the rates were 375/100,000 for mumps and 1,072/100,000 for dysentery. This latter rate is three times that among UNRWA refugees in Jordan.²² Given the reported problems with water quality (see the companion Water and Sanitation report), the rates of dysentery should be carefully monitored.

Brucellosis, a cattle disease which is transmitted to humans through contaminated milk products, was first reported in the Occupied Territories in the early 1970s.²³ Early detection and treatment with antibiotics successfully cures the disease, but late diagnosis leads to long-term hospitalization. Brucellosis has also been associated with miscarriages. Reported cases in the West Bank have increased from the first diagnosed case in 1973, to 13 cases in 1976, to 192 cases in 1981 (when private physicians were trained and encouraged to report cases), and then to 737 cases in 1987 (when a public information campaign was mounted in local grocery stores).²⁴ In 1991, 620 cases were reported in the West Bank;²⁵ however, under reporting is now estimated to be 50%.

The nutritional status of Palestinians has been a concern among donor agencies and Palestinian health personnel. During a recent A.I.D.-sponsored Food and Nutrition Assessment in the Occupied Territories,²⁶ it was confirmed that widespread malnutrition does not exist among the Palestinian population residing in the Occupied Territories. However, specific nutritional deficiencies such as inadequate growth, high prevalence of anemia and protein deficiencies are evident among segments of the population in the Occupied Territories. The most common nutritional deficiency found among children aged five and under (excluding organic causes of malnutrition) is caloric-protein malnutrition, manifested by inadequate physical growth.

Results from two recent nutritional studies have shown significant improvements in growth measurements of children in the past few years. The 1990 UNRWA study found a marked improvement in height-for-age among refugee children under three compared with a similar survey done in 1984. A study also found similar improvements in height-for-age between a 1987/88 cohort and a 1989 cohort of Gazan children aged one to 18 months. Anemia is very prevalent in the Occupied Territories although the severity of anemia among the general population is not known. Rates of anemia are high among women, both pregnant and non-pregnant, as well as among children and adolescents. For example, the 1990 UNRWA study found a prevalence of anemia of 58% and 70% among children in West Bank and Gaza Strip refugee camps, respectively. In the same study, 28% of the refugee women were assessed as anemic in the West Bank compared to 44% of the women in the Gaza Strip.²⁷

B.3 Disability in the Occupied Territories

A number of studies have indicated that the prevalence of disabilities in the West Bank and Gaza Strip is comparable to the estimates made by the WHO for the world's population at large for all levels of severity (approximately 10%), but is significantly higher for those in need of rehabilitation (which is 1.5% worldwide), not including Intifada-related injuries.²⁸ In 1989, Giacaman *et al* concluded that at least 150,000 Palestinians in the Occupied Territories were disabled at some degree of severity (from very mild to very severe). The authors also estimated that between 2% and 2.5% of the population were in need of rehabilitation services; that is, approximately 16,000-25,000 persons in the West Bank and 14,000-17,500 persons in the Gaza Strip.²⁹ These prevalence estimates do not include those related to Intifada injuries. Based on data obtained from facilities offering rehabilitation services throughout the Occupied Territories, the authors estimated that 9,000 persons were disabled due to hearing, speech and sight impairments;

1,100 persons had some other form of physical disability; 7,000 persons were mentally disabled and the remainder suffered from a combination of disabilities or other disorders.³⁰ These estimates excluded those requiring rehabilitation as a result of injuries related to the Intifada.

According to the UNRWA Board on Intifada Injuries, at the end of 1991 there had been a total of 45,656 casualties related to the Intifada. In a detailed analysis of 473 randomly selected cases of 2,500 persons admitted to hospitals in the West Bank during the period March, 1988 to March, 1989, 22% were mild injuries with no permanent disability, but perhaps requiring short-term, community-based rehabilitation; 38% were moderate with no permanent disability, but perhaps requiring rehabilitation for a limited duration; and 40% were serious, with permanent disability, requiring both long-term institutional and community-based rehabilitation.³¹

B.4 Mental Health and Drug Abuse

No population-based study of the prevalence of mental health conditions has been conducted in the Occupied Territories. However, data derived from primary health care facilities and other health facilities, as well as from other sources, indicate a severe problem and a largely unmet need for services. For example, a recent assessment in the Gaza Strip estimated that approximately 15,000 individuals needed psychiatric/psychological treatment.³² While no comparable estimate has been made in the West Bank, visits to clinics alone provide an indication of the need for services; for example, in 1988 there were 6,737 visits to clinics for mental disorders.³³

A number of reports over the past three years have indicated increasing signs of the availability and use of illicit drugs in the West Bank and Gaza Strip. This is of considerable concern, especially in view of the fact that efforts to prevent and treat such use are minimal and receive little support from donor agencies. Health professionals have reported substantial increases in availability and use of illicit drugs for the past several years. This increase reached alarming proportions during the Gulf War, but seems to have subsided somewhat since then. In the Gaza Strip, there have been reports of increases in the availability of illicit drugs (particularly among laborers working in Israel) and reports that physicians are themselves abusing prescription drugs.³⁴

IV. INSTITUTIONAL ARRANGEMENTS AND SERVICE DELIVERY IN THE HEALTH CARE SYSTEM

A. HEALTH SYSTEM ORGANIZATION

The Occupied Territories do not have a rationally-organized system of health care. Rather, there is a mix of public, private and UNRWA services, with donor agencies playing a major role vis-a-vis the private sector and UNRWA. There are three categories of providers of health services in the Occupied Territories:

Government Health Services (GHS) provides health care services under the aegis of the Ministry of Health in Jerusalem through the Coordinator for Health in the Occupied Territories. Direct linkage with health services delivery is through the Civil Administration, which is part of the Ministry of Defense. The GHS operates primary care facilities and hospitals (including one mental hospital) in the Occupied Territories and is responsible for immunizations and other preventive services. GHS services are gratis for children three years and under and for pregnant women; others must pay the required fees if they are not covered by the health insurance system. With the exception of the Israeli Coordinator for Health Services, virtually all employees of the GHS are Palestinians. The food distribution program is administered jointly by the GHS and the Catholic Relief Services (CRS).

United Nations Relief and Works Agency for Palestine Refugees (UNRWA) has provided health services for Palestinian refugees since 1948. UNRWA's health policies and regulations are formulated at its headquarters in Vienna, Austria; the agency also has local administrative centers in Jerusalem (for the West Bank) and Gaza. UNRWA provides preventive, primary, curative and rehabilitative health services for refugees residing within and outside the camps, both in UNRWA-operated facilities and through the purchase of services in GHS and private facilities. The agency also has an environmental (sanitation) and food distribution program. UNRWA charges no fees for the services it offers directly or for contracted services.

Private/Non-government Organization (NGO) sector services are provided primarily through regional and local charitable organizations; they operate primary, secondary, tertiary facilities, as well as rehabilitative and mental health facilities. The organizations which predominate in the private/NGO sector are:

- Patient Friends Societies (PFS) and the Red Crescent Societies (which are independently operated throughout the Occupied Territories, although there is a consortium for the Red Crescent Societies and for PFS). These NGOs operate primary and secondary facilities, as well as ambulance services, and
- other independent charitable associations and health committees which either sponsor or operate services (e.g., the Mokassad and Ittihad Hospitals and the Union of Palestinian Medical Relief Committees and the Health Care Committees).

All private organizations charge nominal fees for service; however, they provide care gratis to those who demonstrate economic need (social cases), and they do not charge for Intifada-related cases. Most do not charge for preventive care for infants (e.g., immunizations).

Accurate utilization and coverage rates are all but non-existent for health services in the Occupied Territories. The following figures are based on the proportion of primary health care and hospital facilities, on estimates provided by Palestinian health administrators and researchers and on observations. Approximately 40% of inpatient and outpatient health services in the West Bank are provided in facilities operated by the private sector, including hospital and rehabilitation services provided for refugees referred by UNRWA. The GHS services account for approximately 40% of services and UNRWA for approximately 20% (the latter primarily in primary care facilities). In Gaza, approximately 20% of all health services are provided in facilities operated by the private sector, 40% in UNRWA facilities and 40% by the GOI; the private sector provides a somewhat smaller proportion of hospital care in the Gaza Strip.

The proportion of health services provided by the private sector has increased since the late 1970's and has grown dramatically--perhaps by as much as 75%--since the Intifada, although it may have leveled off somewhat since 1990. Patient preference for private sector facilities is reportedly due to these factors:

In the past three years there has been a three-fold increase in the premium for national health insurance and a decrease in the proportion of those covered from an estimated 35% overall in 1989 to an estimated 16% in the West Bank and 25% in the Gaza Strip in 1991.³⁵ Participation in the program has become more costly to patients than the use of fee-for-service private facilities, many of which have minimal charges and charge fees on a sliding scale basis.

Since the Intifada, Palestinians have had substantially decreased levels of access to hospitals within Israel. Previously, there was a strong incentive to participate in the national health insurance program because of the comparatively high quality of care provided in these facilities.

There have recently been substantial increases in fees-for-service in government hospitals (e.g., a three-fold increase in charges for normal deliveries between 1988 and 1991). Because data are not available for review, there is no means of determining the relationship between these substantial increases and the real cost of delivering services in the government hospitals.

An increasing number of Intifada-related cases do not self-admit to government facilities, because of the fear of being either reported to the government (such reporting is required by the GOI), or of being forcibly taken from a government health facility by soldiers or border police. Seizure of Intifada-related patients from hospitals is reportedly more common in government hospitals than in private sector facilities.

Competition among the private health care organizations increased during the period of the Intifada, when donors were providing substantial funding for health facilities and services. With the current interest on the part of donors in economic development and their apparent decreased interest in the health sector, this competition among Palestinian NGOs for capital and operating funds has again increased. In some cases, organizations are planning and implementing new services in areas which already have at least minimal coverage, while other villages have no services. At the same time, some organizations are decreasing the number of facilities they support or operate because the operating costs have become unsustainable.

B. HEALTH SERVICES FACILITIES AND SERVICES IN THE OCCUPIED TERRITORIES

Brief descriptions of primary, secondary and tertiary services and of mental health and rehabilitative services in the Occupied Territories follow, as does an overview discussion of health care financing in the area.

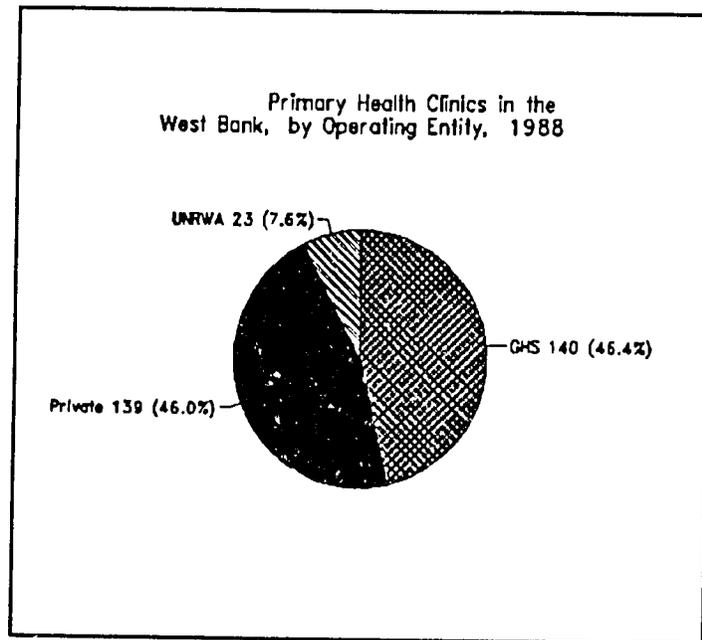
B.1 Preventive and Primary Health Care and Outpatient Services

With the exception of immunization coverage, disease prevention and health promotion activities are not extensive, although some are carried out sporadically in primary health clinics. Both the GOI and local NGOs report that immunization coverage continues to be generally high (90% or more) in both the West Bank and Gaza Strip, although periods of curfews and strikes hamper efforts. Government health authorities and UNRWA work cooperatively with private voluntary organizations to utilize their facilities and staff for immunization, particularly for children.

While a few of the NGOs have developed health education programs which target health needs identified through morbidity and mortality data, there has been no comprehensive, coordinated regional or inter-regional prevention campaign, and there is little linkage with related sectors. Thus, while many health professionals believe that poor water quality is related to the increase in high rates of dysentery in the Occupied Territories, only a few local assessments of water quality and water-borne diseases have been conducted.³⁶ Moreover, Palestinian health professionals have little access to recently successful prevention campaign methods and materials used elsewhere, and circumstances inhibit coordination with other sectors, which is seen as critical by public health professionals in international organizations (e.g., WHO) and in other countries or jurisdictions.

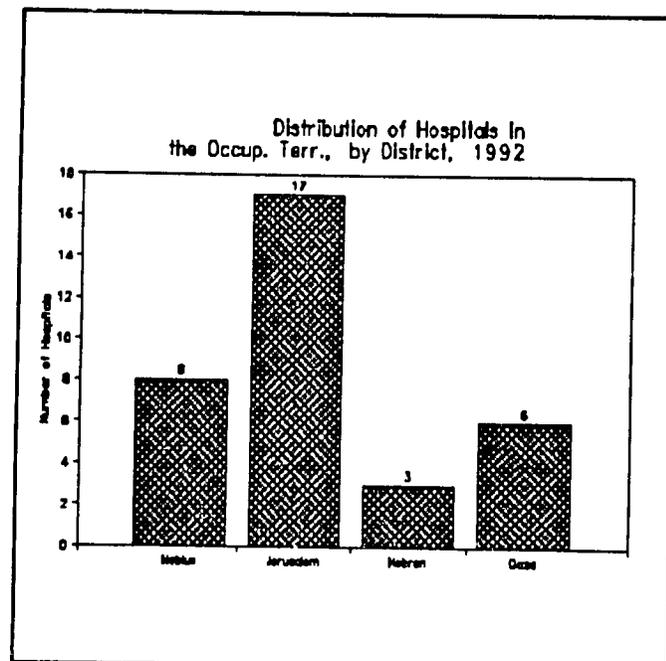
Primary health care (PHC) access and quality continue to be problems in the Occupied Territories. Figure 3 presents the distribution of numbers of primary health centers in the West Bank by operating organization in 1988 (no comparable data are available for the Gaza Strip for that year); Figure 4 shows the geographic distribution of this level of care throughout the Occupied Territories. Even with the considerable expansion of primary health services in the 1980s, estimates of rural population centers with no immediate access to health services range from 20% to 30% in the West Bank. Although the Israeli government and UNRWA operate primary health clinics throughout the Occupied Territories, the private sector has played an increasingly important role in the past decade.

Figure 3



Source: Ministry of Foreign Affairs. Rome, Italy. General Survey: Health Services in the Occupied Territories: Jerusalem; November 1989.

Figure 4



Source: Ayed, N. Health. In: Palestine Studies Project, Masterplanning the State of Palestine. Ramallah: Center for Engineering and Planning; 1992.

Government Services. According to official Israeli statistics, as of the end of 1991 the CIVAD operated 463 primary health clinics in the West Bank³⁷ and 27 in the Gaza Strip.³⁸ However, in 1989, a WHO report indicated that the GOI operated 150 primary health clinics in the West Bank and 51 in the Gaza Strip.³⁹ Given the fact that the number of governmental primary health care clinics has not increased substantially in the West Bank nor decreased substantially in the Gaza Strip during the period 1989-91, it is unlikely that the figures are accurate. Prior assessments have identified a tendency on the part of the GHS to over count PHC facilities. For example, a 1989 survey of health facilities in the Hebron area found a total of only 33 government PHC clinics, 10 to 15 of which included maternal and child health (MCH) services in the same facility.⁴⁰ In contrast, a 1989 report of the Israeli Ministry of Health stated that the Government of Israel operates 29 general clinics and 21 MCH centers in the Hebron District, for a total of 50 clinics.⁴¹ In fact, the clinics listed were units of services rather than freestanding facilities. Thus, a single site (facility) invariably has multiple units of service (e.g., prenatal care, early childhood immunization). In the West Bank, two mobile health units are used by the GHS for both immunizations and minor curative care, but there are reports that the mobile units are used almost exclusively for immunizations.

According to GOI reports, their PHC clinics have a nurse on staff and regular visits from physicians, with the frequency of visits depending on the size of the facility; the norm is two visits for 2-4 hours each week. However, according to health providers and other observers in the Occupied Territories, the clinics do not have an adequate number of trained staff and are often short of supplies and essential equipment.

No independent survey of actual health facilities and PHC services provided by the GHS is available; however, in many villages these are the only source of preventive and primary care. Many of the Palestinian physicians now working in private facilities gained experience in the government clinics.

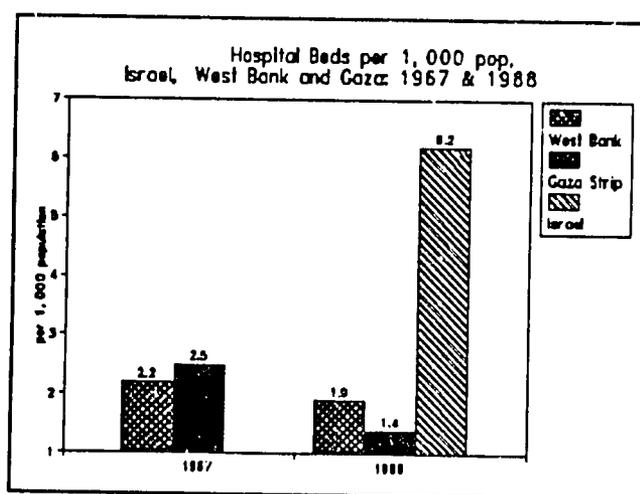
UNRWA. UNRWA provides primary health care for refugees both within and outside the camps. As of April, 1992, UNRWA had 19 PHC facilities within refugee camps in the West Bank and five outside the camps, in addition to 10 health posts (which provide basic services only).⁴² In the Gaza Strip, the agency has nine PHC clinics and several health posts, all within the camps. Two of these operate 24-hours per day, and seven operate in the morning and afternoon.⁴³ UNRWA provides MCH services, immunizations, early detection and screening as well as treatment for childhood and adult conditions and basic emergency care referral for secondary and tertiary services.

Private Sector. In the West Bank, an estimated 140 primary health clinics were operated by non-profit organizations in 1988;⁴⁴ eight such organizations operated 20 facilities in the Gaza Strip in 1991.⁴⁵ In both areas, the facilities are often open daily and linked to other types of social or support services directly and indirectly related to health care; for example, nutrition programs, health education activities, literacy or cultural programs, income generating projects and outreach (home health) services. The organizations also conduct vaccination campaigns, supplementing the GHS immunization programs.

B.2 Secondary and Tertiary Health Services

In total, there are 20 hospitals with a total of 1,151 beds in the West Bank, not including the small (i.e., less than 30-bed) maternity hospitals. Nine of these hospitals are operated by the GHS, ten by the private sector and one by UNRWA. Six hospitals are in operation in the Gaza Strip, with a total of 864 beds; five of these hospitals are operated by the GHS and one by the private sector.⁴⁶ Notably, the number of hospital beds represents a decrease from 1967, when there were 1,265 beds in the West Bank and 955 in the Gaza Strip. At the same time, there has been a 70% population increase in the Gaza Strip and a 114% population increase in the West Bank.⁴⁷ The hospital bed per capita ratio has thus decreased from 2.2/1,000 in the West Bank in 1967 to 1.9/1,000 in 1988; in Gaza, the beds' ratio has decreased from 2.5/1,000 in 1967 to 1.4/1,000 in 1988 as shown in Figure 5 below. This ratio is deficient overall, even given the trend towards non-hospital based care in middle- and upper-income countries. The present ratios also are significantly below those in Israel (with a bed ratio of 6.2/1,000 in 1988)⁴⁸ and Jordan. Moreover, the hospital beds are severely maldistributed; the bed ratio is .5/1,000 in Hebron, .8/1,000 in Nablus and 2.3/1,000 in the Jerusalem area.⁴⁹

Figure 5



Source: Population data obtained from the Statistical Abstract of Israel, 1967 and 1988. Hospital bed ratios obtained from Ayed, N. Health. In: Palestine Studies Project. Masterplanning the State of Palestine. Ramallah: Center for Engineering and Planning; 1992.

Reportedly, the general hospitals have had 80% or more utilized bed capacity from 1986 to 1991, with some hospitals and some units operating over capacity for much of the time. Recent, verifiable bed utilization data for GOI or private hospitals were not available; however, with the expanding capacity (supported largely by donors), it may be that utilization has decreased in the past two years. This would have implications for bed capacity and needs. Importantly, those areas which have had the lowest bed/population ratios (e.g., Jenin, Tulkaram and Hebron) currently have hospitals under construction. If completed within the next two years, these hospitals should considerably improve the bed distribution as well as the bed/population ratios.

There is a severe maldistribution of both basic and advanced medical equipment in the West Bank and Gaza. In some facilities, even the most basic equipment is not available; equipment that would allow for minimal diagnosis and/or treatment, including basic emergency treatment. In other cases, sophisticated equipment is available which may be underutilized or inappropriately utilized. An additional issue with respect to diagnostic procedures is that, while most procedures can be performed in the West Bank or Gaza, there are some types of procedures for which the patients themselves or specimens must be sent to Israel. Consequently, tests results at best are delayed and at worst unavailable.

Government services. The government operates nine hospitals in the West Bank (including a psychiatric hospital) and five in the Gaza Strip. As of 1990, the total number of hospital beds was 682 in general hospitals, 320 in the psychiatric hospital in the West Bank and 789 beds in Gaza.⁵⁰ At least one hospital in the West Bank currently has the capacity for general and cardiac surgery, pediatric care, obstetrical and gynecological care, oncology (minimal) and general medicine. No government hospital in the West Bank has a neonatal intensive care unit (NICU) that would be considered comparable to Level II or III in the United States, and there are no government facilities for severe head trauma, cardiac catheterization, burns or dermatology. The hospitals also have staff, equipment and supply shortages. Several of the facilities are in deteriorating condition.

Private sector and UNRWA. The private sector operates four general hospitals and six specialty hospitals in the West Bank, with a total of 270 general beds and 267 specialty beds.⁵¹ Only one private sector hospital operates in the Gaza Strip, with a total of 85 beds.⁵² Several private organizations provide outpatient and short-term inpatient secondary care in both the West Bank and Gaza Strip. In the West Bank, the private sector hospitals have the capacity for general and cardiac surgery, pediatric care, obstetrical and gynecological care, neonatal intensive care, oncology (minimal), urology, general medicine and diagnostic services (including CAT scanning). The private hospital in Gaza has the capacity for only general and orthopedic surgery, pediatric care, obstetrical and gynecological care, emergency services and general medical care.

UNRWA operates one hospital in the West Bank (Qalqilia), which has a total of 36 beds. UNRWA also subsidizes a total of 208 of the beds in private hospitals in the West Bank and 50 of the 85 private beds in the Gaza Strip. This limits the availability of the UNRWA-subsidized hospital beds to the non-refugee population.⁵³

B.3 Rehabilitation Services

Virtually all rehabilitation services in the Occupied Territories are operated by the private sector. The Giacaman *et al* report identifies 32 facilities in the Occupied Territories that provide rehabilitation services for the physically handicapped.⁵⁴ Most of these facilities are located in the West Bank; for example, there are four inpatient rehabilitation facilities in the West Bank but none in the Gaza Strip.

Even in the West Bank, the distribution of rehabilitative services is heavily clustered around urban areas, particularly in the Jerusalem-Bethlehem area. Patients from Hebron and Gaza are referred to facilities in the Jerusalem/Bethlehem area for inpatient care. Even in the largest facilities, the occupancy rates are not high. In fact, one facility with 40 inpatient beds has never operated at full capacity. This raises questions of whether there is now a surplus of inpatient rehabilitation beds, and, if so, what alternative use could be made of them. Unfortunately, these centers are not located in areas underserved by hospitals. While health care planners might consider alternative uses of these expensive facilities, such uses could not ameliorate the present need for secondary services in Hebron and Jenin/Tulkaram.

In the Gaza Strip, the Benevolent Society in Gaza City operates an outpatient physiotherapy center (for an average of 15 patients per week) and manufactures orthopedic devices for their patients. Physiotherapy services are also offered at five of the UNRWA health clinics in Gaza. The Society for the Care of Handicapped Children has provided services for handicapped children and their mothers since 1975 and also provides preventive services for at-risk children and their mothers. The Child Development Center in Gaza provides outpatient treatment and preventive services for children with a wide range of disabilities.

A number of private voluntary organizations (e.g., the Catholic Relief Service and the Bethlehem Arab Society) have initiated programs for at-home care of the physically handicapped in villages or refugee camps. In addition, Diaconia (a Swedish NGO) supports an expanding network of community-based rehabilitation centers in the West Bank and Gaza Strip.

B.4 Mental Health Services

Notwithstanding the need for mental health services, there are scant facilities in the Occupied Territories to provide such care. The government's mental health services facilities for the Occupied Territories include a 320-bed psychiatric hospital in Bethlehem, which also has an outpatient department, and mental health outpatient services provided in only five PHC government clinics in the West Bank. In the Gaza Strip the government has no mental health inpatient facility and offers such services on an outpatient basis in only two PHC clinics.

The private sector has begun to provide outpatient mental health services. There are few trained psychologists or counselors, and the services are provided mainly by trained social workers. Few donors support such services, although more have begun to do so since 1989. For the most part, services are provided in existing general health facilities or in small, special purpose facilities operated by small private organizations. Only one stand-alone private mental health clinic exists in the Occupied Territories, the Community Mental Health Center in Gaza (GCMHC). This center provides diagnosis and outpatient treatment and has an extensive training program for its own staff as well as for health care providers working in governmental and private health facilities. While UNRWA has no mental health facility of its own, it has an agreement with the GCMHC to provide outpatient services to refugees referred by the agency.⁵⁵

It should be noted that in 1984, three years before the Intifada, a severe need for additional mental health services was identified in the annual WHO report on health conditions in the Occupied Territories.⁵⁶ Given the conditions of the Occupation, including the extensive closures and curfews as well as armed and unarmed conflict among the Palestinian population, the Military forces and settlers, the existing mental health services are woefully inadequate.

B.5 Family Planning

In spite of the high birth rate in the Occupied Territories--the rate in the Gaza Strip may be among the highest in the world--and the comparatively high infant mortality rate (which may be related to high parity), few family planning programs exist, and those which do have often maintained a low profile for political reasons. In most reports on health in the Occupied Territories, no mention is made of family planning services. Increasingly, however, organizations are making intrauterine devices (IUDs) and, to a lesser extent, oral contraceptives, available to women upon request. And increasingly, women of all political affiliations are requesting these services.

UNRWA provides family planning services upon request to refugee women in the West Bank and Gaza Strip as part of their overall women's health program. That program includes health education as an integral part of providing the IUD or oral contraceptives. The UPMRCs also provide IUDs to women upon request in the West Bank and are planning to do so in the Gaza Strip by late 1992. The UPMRC provides this service as part of its comprehensive women's health program, which also includes, for example, health education and pre and post natal care. Private physicians also make IUDs (and oral contraceptives) available to women upon request. The Jordan Family Planning Program (JFPP) has a network of services in the West Bank. Recently, the JFPP conducted a seminar for health professionals to discuss family planning issues.

C. HEALTH CARE FINANCING

Primary data for costs and financing of governmental and private health services are essentially unavailable; the following description of findings is thus based on interviews with health care administrators and providers and on published secondary data sources. This section of the report also describes issues related to the discussion of devolution of responsibility for GHS health facilities to the Palestinian private health sector.

C.1 Health Care Costs and Fees by Operating Entity

Almost all health services provided in the Occupied Territories are subsidized by the GOI (through taxes collected from Palestinians), external donors (to the Palestinian private sector) or UNRWA (using funds provided by governments). The total amount of funds expended in the health sector in a given year is an elusive figure; however, in the Gaza Strip alone, it is estimated that the GOI expends \$15-\$17 million, UNRWA \$12 million and external donors (other than funds through UNRWA) an additional \$6.5 million.⁵⁷ This does not include funds derived from remittances or contributions from individual Palestinians or Gulf States and payments by individual Palestinians for health care services; unfortunately, no estimates of these figures are available.

Government Services. Funds to support government facilities in the Occupied Territories are derived from revenues received from national health insurance premiums paid by the population, fees received for services provided in government hospitals and general taxes paid by the population in the Occupied Territories. According to a 1988 A.I.D. report, "the Occupied Territories are 'closed systems' financially speaking: expenditures for the delivery of social services [including health-related services] do not exceed the revenues raised internally from taxes and other fees."⁵⁸

While data and documentation are not available to verify the "closed system" nature of the fiscal arrangement, interviews with Palestinian health professionals and observations confirm that assessment. According to several health providers and administrators, fees paid to government facilities in the Occupied Territories are reportedly returned to the general budget of the GOI, rather than to the budgets for the facilities in the Occupied Territories. Further, fees paid to Israeli hospitals for specialty and other services not available in the Occupied Territories are estimated to total approximately \$5-7 million annually. These include fees paid by UNRWA, those deducted from the budgets of government hospitals in the Occupied Territories for referred services and those paid by individuals or private insurance companies.

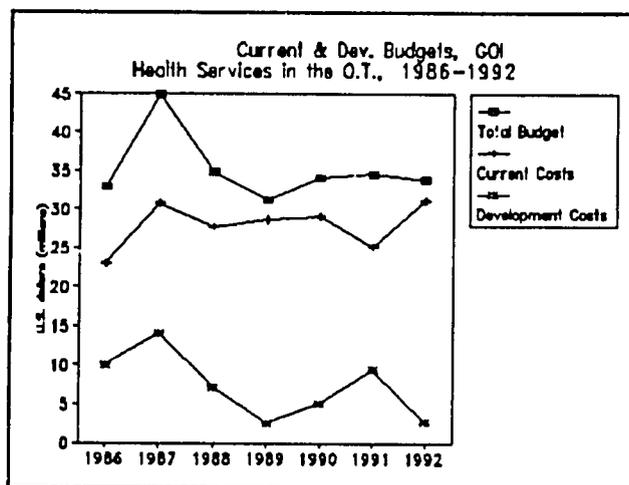
Table 3 and Figure 6 present the current (operating cost) and development (capital) budgets for GHS health services in the West Bank for the period 1986 through 1992. The budget for 1992 (\$33.8 million) is well below that for 1987 (\$44.9 million); in the interim, it had reached even lower levels, dropping to \$31 million in 1991. The operating costs allocated for hospitals alone in 1992 totaled \$22 million, or 71% of the total operating budget for GHS services in the West Bank. In 1988, the GHS mandated an approximate 45-60% reduction in the allocation for health services in the Occupied Territories, including a cessation of all development in hospitals and clinics (e.g., no hiring of new staff, no replacement of vacant positions and termination of approximately 85 staff posts; in addition, no new equipment or instruments were to be purchased, and physical rehabilitation and new construction of hospitals and clinics was ceased, with the exception of new construction at the Shifa Hospital in Gaza). There was also an across-the-board 10% reduction in operating costs in 1989.⁵⁹

TABLE 3: CURRENT AND DEVELOPMENT BUDGETS FOR HEALTH SERVICES IN THE OCCUPIED TERRITORIES, 1986-1992

	Total (U.S. dollars, millions)	Current	Development
1986	\$32.95	\$23.00	\$9.95
1987	\$44.87	\$30.77	\$14.10
1988	\$34.88	\$27.78	\$7.10
1989	\$31.25	\$28.71	\$2.55
1990	\$34.16	\$29.11	\$5.05
1991	\$34.61	\$25.21	\$9.40
1992	\$33.81	\$31.18	\$2.63

Source: Policy Research Incorporated (PRI), Clarksville, MD; 1992.

Figure 6



Source: Policy Research Inc., Clarksville, MD; 1992.

In 1990, the average Israeli per capita expenditure on health services in the West Bank was just over \$40, compared to \$450 per capita in Israel.⁶⁰ This GHS allocation for health services in the Occupied Territories is the second lowest of the 36 low-income and lower middle-income countries included in the most recent comparison study by the World Bank.⁶¹ No expenditure data were available for GHS services in the Gaza Strip.

All Palestinians living in the Occupied Territories are eligible for the GOI National Health Insurance (NHI) program. Those who are employees of CIVAD and of Israeli firms are required to enroll; in fact, the premiums are automatically deducted from their salaries. Palestinian health officials estimate that only 16% of West Bank residents are covered through the NHI program; 25% of Palestinians in the Gaza Strip are covered. This is reportedly a substantial decrease since 1987, when overall enrollment in the Occupied Territories was estimated at 30%. This decrease in population coverage is likely due to three factors: 1) the increase in premiums, 2) the decrease in Palestinians employed by the GOI and 3) the overall economic recession among the Palestinian population. The 1992 premium for a family is approximately \$33 per month. Given that the average income per capita for Palestinians is estimated to be \$250/month, health insurance premiums would consume roughly 13% of monthly income.

For those not covered through the national health insurance program, fees are charged for services in government facilities. These fees have increased significantly since the mid-1980s--the current hospital inpatient (per night) charge is \$150 and an outpatient consultation is \$17. This is reportedly much higher than for comparable services in government hospitals in Jordan. It has been suggested that the policy of increasing fees may be attributed to the strategy of encouraging voluntary enrollment in the national health insurance program.⁶²

As is the case in most national health systems, fees are not charged for certain types of services and for certain populations. Specifically, government health facilities do not charge fees for childhood immunizations, care for children under 36 months of age, or for services for those with contagious diseases and those certified as indigent by the Ministry of Labor and Social Welfare.⁶³

UNRWA. For specialty care not available in the West Bank, UNRWA refers patients to Israeli hospitals. This is a costly arrangement for UNRWA. For example, in 1988, UNRWA paid \$816,000 to Hadassah Hospital for the care of 341 refugees. In 1991, the total amount paid by UNRWA to Hadassah was approximately \$200,000. This decrease resulted from UNRWA efforts to decrease dependency on Israeli hospitals as well as from the expanded capacity of Palestinian private sector hospitals to provide more specialized diagnostic and treatment services. While UNRWA must reimburse the GOI fully for services received by refugees in Israeli hospitals, they have frequently depleted their health budget prior to the end of their fiscal year. As a result, the private sector organizations in the West Bank and Gaza Strip are often not reimbursed in full for health services they provide to refugees. These facilities therefore cannot adequately carry out even short-term financial planning because they cannot fully depend on UNRWA. The facilities nevertheless usually continue to provide services to the refugees.

Private Services. The substantial decreases in GOI allocation for health services have effectively resulted in the system deteriorating over the past six years, with the burden for medical care costs shifting to the private sector and to the population, which has few resources to bear such costs. As a result, the dependency on external donors for capital expenditures and operating costs has increased. This dependency relationship is both volatile and detrimental to the effective delivery of services. During and subsequent to the Gulf War, external sources of funds (with the exception of European and U.S. donors) were

significantly diminished. The decrease in funds available to the health sector resulted from a significant decrease in contributions to health facilities directly on the part of individual Palestinians residing in the Gulf States and a significant increase (estimated at 20%-40%) in the number of social cases (i.e., medically indigent patients) whose economic support was derived largely from relatives working in the Gulf States or who have been unemployed since the Gulf War.

Fees for private in-patient services vary widely, but virtually all private facilities that charge fees do so on a sliding scale basis, and patients who cannot afford to pay are not required to do so. Furthermore, no private facility charges a fee for Intifada-related cases. A typical fee for an outpatient visit is U.S. \$3.00. Inpatient obstetrical delivery ranges from U.S. \$100 to U.S. \$300. These fees are comparable to those charged for private sector services in Jordan.

Only one private health insurance company operates in the West Bank, the Ibrahim Abohil Hadi Insurance Co. Only 10,000 Palestinians are covered through this private company, which charges a premium of U.S. \$132/year for family coverage, including those up to 60 years of age.⁶⁴ Reportedly, most participating families are in the middle and upper income strata. The Union of Palestinian Medical Relief Committees (UPMRC) initiated an experiment in private insurance in the Jordan Valley, with a premium of U.S. \$180/annum, but the effort was halted after several months.⁶⁵ According to the UPMRC, insufficient planning resulted in the program's lack of success. Several other organizations are exploring the potential for implementing of private health insurance schemes, including the Engineers Association in Gaza, which is planning for implementation of a system linked with Ahli Arab Hospital, the Patients Friends Society and local private practitioners.⁶⁶

The Beit Sahour Health Cooperative was identified in a 1989 report for A.I.D. as an example of the type of Palestinian health facility which could serve as a model for alternative health care financing mechanisms.⁶⁷ This cooperative has for several years had a membership of approximately 1,200. It provides discounted ambulatory and surgical services to its members and also provides ambulatory care and other services on a fee-for-service basis for non-members. More recently the cooperative has initiated a contract with a Palestinian labor union for coverage of services for 5,000 persons (union members and their families) and with a local bus company (for a total of 150 persons).⁶⁸ Other multipurpose outpatient health facilities also have a patient load sufficient to be considered as a site for the demonstration of alternative forms of health care financing. However, the current economic climate is probably not propitious for this type of project. The failure of pre-paid programs serving low-income populations in the U.S. and developing countries is widespread; Palestinians and others involved in exploring these alternatives should carefully review the experience of such mechanisms.

C.2 Devolution of Authority for GHS Health Facilities in the Occupied Territories

Discussions concerning the devolution of responsibility for the GHS health services to the Palestinian private health sector have taken place for nearly two years and have accelerated since the initiation of the Peace Talks in 1991. However, it is not clear how the services currently provided by the GHS will be supported financially and how Palestinian health professionals--many of whom have received training and gained experience in the U.S., Europe and the Middle East (including Israel)--can most expeditiously assume responsibility for this system. While most employees in the GHS health care system have been Palestinians, they have not had decision-making authority with regard to system-wide planning, health care financing or other key management functions. In some cases, they have had minimal decision-making responsibility at the facility level, and have not had access to the data requisite for planning and management.

The issues related to assumption of the GHS health care system are many and complex; they raise a number of critical health policy questions, including, for example:

What is the most appropriate way to effect the rationalization of the disparate delivery system mechanisms (e.g., GHS, NGOs, UNRWA) in order to ensure that a coordinated health system is in place, and what is the most effective and efficient approach to phased-in implementation of such a rationalization of health services planning and delivery?

When and how will existing health-related regulatory systems be transferred to Palestinian control, and what assistance will be provided to Palestinians in the development of related policy instruments? Such systems, including for example, licensure of health facilities and testing and approval of pharmaceuticals and medical devices, are key aspects of a health care system, but Palestinians have had minimal involvement in these regulatory systems during the Occupation and thus lack experience and expertise to manage such systems. Because such systems have been successfully designed and implemented in some countries (e.g., Costa Rica) over a minimal time period, and because both Israel and Jordan have regulatory systems from which much could be learned, this process should be facilitated, particularly if Palestinians could begin to be brought into the Israeli regulatory process which relates to the Occupied Territories' health care system as soon as possible. How can this process be initiated and under what aegis?

What funds will be available to Palestinians for operating and development (capital) costs from the health and general budget, for what period of time, and with what degree of discretionary spending on the part of Palestinians? The mechanism by which there will be a transfer of GHS funds derived from taxes and other fees collected by the GOI from Palestinians living in the Occupied Territories to "public" services such as the health care system, as well as the timing of such transfer and estimated level of funds to be transferred, would need to be determined well in advance of the transfer of authority and responsibility for the GHS health

care system. This is particularly important in advance of the transfer of GHS hospitals, which (as has been mentioned previously) constitute approximately 70% of the GHS health care budget for the Occupied Territories. It will also be necessary to determine how Palestinian health care professionals will be provided with detailed cost and other information related to the GHS system, so they can adequately devise and implement health care financing plans. How can these health finance and management issues be most appropriately addressed in the current context?

How long will Palestinian control of the tax system have to be in place and functioning prior to devolution of responsibility by the GOI for the health (and other social) sectors? This is critical, if Palestinians are to be assured of adequate public resources to support health services for those unable to afford care.

Will authority for health services be transferred after elections are held in the Occupied Territories and after appointments of Palestinian health officials have been made? Not only financial systems, but organizational structures and personnel would need to be in place and prepared to assume responsibility for a fully functioning health care system.

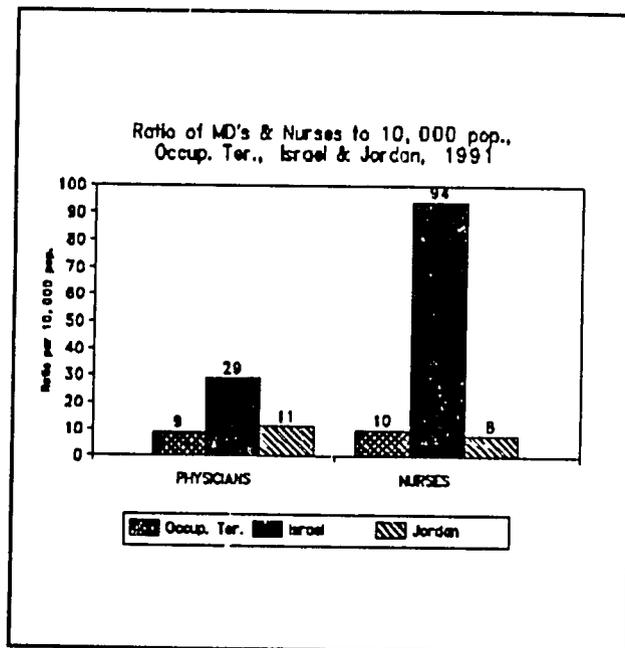
Palestinians are keenly interested in assuming responsibility for their health care system. However, as has been discussed previously, they are aware of the likely economic social cost of assuming responsibility for this system under present circumstances. Given the significant decreases in funding for government facilities between 1987 and 1991, extraordinary funding will need to be available to cover both capital and operating costs. While donors have supported private health services in the past, they have been reluctant to cover operating expenses (with the exception of Arab donors, who have provided operating costs). The private health sector has never been financially self-sufficient in the Occupied Territories, and has depended largely on external donors. Patient fees contribute only a small proportion of operating costs of private sector facilities. This is no different from other jurisdictions. Even in countries that have significant private sector involvement in health care delivery, government payments and subsidies and employer financing of care contributes substantially to the private health sector. With a minimal tax base, the Palestinian "public" sector can ill-afford to ensure adequate coverage for those unable to pay for services.

The essential question is, what is the most appropriate mechanism and timing for transfer of authority for the health services to ensure that services are not disrupted, that the quality of care is maintained (if not improved) and that efficiencies in care are realized? Donors can play a key role in guiding the Palestinians in deliberations and negotiations with respect to the complex issues that confront those planning for a rational health care system in the Occupied Territories.

D. HEALTH MANPOWER DEVELOPMENT AND TRAINING

In 1990, there were reportedly 1,243 physicians registered by the Arab Medical Association in the West Bank⁶⁹ and 850 in Gaza, of whom only 760 actually reside in Gaza.⁷⁰ As of 1990, there were an estimated 10.3 physicians/10,000 inhabitants in the West Bank; the ratio for Gaza was 8.4. These ratios are far below those of Israel but comparable to those of Jordan. See Figure 7 below. There is a severe lack of some medical specialties; for example, there is no trained oncologist or hematologist in the West Bank, and there are few trained technicians to perform critical diagnostic services.

Figure 7



Source: Prepared based on population data presented in this report and on registered physician and nurse data presented in Husseini, S.; 1992 and Tarazi, J.; 1992

In spite of the maldistribution and relative shortage of physicians, reports from a variety of sources indicate that between 200-300 physicians are currently unsalaried--or underemployed--because GHS services have not been expanded or because the GHS budget has decreased since FY 1987. Reportedly, most of these physicians are working part-time in village clinics operated by a variety of medical relief committees. This arrangement begs the question of the means by which a Palestinian health system will be able to pay the salaries of these or of newly trained and hired physicians.

Physicians in the Occupied Territories are employed primarily in government-operated facilities and privately-operated facilities. In addition, some have their own clinics in which they work exclusively, and 50 work for UNRWA.⁷¹ As is the case in most countries which have a national health system, most physicians in the Occupied Territories who work for the government also work part-time in private facilities or have their own "clinic" (usually providing services in a small office) in the afternoon.

The total number of nurses working in the West Bank and Gaza Strip was 2,320 in 1990, of whom 70% were employed in hospitals. The shortage and maldistribution of nurses is apparent: the ratio ranges from 5/10,000 population in the north (Jenin and Tulkaram) to 30/10,000 in the Jerusalem District.⁷² This would parallel the shortage that pertains in most countries, now considered a worldwide problem.⁷³ However, the comparable nurse ratio for Israel in the same year was 94/10,000--nearly ten times that of the Occupied Territories.

As a result of injuries sustained during the Intifada, physiotherapists are much in demand. As of 1990, there were reportedly 25-30 trained physiotherapists in the West Bank and 25-30 in the Gaza Strip, with an estimated 50 in training.

The shortage of trained technicians and other staff able to maintain and repair equipment has been identified since 1989.⁷⁴ This shortage is of particular concern given the fact that the amount of sophisticated equipment being introduced to the Occupied Territories appears to be increasing, and there is scant availability of service from the equipment suppliers in Israel. In fact, in many cases, vital equipment such as x-ray machines had been in disrepair for as long as 6-8 months because Israeli suppliers will not enter the West Bank (or Gaza) to repair non-functioning equipment.

There is no medical school in the Occupied Territories and no other formalized system for training of physicians. Although Palestinian physicians have participated in residency training in Israel (with U.S. funding for the Israeli institutions), this training is not sufficient to qualify the Palestinian physician as a full specialist in the field of study. Most Palestinian physicians with specialty training have participated in residency programs in Arab countries, Europe or the United States.

There are, however, two schools offering BSN degrees (Arab College of Medical Professionals and Bethlehem University). In addition, 18-month nursing programs are offered at Caritas, St. Johns, Mrs. Habash Nursing School, St. Luke's Hospital and Makassad Hospital; there is also a three-year nursing diploma program at Ahli Arabi Hospital in Gaza. The government also has three nursing schools in the Occupied Territories. The Arab College of Health Professionals also trains Medical Technicians and X-ray Technicians. The Union of Palestinian Medical Relief Committees has trained 60 village health workers since 1988, and approximately 200 community health educators have been trained through Catholic Relief Services. Unfortunately, the closure of schools of higher education between 1987 and 1991 exacerbated the problem of shortage of nurses and technicians.

Donors' involvement in continuing education of health professionals has increased significantly over the years. AMIDEAST and other PVOs sponsor local, regional and U.S.- and European-based short-term training courses. However, there is no system for approving courses and ensuring the quality of continuing medical education. Moreover, there is no link between continuing education and either licensure or monetary or other rewards for health professionals.

Because of the lack of adequate continuing education and training of health providers, medical and technical staff have simply not kept up with the new equipment being donated, thereby affecting the ability of health providers to appropriately and safely use the new technologies. The same is true for new pharmaceuticals and treatment procedures. One glaring example of problems with use of new technology is mammography equipment, which two physicians in two separate facilities indicated would be used on a routine basis every six months for women over 35 years of age. This would not only be excessive, but would likely be dangerous; it far exceeds the recommended use of this procedure in the U.S.

E. PLANNING FOR HEALTH NEEDS

Several local committees are involved in development of plans for the health sector; these include:

- * locally-formed committees in both the West Bank and Gaza Strip, comprising representatives of several Palestinian interest groups. These committees are addressing health care issues at the primary, secondary and tertiary level as well as rehabilitation and health personnel development and training; and
- * a Jerusalem-based committee which includes representatives of the GOI health services, local NGOs and consultant health advisors and has been in the process of reviewing and reformulating the Draft "National Health Plan," that was first released in 1990. This final draft is scheduled to be released in early November, 1992.

In addition, the technical committees related to the peace process have recently been preparing planning documents related to the health sector. Other organizations (e.g., the Health Development Information Project and the Arab Medical Relief Association) have prepared studies of specific levels of care, geographic areas or specialties.

Few comprehensive assessments of the health care system in the West Bank and Gaza Strip have been conducted. In fact, such assessments are limited by the paucity of data from both the public (GOI) and private sectors and by hindrances to health researchers data collection and analysis. Further, the annual GOI statistical reports are incomplete, as they do not reflect private sector services or diagnoses.

Notwithstanding the paucity of health and health services data, there is considerable interest on the part of the private health sector in the West Bank and Gaza in developing the capacity both to plan individual facilities and service

provision and to plan cooperatively for provision of services in defined geographic areas. A number of individuals and organizations have initiated development of health information systems (albeit not standardized within or across facilities) that could provide a basis for health information systems which would support improved facilities and services planning.

The lack of clarity with regard to funds available for the health sector from United Nations agencies UNRWA, United Nations Development Program (UNDP), United Nations Children's Fund (UNICEF) and World Health Organization (WHO) and from other sources severely impedes the ability of Palestinian organizations to identify funding needs and plan for services. The criteria used by donors to determine the facilities which should receive the funds and what the funding levels should be are often unclear, leading to confusion, raised expectations and increased competition among the numerous organizations in the health sector. Recently, the UNDP has spearheaded an effort to compile information concerning donor funding for development projects, including health-related activities. This should substantially improve the bases on which Palestinians can implement rational planning and allocation of donor funding.

F. DONOR INVOLVEMENT IN HEALTH AND NUTRITION

From 1984 to 1991, donors have contributed nearly \$48 million to health care projects in the Occupied Territories, not including Arab donors and contributions to UNRWA for refugee health services. Of the total amount provided by donors for health projects for the same period, A.I.D. has contributed \$3.5 million, not including support for the food distribution program which amounted to \$8.1 million for the period 1989-91 alone.⁷⁵ The total dollar amount for currently planned health projects over the next few years is estimated at \$10.3 million from all donors from which data were available, not including the estimated \$15 million contribution from the EC for the UNRWA hospital in the Gaza Strip.

Only recently has there been any formal coordination of donor funding in the Occupied Territories. This is, perhaps, understandable for a variety of reasons, but it nonetheless renders rational allocation of scant resources difficult. This lack of coordination has been problematic because, while the Intifada has focused attention on the health needs of the Occupied Territories, the donations have not always been based on a clear definition of needs on a regional or territory-wide basis. The recent coordination efforts (which have resulted in the UNDP compendium donor-funded projects) are laudable and bode well for the future of health project planning. The participating organizations are also coordinating more frequently than in the past with Palestinian planning organizations. Unfortunately, the possibility thus arises that the health care services in the Occupied Territories will continue to be primarily "donor-driven"; that is, that they will be linked as much to the policies, programs and capabilities of the donors as to the needs of the Palestinians they are intended to benefit.

V. CONSTRAINTS TO IMPLEMENTATION OF HEALTH SECTOR PROGRAMS

The two overriding constraints which impede the development and implementation of quality health services, access to care and efficiency of service delivery are:

- 1) an inadequate economic base from which to derive sufficient resources to support health care, and
- 2) the absence of a coordinated system of care.

These constraints have impact on all aspects of health services planning and delivery in the Occupied Territories. The first is described in detail in the companion sectoral report, Finance and Credit. The second is described in the Introduction to this report. In addition to these two impediments to effective and efficient delivery of health services, a number of constraints impact specifically on various aspects of health status and service planning and delivery; they are described below under the following headings: GOI Bureaucratic and Other Policies, Data and Information and Lack of Coordination Among Palestinian Institutions.

Additional constraints which impede the effective and efficient delivery of health care services are bureaucratic policies, an inadequate managerial infrastructure, inadequate data and information, and lack of coordination among donors and among Palestinian institutions. The problem with respect to donor coordination has been described in Part IV; the remaining constraints are highlighted below.

A. POLICIES OF THE GOI

Certain policies of the GOI have significant impact on health services and on the health status of the population, either directly or indirectly. Incidents reported by UNRWA officials and Physicians for Human Rights have included:

- 1) imposing extended curfews and in some cases withholding electricity and water from refugee camps or areas of conflict for lengthy periods of time. Such curfews have resulted in shortages of food and cooking gas, which can be considered to constitute a serious public health hazard. The withholding of water impedes sanitation and contributes to dehydration (a leading cause of death and illness in the Occupied Territories). The curfews and strikes also impede access to health care services by patients and some staff of health care facilities;
- 2) the pass-system imposed by the GOI, which impedes travel by patients and their families, health care providers and PVO staff and representatives or of their sub-grantees and thereby limits the degree to which projects can be effectively supported, implemented and monitored;

- 3) imposing excessively difficult and time-consuming bureaucratic mechanisms for submitting, processing, and approving licenses and permits for the construction, rehabilitation and operation of health care facilities; and
- 4) the project-level permit system imposed by the GOI, which impedes the degree to which projects can be effectively planned and implemented.

The latter two constraints have posed particular problems for health planning. Consideration of plans for health care facility construction and rehabilitation must take into account the fact that the GOI has the authority to require and approve licenses for construction and operation of such facilities. While an accepted practice in virtually every country (to limit excess hospital beds and ensure adequacy of services, for example), the process of licensure in the Occupied Territories has no clearly delineated criteria or health systems rationale. For example, Hebron Patient's Friends Society received the license for its proposed hospital after a five-year delay. This delay in approval, with no defined guidelines, makes it difficult to project with any precision how many hospital beds (or what types of acute care services) will be available within, for example, a five-year period. The same applies for other types of health care facilities.

B. INADEQUATE DATA AND INFORMATION

The lack of adequate data and information with respect to Palestinian health status, direct and ancillary health services, health manpower, health care costs and financing and other health-related issues has been described for some time.⁷⁶ With the advent of a Palestinian health system approaching, the paucity of such data is abundantly clear. Of critical importance are the absence of financial and other managerial data, the lack of independent studies of the quality of care (none has been identified during the preparation of this report) and the lack of quality assurance systems in hospitals and other health care settings. The issue is distinct for each of the three entities responsible for health services:

Government Health Services. While simple mortality and morbidity data are available, they are inadequate, incomplete and contradictory. Given the high skill and experience level of the responsible Israeli officials, the condition of the data may reflect excessive workloads and lack of adequate training and experience on the part of Palestinian staff. The critical missing data relate to cost and financing as well as to quality of care. It is imperative that Palestinians, and those working with them, have access to the full range of cost and financing data required to plan for the management of health services. It should also be in the interest of the GHS to engage Palestinian health administrators and health providers in discussions with respect to health care financing as a means of ensuring cost efficiencies during a period of transfer of authority.

Private/NGO Sector. Adequate data have not been maintained by the private sector because staff members have not been adequately trained in data collection and analysis. They have not had computerized information systems (or when they have been provided by donors, they have been developed *de novo*, rather than using compatible, generally available software). Given the disparate data collection efforts on the part of donors, PVOs and local NGOs, data are usually non-comparable (e.g., with respect to age groups and definitions of types of service). A large-scale household survey recently undertaken by a Norwegian donor may provide baseline data regarding health status and service utilization.

UNRWA collects and distributes mortality, morbidity and service data concerning the refugee population. These data often represent the only source of information on health status and health service in a given area. For example, many of the available nutrition studies have been carried out with the refugee populations. However, financial data are scarce and not generally available.

C. LACK OF COORDINATION AMONG PALESTINIAN INSTITUTIONS

The inability of the donors to adequately address the health needs of Palestinians is partially explained by the lack of a clearly defined plan for the health system in the Occupied Territories. Perhaps more importantly, local private organizations are increasingly competing with one another for scarce donor funds; the health sector overall is also in competition for funds with the productive private sector, to which donors are increasingly providing funds as a means of improving the local economy.

Unfortunately, international PVOs have not been exemplary in efforts to coordinate their health and health-related activities with one another or with Palestinian NGOs. Linkages among PVOs concerning distribution of equipment and training of health staff are minimal. It is even possible to find multiple projects funded by more than one donor in a single project site without the PVOs' being aware of this reality. International PVOs have also supported primary health care centers in villages which already have either a freestanding facility or regular access to a mobile health unit. Each of these problems contributes to the poor distribution of primary care services in the Occupied Territories and certainly does not provide Palestinian organizations with a model for health planning and coordination.

There have been some recent improvements in coordination among local health organizations. For example, since 1991 a National Health Committee comprised of representatives of most of the health services organizations, has been involved in a planning process. The committee has reviewed the National Health Plan (prepared by the Palestinian Red Crescent Society in October, 1990, and revised in Spring, 1991) and conducted a series of planning workshops. Other committees also have been involved in the planning process in health and health-related areas (e.g., rehabilitation). These activities will contribute significantly to the ability of donors to link their potential contributions to consensually defined (rather than individually perceived) needs. Local NGOs are also committed to grassroots development, to projects which encourage self-sufficiency and to alternatives to hospital-based, physician-based care. These NGOs and many Palestinian health

professionals are also increasingly aware of and concerned about the interdependence of sectoral development (e.g., health status and services with economic development and nutrition with agricultural development). These are encouraging signs for the future.

VI. CONCLUSIONS AND RECOMMENDATIONS

A. DEVELOPMENT OPPORTUNITIES

Mortality and morbidity data in the West Bank follow the patterns for industrialized countries and for developing countries whose patterns have changed positively in the past decade; however, data for the Gaza Strip are more reflective of the health status of developing countries. With the exception of illness and injury related to the political situation in the Occupied Territories, health status improvements are possible through the initiation of prevention campaigns--particularly those targeted to prevalent health problems--improvements in the knowledge, attitude and practices of health personnel and improvements in the maldistribution of services.

Maldistribution of health services is particularly problematic in the West Bank, but pertains in Gaza as well; it is exacerbated by the impediments to comprehensive planning (see previous sections of this report) and by inappropriate competition among local health organizations and to some extent among international PVOs. Not only are facilities maldistributed, so too are health personnel and equipment. Some shortages do exist, for example, in terms of trained personnel and equipment for use in certain diagnostic and treatment procedures, trained community health workers and mental health services. However, there are burgeoning excesses in others; for example, when obstetrical/gynecological services were seen as a source of revenue in the late 1980's, NGOs began to significantly expand their capacity in this area. Unfortunately, the expansion has been largely in relatively costly facilities (hospitals) rather than in community-based centers.

Few Palestinian health professionals have training or experience in health services administration, planning or management (including facility and manpower planning), health care financing, epidemiology and the prevention and treatment of occupational and environmental diseases (e.g., those related to water quality). All of these skills are needed for effective and efficient planning and delivery of health services.

The current economic crisis in the health sector specifically and in the West Bank/Gaza Strip generally may hinder action regarding current opportunities that exist for alternative approaches to financing health services. A number of organizations and facilities have been seen as potential loci of alternative health financing demonstrations for several years. Some still are potential loci of such demonstrations. However, many of these facilities have experienced significant increases in social cases since 1988; and many have also expanded the types of services provided without having clearly defined plans for cost recovery. These expansions, undertaken largely with external financial support from donors have often been followed by decreases in donor support. These factors, in the context of the deteriorating economic situation, have combined to make self-sufficiency a

longer term, more abstract goal. Nevertheless, specific approaches to improving financial and facility management could be demonstrated at these and other facilities.

Opportunities abound for donor investment to help develop efficient and effective health services in the Occupied Territories. Donors can contribute importantly to projects which focus on improving management and efficiency of services delivery at all levels as well as developing and implementing more cost-effective preventive and curative services at all levels, with a focus on primary care. However, donors should be cognizant of the need to redress critical deficiencies in services, while at the same time recognizing the economic realities which make it difficult for the private sector to continue to provide a significant proportion of the health services.

B. RECOMMENDATIONS

Table 1 summarizes conclusions and related recommendations with respect to health sector development in the West Bank and Gaza Strip. The recommendations are intended as preliminary ideas for those involved in development planning for the Occupied Territories. They should be considered in light of the discussion on overall development opportunities in the Occupied Territories which is included in *Visions of a Sustainable Future*--Appendix II to this report.

These recommendations are, for the most part, applicable whatever the outcome of the current peace process. Whether or not the Palestinian population assumes authority and responsibility for GHS services, improvements must be made in the management and quality of services. Improving access through expansion of services should be supported only when determined to be clearly necessary and only if defined strategies to help minimize dependence on donors have been identified.

TABLE 1

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Recommendations

Health Planning and Management

- | | |
|---|--|
| <p>1. Few Palestinians have experience in health systems planning and management, which is imperative for the effective and efficient organization and delivery of health services at all levels.</p> | <p>1.1 International and local short-term training in health systems planning and management should be expanded, including study tours to relevant health systems in the ME region and elsewhere, as appropriate.</p> <p>1.2 For the immediate future, expansion of graduate (masters level) training in health systems planning and management should be limited, with such expansion to be accelerated if Palestinians assume responsibility for GHS hospitals and other GHS services.</p> <p>1.3 Donors should provide expanded technical assistance in health systems planning and management, with particular attention to the organization and financing of health services and linkages with other sectors to address priority health problems. Such TA is required at the facility, regional (e.g., Nablus and Jerusalem areas and the Gaza Strip) and inter-regional level (i.e., for the Occupied Territories as a whole).</p> |
| <p>2. Health planning activities are embryonic, and planning techniques and tools are not readily available. Given the urgent need for such activities, they should be supported and encouraged.</p> | <p>2.1 Health planning activities in the Occupied Territories should be encouraged and supported. Such support includes the provision of published and unpublished documents and planning software. Such support should encourage activities which include the broadest possible representation on the part of private sector groups and providers involved in the delivery of health care services, as well as including representatives of the Palestinian user community.</p> |

3. Health data and information are scarce and of questionable reliability and validity. The GHS either does not collect and analyze data and information required for health care decision-making or does not make such data available to Palestinians. This is particularly true for data required for financial planning. Because no national planning or regulatory body exists, the private sector is not required (nor are there incentives) to collect health and health services data. It will be important for clear targets to be set for public health measures directed toward the Occupied Territories' most common preventable diseases, and for the international health community to ensure that every possible action is being taken to ensure that such targets are met; however, unless and until adequate data are available, such targeting and its monitoring are severely hampered.

4. While regional and disease-specific health needs assessments have been conducted by NGOs, no comprehensive, inter-regional study has been carried out. Moreover, there are health status and utilization studies which individual providers or facilities have undertaken, but the data have not been analyzed and disseminated for lack of support; such studies could provide useful information for planning purposes.

5. There is considerable interest on the part of the private/NGO health sector in the West Bank and Gaza in developing the capacity to plan for both individual facilities and service provision and to plan cooperatively for provision of services in given geographic areas. Several organizations have initiated development of health information systems (albeit not integrated across facilities); these could serve as the basis for health information systems which would support improved planning for facilities and services.

3.1 Donors should engage with the GOI in policy dialogue to ensure that Palestinians and donors, as appropriate, have access to GHS health-related data for the Occupied Territories.

3.2 Donors should provide training, technical assistance and other support for public and private sector health personnel in the collection, analysis and dissemination of health-related data, with such support for public sector personnel to accelerate if autonomy is assured and Palestinians assume responsibility/authority for the GHS health services.

3.3 Support for the expansion of information resources for the health sector should be continued and increased. Such support could include published and unpublished documents and audiovisual training and education materials for use with providers and the general population.

4.1 Community-based needs assessment studies which address such issues as health conditions, utilization patterns, and user ability/willingness to pay for services should be carried out in all regions of the Occupied Territories.

4.2 An assessment of existing studies, data bases and other data sources should be conducted. Such assessment (and data, as appropriate) should be disseminated to Palestinian organizations and others involved in planning and managing health services in the Occupied Territories.

5.1 Development and implementation of facility and across-facility level health information systems, including but not limited to computer-based systems, should be expanded. However, such systems should be compatible insofar as possible and relevant to facility and regional decision-making needs.

Health Services Delivery

6. There is a severe shortage of both staff and practical nurses, auxiliary health care providers (e.g., technicians and physiotherapists), community health workers and occupational therapists.
 - 6.1 Training resources should be augmented to ensure an adequate supply of skilled nurses and auxiliary health care providers, including technicians who operate and maintain sophisticated medical equipment. However, it should also be determined in advance (insofar as possible) whether or not health facilities have sufficient job openings for trainees.
 - 7.1 Continuing education of health providers at all levels should be strengthened, to improve their capacity to diagnose, prevent and treat health conditions in the Occupied Territories. Such training should be planned based on existing studies of continuing education needs (e.g., for nurses) or on de novo studies for those areas in which needs assessments have not been conducted. Insofar as possible, local training resources should be utilized.
 - 7.2 Relevant practice guidelines should be adapted for use by Palestinian practitioners for general practice and specialty areas for all categories of health providers.
 - 8.1 Guidelines and materials should be developed for use by facilities in assessing their equipment needs and current equipment use, selecting among alternative sources of equipment and introducing new or unfamiliar equipment into their facilities (including, for example, training of staff--see above).
 - 9.1 Primary health care services should be expanded to ensure coverage in villages which lack access to such services.
 - 9.2 The quality of primary health services delivery should be improved through the provision of appropriate equipment and supplies, training of health personnel and development and implementation of standards of care.
 7. Health personnel (physicians and nurses) lack training which would enable them to more appropriately request and interpret diagnostic and/or treatment tests and utilize available drugs, treatment procedures and equipment. In some cases, diagnostic and treatment equipment and drugs might be excessively and unnecessarily or inappropriately used, possibly resulting in iatrogenic effects. These problems contribute to deficiencies in quality of care at all levels.
 8. Medical equipment is maldistributed and often in poor condition, limiting its utility and raising concern for inaccurate findings. Most facilities lack the capacity to appropriately manage the diffusion and use of new technologies.
 - 8.1 Guidelines and materials should be developed for use by facilities in assessing their equipment needs and current equipment use, selecting among alternative sources of equipment and introducing new or unfamiliar equipment into their facilities (including, for example, training of staff--see above).
 - 9.1 Primary health care services should be expanded to ensure coverage in villages which lack access to such services.
 - 9.2 The quality of primary health services delivery should be improved through the provision of appropriate equipment and supplies, training of health personnel and development and implementation of standards of care.
 9. Primary health care (PHC) services, and maternal and child health (MCH) services in particular, are maldistributed, and many are deficient in quality. Given the high birth and infant mortality rates, particular attention should be paid to MCH services.

10. Primary, secondary, tertiary and rehabilitation services are maldistributed in both the West Bank and Gaza Strip.
- 10.1 The private sector should be encouraged and supported to develop health facilities plans which make the most effective and efficient use of resources and which at the same time meet the most pressing needs of the Palestinian people. This would include, for example, developing regional systems of care which link various levels and types of care through a defined system of referral and follow-up.
- 10.2 Rehabilitation services that are primarily outpatient and community-based and which include an occupational therapy component should be emphasized.
11. One of the health problems for which services are clearly deficient (rather than simply maldistributed) is mental health. Although mental health services are usually excluded from activities supported by most donors, donor support is strongly justified by the compelling needs and the fact that related physical health problems such as hypertension are among the most prevalent conditions in the OT.
- 11.1 Private sector mental health services should be upgraded and expanded. Such activities will require donor assistance for training, technical assistance and operating costs (in some circumstances), but construction of additional facilities is not urgent, as services can be integrated within existing health care facilities.
12. Health services at all levels require substantial improvements in facility and patient management.
- 12.1 Software packages for facility and patient management should be purchased for those facilities which have microcomputers available, and training should be provided in the use of such software. Where appropriate, health information systems should be supported (including the provision of microcomputers), with linked systems established when possible.

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APPENDIX I

CONTEXT OF DEVELOPMENT IN THE OCCUPIED TERRITORIES

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CONTEXT OF DEVELOPMENT IN THE OCCUPIED TERRITORIES

This appendix describes the overall context in which development opportunities exist in the Occupied Territories, including land size and population data, governance, recent economic trends and the role of donors in development activities. As necessary, these factors are discussed in more detail in each of the reports included in the full set of sector analyses for the Occupied Territories. For example, population data are discussed more fully in the companion report on Health, and economic trends are described in the separate reports on Finance and Credit and on Trade.

Several parameters of this report should be clarified. The term "Occupied Territories" is used to describe the geographic area of the West Bank and Gaza Strip as it is the accepted term for the U.S. government and U.N. agencies. It refers only to the West Bank and Gaza Strip, not to the Golan Heights or the Israeli security zone in Lebanon. The term Judea and Samaria is used when quoting Israeli statistics or other references, as this is the designation used by the GOI for the West Bank area. Unless otherwise stated, the West Bank statistics, information and recommendations presented in this report include East Jerusalem. Where necessary, East Jerusalem is referenced separately, for example in cases where data have clearly excluded East Jerusalem. It must be noted at the outset that the statistical data available from the GOI (i.e., those published in the Statistical Abstracts and other governmental sources) which can be used to numerically describe the sectors do not include East Jerusalem. This significantly skews the data and inhibits analysis of trend data which could be used for economic planning. Moreover, as Benvenisti has suggested,

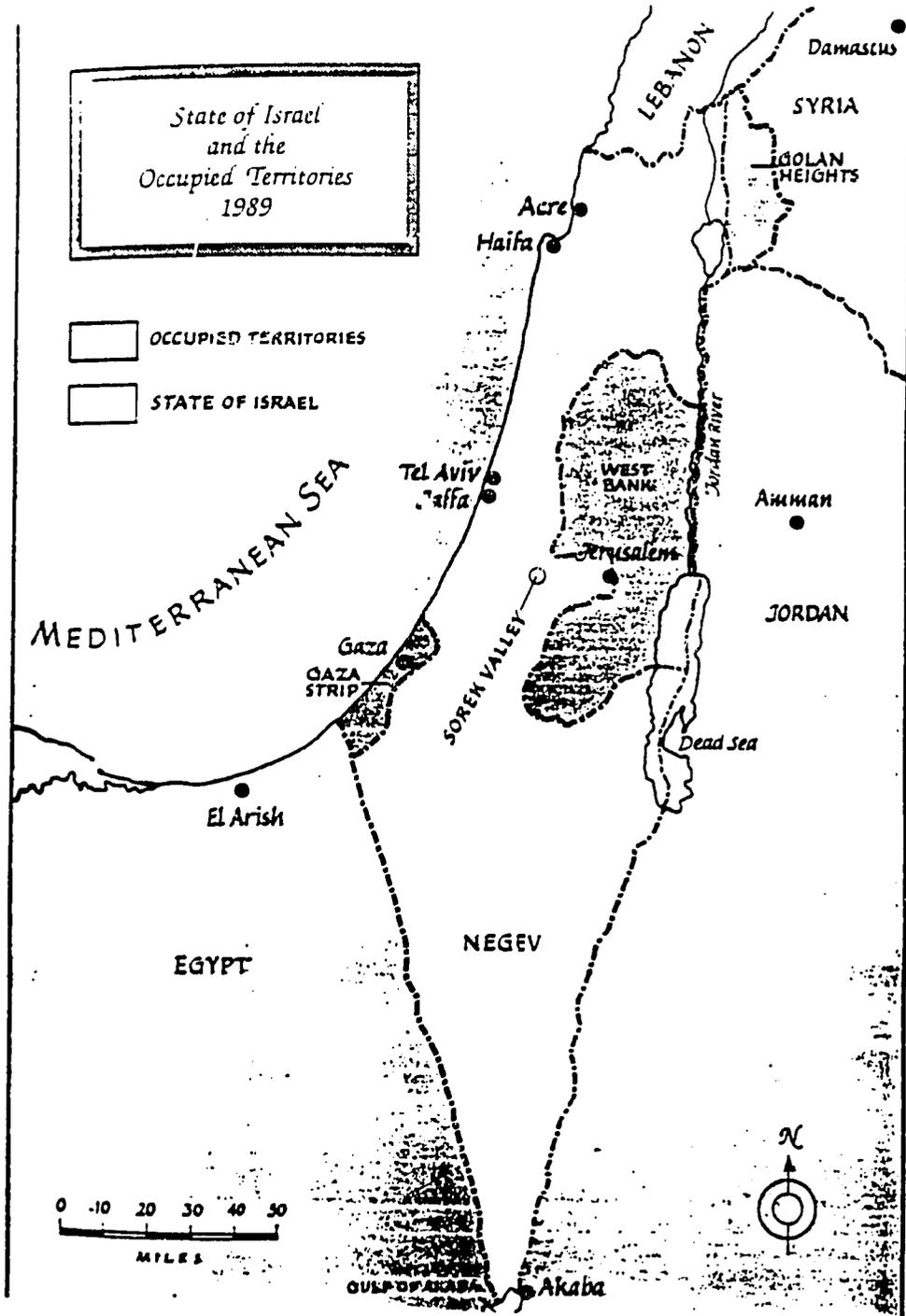
"For statistical purposes the West Bank and Gaza Strip are considered by Israel's Central Bureau of Statistics to be units independent of Israel. Economic activity there is investigated and reported as though it constitutes a 'national economy' united with Israel in a 'common market.' The official reporting of GDP, GNP, exports and imports and balance of payments of the territories is, however, inaccurate at best and misleading at worst. The daily, complex, economic interaction over the nonexistent 'green line', lacking any effective monitoring and control, calls the reliability of the statistics into question."¹

Unfortunately, because of the serious impediments faced by Palestinians and others in conducting empirical studies in the West Bank and Gaza Strip, most studies of the Occupied Territories depend primarily--and necessarily--on GOI statistics, notwithstanding their limitations.

Finally, although Israeli settlements in the Occupied Territories have considerable impact on economic and social development in the area, only minimal data and information are available with respect to either plans for settlements or specific factors pertaining to individual sectors (e.g., infrastructure and industry).

A. THE LAND AND THE PEOPLE

The West Bank and Gaza Strip are bordered by Israel, Jordan and Egypt as shown in Figure 1. The total land area of the Israeli-occupied West Bank and Gaza Strip (as defined by pre-1967 borders) is 5,939,000 million dunums (one dunum = .23 acres) of which 5,572,000 are in the West Bank and 367,000 are in the Gaza Strip.²



Source: M. Kunstel and J. Albright, *Their Promised Land*. Crown Publishers, Inc., New York; 1990.

According to the U.N., as of 1985, approximately 52% of this land was under Israeli control--that is, within the jurisdiction of the GOI or of Israeli citizens (settlers). Estimates of Israeli control of land as of early 1992 are shown below:³

Source of Estimate	West Bank	Gaza Strip
Al Haq	65%	50%
Land and Water	67%	50%
PHRIC	70%	52%

Because the most recent census was conducted twenty-five years ago (in 1967),⁴ accurate demographic data for the Occupied Territories are virtually impossible to obtain. Thus, all population data have been estimated for the period after the 1967 census. The three primary sources of information regarding population are the Central Bureau of Statistics (CBS), the Ministry of the Interior (MOI) and estimates prepared by the Jordanian Medical Association in 1986. In the summary of demographic and other data published by Benvenisti and Khayat in 1988, it was noted that the Palestinian population data presented by the CBS and by the MOI for the Occupied Territories differ. For example, the data for 1987 showed CBS estimates of a total Palestinian population of 858,000 for the West Bank, while the MOI estimated the population to be 1,252,000.⁵ The CBS estimates exclude East Jerusalem, which has a Palestinian population generally considered to be approximately 150,000.

Using the Statistical Abstract of Israel for 1990 as a basis, and assuming a 3.5% annual growth rate in the West Bank and a 4.5% annual growth rate in Gaza, the following estimates were calculated for 1991:⁶

West Bank (including East Jerusalem)	1,104,799
Gaza Strip	<u>1,010,640</u>
Total:	2,115,439

More than 35% of the Palestinian population is rural (see Figures 2-4), with 15% living in villages with populations of 2,500 or less. The Palestinian population is also a youthful one; nearly half (47.4%) of the Palestinian population in the West Bank is under the age of 15, as is 49.5% of the population of the Gaza Strip.⁷ This age distribution and the high birth rates have important implications for social service needs as well as for labor force concerns.

Figure 2

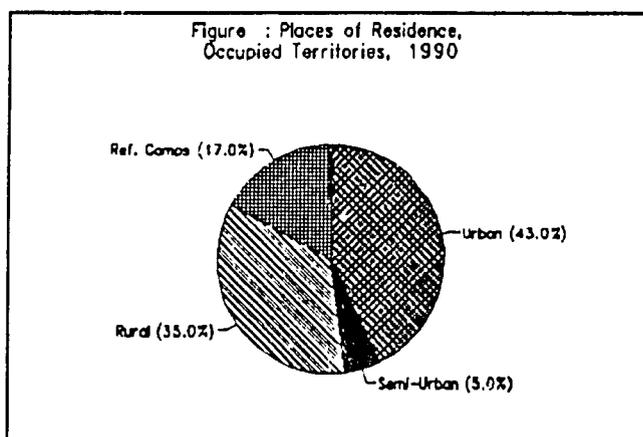


Figure 3

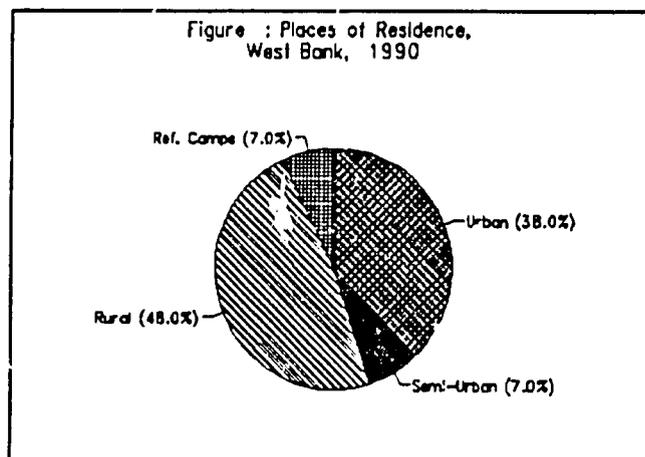
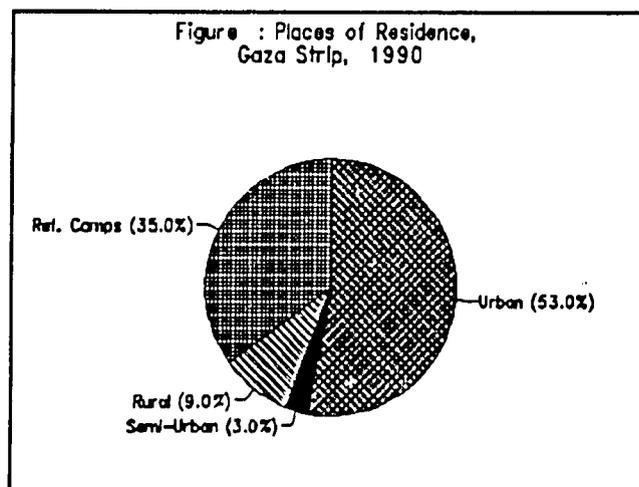


Figure 4



Source: Calculated from Statistical Abstract of Israel 1990. Central Bureau of Statistics: Jerusalem; 1990.

As of January, 1992, 451,695 individuals (or approximately 40% of the population) in the West Bank were registered as refugees. Of these, 119,172 (26%) lived in UNRWA camps. In the Gaza Strip, 549,675 Palestinians were registered refugees (approximately 80% of the population); of these, 302,977 (55%) lived in UNRWA camps.⁸

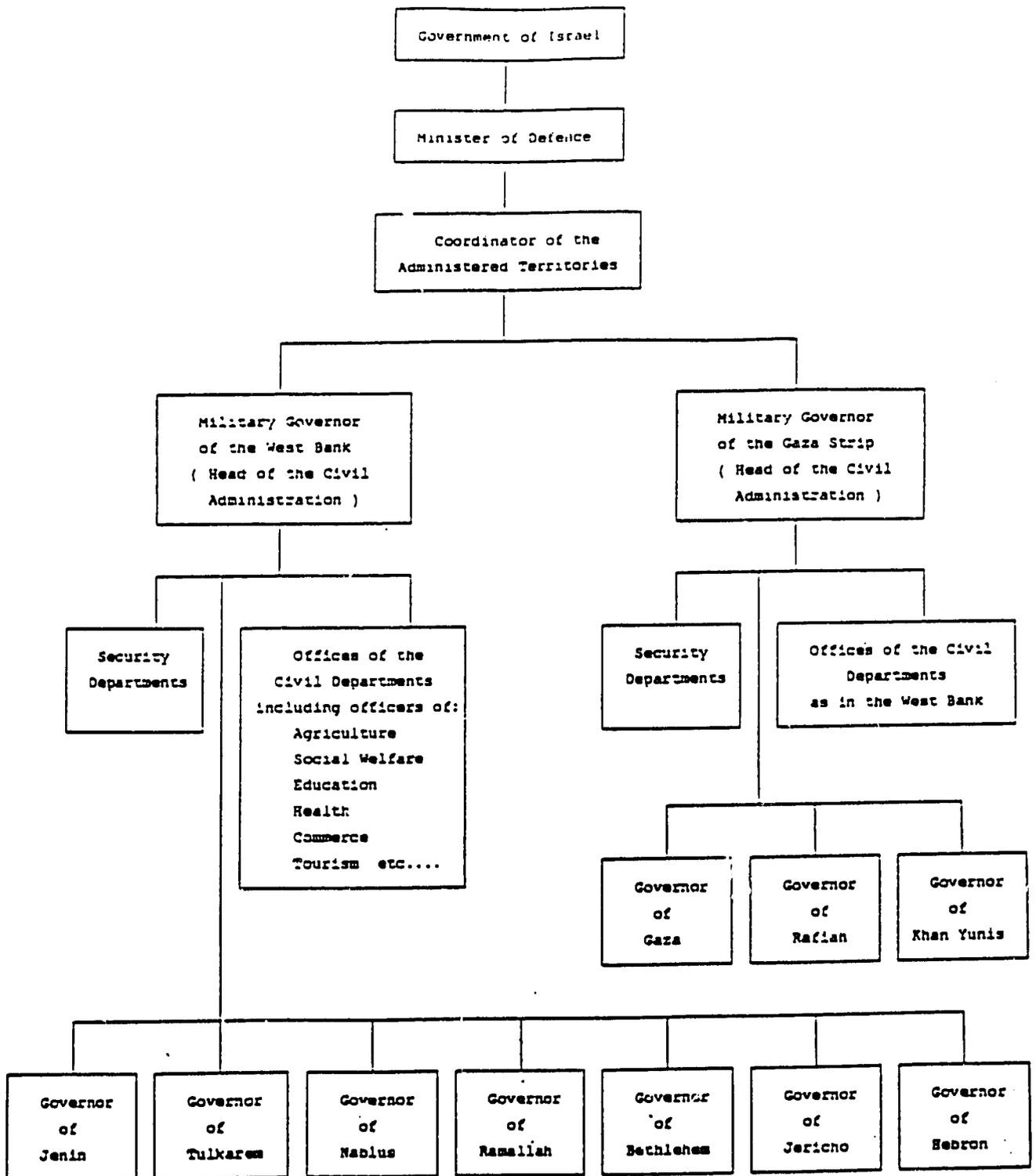
In spite of the high natural rate of increase, until 1991 the population had a relatively low rate of population growth. This resulted from emigration to Jordan, the Gulf States and outside the region, primarily for job opportunities. Even prior to the Gulf War and the influx of Palestinians from the Gulf States, an important population variable in the Occupied Territories, and particularly in Gaza, was the number of residents who returned from the Gulf States annually for summer vacation. It is reported that approximately 100,000 were doing so in the Gaza area for 2-3 months each year; no estimates of similar temporary residents were available for the West Bank. Since the Gulf War, an estimated 25,000 to 35,000 Palestinians have returned to the Occupied Territories from the Gulf States; an estimated 40% of them are currently residing in the Gaza Strip.⁹ Most are university graduates but are unemployed or underemployed. However, those who are unemployed reportedly are not eligible for social benefits from the GOI. Some are eligible for services through UNRWA.

B. GOVERNANCE IN THE OCCUPIED TERRITORIES

From 1950 to 1967, the West Bank was under the authority of the Jordanian government, which in 1955 devolved public administration authority to elected municipal governments. From 1948 to 1967, Gaza was under Egyptian control, with appointed municipal governments. Subsequent to the 1967 War, the Israeli military authorities assumed control of the Palestinian population in the occupied West Bank and Gaza Strip. Since 1967, no local elections have been held in Gaza; no municipal elections have been held in the West Bank since 1977.

In 1981, the Israeli government initiated a system of civil administration (CIVAD). Figure 5 on the following page shows the organizational structure of the CIVAD. The CIVAD's "jurisdiction includes all the civil powers of the military government but not the authority to enact primary legislation, which has remained in the hands of the Military Commander."¹⁰ In virtually all CIVAD offices, a military officer directs the departments, but Palestinians comprise most of the technical and administrative staff. According to the Fourth Geneva Convention, the GOI is responsible for the provision of public services for the Occupied Territories, based on tax and other remittances from the Palestinians residing in the West Bank and Gaza Strip and from the GOI budget. These governmental functions are carried out by the CIVAD, with specific responsibility for sectoral programs being coordinated with the relevant Israeli ministry or regulatory body.

FIGURE 5: ORGANIZATIONAL STRUCTURE OF THE CIVIL ADMINISTRATION (CIVAD)



Source: "Food Security in the West Bank and Gaza Strip," Oct 1985, p.4.
 Arab Scientific Institute for Research and Transfer of Technology (ASIR);
 El-Bireh, West Bank.

The CIVAD currently serves as the "authority" in most municipalities in both the West Bank and Gaza Strip--no municipal elections have been held since a military order suspended elections in December, 1977.¹¹ Some municipalities have Palestinian officials appointed by the CIVAD, but their authority is limited. Local municipalities carry out activities which in other circumstances would be either public or private sector responsibilities. These range from wholesale produce markets to operating slaughterhouses. In doing so, they liaise with both the CIVAD and Palestinian private sector organizations as appropriate and necessary. For all intents and purposes, both CIVAD and the municipalities therefore constitute "public" agencies in the Occupied Territories. Village councils, of which there are approximately 75 in the West Bank and eight in the Gaza Strip, have even less authority than municipal councils. As with the municipalities, no elections have been held for village councils since December, 1977.¹²

Chambers of Commerce also perform services which in other contexts would be within the purview of governmental or quasi-governmental bodies. For example, they are involved in expediting approval of exports to Jordan (see the companion Trade report for further discussion of their role in export). Elections for Chambers of Commerce were not held from December, 1977 until early 1992, when the GOI allowed such elections in six areas in the Occupied Territories.¹³

C. RECENT TRENDS IN THE ECONOMY OF THE OCCUPIED TERRITORIES

According to some reports, the economies of the Occupied Territories began to decline in the early 1980s. This decline resulted from stagnation in the Israeli and Jordanian economies.¹⁴ The economy further declined in the late 1980s, even prior to the Gulf War. UNCTAD reported in 1991 that their review of Israeli and Palestinian data indicated "a rapid deterioration in the performance of the economy of the Occupied Territories during 1988-1990."¹⁵ According to that report, the gross domestic product (GDP) for the Occupied Territories decreased by 12%/annum during that period, to just over \$1.2 billion in 1990. Consistent with previous patterns, the decline in the Gaza Strip was more severe than in the West Bank: 17% versus 11%, respectively.¹⁶ Gross national product (GNP) decreased by a comparable amount annually (11%), to approximately \$1.8 billion. Per capita GNP was estimated to be \$1,400 in the West Bank and \$780 in Gaza in 1990.¹⁷ By comparison, the GNP in Jordan for 1989 was \$1,730.¹⁸ In Israel it was \$10,920 in 1990.¹⁹

With the exception of agriculture, all sectors exhibited significant decline in the period 1988-1990; for example, according to the 1991 UNCTAD report, industrial output decreased by an annual average of 14%, and construction decreased by an annual average of 23%. Other sectors combined (public and personal services, trade, transport and communications) declined by 17%.²⁰ As a consequence, the contribution of the agricultural sector to the GDP increased from 25% to 31% from 1988-1990, while construction decreased from 17% to 14%; industry has remained at 9% of GDP (although output had decreased). The UNCTAD reports that the decline in the industrial sector "bodes ill for the future of the Palestinian economy."²¹ It should be pointed out, however, that several researchers have suggested that traditional economic indicators (e.g., GNP, per capita GNP, GDP)

are not appropriate for the Occupied Territories as they have been devised to study productive economies. Given that the West Bank and Gaza Strip depend largely on transferred resources, the limitations of these indicators should be considered.²²

The New Israeli Shekel (NIS) is the currency used predominantly in Occupied Territories, although the Jordanian dinar (JD) is still used by some in the West Bank. As of January, 1992, the rate of exchange was NIS 2.3/US \$1 for the Shekel and JD 1/US \$0.68 for the Jordanian dinar. Given the inextricable ties between the economies of the West Bank and Gaza and those of Israel and Jordan, pricing and inflation in these two countries have a significant and deleterious impact on the Occupied Territories. Several key examples of recent impacts are:

- * increased prices for goods imported through Israel, which accounted for 91% of goods imported into the West Bank and 92% of goods imported into the Gaza Strip in 1986, the most recent year for which data are available;²³
- * decline in the wages of Palestinians working in Israel and a decline in real disposable income of most income groups in the Occupied Territories (an example of the deleterious impact of Palestinian wages' being tied to the Israeli economy); and
- * the differential in the consumer price indices of the Occupied Territories and Israel, which has led to both 1) a decrease in value of sales of Palestinian goods to Israeli buyers, and 2) an increase in purchase by Palestinians of consumer and durable goods from Israel (until the economic boycott of the Intifada, when this practice decreased considerably).

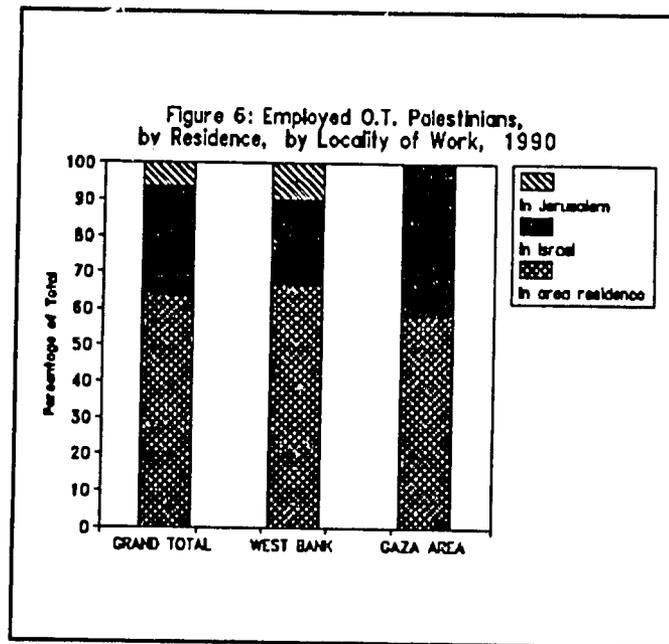
The economic impact of the Gulf Crisis on the Occupied Territories was--and continues to be--significant in all sectors. As the 1991 UNCTAD report noted, the economic impact resulted from both external and internal pressures; these are summarized below:²⁴

- * reduction in private remittances from Palestinians working in the Gulf states, estimated at \$120 million to \$340 million annually prior to the Gulf War;
- * involuntary return of Palestinians working in the Gulf states to the Occupied Territories resulting in increased pressure on an already distressed job market;
- * decreases in both public and private financial support from the region for Palestinian private sector development in both social services and productive enterprises (this support was estimated to be \$150 million in 1989); and
- * disruptions in traditional export and in port markets (note: the market share in Jordan had begun to decline prior to 1991²⁵).

The total estimated economic impact of the Gulf War (based primarily on lost remittances, transfers and exports) was between \$250 and \$750 million in 1990 alone (55% to 80% of the total generated by these three sources in 1989), or approximately 10% of gross national disposal income.²⁶ Few knowledgeable individuals believe that there have been substantial moves toward an improvement in the economy of the Occupied Territories since the end of the Gulf War.

Estimates of current unemployment rates vary considerably. Israeli statistics for 1990 show a 13%-15% unemployment rate (including both those officially registered at the CIVAD labor exchanges and those defined by the Central Bureau of Statistics as "employed persons, temporarily absent from work"). Other estimates of unemployment in both the West Bank and Gaza Strip range between 30% and 40% of the work force.²⁷ While Palestinians now have regained minimal access to the Gulf States as a source of employment (and remittances), they are still dependent on employment in Israel (see Figure 6 below), although this alternative for export of labor capital is also highly volatile. As a result of reduced personal income, there has been a concomitant reduction in consumer demand (estimated 20-30% reduction)²⁸ and reduced funding available for investment.

Figure 6



Source: Israeli Statistical Abstract, 1991. Central Bureau of Statistics: Jerusalem; 1991.

Reductions in local funding available for investment are particularly critical for economic development in the Occupied Territories because between 70% and 95% of capital investment in industry in the Occupied Territories is provided by the individual owners or their families. Importantly for economic development, the period 1988-1990 saw a 4% annual decrease in private investment.²⁹ Moreover, the external trade sector has not yet shown signs of improvement since the end of the Gulf War, in spite of efforts to re-establish economic relations with traditional trading partners in the region. Exports of both goods and services decreased an average of 30% per annum during 1988-1990, with the decrease far more dramatic in the Gaza Strip (50%) than in the West Bank (16%).³⁰ Imports of goods and services also declined during this period: 16% in the West Bank and 19% in the Gaza Strip.³¹ As of the beginning of 1992, markets outside of Israel remained largely closed to Palestinian products, and the decreased purchasing power of Palestinian consumers continues to result in decreased imports available for Palestinians and decreased internal markets for Palestinian products as well.

D. DONOR ASSISTANCE

In addition to remittances from Palestinians working abroad, the economies of the West Bank and Gaza Strip depend to a large extent on donor countries and organizations, each of which has its own particular interest in the Occupied Territories and therefore directs the aid in a particular way. In 1991 alone, \$69 million in funding was allocated by donors for projects in the Occupied Territories.³² This figure does not include funds provided by Arab states, as these data are difficult to obtain. A large proportion of donor funds are allocated through international private voluntary organizations (PVOs). Therefore, while the amount of donor funds allocated to the Occupied Territories appears large in proportion to the GNP (in 1991, the UNRWA budget alone accounted for 6% of GNP), a relatively large percentage of the funds do not directly enter the economy of the Occupied Territories. Much of the bilateral and multilateral funding remains in the country of origin to purchase goods and supplies which are donated to beneficiary groups in the Occupied Territories, or to pay for training and technical assistance. Similarly, while the "overhead" rate of the international agencies (e.g., UNRWA) and the international PVOs is relatively low (usually representing 20% - 45% of the total project budget), this does represent funds which are not part of the economy of the Occupied Territories. It should be emphasized that, in this respect, the West Bank and Gaza Strip do not differ from most other recipients of donor funds. However, in view of the fact that such funding is crucial for operation of basic human services and support of infrastructure in the Occupied Territories, it becomes a more critical issue. Moreover, there is little flexibility in the allocation of funds within the Occupied Territories: donor funding and other types of development assistance by international and bilateral agencies such as the World Health Organization (WHO), the UNDP and A.I.D., must be carried out by the donors and agencies with the approval of the GOI.

The importance of the economic role of UNRWA cannot be overlooked. In 1990, its annual budget for the West Bank and Gaza Strip was \$98.6 million. In 1991, the UNRWA budget was \$98.3 million; the approved 1992/1993 budget is \$217.8 million (roughly \$109 million per year).³³ In addition, from 1988 to 1991, approximately \$949.9 million has been contributed to UNRWA, primarily by the

U.S. and European governments, to operate refugee camps and to provide services to the refugees under its aegis. Approximately 40% of these funds are utilized for the West Bank and Gaza Strip.³⁴ Until recently, UNRWA has expended only minimal funds for economic development projects. However, the agency plans to raise \$20 million over the next five years for income-generating projects in the Near East.

It is important to distinguish between the ultimate source of external funds (e.g., governments and private donors to non-profit organizations) and the vehicles through which such funds are disbursed. The most important sources of external aid have been:

individual Palestinians in the diaspora, who contribute to a variety of organizations and institutions (as distinct from the remittances sent by individuals to their families in the Occupied Territories);

Arab governments and individual Arabs, contributing to:

- individual Palestinian organizations and institutions, including municipalities;
- the Joint Jordanian-Palestinian Committee for the Steadfastness of the Palestinian People in the Occupied Homeland;
- the Palestinian Liberation Organization (PLO); and
- various U.N. agencies operating in the Territories, including the UNRWA and UNDP.

the U.S. Government, which disburses funds through:

- various U.N. agencies operating in the Territories, including the UNRWA and UNDP;
- the Agency for International Development (A.I.D.) Jordanian Development Program (until 1989); and
- U.S. private voluntary organizations (PVOs) operating in the West Bank and Gaza Strip and one Palestinian PVO.

private U.S. individual donors and foundations, providing funds to:

- individual Palestinian organizations and institutions; and
- U.S. private voluntary organizations operating in the West Bank and Gaza Strip.

- * European, Canadian, Japanese and other governments, which provide contributions to:
 - individual Palestinian organizations and institutions;
 - the European Community (EC); and
 - various U.N. agencies operating in the Occupied Territories, including the UNRWA and UNDP.
- * European individual donors and foundations, which provide contributions primarily to individual Palestinian organizations and institutions.

Understanding the nature of the sources of external funds is important to an understanding of the dependency of the Palestinian economy on the vagaries of external conditions. Ultimately, the U.S. and European governments and Arab states (and, increasingly Japan) are the major sources of funding. The major funding vehicles, including the several U.N. agencies and the U.S. PVOs, derive their funds from the same sources, governments and a few foundations and individuals.

For the most part, external funds have been provided for:

- * construction of health and social service infrastructure projects and some housing,
- * operating costs for health and social service programs (and lately for rehabilitation services, more popular during the height of the Intifada),
- * agricultural cooperatives,
- * municipalities (for construction and operating costs),
- * human resources development and training, including local and overseas long-term and short-term education, and
- * infrastructure and public works.

With the exception of agriculture, minimal donor funds have been provided for the productive private sector.

It is hoped that this sector analyses, and the others which comprise the cross-sectoral assessment of development opportunities in the Occupied Territories, will contribute to the efforts of Palestinians to be more proactively involved in planning for and implementing donor-funded projects. The reports may also contribute to donors' plans for more appropriate--as well as more effective and efficient--use of the resources they allocate for the Occupied Territories.

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APPENDIX II

VISIONS OF A SUSTAINABLE FUTURE

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APPENDIX II: VISIONS OF A SUSTAINABLE FUTURE

This appendix to the sectoral analysis presents a summary assessment of the overall potential for development opportunities in the Occupied Territories. The analysis was conducted within sectors, and, insofar as possible, across sectors. This assessment is based on the analyses and conclusions presented in each of the individual sector reports prepared by Policy Research Incorporated (PRI). The eight individual sector reports include agriculture, education, finance and credit, health, industry and enterprise, infrastructure, trade, and water and sanitation.

Appendix II includes 1) a discussion of alternative assumptions under which economic and social planning will likely occur in the Occupied Territories; 2) a summary of the factors which constrain development across the sectors; 3) a summary of recommendations within and across the sectors; and 4) a list of issues that warrant discussion in the process of considering development alternatives for the Occupied Territories. Brief summaries of the findings of each of the sector reports are included as Executive Summaries with those reports.

A. DEVELOPMENT IN THE CONTEXT OF ALTERNATIVE SCENARIOS

The move toward Palestinian economic self-reliance expanded considerably with the advent of the Intifada in 1987. Generally, the intent of this movement has been to promote a more productive allocation of investments, both internally (Palestinian) and externally (from donors). Specifically, Palestinians involved in development planning have sought to "enhance self-reliance in production, lessen dependence on external financial sources, diversify, rationalize and integrate domestic production branches, [and] reorient consumption patterns towards less conspicuous modes."¹ To this end, Palestinians have begun to 1) develop sectoral and regional plans; 2) design and implement experimental projects and new institutional forms and entrepreneurial initiatives; and 3) initiate a range of popular 'participatory development' efforts involving families, communities, regions, cooperatives, enterprises and professional associations.

In order to ensure that these sectoral analyses are as useful as possible for development planning, the recommendations summary recommendations presented in this appendix are listed assuming one of two alternative political scenarios:

- 1) no change in the current political status (with perhaps some relaxation of constraints), including programs and activities that could have short-, medium- and long-term impact without respect to a change in governance; and
- 2) a change in governance (e.g., interim self-government or autonomy).

There are, of course, many shades within this spectrum, but it is hoped that presenting the recommendations in this way will provide an option for discussion of development in the Occupied Territories. The development recommendations that assume the status quo are intended to meet immediate needs identified in the conclusions to which they are linked as well as to provide a foundation for

development under whatever political solutions are realized. They are thus building blocks toward a sustainable future under alternative political scenarios. It should be emphasized that the recommendations listed under "assuming political change" could also be carried out within a status quo scenario, but would likely necessitate elimination or significant amelioration of existing bureaucratic and other constraints.

Under the present circumstances, it is all too easy to assume that little can be accomplished other than minimal support for existing projects; this approach defeats the intention to promote sustainable development. On the other hand, to assume independence (statehood) as the only basis for planning economic and social development negates the reality of the present political situation (that is, of the Occupation) as well as the possibility of an interim self-government. It also does not take into account that, even in the event of autonomy, it will be necessary to design phased implementation of policies and programs. For example, it will be necessary to ensure that:

- * a Palestinian tax system as well as an organized health system are in place before assumption of responsibility for financially burdensome public hospitals;
- * economic support structures are in place prior to significant expansion of industrial capacity;
- * cross-regional planning is in process, including the consideration of issues such as the trade-offs necessary between agricultural and industrial development in the water-poor Gaza Strip; and
- * Palestinian planners and donors develop effective plans for physical infrastructure and other projects, ensuring that they will be used by their intended beneficiaries (i.e., Palestinians) given the possibility that such projects could be established within settlement areas in the future.

In any case, donors should accept the possibility that their medium-term and long-term (and even many short-term) development expectations could be considerably diminished under the present circumstances, even in the event of autonomy. In this most abnormal political situation, the traditional indicators of change--difficult to obtain, verify and attribute to donor programs under any circumstances--are of questionable validity and utility.

B. CONSTRAINTS TO DEVELOPMENT IN THE OCCUPIED TERRITORIES

Sustainable economic development is proving to be an elusive goal even under "normal" circumstances in developing countries, and increasingly so for countries of all income levels. As this and the companion sectoral analysis reports demonstrate, the socioeconomic situation in the Occupied Territories do not approximate normal circumstances. Given the status of the various sectors of Palestinian economy and society, and in particular given bureaucratic and other impediments, what are the opportunities for economic and social growth and

development in the West Bank and Gaza Strip? The technical and managerial issues are myriad and complex, both within and across sectors.

While this is true in any country or jurisdiction; however in the Occupied Territories these issues are complicated by the volatile and fluid political realities and by the significant dependence on external donors for support for any type of development. Donor investment and support are, in turn, complicated by the fact that the traditional role and involvement of donors in developing countries has been severely limited in the Occupied Territories. The normal mechanisms for rational allocation of donor assistance (e.g., donor negotiations with a ministerial level planning agency or external donors' department within a Ministry of Finance) do not exist, while constraints to planning effective use of donor funds are apparent.

It is important that those involved in planning for development in the Occupied Territories be aware of the constraints under which the various sectors operate and within which development occurs. The constraints which pertain to each of the sectors are described in the corresponding section of each sectoral analysis, with a discussion of the manner in which the constraints impact on development in that specific sector. However, several types of constraints have especially broad impacts on development; these are summarized below.

B.1 Bureaucratic constraints

Bureaucratic constraints include GOI regulations which discriminate against Palestinians and their public (municipal) and private sector institutions and organizations. These regulations are subject to change (sometimes without notice) and to enforcement by individual members of CIVAD without approval (or knowledge) of their superiors. Examples include:

- curfews (sometimes imposed for extended periods of time),
- barriers to physical mobility constituted by pass requirements and other factors,
- onerous procedures for obtaining building and other permits and arbitrary application of such procedures,
- taxation policies and enforcement which have been perceived by the International Jurists Commission and others as inappropriate and a violation of Geneva Conventions,
- restrictive labelling and export requirements on Palestinian products, and
- control of and restrictive policies with respect to basic physical infrastructure including electrification, communications and transportation, water use, and land use.

An important impediment to effective planning and implementation of development programs and projects is the fact that all those involved in development planning, including Palestinians and donors, lack access to critical fiscal, economic and technical information which is collected, processed and maintained by the CIVAD (or the GOI). While some information is available to Palestinians and others through the Central Bureau of Statistics (and other sources), other critical information is not. This includes, for example, revenue and expenditure information which is critical for an understanding of operating costs and cost recovery possibilities within the health and education sectors. Palestinians (and donors supporting projects in the Occupied Territories) also have no information with respect to plans for settlement areas, including plans for physical infrastructures to support the settlements.

The complex mixture of residual laws (in force at the time of the Occupation), Israeli civil laws and regulations and military regulations vastly complicate development planning and implementation of specific projects and general sectoral programs. Virtually all court cases involving Palestinians are adjudicated in the military courts, including all civil cases (e.g., with respect to contracts and taxes). The effective absence of a civil court system makes it all but impossible to formulate and enforce contractual arrangements.

Palestinians have no adequate mechanism to generate revenues and provide public services. As a result, Palestinian NGOs and municipalities operating health and social programs or public infrastructure systems (e.g., water and sanitation, road networks, electrification) face unusual obstacles in attempting to cover their operating costs and adequately maintain physical plants and equipment.

There have been some positive indicators that GOI constraints have relaxed since 1991. In late 1991 the GOI initiated relaxation of restrictive policies which impede economic development, including: approval of licenses for a number of new small- and medium- scale manufacturing, agricultural and commercial projects and relaxation of restrictions on the inflow of external financial resources by raising the limits on such inflow per person entering the Occupied Territories--from \$400 to \$3,000.²

It may well be that international organizations (e.g., the U.N.) and bilateral and other donors can convince the GOI that relaxation of other bureaucratic constraints is beneficial to the economies and social structures of both Israel and the Occupied Territories. Simultaneously and independently, the international organizations and donors should work with the Palestinians (and Arab states) to ensure that, insofar as possible, constraints that result from Palestinian practices and the policies of Arab states are ameliorated or eliminated. Finally, the U.S., and other countries should remove constraints imposed by their governments or apply policies which would encourage development (e.g., labelling and most favored nation status). These governments should also ensure that their investment policies and programs are consistent both internally--that is, within the bilateral program--and externally--that is, between and among the various donor agencies and organizations. Donor investment policies should also be consistent, insofar as possible, with available development plans generated within the Occupied Territories.

B.2 Economic and other constraints

Given the inextricable linkage with the Israeli economy, from which the Occupied Territories derive questionable benefit, there is, effectively, no free external market, and a severely limited free internal market. Moreover, the public (GOI) and private (Israeli and Palestinian) environment is not, to say the least, conducive to sustained economic development. The economic and physical infrastructures and systems on which development normally depends range from grossly inadequate to nonexistent. In addition, the Occupied Territories have few natural resources, a shortage of water and an increasingly diminishing land area.

The local work force, which in the past served as an important source of income (through export of labor to the Gulf States and other countries) is unbalanced with respect to education and training. That is, a large (though not specifically defined) proportion of Palestinians are highly educated but underemployed professionals or skilled and semi-skilled workers who have only minimal access to training that would enable them to become updated on technological advances.

Since the onset of the Gulf crisis, the "safety-valve" of Palestinian emigration to the Arab Gulf has been closed, and Palestinians have returned to the Occupied Territories or to Jordan. As a consequence, remittances from the Arab Gulf, on which the Palestinian economy was heavily dependent, have been significantly reduced. As a result of the extremely limited opportunity to engage in external trade and the virtual absence of support structures for economic and social development (e.g., marketing systems for agricultural and industrial trade), Palestinians have little competitive advantage, with the exception of their low-scale wages, which have some negative socioeconomic consequences as well.

Development and implementation of potentially effective national and regional level plans require a governmental base through which to link sectors and public/private sector initiatives and programs. It also requires data and information as well as experience in the selection and application of planning techniques. However, neither the CIVAD nor the municipalities (which together constitute the de facto public systems in the Occupied Territories) plan and implement programs and projects across sectors. Nor do most Palestinians working in these entities have substantial experience in such cross-sectoral planning and program and project management. Not only have they been minimally involved in the design, use and application of data and information systems, they have also had little access to data and information required for planning and managing public and private sector organizational structures and functions.

Physical infrastructure (communications, electrification, and transportation networks) and water and sanitation systems are in poor repair and wholly inadequate. This severely impedes operation and expansion of the public and social service sectors and the productive private sector. Moreover, political and economic factors impede the efficient linkage of critical physical infrastructure such as electrical, communications, and road networks.

Unfortunately, as discussed in the individual sector reports, the political situation in the Occupied Territories militates against investment in private sector economic activities which may have the greatest potential for economic impact, as well as in social or physical infrastructure projects which take into consideration economies of scale. With respect to the latter (which include, for example, telecommunications, electrification and health services), this limitation has fostered wasteful and costly duplication. It has also hindered the ability of Palestinian institutions and donors to provide adequate basic services for the population as a whole and for the industrial sector in particular. For example, Palestinians are prohibited (for security reasons) from using much of the extensive road network which serves settlers, although access to these roads would facilitate access to markets. Similarly, electrification projects (largely funded by donors) have focused on electrification of the smaller villages, rather than on ensuring that industries have access to services adequate to meet their production needs.

The present economic outlook. The worsening economic situation in the Occupied Territories bodes ill for development opportunities. Extensive development is difficult for projects that rely on private sector initiative, as well as those that rely on public (municipal) initiative. At the same time, the relatively young, disaffected (and unemployed) youth can potentially both participate in social unrest and contribute to social and economic change.

C. DEVELOPMENT OPPORTUNITIES

Even given these constraints, however, substantial improvement can and should be made in economic and social development in the Occupied Territories. It is critical that Palestinians and donor agencies rationalize the existing scattered projects within and across sectors. This rationalization must include identifying linkages across sectors that can improve the likelihood of development under both the status quo and potentially changed political and administrative circumstances.

Table 1 presents a summary of recommended programs by sector for both the status quo and political change scenarios. The recommendations for the political change option are in addition to those for the status quo, which are intended as building blocks for development, whether or not positive political change is achieved. The recommendations were devised based on the needs identified in each of the sectors independently. It should be noted that because detailed recommendations are included in each sector analysis report (e.g., education, health, industry), the recommendations in Table 1 are abbreviated in order to present them in a tabular format. Also, the term "public" or "quasi-public", as used in Tables 1 and 2 and in the following discussion, refers to municipalities and to other entities that undertake activities that under normal circumstances would fall within the purview of public (or quasi-public) entities (e.g., local water authorities). The recommendations are not presented in priority order.

An assumption supporting all recommendations is that donors would utilize local (Palestinian) resources wherever possible, as well as appropriate and cost-effective resources from the region (including Israel and Jordan, for example) and from donor countries (e.g., the U.S., Japan and Europe). Donors are encouraged to include a wide range of community-based and other organizations in order to

provide them with the opportunity to participate in comprehensive development across sectors and to promote broad-based support for such development among these groups.

To prepare for specific plans within and across sectors, to derive maximum benefits from available resources, in the Occupied Territories, and to promote sustainable development, Palestinians and donors involved in supporting development in the Occupied Territories should: 1) identify overall development goals and specific objectives, 2) assess the relative utility of alternative development approaches, 3) consider the cross-impacts of the development goals and specific programmatic foci and projects within and across sectors, and 4) set priorities for projects within and across sectors. Whenever possible and appropriate, donors should assist Palestinian organizations in this planning process.

To provide an example of how the interrelationships among project proposals and objectives can be considered, Table 2 presents each specific sector recommendation identified in Table 1 and indicates the specific objectives for development to which the project or activity would contribute. These general and generic development objectives were identified from two sources: the most recent World Bank reports.³

A review of the recommendations presented in Table 2 makes it clear that there is a consistent pattern across the sectors and across the objectives. Review of this pattern might be useful for those involved in considering a rationalized development approach for the Occupied Territories. The principal foci of recommendations across sectors are:

strengthen the capacity of Palestinian quasi-public and private sector institutions and organizations to plan, manage and evaluate policies, programs and projects at the national, regional and local level through:

- selecting and improving access to and use of information resources both internally (within the Occupied Territories) and externally;
- providing technical assistance, training (for managerial and technical staff) and other support for the enhancement or development of quasi-public and private sector institutions and organizations that are responsible for or are involved in economic and social infrastructure support systems (e.g., water and sanitation, quality control, marketing systems, civil courts, tax collection and social welfare. This would include, for example, assisting in the definition and adaptation of standardized procedures; and
- improving education and training at the primary through university levels, including vocational/technical training, and literacy, self-instruction and distance (remote) learning programs.

improve the development, diffusion, use and assessment of technology in the quasi-public and private service and productive sectors through:

- providing technical assistance and training to enhance the selection and use of equipment and of new procedures (technologies) in agriculture, industry, health and education and physical infrastructure, including assessment of the economic, social and environmental impacts of new technologies and procedures;
- providing grants and loans (as appropriate) for the purchase of equipment which has been demonstrated to be useful and appropriate for enhancing productivity or effectiveness in the sector to which it applies (e.g., new technologies in crop production, cardiovascular disease prevention and treatment or alternative energy sources); and
- providing grants and loans (as appropriate) to enhance the capacity of Palestinian universities and research institutions to develop and/or adapt appropriate technologies for use in the West Bank and Gaza Strip and for export (including, for example, computer software).

improve management of, access to and use of credit and financial resources, through:

- training of existing personnel in banks and credit institutions;
- technical assistance and other support to improve management of bank and credit institutions;
- facilitating loans through international and regional development banks and private sector financial institutions; and
- supporting the development of credit circles and other locally based organizations which foster savings and loan arrangements for local development.

improve the collection, analysis and distribution of data and information for use in quasi-public and private sector programs and projects, through:

- training in data and information management;
- technical assistance and other support for the development of clearinghouses and information systems in each primary economic and social sector (e.g., agriculture, industry, water and sanitation); and

encouraging the provision of relevant data sets from the GOI to Palestinian public and private institutions.

improving the physical infrastructure which supports both quasi-public and private sector services and productive enterprises, including, for example, communications, electrification and transportation networks;

strengthen health and social welfare services which are critical for human growth, development, welfare and performance and are linked to a society's economic development; and

encourage effective and efficient use of energy resources and prospective protection of the environment in the process of economic, and particularly industrial expansion.

D. DEVELOPMENT ISSUES IN THE OCCUPIED TERRITORIES

A number of complex issues must be faced by those involved in development planning for the Occupied Territories. This section of the appendix briefly summarizes several of those issues.

Linkages Across Sectors. While it is true that devising plans for economic and social development in the Occupied Territories is difficult under the present circumstances, the opportunity nonetheless exists for the design and enhancement of public and private sector systems which avoid the problems of entrenched bureaucracies and make the most effective use of Palestinian entrepreneurship and community and support networks. All too often it is necessary to prepare development plans in the context of bureaucratic structures which are not disposed to interact with one another (e.g., the Ministry of Health with the Ministry of Agriculture) or with the private sector (e.g., industry with public environmental agencies). In the virtual absence of such bureaucratic structures at the regional (i.e., West Bank or Gaza Strip) level, the potential exists to plan for the most effective and appropriate use of limited resources for Palestinian development. Moreover, donors and Palestinians have a unique opportunity to establish incremental programs and projects on which broader or more extensive development can be based both within and across sectors. For example:

- educational and training programs can be devised in light of short-, medium-, and long-term economic development plans in general and industrial expansion and agricultural trade specifically;
- innovative approaches to expansion of health services and to health promotion and disease prevention can be devised in recognition of and in cooperation with the productive private sector (e.g., workplace-based PHC and prevention activities); and
- support for industrial expansion and infrastructure development can be linked to appropriate and efficient use of natural resources and designed to promote protection of the environment.

Benefiting from Israeli Experience. The factors of development in the Occupied Territories place them at a significant disadvantage with their primary trading partners--Israel and Jordan--and this has been seen primarily as negative with regard to development. However, opportunities exist for the Occupied Territories to learn from the experience of their most successful trading partner, Israel, as well as to learn from their specific economic interaction with that country. For example, educational and training opportunities in the Occupied Territories stand in stark contrast to those available in Israel. As the Israeli economist Aharoni has noted, human resource development in Israel has been a foundation of economic development. He states that "The long-term competitive advantage of Israeli firms is largely a function of their ability to exploit unique human capital capabilities."⁴ Israeli investment in the educating and training its population is exemplary. Palestinians and donor organizations which support development in the Occupied Territories should consider adaptation of applicable Israeli educational and training policies and programs to their development plans.

Addressing development policy questions. The current situation in the Occupied Territories also provides the opportunity for consideration of broad-based policy issues which entrenched bureaucracies often avoid facing. The policy questions that should be considered by Palestinians, donors and other involved in planning for development in the Occupied Territories include, for example:

1. Given that there no mechanism exists to ensure coordinated planning across sectors, what are the opportunities to ensure (insofar as possible) intra- and inter-sectoral linkages and decision-making for sustainable development? Such linkages include, for example, investment in productive industries which are not environmentally hazardous and in crop and livestock production which places minimum burden on land and water resources. A related consideration is that given the importance of integrated planning and the inherent difficulties in achieving it under the current circumstances, what should be the priority projects for the immediate (1-3 years), medium (3-5 years) and long-term (5-8 years)?
2. What will/should be the relative priority of public social and economic infrastructure systems (e.g., unemployment insurance, welfare, public health, social security/pensions as well as quality control and testing of medicines, protection of the environment, etc.) vis-a-vis investments in the productive private sector (e.g., tax benefits for private investment, public support for physical infrastructure for industrial zones)?
3. What contributions should donor agencies (bilateral, multilateral and private) make to improve the capacity of public services (e.g., health, education, physical infrastructure), pending a political resolution? Should such contribution include, for example, training the existing or an emerging cadre of municipally-based physical infrastructure employees (communications, electrification, transportation and water and sanitation) and/or investment in physical infrastructure projects themselves? What should be the relative priorities of investment in education and investment in improvements in technologies in the public and private sectors? While human resources development (education and training) is necessary (and a traditional investment role by itself), it is simply insufficient and could

lead to problems of social and/or economic instability if the economy does not soon rebound. Moreover, focusing exclusively on human resource development (in particular on degree training) has the disadvantage of requiring a long lead time before impact on economic development is realized.

4. What is the most appropriate and feasible degree of centralization/decentralization of public and quasi-public services, given cultural/geographical realities and practical economic and administrative considerations? What role could/should donors play in planning and preparing for centralization or decentralization of such services?
5. What is the most appropriate role for donors with respect to investment in the productive private sector? Given that the mechanisms used in both market and mixed economies to encourage investment and jobs creation are minimal (at best) in the Occupied Territories, what should donors do to assist in "jump starting" the economy in the Occupied Territories? What investments should be made in the cooperatives, which have (for all intents and purposes) assumed the role of quasi-shareholding for-profit companies, competing with privately held companies? Donors have supported the cooperatives extensively but have provided little support to the private sector. Should donors now provide financial support to privately-held, productive private sector companies comparable to such support provided to private companies in the U.S., Europe and the Pacific Rim (e.g., the U.S. government's Small Business Innovation Program)? Should donors work with the international banking community to facilitate loan guarantees to the private sector in the Occupied Territories for industrial development? To what degree should donors encourage or discourage small-scale enterprise in lieu of investments in medium- and large-scale industrial enterprises?
6. What should be the role of donors in preparing for assumption of certain public services (e.g., health, education, tax, regulatory and court systems)? On the one hand, there is considerable pressure for the Palestinians to assume responsibility for the social systems (e.g., health and education) in spite of the fact that they are not now responsible for the governmental systems with which those social service systems are inextricably linked (e.g., tax and regulatory systems). On the other hand, creating the basic (non-physical) infrastructure required for assumption of these responsibilities could consume a large proportion of the current donor allocation for the Occupied Territories.
7. Given that current policies of many donors, including the European Community and A.I.D. (as well as the World Bank, which has had representatives at the multilateral economic discussions), encourage privatization of services which are currently owned or managed by the public sector in some countries (e.g., electrification, transportation, communications, health), what investment should be made in municipal control of such services in the Occupied Territories? What rationale is there for such investment versus investment in encouraging private sector ownership/management of such services? Donors should be consistent in

their policies--if they support private sector development in the Occupied Territories, they should be prepared to invest in, or facilitate such development.

8. Given the current deteriorating economic situation what is the realistic potential for donors to consider immediate support for a large-scale public works program? Such a program--which could be comparable to that of the Civilian Conservation Corps (CCC) in the U.S. in the 1930s (and presently under consideration for adaptation by the incoming U.S. administration) focus on small- and medium-scale physical infrastructure projects (e.g., farm to market roads and environmental clean-up or protection). Moreover, the economic crisis would seem to call to developing a formalized social safety net--the absence of which helps to foster social disequilibrium in the Occupied Territories. Such a safety net could be comparable to those being designed by the World Bank for several developing countries; however, such programs require large infusions of financing--are donors prepared to provide such financing?

E. TOWARD SUSTAINABLE DEVELOPMENT

The small population base of the Occupied Territories and other factors suggest that economic growth depends on export-oriented industry and domestic service enterprises (e.g., tourism); this builds on the historical mercantile tradition of Palestinians. In any case, such development must be as diversified as possible (and as practical), in order to lessen the dependence on one or another source of financing for economic development. It must also be based on improvements in the capacity of Palestinians to compete in the increasingly competitive and dramatically changing global economy and to manage their domestic quasi-public and private institutions.

Development planning in the Occupied Territories is taking place in the context of a dynamic and shifting political environment. When the preparation of these sectoral analyses was initiated in December, 1991, the Peace Talks had only just begun, and a different political party was in office in Israel. Since then, several sessions of the Peace Talks have taken place (with some progress, at least at the technical level), and elections in Israel and the United States (a co-sponsor of the Peace Talks) have resulted in changes in government in both countries.

In order to ensure that they are contributing most positively to the process of economic and social development in the Occupied Territories, donors should increasingly turn their attention to support of policies, programs and projects which are linked across sectors in ways which most effectively make use of the resources available. Moreover, in the event of political change, it will be necessary for donors and international private voluntary organizations (PVOs) currently operating projects in the West Bank and Gaza Strip (and most importantly for UNRWA) to recognize that they most likely will have different roles in the process of planning and implementing economic development and social programs in the area.

In the long run donors will need to recognize that the eventual fulfillment of great expectations of economic growth in the Occupied Territories will require infusion of sufficient funds for operating costs and capital investment, as well as technical assistance and training help create jobs and develop a healthy, competitive economy. If donors cannot provide a sufficient quantity of such funds directly, then facilitating access to funds from other appropriate sources should become a priority. Donors should also encourage cooperation--economic and otherwise--within the Middle East region, and in particular between Israel and the Occupied Territories. Such cooperation would strengthen the capacity of the countries in the region (and of the Occupied Territories) to compete in the changing global marketplace. It may also contribute to political and social stability in the area and in the Occupied Territories specifically.

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Summary of Recommendations by Sector

Agriculture	Education & Training	Finance & Credit	Health	Industry & Enterprise	Infrastructure (Communications, Electrification, Transportation)	Trade	Water & Sanitation
ASSUMES STATUS QUO							
Short-term relief program including agricultural feeder roads, land reclamation	Improve computer, laboratory & library facilities at public & private K-12 level & post-secondary educational & training institutions	Expand community-based savings & credit institutions (e.g., credit circles)	Strengthen health systems' planning & management at all levels of the health care system	(See finance & credit for related recommendations)	(See education for related recommendations)	(See agriculture & industry for related recommendations)	Design & implement small-scale water & sanitation projects, in the West Bank & Gaza Strip, using the most appropriate technologies
Improve capacity of Palestinian institutions to plan, manage & evaluate programs & projects	Expand & improve private sector initiatives in literacy & distance learning	Improve capacity of banks, credit institutions & insurance companies to plan, manage & evaluate their activities	Improve financial management capacity & potential for cost recovery at all levels & types of facilities	Enhance capacity of industry & enterprise in terms of productivity, quality control, management (financial, personnel, etc.)	Improve managerial & planning of Palestinians currently or potentially responsible for infrastructure projects	Conduct marketing studies & surveys to generate require trade-related data	Immediate design & implementation of wastewater recycling, large-scale water-catchment & other related projects in the Gaza Strip
Improve & expand marketing information & support systems; coordinate with other sectors, (e.g., industry for food processing)	Physically rehabilitate existing K-12 schools & construct new schools as necessary, include facilities for recreation & community-based education in rehabilitated & new schools	Develop finance & credit data and information clearinghouse	Expand facility, regional and inter-regional health planning & needs assessment activities	Develop & expand linkages between Palestinian industry & enterprise foreign universities & research institutions	Upgrade capacity of skilled and semi-skilled workers in infrastructure (focusing on skills in new technologies)	Expand & improve linkages between Palestinian firms and trade inst. & foreign business & trade and related institutions	Design & implement small- and medium-scale sanitation projects
Expand use of improved irrigation systems making better use of scarce water resources	Revise K-12 and post-secondary curriculum, including ensuring linkage of curriculum to development needs and employment opportunities	Expand credit for the productive private sector (e.g., loan guarantees)	Expand & improve capacity of institutions to collect, analyze & disseminate data & information for expanded health educational programs	Conduct comprehensive industry/enterprise inter- and intra-regional planning (including for feasibility/appropriateness of industrial zones)	Develop computer-based information systems for planning & management of infrastructure projects	Expand & improve economic infrastructures which improve domestic & import markets (e.g., capital projects & systems for monitoring quality control of products)	Upgrade capacity of Palestinian institutions to conduct water quality & other environmental studies
Expand and improve crop varieties & livestock production (to enhance marketing potential, improve land & water use)	Expand & improve teacher training in educational theory & practice & in grade levels & subject areas for which they are responsible	Conduct study of capacity of existing inst. to manage larger loans to the productive sector	Conduct an assessment of existing health research studies & data bases; disseminate results	Strengthen institutions which support industry & enterprise (e.g., industrial Union(s), Chambers of Commerce, economic development institutions)	Upgrade & expand road networks, particularly key market access roads & roads in villages with little or no access to areas having basic services	Expand Palestinian trade missions & related short-term visits to foreign countries	Conduct water, air and other environmental studies, focusing heavily on high risk areas
Develop industrial sector in Gaza, in lieu of expansion of agricultural sector, in view of water shortage	Expand availability of new educational technologies at K-12 & post-secondary levels & train teachers in use of same	Conduct study of & plan for broad-based insurance needs	Develop & implement facility and cross-facility health management & information systems	Develop/expand industry/enterprise data & information systems & clearinghouses (e.g., marketing information systems)	Develop regional infrastructure plans, by subsector (e.g., electrification), focusing on most cost-effective systems, & expand community involvement in infrastructure planning	Develop trade-related data & information systems & clearinghouses (linked to regional & international information systems)	Improve capacity of municipal & private companies to plan, manage & evaluate water & sanitation services & systems, including improving their capacity to recover costs of services
Expand capacity of Palestinian research & extension services	Improve management of educational & training institutions at all levels	Improve capacity of Palestinian institutions to carry out planning & devise policies & programs at the macroeconomic and microeconomic levels	Expand continuing education for health care providers to help ensure quality of care	Expand capacity for and conduct applied research studies of productivity & quality control, including directly & indirectly related factors (e.g., labor/management relations, occupational & environmental health practices, quality control mechanisms)	Conduct demonstration projects on alternative energy sources	Upgrade capacity of Palestinian firms to have competitive advantages (e.g., in new product development, quality control requirements of trading partners, marketing techniques)	Improve capacity of skilled & semi-skilled employees, focusing on new technologies & processes
Expand & improve linkages between Palestinian institutions and foreign public & private sector agricultural research & development institutions	Expand capacity of post-secondary institutions to provide short-term training in marketable skill areas		Develop/adapt practice guidelines for all provider categories & levels of care		Improve capacity of public, quasi-public & private organizations to design/adapt & manage infrastructure financial systems & to recover costs of related services	The U.S. should explore relaxation of any trade barriers on Palestinian products & implementation of favorable trade regulations	Conduct study of water pricing & utilization
Develop/expand an agricultural data & information clearinghouse	Expand capacity of post-secondary institutions to conduct applied research & development projects for the private sector (including expanding facilities & training of faculty)		Expand primary & secondary level care, community-based rehabilitation services, & mental health services to underserved areas		Expand electrification to villages without services & upgrade existing equipment		Develop/improve water & sanitation information systems
	Develop/expand an education & training data and information clearinghouse		Plan and implement regional systems care, to make the most effective and efficient use of scarce resources & improve care delivery	Design & expand support systems for industry/enterprise (e.g., quality control, product testing, consultation for environmental & occupational health & safety, trade)			Develop a water and sanitation data & information clearinghouses
	Develop & improve the design & use of educational assessment materials for use with teachers and students		Improve existing health data & clearingh' causes	Improve ergonomics and productive capacity of existing and selected new industries/enterprises			
	Conduct an assessment of university programs to identify potential areas for regional coordination and resource sharing		Develop capacity of Palestinian facilities & health care providers to provide services which are not available in the O.T., if doing so would improve effectiveness & efficiency				
ASSUMES POLITICAL CHANGE							
Expand support for graduate training	Expand construction of new public schools, as necessary	Expand credit for productive private sector through loan guarantees, etc. through donor agencies, international, regional and national banking institutions	Support integrated health systems	Design & develop industrial zones, determined to be appropriate (see above)	Expand communications systems, using appropriate, low-cost technologies	Develop multi-national trade data & information systems	Plan & implement large-scale water & sanitation projects, as necessary
Expand support for improved buildings & laboratories for educational institutions	Expand research & development related to the productive private sector	Expand banking & credit services (branches of existing banks or institutions or new banks or institutions) to geographic areas in which no such services exist	Support public & private health financing mechanisms	Adapt/develop new products through loans or small grants	Expand integrated electrification system, using low-cost appropriate technologies	Develop/expand free trade zones	Expand support for multi-national water & sanitation projects in Middle East
					Expand road network & link with Israeli & Jordanian road networks		

NOTE: This table does not include recommendations concerning donor coordination, nor those related to removal of bureaucratic or other constraints to development.

Table 2.
Linkage Between Sectoral Recommendations & Development Goals & Objectives

Recommended Sectoral Activities	GOAL		Objectives		
	Improved economic & social well-being of the population	Increased productivity & marketing of agricultural & manufactured goods	Strengthened capacity of both public & private sector institutions to plan & manage on-going & development policies, programs & projects	Improved educational attainment, health, and participation in the workforce on the part of the population	Improved use of renewable resources
<u>Across Sectors</u>					
Elimination or alleviation of bureaucratic and other constraints	X	X	X	X	X
Strengthening the capacity of Palestinian public and private sector institutions to plan, manage & evaluate policies, programs & projects at the national, regional and local level	X	X	X	X	X
Improving the development, diffusion, use access to, evaluation & acquisition of technology in the public and private sectors	X	X	X	X	X
Improving management of and access to use of credit and financial services.	X	X	X		X
Improving the collection, analysis & distribution of data & information for use in public and private sector programs & projects, as well as access to relevant GOI and other data and information	X	X	X	X	X
Improving physical infrastructure & water & sanitation systems which support the public & private sectors & meet basic human needs	X	X	X		X
<u>Agriculture</u>					
Short-term relief program, including agricultural feeder roads and land reclamation	X	X		X	X
Improve capacity of Palestinian institutions to plan, manage & evaluate programs & projects	X	X	X	X	
Improve & expand marketing information & support systems	X	X	X	X	X
Expand use of improved irrigation systems, better use of scarce water resources	X	X	X	X	X
Expand and improve crop varieties & livestock production (to enhance marketing potential, improve land and water use)	X	X		X	X
Develop industrial sector in Gaza, in lieu of expansion of agricultural sector, in view of water shortage	X	X		X	X
Expand capacity of Palestinian research & extension services	X	X	X	X	
Expand & improve linkages between Palestinian institutions and foreign public & private sector agricultural research & development institutions	X	X	X	X	X
Develop/expand an agricultural data & information clearinghouse	X	X	X	X	X
Expand support for improved buildings & laboratories for agricultural training	X	X		X	
Expand support for graduate training	X	X	X	X	X

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Table 2, continued

Linkage Between Sectoral Recommendations & Development Goals & Objectives

Recommended Sectoral Activities	GOAL		Objectives		
	Improved economic & social well-being of the population	Increased productivity & marketing of agricultural & manufactured goods	Strengthen the capacity of public & private sector institutions to plan & manage on-going & development policies, programs & projects	Improved educational attainment, health, and participation in the workforce on the part of the population	Improved use of renewable resources
Education					
Improve computer, laboratory & library facilities facilities at public & private K-12 level & post-secondary education & training institutions	X	X	X	X	
Expand & improve private sector initiatives in literacy & distance learning	X	X	X	X	
Physically rehabilitate existing K-12 schools & construct new schools as necessary; include facilities for recreation & community-based education in rehabilitated & new schools	X	X	X	X	
Revise K-12 and post-secondary curriculum, including ensuring linkage of curriculum to development needs & employment opportunities	X	X	X	X	
Expand & improve teacher training in educational theory & practice & in grade levels & subject areas for which they are responsible	X	X	X	X	
Expand availability of new educational technologies at K-12 & post-secondary levels & train teachers in use of same	X	X	X	X	
Improve management of educational & training institutions at all levels	X	X	X	X	
Expand capacity of post-secondary institutions to provide short-term training in marketable skill areas	X	X	X	X	
Expand capacity of post-secondary institutions to conduct applied research & development projects for the private sector (including expanding facilities & training of faculty)	X	X	X	X	
Develop/expand an education & training data and information clearinghouse	X	X	X	X	
Develop & improve the design & use of educational assessment materials for use with teachers and students	X	X	X	X	
Conduct an assessment of university programs to identify potential areas for regional coordination and resource sharing	X	X	X	X	
Expand construction of new public schools, as necessary,	X			X	
Expand research & development related to the productive private sector	X	X	X	X	

Table 2, continued

Linkage Between Sectoral Recommendations & Development Objectives

Recommended Sectoral Activities	GOAL		Objectives	
	Improved economic & social well-being of the population	Increased productivity & marketing of agricultural & manufactured goods	Strengthened capacity of both public & private sector institutions to plan & manage on-going & development policies, programs & projects	Improved educational attainment, health, and participation in the workforce on the part of the population
Finance & Credit				
Expand community-based savings & credit institutions (e.g., credit circles)	x	x		x
Improve capacity of banks, credit institutions & insurance companies to plan, manage & evaluate their activities	x	x		
Develop finance & credit data and information clearinghouse	x	x	x	x
Expand credit for the productive private sector (e.g., loan guarantees)	x	x	x	x
Develop the management infrastructure for the finance & credit sector (e.g., policy instruments for financial regulation & standardized credit applications)	x	x	x	x
Conduct study of capacity of existing institutions to manage larger loans to the productive sector	x	x	x	x
Conduct study of & plan for broad-based insurance needs	x	x	x	x
Improve capacity of Palestinian institutions to carry out planning & devise policies & programs at the macroeconomic & microeconomic levels	x	x	x	x
Expand credit for productive private sector through loan guarantees, etc., through donor agencies, and international, regional and national banking institutions	x	x	x	x
Expand banking & credit services (branches of existing banks or credit unions or new banks or credit institutions) to geographic areas in which no such services exist	x	x	x	x

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Table 2, continued

Linkage Between Sectoral Recommendations & Development Objectives

Recommended Sectoral Activities	GOAL		Objectives		
	Improved economic & social well-being of the population	Increased productivity & marketing of agricultural & manufactured goods	Strengthened capacity of both public & private sector institutions to plan & manage on-going & development policies, programs & projects	Improved educational attainment, health, and participation in the workforce on the part of the population	Improved use of renewable resources
Health					
Strengthen health systems' planning & management at all levels of the health care system	x		x	x	x
Improve financial management capacity & potential for cost recovery at all facility levels	x		x	x	
Expand facility, regional and inter-regional health planning & needs assessment activities	x		x	x	
Expand & improve capacity of institutions to collect, analyze & disseminate data & information for expanded health education programs (incl. disease prevention & occupational and environmental health, for example)	x		x	x	
Conduct an assessment of existing health research studies & data bases; disseminate results	x		x	x	x
Develop & implement facility & cross-facility health management & information systems	x		x	x	
Expand continuing education for health care providers to help ensure quality of care	x		x	x	x
Develop/adapt practice guidelines for all provider categories & levels of care	x		x	x	x
Expand primary & secondary level care, community-based rehabilitation & mental health services to underserved areas	x		x	x	x
Plan and implement regional systems care, to make the most effective & efficient use of scarce resources & improve care delivery	x		x	x	x
Improve existing health data & clearinghouses	x		x	x	x
Develop capacity of Palestinian health facilities & to offer diagnostic & treatment services not available in the O.T., IF doing so would improve effectiveness efficiency of the system	x		x	x	
Support integrated health systems	x		x	x	
Support public & private health financing mechanisms	x		x	x	

Table 2, continued
 Linkage Between Sectoral Recommendations & Development Objectives

Recommended Sectoral Activities	GOAL		Objectives		Improved use of renewable resources
	Improved economic & social well-being of the population	Increased productivity & marketing of agricultural & manufactured goods	public & private sector institutions to plan & manage on-going & development policies, programs & projects	Improved educational attainment, health, and participation in the workforce on the part of the population	
Industry & Enterprise					
Enhance capacity of industry & enterprise in terms of productivity, quality control, management (financial, personnel, etc.) & research	x	x	x	x	
Develop & expand linkages between Palestinian industry & enterprise & foreign universities research institutions	x	x	x	x	x
Conduct comprehensive industry/enterprise inter- and intra-regional planning (including for feasibility/appropriateness of industrial zones)	x	x	x	x	x
Strengthen institutions which support industry & enterprise (e.g., Industrial Unions, Chambers of Commerce, & economic development institutions)	x	x	x	x	
Develop/expand industry/enterprise data & information systems & clearinghouses (e.g., marketing information systems)	x	x	x	x	x
Expand capacity for and conduct productivity & quality control, including direct & indirect related factors (e.g., labor/management relations, occupational & environmental health practices & quality control mechanisms)	x	x	x	x	
Design & expand support systems for industry/enterprise (e.g., quality control, product testing, consultation for occupational health, trade)	x	x	x	x	x
Improve ergonomics and productive capacity of existing and selected new industries/enterprises	x	x	x	x	
Design & develop industrial zones, if determined to be appropriate (see above)	x	x	x	x	x
Adapt/develop new products through loans or small grants	x	x	x	x	x

Table 2, continued
 Linkage Between Sectoral Recommendations & Development Objectives

Recommended Sectoral Activities	GOAL			
	Improved economic & social well-being of the population	Increased productivity & marketing of agricultural & manufactured goods	public & private sector institutions to plan & manage on-going & development policies, programs & projects	Improved educational attainment, health, and participation in the workforce on the part of the population
Infrastructure (Communications, Electrification, Transportation)				
Improve managerial & planning capacity of Palestinians currently or potentially responsible for infrastructure projects	x		x	x
Upgrade capacity of skilled and semi-skilled workers in infrastructure	x		x	x
Develop computer-based information systems for planning & management of infrastructure projects	x		x	x
Upgrade & expand road networks, particularly key market access roads & roads in villages with little or no access to areas having basic services	x		x	x
Develop regional infrastructure plans, by subsector, focusing on most cost-effective systems, and expand community involvement in infrastructure planning.	x		x	x
Conduct demonstration projects on alternative energy sources	x		x	x
Improve capacity of public, quasi-public & private organizations to design/adapt & manage infrastructure financial systems & to recover costs of related services	x		x	x
Expand electrification to villages without services & upgrade existing equipment	x		x	x
Develop/adapt certification & standards for standards for physical infrastructure personnel for use in initial and on-going assessment of skills among municipal & quasi-public employees	x		x	x
Expand communications systems, using appropriate, low-cost technologies	x		x	x
Expand integrated electrification system, using low-cost, appropriate technologies	x		x	x
Expand road network & link with Israeli & Jordanian road networks	x		x	x

Table 2, continued
 Linkage Between Sectoral Recommendations & Development Objectives

Recommended Sectoral Activities	GOAL				
	Improved economic & social well-being of the population	Increased productivity & marketing of agricultural & manufactured goods	public & private sector institutions to plan & manage on-going & development policies, programs & projects	Improved educational attainment, health, and participation in the workforce on the part of the population	Improved use of renewable resources
Trade					
Conduct marketing studies & surveys to generate require trade-related data	x	x	x	x	
Expand & improve linkages between Palestinian firms and trade institutions & foreign institutions, firms, & business & trade institutions	x	x	x	x	
Expand & improve economic infrastructures which improve domestic & import markets (e.g., capital projects & systems for monitoring quality control)	x	x	x	x	
Expand Palestinian trade missions & related short-term visits to foreign countries	x	x	x	x	
Develop trade-related data & information systems & clearinghouses (linked to regional & international information systems)	x	x	x	x	
Upgrade capacity of Palestinian firms to have competitive advantages (e.g., in new product development, quality control requirements of trading partners, marketing techniques)	x	x	x	x	
Develop multi-national trade data & information systems	x	x	x	x	
Develop/expand free trade zones	x	x	x	x	
Water & Sanitation					
Design & implement small-scale water & sanitation projects in the West Bank & Gaza Strip, using the most appropriate technology	x	x	x	x	x
Immediate design & implementation of wastewater recycling, large-scale water-catchment & other related projects in the Gaza Strip	x	x	x	x	x
Design & implement small- and medium-scale sanitation projects	x	x	x	x	x
Upgrade capacity of Palestinian institutions to conduct water quality & other environmental studies	x	x	x	x	x
Conduct water, air and other environmental studies, focusing initially on high risk areas	x	x	x	x	x
Improve capacity of municipal & private companies to plan, manage & evaluate water & sanitation services & systems, including improving their capacity to recover costs of services	x		x	x	x
Improve capacity of skilled & semi-skilled employees, focusing on technologies & processes	x		x	x	x
Conduct study of water pricing & utilization	x		x	x	x
Develop/improve water & sanitation information systems	x		x	x	x
Develop a water and sanitation data & information clearinghouse	x		x	x	x
Plan & implement large-scale water & sanitation projects, as necessary	x		x	x	x
Expand support for multi-national water & sanitation projects in Middle East	x		x	x	x