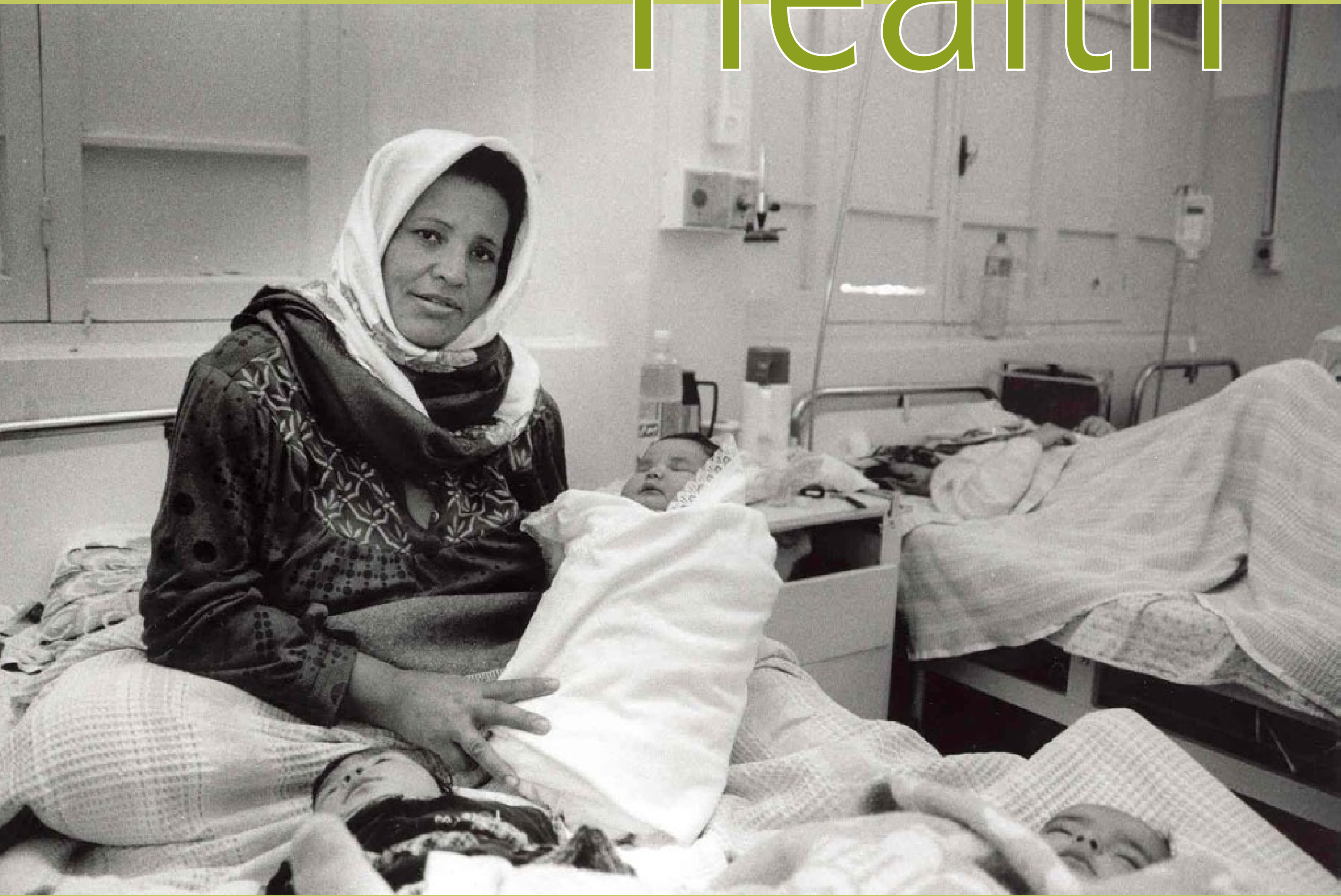
Health



Reforming Prudently Under Pressure: Health Financing Reform and the Rationalization of Public Sector Health Expenditures

Public sector health financing is at a critical crossroads in the West Bank and Gaza Strip. The emergency environment in the Palestinian Territory since 2000 has engendered significant and unsustainable imbalances in the financing of public sector health services. While economic growth and fiscal revenues contracted during the post-2000 period due to continued Israeli-imposed economic closures, public sector health spending ballooned, particularly during 2003-2005. This expansion in expenditures was driven by an increase in Ministry of Health (MoH) employment, an increase in average salary levels, greater spending on pharmaceuticals and specialty care referrals for treatment to private and overseas providers. Spending by MoH alone increased from US$ 95 million to 157 million from 2000 to 2005 – a 65 percent increase. Other public sector expenditures included spending by the Humanitarian Aid Committee attached to the Office of the President. Part of the financial imbalance also stemmed from policy decisions related to the design of the Government Health Insurance Scheme (GHI). Since its establishment as an extra revenue-generating scheme for the MOH, there has been a significant financial gap between insurance revenues and the cost of benefits extended by the GHI. This financial disequilibrium grew with the adoption of the 'free' Al Aqsa program – a PA voluntary insurance program aimed at ameliorating the social conditions of the unemployed population after the beginning of the Second Intifada.

The World Bank Health Policy Report entitled 'Reforming Prudently Under Pressure: Health Financing Reform and the Rationalization of Public Sector Health Expenditures' addresses and analyzes these policy concerns related to health financing with a focus on providing recommendations for medium-term reforms. The report builds on previous analytical work conducted by the World Bank on the Palestinian health sector and is aligned with the strategic objectives of the Palestinian Reform and Development Plan (PRDP) and the MOH National Strategic Health Plan (NSHP) for the years 2008-2010. Below is a summary of the core issues and messages highlighted in the report. The summary begins with a synopsis of the key challenges facing the health sector and then addresses the key issues related to health insurance reforms, financial management reforms, MOH human resource management reforms, pharmaceutical cost containment strategies, and public sector expenditures on contracted specialty care services.

Key Challenges Facing the Health Sector

- **Conflict conditions and closure policies** – The recent conflict between Israel and the Hamas government in Gaza and the ongoing Israeli security policies in the West Bank have had a profoundly negative impact on public health and access to basic health services. The conflict in December 2008-January 2009 resulted in hundreds of fatalities and thousand of injuries; and further undermined the already weakened state of the water, sanitation and power sectors in the Gaza Strip. Medical supplies were in very short supply and health facilities were often not able to treat the sick during the crisis. The checkpoints riddling the West Bank continue to hamper access to health services.

- **Fragmented institutional framework** – The governance of the healthsector is fragmented across two authorizing institutions in the West Bank and in the Gaza Strip. The division between the PA and the Hamas government has effectively created two Ministries of Health and fragmented the decision-making related to operational issues, investment planning and government initiated-reforms in the health sector.

- **Unpredictable health financing and donor dependency** - The unpredictability of budget revenues for the MoH hampers medium-term investment and recurrent expenditure planning. Due to the fiscal contraction in recent years, priority expenditures have focused on covering the wage bill and a share of the recurrent expenditures with fluctuating donor support making up the difference. This unpredictability will probably prevail over the short to medium term.

- **Efficiency of public sector health expenditures** - The efficiency of public sector health expenditures warrants continued attention by the Ministries of Finance and Health. Recurrent MoH spending on salaries almost doubled from 2000-2005 ($48 million to $83 million) and public sector expenditure on outside treatment referrals increased ten times during the same time period ($6 million to $60 million) taking into account the expenditures by the Humanitarian Aid Committee connected to the Office of the President.

- **Inadequate financial protection from illness** - Around 40 percent of total health expenditures in the West Bank and Gaza is in the form of out-of-pocket household expenditures. In 2004, the lowest income quintile of households spent an estimated 40 percent of their monthly income on health services while the richest quintile spent around 15 percent. When payments are catastrophic and beyond 40 percent of household incomes, families can sink into poverty. Between 1998 and 2006-2007, both the percentage of households making catastrophic health payments and the 'intensity' of the poverty gap attributable to health payments (extent to which household fall under the poverty line due to health payments), increased considerably.

- **MoH management capacity constraints** – The Ministry of Health is burdened with capacity constraints impacting its institutional effectiveness. The recent fiscal pressures leading to delayed salary payments, sometimes up to six to nine months, has weakened MoH capacity to motivate employees and attract new high-performing individuals. This environment of weakening incentives affects MoH management functions ranging from procurement of medical supplies and drugs to hospital claims processing to GHI enrollee management.
- **Increasing burden of chronic disease** – Chronic diseases and injuries are increasingly forming a larger part of disease burden in the West Bank and the Gaza Strip. Cardiovascular diseases, hypertension, diabetes mellitus are among the leading causes of adult mortality and morbidity among the Palestinian population. In 2004, heart diseases caused the highest number of adult deaths with a mortality rate of 60.5 per 100,000 in males and 48 per 100,000 in females.

Health Insurance Reforms

The Palestinian Authority (PA) and the MoH have already taken remedial measures to begin redressing the financial imbalances and administrative weaknesses of the GHI scheme. High-level decisions were taken to unify the decision process governing outside referrals for the insured under MoH authority and to consolidate the insurance and outside referral units under one administrative directorate in the MoH. Other decisions were taken to substantially reduce the volume of overseas treatment referrals and to develop stricter criteria for outside referrals in general. Beyond the short-term options, the PA is currently contemplating establishing a separate national health insurance agency under the chairmanship of the Ministry of Health. This policy direction signals an intention to by the PA to place health financing arrangements on a path towards achieving universal coverage through social health insurance.

The Bank report examines the pre-requisites and enabling factors for an effective social health insurance system based on lessons from international experience. The report also reviews earlier draft legislation prepared by the MOH for the establishment of an independent health insurance agency and provides recommendations for improving the legislation. In the report, three medium to longer term health financing reform options are examined including the option currently being considered by the MOH.

The three reform options are to:

1. Consolidate MoH as an integrated national health service (NHS) that both pools resources and provides services
2. Maintain the MOH as the primary financing agency – but introduce broader purchasing reforms including contracting NGO and private providers
3. Move towards establishing a social health insurance system based on mandated contributions and administered by an independent national health insurance agency

The main features, advantages and disadvantages associated with each reform option are summarized in the Table below:

Table 1. Summary Description of Features, Advantages and Disadvantages of Options

Policy Options	Features	Advantages	Disadvantages
Policy Option 1: Consolidate MoH as integrated national health service	**Resource mobilization:** Predominantly general tax revenues **Fund management:** Ministry of Health **Purchasing:** Potential reform in the internal budget process, including the introduction of global budget and performance-based payments within MOH	- Easy to implement - Provides universal access to health services	- Difficult to reform budget process and introduce performance payments - Services limited to MoH facilities
Policy Option 2: Maintain the MOH as the primary financing agency but strengthen the purchasing capacity of the MOH.	**Resource mobilization:** Predominantly general tax revenues, supplemented by co-payments, other fees **Fund management:** Ministry of Health **Purchasing:** Contracting providers, alternative payment methods	- Provides universal access to health services - More tools to introduce strategic purchasing - Expands choice of providers for patients (NGO, private)	- Technical expertise and capacity required to manage contracts
Policy Option 3: Move towards establishing a social health insurance system based on mandated contributions and administered by an independent national health insurance agency	**Resource mobilization:** Contributory system (payroll tax, fees, copayments) with general revenues for targeted subsidies **Fund management:** National Health Insurance Agency **Purchasing:** Contracting providers, alternative provider payment methods	- Establishes an independent financing agency with better defined accountability - - Potential efficiency gains through better purchasing - Expands choice of providers for patients	- Expanding coverage difficult if economy poor and informal sector is large - Potential access problems for non-contributing members - Exacerbates informality if contribution rates are high - Cost escalation could become problem if purchasing capacity is weak

The policy approach currently being contemplated by the MoH (Option 3), given the current emergency conditions in June, 2009, is risky. The pre-requisites and enabling factors for successfully pursuing Option 3 at the present time are in short supply. The PA and the MOH could, alternatively, give greater consideration to pursuing Options 2 over the medium-term as an interim step during a transitional phase towards achieving universal coverage through social insurance. Ultimately, however, the decision to organize a health financing system in a given way (to mobilize resources for healthcare, pool and manage those resources, and use them for the purchase of health services) is, at its core, a social choice and governed by political, economic, and institutional factors prevailing in a country context.

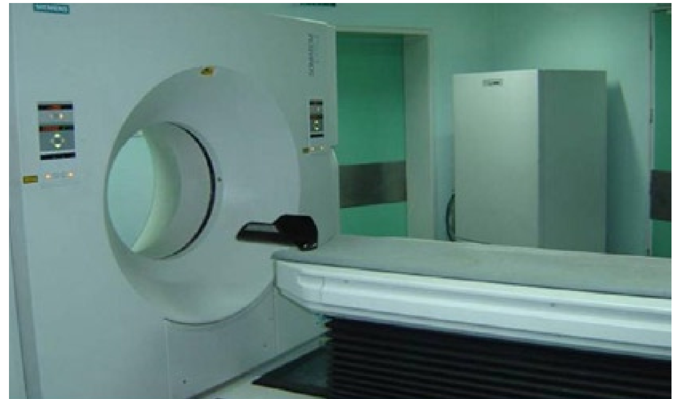
Financial Management Reforms

In 2007-2008, the PA initiated broad-scale public financial management (PFM) reforms with the aim of improving public sector accountability and financial control. Under a restructured financial management system, the PA aims to increase the authority and accountability of specific ministries (including the MoH) through the allocation of funds to line ministries in accordance with an appropriation approved by the parliament. The Minister of Health will be authorized to disburse funds within the limitations imposed by the parliamentary appropriation and account for the performance of their responsibilities through the preparation of an annual financial statement. The current MoH financial management system needs to be redesigned and modernized so that the Minister of Health can properly discharge these new financial responsibilities. The existing system does not provide: (i) a reliable basis for preparing forward estimates; (ii) reasonable assurance about legislative regularity of all expenses; (iii) an efficient and timely mechanism for the payment of accounts payable; (iv) complete and accurate information about the real cost of health services.

There are five proposed reform options:

1. **Long-Term Transfer of Responsibility from the Ministry of Finance to the Ministry of Health** - In the medium-term the Ministry of Health should concentrate on developing appropriate commitment controls before it is authorized to assume responsibility for two important functions: (i) payment of salaries and wages and (ii) internal control and internal audit services.

2. **Reform the Budgetary Cycle** – As part of a comprehensive government approach to strengthening the budgetary cycle led by the Ministry of Finance, the Ministry of Health should implement a performance monitoring program to support the introduction of a new program-based budgeting cycle. The Ministry of Finance should provide assistance and guidance to line ministries to assist the development of an agreed program structure, appropriate performance measurement tools and reporting requirements.



3. **Re-engineer the System of Internal Control** - The existing system of internal control is old-fashioned and labor intensive. The release of a new financial management system within the Ministry of Finance provides an opportunity for the Ministry of Health with the direct and specific support of the Ministry of Finance to: (i) implement control measures to detect and investigate fraud and over-servicing; (ii) re-engineer core financial management processes, i.e. collection of contributions, payment of accounts and procurement of services; (iii) expand the range of payment options available to contributors.

4. **Establish a New Chart of Accounts** - The existing chart of accounts does not support the accurate costing of specific services and/or service delivery outlets. As part of the general move to program budgeting, the Ministry of Health (MoH) chart of accounts should be re-designed to facilitate the production of regular reports aligned to programs specified in the budget.

5. **Prepare Comprehensive Financial Statements** - The annual financial report prepared by the Ministry of Finance is not a complete record of all health portfolio assets and liabilities. In the short-term the Ministry of Health should focus on preparing a cash-based annual statement that accounts for all revenue and expenses assigned to the Minister of Health via the budget law.

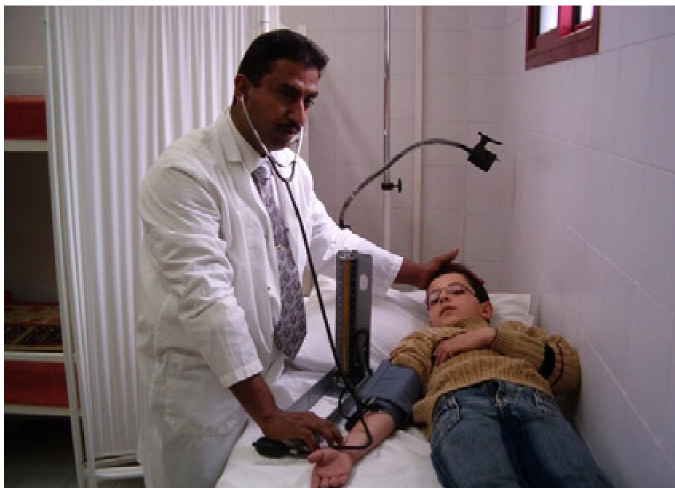
In the longer term, the financial statements should be expanded to encompass all health related financial activity. This should include all non-current assets and liabilities such as plant and equipment and the accrued value of any deprecation of those assets. The Ministry of Health should develop accounting procedures for the valuation and depreciation of assets. These values should be included in the annual financial statements. The financial statements should comprise a balance sheet, a cash flow statement and an operating statement

MoH Human Resource Management Reforms

The political and macroeconomic environment in the West Bank and Gaza during 2000-2006 induced a rapid expansion in public sector employment particularly in the health, education, social development, and security sectors. The severe economic stagnation and growing unemployment in the private sector, particularly during the 2001-2003 period, prompted the PA to expand the scope of public employment. The total number of MoH employees during 2000-2006 increased from 7,500 to 13,057 and the MoH wage bill similarly rose from US $48 million in 2000 to US $83 million in 2005. This rapid increase in MoH employment, particularly among paramedical workers in the first six years after 2000, reversed course during the 2007-2008 due to employment retrenchment policies imposed by the PA.

As part of a reform agenda, a new Civil Service Law was passed in 2005 to bring greater uniformity and transparency to the recruitment practices of the public sector. This initiative helped rationalize the employment practices of the different PA Ministries including the MoH. Additional reforms by the MoH itself in the areas of human resource management and planning could further rationalize MoH employment policies and its overall wage bill. These reforms include the following:

1. Consolidate disparate human resource management functions under a new MoH human resources department;
2. Conduct a series of in-depth analyses on human resources in the MoH (mapping analysis, staff motivational survey) and preparing a comprehensive human resource development plan;
3. Strengthen existing recruitment procedures and the development of a new MoH recruitment handbook;
4. Prepare a training plan and calendar for the period 2010-2012;
5. Adopt a new human resource management information system for the MoH. These reform measures could be implemented over the course of a year with the necessary technical and financial assistance of the donor community.



Overall spending on pharmaceuticals in the West Bank and Gaza has expanded in recent years despite increasingly limited resources in the public and private sectors. This expansion has been fuelled by several factors including a growing number of publicly procured medicines, higher demand from a growing population and high pharmaceutical prices due to existing trade barriers and new expensive drugs entering the Palestinian market. The key pharmaceutical cost containment issues in the West Bank and Gaza Strip are as follow:

- **Current procurement policies in the public sector** - Aside from medicines donated in-kind by donors, all medicines available in the public sector are bought via government tenders. Drugs procurement guidelines follow PA general laws and regulations for general goods and services and do not take into account the specialized nature of pharmaceuticals (e.g. regarding their patent situation). Conditions of weak market competition, also, compel the MoH to buy either from Israeli companies, local manufacturers or the local providers at higher prices than those that could be achieved via more competitive tendering.

- **Current pricing policies in the private sector** - In the private market products are basically purchased by the pharmacists directly from agents or local manufacturers. Pharmacy retail prices are quite high. The reason for these high prices is that the list prices at the level of the manufacturer, importer or agent levels are not effectively regulated but are usually suggested by the manufacturers, agents or importers. Agents usually have exclusivity contracts1 for the branded medicines they import guaranteeing them a monopoly position with reported profits of 100 percent and more since the maximum allowed add-ons are not regulated. They are granted such contracts by both the Ministry of National Economy (MONE) and the MoH.

- **Existing Trade Agreements** – The 'Paris Protocol' Trade Agreement of 1993 between Israel and the PLO represents, according to many stakeholders, one of the main barriers to trade and competition. Israeli authorities rely on certain stipulations ('standard requirements') in the Paris Protocol2 to require that all pharmaceutical goods (and raw materials needed for production) entering the Palestinian Territories need to comply with Israeli process standards. This requirement means that all medicines not produced in Israel and not donated in-kind by international organizations such as the UN are required to pre-register in Israel. The stated rationale of the Israeli authorities is that the medicines need to comply with Israeli public health standards and to avoid a potential backwash of medicines from the West Bank and Gaza Strip into Israel. These expensive and time-consuming pre-registration requirements are a major barrier to competitive trade and discourage interest in the Palestinian pharmaceutical market.

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1 Exclusivity contracts are a part of the market authorisation/registration process, to guarantee the availability of the medicine.

The main pharmaceutical cost containment recommendations are:

Table 2. Recommended Pharmaceutical Cost Containment Measures

Recommendations	Proposed action	Feasibility	Fiscal Impact	Lead by
A) Preparing a National Drug Policy	- Prepare a new national drug policy	Possible	Intermediate	MoH
B) Promoting Rational Drug Use	- Develop an operational instrument to promote rational drug use, and the monitoring of prescription patterns	Possible	Intermediate	MoH
C) Reducing the overall price level of pharmaceuticals	- Redraft the pricing ordinance after an evaluation of its objectives and impact. - Define that the procured price may not exceed the registered (approved) maximum price and try to cap the profit of agents. - Standardize the approval procedure for pricing requests by manufacturers/ importers (in the long-term price increases shall only be possible after approval by the Technical Committee). - Improve strategic price negotiations. - Seek reliable information on price by enhancing data collection e. g. in cooperation with the Pharmacists Association. - Measures shall be directed at procurement and private market	High	Immediate	MoH
D) Further encouragement of competition and enhancement of procurement system	- Increase number of bidders in procurement by addressing potential foreign bidders for multi-source products directly and guaranteeing them a timely payment. - Long-term: building up of electronic procurement - Customization of the standard bidding documents for goods to address any particular technical or legal requirement related to the purchase of medical equipment must be done through the Bid Data Sheet, the Special Conditions of Contract, and the Technical Specifications. - Not allow exclusivity contracts for agents - Try to promote "parallel imports"	Possible	High	MOH MONE MOF
E) Minimize Trade Barriers	- Review Paris Protocol and accepted interpretation of its articles related to pharmaceutical supplies - Prepare a thorough dossier with a documentation of all unfavorable occurrences that impose non-tariff barriers (assisted by industry). - Start active discussions with the Israeli authorities on how to facilitate entry of medicines. - Improve efficiency of registration.	Doable, but strong political support necessary	High	MONE together with Joint Economic Committee (JEC)
F) Modification of the Technical Committee and its subcommittee on Pricing	- Role and set-up of Committees should be redefined to avoid potential conflict of interest. - Voting process shall be made clear. - More weight for payers. - Involvement of independent experts in the field (one legal adviser already nominated).	High	Linked to the draft pricing ordinance	MOH eventually jointly with MONE and MOF

Public Sector Expenditures on Contracted Specialty Care Services

The recent expansion of public sector expenditures on contracted specialty care services, as with human resources and pharmaceuticals, contributed significantly to the overall rise in public sector health spending in the West Bank and Gaza. In 2000, referrals for outside tertiary cares services reported by the Ministry of Health slightly exceeded 5,000 cases. By 2005 this figure exceeded 30,000 – a 500 percent increase in five years. The factors driving this increase in outside referrals, according to the Ministry of Health officials, were several: (i) a general environment during the Second Intifada which induced the government to expand the number of outside referrals (deepening economic hardship; increased psycho-social stress on Palestinian households; higher incidence rate of conflict related injuries); (ii) an increase in the total number of beneficiaries under the Government Health Insurance (GHI) scheme as large numbers of non-contributing enrollees were brought under the scheme; and (iii) a loosening of the management and control mechanisms authorizing public sector referrals for specialized care services.

As part of its reform agenda, the PA and the MoH recently undertook several indirect and direct measures to contain and rationalize these public sector expenditures on specialty care services. The indirect measures involved efforts to design and implement new health promotion and prevention programs (e.g. smoking cessation, cancer screening). The direct measures involved the development of regulatory criteria for capital investments in specialty care services and facilities; and a move to strengthen the existing contracting mechanism with local providers through the development of a new model contract and the implementation of a competitive-based bidding approach. Due to technical capacity constraints in the MoH, implementation of this innovative approach suffered from long implementation delays and bottlenecks. Over the next two years, 2009-2010, it will be important for the MOH to evaluate, strengthen, consolidate and possibly expand (to include overseas referrals) this new contracting mechanism. External technical assistance would help facilitate and guides this process.