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Report No: PAD 1069

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT IN THE AMOUNT OF US$8.5 MILLION

TO THE

PALESTINE LIBERATION ORGANIZATION
(FOR THE BENEFIT OF THE PALESTINIAN AUTHORITY)

FOR A

HEALTH SYSTEM RESILIENCY STRENGTHENING PROJECT

January 6, 2015

Health, Nutrition and Population Global Practice
Middle East and North Africa Region

GOVERNMENT FISCAL YEAR

January 1 – December 31

CURRENCY EQUIVALENTS

(Exchange rate effective December 18, 2014)

Currency Unit = Israeli New Sheqalim (ILS)

US$ 1 = ILS 3.94

ILS 1 = US$ 0.25

ABBREVIATIONS AND ACRONYMS

AS	Assistance Strategy
DA	Designated Account
DFID	UK Department for International Development
DP	Development Partners
DPG	Development Policy Grant
EU	European Union
FM	Financial Management
FY	Fiscal Year
GDP	Gross Domestic Product
GHI	Government Health Insurance
HIS	Health Information System
HMIS	Health Management Information System
HQ	Headquarters
IA	Implementing Agency
IBRD	International Bank for Reconstruction and Development
ICT	Information and Communications Technology
IDA	International Development Association
IFR	Interim Financial Report
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPF	Investment Project Financing
IS	Interim Strategy
IT	Information Technology
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MIS	Management Information System
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOH	Ministry of Health
MTR	Mid Term Review
NCDs	Non Communicable Diseases
NDP	National Development Plan
NGOs	Non-Government Organizations
NORAD	Norwegian Agency for Development Cooperation
OMR	Outside Medical Referrals
OOP	Out-of-Pocket
OP	Operational Policy
ORAF	Operational Risk Assessment Framework
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics

PDO	Project Development Objective
PHC	Primary Healthcare
PFHS	Palestinian Family Health Survey
PFM	Public Financial Management
PHC	Primary Healthcare
PHCCs	Primary Healthcare Centers
PLO	Palestine Liberation Organization
PMU	Project Management Unit
PNDP	Palestinian National Development Plan
PP	Procurement Plan
PPL	Public Procurement Law
PT	Palestinian territories
SC	Steering Committee
RFP	Request for Proposals
RIS	Referral Information System
TA	Technical Assistance
ToRs	Terms of Reference
TTL	Task Team Leader
U5MR	Under-5 Mortality Rate
UHC	Universal Health Coverage
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency of International Aid
WA	Withdrawal Application
WBG	West Bank and Gaza
WHO	World Health Organization

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West Bank and Gaza
Health System Resiliency Strengthening Project

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West Bank and Gaza

Health System Resiliency Strengthening Project (P150481)

PROJECT APPRAISAL DOCUMENT

MIDDLE EAST AND NORTH AFRICA

Report No.: PAD1069

Basic Information		
Project ID P150481	EA Category C - Not Required	Team Leader Samira Ahmed Hillis
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [X] - Fragile States - Post-Conflict - Natural or man-made disaster	
	Financial Intermediaries [ ]	
	Series of Projects [X]	
Project Implementation Start Date 21-Jan-2015	Project Implementation End Date 31-Dec-2019	
Expected Effectiveness Date 10-Feb-2015	Expected Closing Date 30-June-2020	
Joint IFC No		

Practice Manager/Manager	Senior Global Practice Director	Country Director	Acting Regional Vice President
Enis Barış	Timothy Grant Evans	Steen Lau Jorgensen	Gerard Byam

Borrower: Ministry of Finance			
Responsible Agency: Ministry of Health			
Contact:	Maria Al-Aqra	Title:	Director of International Relations
Telephone No.:	0598949104	Email:	alaqra@yahoo.com

Safeguards Deferral (from Decision Review Decision Note)
Will the review of Safeguards be deferred? [ ] Yes [X] No

Project Financing Data(in USD Million)		
[ ] Loan	[ ] IDA Grant	[ ] Guarantee

[ ]	Credit	[ ]	Grant	[X]	Other

Total Project Cost:	8.50	Total Bank Financing:	8.50
Financing Gap:	0.00		

Financing Source	**Amount**
Borrower	0.00
Special Financing	8.50
Total	8.50

Expected Disbursements (in USD Million)

Fiscal Year	2015	2016	2017	2018	2019	2020
Annual	2.00	1.50	1.50	1.50	1.50	0.50
Cumulative	2.00	3.50	5.00	6.50	8.00	8.50

Institutional Data

Practice Area / Cross Cutting Solution Area

Health, Nutrition & Population

Cross Cutting Areas

[ ] Climate Change
[X] Fragile, Conflict & Violence
[ ] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	60
Human development	Injuries and non-communicable diseases	30
Human development	Other human development	10

Total	100

Proposed Development Objective(s)

The project PDO is to support the Palestinian Authority in securing continuity in healthcare service delivery and building its resilience to withstand future surge in demand for effective healthcare coverage.

Components

Component Name	Cost (USD Millions)
Component 1: Emergency and Rapid Response Window	2.00
Component 2: Rationalizing Outside Medical Referrals	3.50
Component 3: Supporting Health Coverage Reform to Strengthen Sector Resilience	2.00
Component 4: Project Management & Capacity Building	1.00

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01		**X**
Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10		**X**
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name: Article IV 5.02	

The Subsidiary Agreement between the Palestine Liberation Organization (PLO) and the Palestinian Authority

(PA) to be signed.

Legal Opinion issued by the Minister of Justice of the PA, confirming that (a) the Grant Agreement has been duly authorized and ratified by, and executed and delivered on behalf of the PLO and is legally binding upon the PLO in accordance with its terms; and (b) the Subsidiary Agreement has been duly authorized and ratified by, and executed and delivered on behalf of the PLO and the PA and is legally binding upon the PLO and the PA in accordance with its terms.

Name: Schedule 2, Section II.A.2	Recurrent	Due Date	Frequency
Mid-term Review		May 15, 2017	Once

Description of Covenant:

Not later than May 15, 2017, the Recipient shall, in conjunction with the World Bank, carry out a mid-term review of the Project (the "Mid-term Review"), covering the progress achieved in the implementation of the Project. To that end, the Recipient shall prepare and furnish to the World Bank not later than March 15, 2017, a report integrating the results of the monitoring and evaluation activities performed on the progress achieved in the carrying out of the Project during the period preceding the date of such report, and setting out the measures recommended to ensure the efficient carrying out of the Project and the achievement of the objective of the Project during the period following such date.

Conditions Article IV 5.01

Description of Condition:
The Grant Agreement shall not become effective until evidence satisfactory to the World Bank has been furnished to the World Bank that the conditions specified below have been satisfied in a manner and in form and substance satisfactory to the World Bank:

(a) The execution and delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental and/or corporate action.

(b) The Subsidiary Agreement referred to in Section I.A of Schedule 2 to this Agreement has been executed on behalf of the Recipient and the Palestinian Authority.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Abdallah Awad	IT Officer, Client Services II	Information and Technology Solutions	ITSCR
Andrianirina Michel Eric Ranjeva	Finance Officer	Finance and Disbursement	CTRLA
Basheer Ahmad Fahem Jaber	Procurement Analyst	Procurement	GGODR
Ece Amber Özcelik	Junior Professional Associate	Health Economics and Finance	GHNDR
Emre Özaltın	Sr. Economist (Health)	Health Economics and Finance	GHNDR
Enis Baris	Practice Manager	Health Policy and Planning	GHNDR
Evarist Baimu	Senior Counsel	Legal	LEGAM

Lilian Frost	Consultant	Bank Operations	GSPDR
Lina Fathallah Rajoub	Senior Procurement Specialist	Procurement	GGODR
Maha Muhammad Bali	Program Assistant	Bank Operations	MNCGZ
Paul Geli	Consultant	Project Implementation and Evaluation	GEDDR
Rafael Cortez	Sr. Economist (Health)	Health Economics and Finance	GHNDR
Riham Hussein	Financial Management Specialist	Financial Management	GGODR
Samira Ahmed Hillis	Senior Operations Officer	Team Lead	GSPDR
Zlatan Sabic	E T Consultant	Health Management Information Systems	GHNDR

Non Bank Staff

Name	Title	City

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
West Bank and Gaza	Gaza Strip	Gaza Strip		X	
West Bank and Gaza	West Bank	West Bank		X	

I. STRATEGIC CONTEXT

A. Country Context

1. **The Palestinian economy slipped into a recession in 2014.** Following a period of sustained economic recovery between 2007 and 2011, when average growth exceeded eight percent, the economy has increasingly weakened. The downturn started in 2012 when growth decelerated to about six percent as a result of a sharp drop in foreign aid. This, against a backdrop of ongoing Israeli restrictions and high political uncertainty,[1] led to a significant fall in public and private consumption, which caused a further drop in growth to around two percent in 2013. The decline continued in 2014 and the economy actually slipped into a recession before the start of the latest Gaza war. Recent estimates indicate that full-year growth in 2014 in the Palestinian territories will amount to about four percent. Severely affected by the latest war, Gaza's economy is expected to have contracted by 15 percent in 2014, while growth in the West Bank is expected to be around 0.5 percent.

2. **Unemployment continues to be high mainly due to low levels of private investment, which has averaged around 15 percent of Gross Domestic Product (GDP) over the past seven years**. There has been a substantial shift in economic activity away from the agricultural and manufacturing sectors toward services, and most private investment has been directed toward non-tradable sectors that are not able to generate adequate growth and employment. In addition, labor force participation is low. In the second quarter of 2014, unemployment reached 26.3 percent (in the West Bank 16.0 percent and a staggering 45.1 percent in Gaza before the conflict—a number expected to increase greatly with the widespread destruction of businesses and factories during the conflict). Unemployment among females and youth between the ages of 15 and 29 is also high (39.6 percent and 39.5 percent respectively). The lack of dynamism in the private sector is clear based on the fact that the Palestinian Authority (PA) employs a substantial proportion of the workforce (almost 23 percent).

3. **Over 1/3 of Palestinians living in Gaza were already poor or vulnerable when the conflict began.** Although the share of people living on less than US$1.25 a day in the Palestinian Territories (PT) is less than three percent and the share of people living on less than US$2.00 a day is five percent, the national poverty rate, measured by households living below the national poverty line,[2] was 25.8 percent in 2011. Furthermore, this was 18 percent in the West Bank and more than double, 39 percent, in Gaza. A Gini coefficient of 0.403 also indicates a significant level of income inequality in the Palestinian territories.

4. **The effects of Israeli restrictions on economic activity, in particular those on trade, movement, and access, pose a binding constraint to economic and social progress in the**

[1] The Government of Israel (GoI) cites security concerns that restrict its ability to further ease or lift various restrictions on economic activity in the West Bank and Gaza.

[2] The national poverty rate is defined as the percentage of the population below the national poverty line, calculated based on expenditures required for basic consumption needs. For a reference household of two adults and three children, the poverty line according to the Palestine Central Bureau of Statistics is set at NIS 2,293 or about US$637 per month.

Palestinian territories. These restrictions were most recently felt during the 2014 summer incursion into Gaza, where hostilities led to widespread loss of life and destruction of property and infrastructure. The conflict exposed major weaknesses in the Palestinian Government's institutional, regulatory, and financial resilience to contain the consequences of these restrictions in times of increased need and its diminished coping ability and capacity for effective service delivery in healthcare. Today, a tipping point has been reached whereby the existing Palestinian health sector's governance and financing model needs to be urgently rationalized and reformed in order to enable it to cope with the increased demand in times of limited resources and higher health and healthcare needs. It is more pressing and important than ever to support the PA to build resilient institutions and systems to ensure the human development of the Palestinian population.

B. Situations of Urgent Need for Assistance and Capacity Constraints

5. **The recent conflict in Gaza has had severe negative consequences for the health of the population in Gaza.** The 51-day conflict which occurred in July and August of 2014 resulted in an estimated 2,145 deaths and 11,231 injuries and placed significant pressure on an already weak health system. Neo-natal and maternal mortality have increased and ten percent of the injuries (over 1,000 cases) are likely to result in long-term disability. The impact of the situation on those requiring specialized services, including those with life-threatening chronic or infectious diseases, has been particularly dire. There has also been a rise in negative coping behaviors including substance abuse and violence, particularly among women and girls. Additionally, Gaza had two ongoing disease outbreaks prior to the conflict: an outbreak of Mumps since April 2013, which continues to spread at an increasing rate, and a viral meningitis outbreak, which started in March 2014 and has continued to spread but at a decreasing rate. In addition, an estimated one-third of the population was displaced during the conflict; many of the displaced are currently residing in shelters or with host families and many have limited access to healthcare and services.

6. **The Palestinian health sector, which was already weak and facing difficulties in meeting sectoral challenges prior to the crisis, is overwhelmed and cannot cope with the current situation.** Although many hospitals had undertaken emergency and contingency planning, the level of destruction and number of casualties far surpassed the worst-case preparedness scenarios. 58 percent of all health facilities were damaged, only 50 percent of primary care centers remain operational, and there is a lack of necessary medicines, equipment, clean water, and fuel. The health sector was overwhelmed by the number of casualties and wounded individuals, and the sector's inability to keep up with housekeeping and sterilization has increased the rate of infections reported after discharge from hospitals and primary healthcare facilities. Additionally, the closing of checkpoints (for entry into Israel and Egypt) has meant that the Ministry of Health (MOH) is limited in its ability to refer patients to outside hospitals for necessary treatments. In the face of these immediate health sector needs, most public health initiatives, particularly those related to prevention, have ceased and key health indicators risk slipping backwards—jeopardizing long-term health outcomes in the population.

7. **The conflict has severely exacerbated the PA's already dire budget problems.** Prior to the conflict, the health sector was already in severe arrears, reaching US$193.2 million[3] in 2013 (excluding salaries) and corresponding to more than half (54 percent) of all of the MOH's expenditures. In addition, these expenditures are projected to have increased dramatically in light of the recent conflict. Between January and September 2014, an estimated 127 percent of the full year budget allocation for the health sector had already been spent, with a large portion of this due to the growing cost of Outside Medical Referrals (OMR), particularly to Israeli hospitals. The conflict has greatly worsened the situation, and the PA is limited in its ability to meet the immediate challenges in the health sector and pay for health services, pharmaceuticals, and recurrent expenditures.

8. **The emergency situation has provided the MOH and Ministry of Finance (MOF) with a strong motivation to address immediate needs and to address underlying problems facing the health sector.** Momentum for reform had been increasing prior to the conflict, where the MOH, for example, had taken concrete steps to demonstrate its strong commitment to addressing challenges facing the health sector. These commitments included appointing an audit firm, working on developing a basis for reviewing referrals, and aiming to establish protocols and guidelines for OMRs. The conflict has brought these system weaknesses into sharper focus and the PA is committed to increasing the capacity of the healthcare system to respond to the population's immediate and emergency health needs in a way that will be sustainable in the longer-term.

9. **There is now a window of opportunity in the current context to push for measures that will alleviate immediate needs and address the fiscal pressures faced by the health system.** The direct impact of the conflict on human lives and health infrastructure is exacerbated by structural limitations and a fiscal crisis driven by a prolonged economic downturn, reduced aid flows, and political stalemate. With limited prospects for recovery without intervention, the Bank is well placed to support the health sector through an emergency operation. In addition to supporting the PA in addressing the immediate health needs of the population, the proposed project will address long-term fiscal pressures by supporting the necessary reforms that will be essential in ensuring that short-term gains are sustainable. Specifically, the proposed emergency operation will: (i) address the urgent health financing needs which have markedly increased as a result of the recent conflict; and (ii) help contain the ever-increasing gap between revenues and expenditures in the health sector by rationalizing OMRs, which are the most expensive item in the health budget as well as the main source of fiscal deficit.

C. Sectoral and Institutional Context

10. **The health system in the Palestinian territories has two distinguishing features:** (i) it operates in a context of political instability and conflict under Israeli control, which undermines effective system governance; and (ii) its financial viability is severely constrained by its

3 Of this US$193.2 million, about US$95 million was due to costs of pharmaceuticals and consumables (as well as others); about US$85.1 million due to costs of purchasing services; approximately US$12.9 million due to capital and other recurrent expenditures.

dependence on donor funding, which is subject to fluctuations depending on political considerations (See Annex 6 for further details on the sectoral context).

11. **Continuing Israeli restrictions, including roadblocks, the need for travel permits, and separation walls, as well as Israel's authority over key aspects of state management, such as the collection of import duties on behalf of the PA, from which the cost of Palestinian health referrals to Israeli hospitals is deducted before transferring them to the PA, strongly affect the effectiveness and functionality of the health system at all levels**. At the macro level, these restrictions limit the MOH's authority and its ability to effectively address the health challenges faced by the Palestinian health system, particularly those challenges due to the recent crisis. They also directly affect the ability of patients to obtain certain health services, especially those requiring referrals to other facilities, including facilities in the West Bank (for those being referred from Gaza), East Jerusalem hospitals that are part of the Palestinian health system, and facilities in Egypt, Israel, and Jordan (See Annex 8 for further details on OMRs).

12. **Fragmented institutional frameworks undermine governance and the ability of the sector to respond to the emergency situation**. At present, the MOH is responsible for all of the functions of the health system, including coordination, financing, service provision, licensing, and regulation. Partly as a result of these overreaching responsibilities, its capacity for effective stewardship of the system and to respond to emergency challenges is limited and most resources concentrate on the provision of a wide range of services. In this context, coordination between key actors in the health sector is essential, particularly between the MOH, private organizations, non-governmental organizations (NGOs), and United Nations Relief and Works Agency (UNRWA). In addition, the creation of reliable health information systems, standards of care for public and private providers, better resource allocations, improved outside referrals, and a strengthened regulatory capacity of the MOH are of particular importance.

Health Status

13. **Remarkable progress had been made in improving child and maternal mortality.** The under-five mortality rate decreased from 43.1 in 1990 to 22.0 per 1,000 live births in 2011.[4] Similarly, the Maternal Mortality Ratio (MMR) declined from 90 per 10,000 live births in 1990 to 64 in 2010.[5]

14. **These important gains however are threatened by the emergency situation and financial crisis.** The decline in under-five mortality remains far from Millennium Development Goal (MDG) 4, which aims to have only 14 child deaths per 1,000 live births. Furthermore, the Palestinian territories had the smallest reduction in this rate compared to all Arab countries, and these rates are likely to increase after the casualties in Gaza.[6] Similarly, although the MMR is better than the regional average, it is more than twice the target value of 22.5 per 10,000 live births. Delivery procedures and the quality of services are partly responsible for the high mortality ratio.

4 UN, 2013.
5 UN, 2013.
6 World Bank. (2014). *Country engagement brief: Palestinian territories*. Washington, DC: World Bank.

15. **The conflict in Gaza profoundly impacted service delivery in the public sector and access to basic health services.** The emergency situation and difficulties in mobility have severely limited access to preventive care, including early screening and participation in health promoting activities. These conditions will likely increase morbidity rates due to late diagnoses and treatments of illnesses, which in turn will increase the costs of care. Significant accomplishments in public health are being undermined, and a number of key indicators are starting to slip backwards. Children and those with chronic conditions are particularly at risk.

16. **The PT are experiencing an epidemiological transition, with the burden of non-communicable diseases (NCDs) rising.** NCDs, mainly cardiovascular diseases, diabetes, and cancers, represent a substantial financial burden for the sector, as they are costly to treat and require more patient interaction with the health system. This disease burden has contributed to the increase in costs in the health sector and necessitates a greater focus on health prevention and integrated disease management.

Health Financing and Financial Protection

17. **The Palestinian health sector is at a critical crossroad.** The emergency situation has highlighted the untenable fiscal position of the sector. Factors including increasing OMRs, pharmaceutical expenditures, salaries, and the prevalence of NCDs requiring long-term and expensive treatments, coupled with uncertain foreign aid flows and apparent inefficiencies and duplications of services due to the current situation, have all been undermining the sustainability of the health sector's financing. OMRs represent one of the most significant cost drivers that undermine the financial sustainability of the health sector. Furthermore, the MOH was unable to pay pharmaceutical companies, which created shortages of drug supplies and increased the costs of drugs. For example, hospitals in East Jerusalem did not receive their payment on time and were at risk of closure until the European Union paid €13 million in July 2013 to ensure continued access to specialized services.[7]

18. **Total health expenditures increased from 8.3 percent of GDP in 1995 to 13 percent in 2012**. In the period following the second Intifada, overall health expenditures continued to increase and averaged 11.5 percent between 2000 and 2007. In 2008, it reached 14.3 percent of GDP (the highest level in the last decade). Although total health expenditure has slightly declined since, it remains high at 12.3 percent in 2012 and is expected to increase as a result of the recent hostilities in Gaza. Between 2000 and 2012, per capita health expenditures increased from about US$125 (in current US$) to almost US$294 (See Annex 7 for further information on health financing in the Palestinian territories).

19. **A large part of health expenditures are financed through Out-of-Pocket (OOP) expenses**. In 2012, households' OOP expenditure accounted for 39.8 percent of the total health

7 Center, E.N.I. €13 million to East Jerusalem Hospitals to provide specialized health services to Palestinians. 2013 [cited 2014 September 18]; Available from: http://www.enpi-info.eu/medportal/news/latest/33739/%E2%82%AC13-million-to-East-Jerusalem-Hospitals-to-provide-specialized-health-services-to-Palestinians.

expenditure, followed by general government spending (38.7 percent), non-profit institutions serving households (18.3 percent), and other external sources (0.9 percent). A 2006 study indicated that more than 13 percent of individuals fell into poverty and another 13 percent fell into extreme poverty due to healthcare expenses. In addition, the poorest groups bear a higher relative share of OOP expenditures compared to their total income and are at the greatest risk of impoverishment due to health spending.

20. **Aside from OOP expenditures, the healthcare system has a segmented financing model that incorporates both tax-based and premium-based financing for different segments of the population.** There is no separation of functions in the Palestinian health system: the MOH is the payer, provider, and regulator of the health sector. The MOH receives its revenue from tax revenues and external donors and investors, and it delivers health services in government facilities through cost-sharing under the Government Health Insurance (GHI) scheme. The MOH also purchases tertiary care for services abroad when the needed medical services are not available in the territories.

21. **Expenditures on OMRs have risen sharply over the last ten years.** The referral system caters to all Palestinians seeking care in the public sector regardless of their insurance status, with the Government bearing the cost of referrals (i.e., one can easily join the GHI for a small fee and have access to the referral system). The number of referrals has increased from 8,123 in 2000 to 61,635 in 2013 and by 36 percent between 2010 and 2011 alone. The corresponding expenditure has also increased significantly from about US$8 million in 2000 to as much as US$144 million in 2013.[8] There are multiple reasons for the increase in the number of referrals, including a lack of resources within the MOH facilities (including a lack of pharmaceuticals, inadequate equipment, and an insufficient number of medical personnel), the increase in the prevalence of NCDs, inefficiency of service delivery, and potential corruption.[9] The Government has, to its credit, shown a strong willingness to tackle these issues and taken some recent steps in this direction, including reforms of the referral approval process (See Annex 8 for further details on OMRs in the Palestinian territories).

22. **The imbalance between the GHI revenues and public expenditures on health is growing.** The GHI scheme was originally designed to provide additional funding for the MOH expenditures. However, in 2000, public expenditure on health was US$125 million, while GHI revenues were US$35 million. By 2009, public expenditure on health reached US$346 million, while GHI revenues declined to about US$23 million. Since 2009, the gap between GHI revenue and public expenditure on health has been widening as the GHI revenues have not been able to match the increase in public expenditures on health. In 2012, public expenditures on health

8 World Bank. Technical Assistance on Health Financing; Report on the analysis of referral data. June 2013.

9 Evidence for corruption is anecdotal: a United States Agency of International Aid (USAID) analysis has revealed that referrals to Israel peaked under a previous head of referrals; there is anecdotal evidence of middle-men facilitating referrals, particularly to Israeli hospitals, for fees; there is some evidence of physicians referring patients to their own private practices; there is possibility that VIPs are using the referral system to receive very high-cost treatments outside of the country; and the same USAID analysis revealed that over 50% of bills from Israeli hospitals examined are referrals that were either not authorized or expired.

reached about US$488 million and GHI revenues were around US$31 million, undermining the sustainability of health financing.[10]

23. **The nature of the emergency situation that prevails in the West Bank and Gaza's health sector today is complex and multi-faceted.** It is the result of a range of factors, including: (i) the immediate impact of direct conflict in damaging human and physical assets, facilities, and infrastructure; (ii) a severe and prolonged economic downturn with few immediate prospects for recovery (accompanied by high rates of unemployment and very limited levels of new private investment); (iii) a derailed peace process; and (iv) an unraveling of some of the critical donor assistance and support structures as well as aid flows. Such circumstances might best be characterized as an "acute-on-chronic" disaster.[11]

D. Higher Level Objectives to which the Project Contributes

24. **The proposed project aligns with the World Bank Group's Assistance Strategy for the West Bank and Gaza (AS) for FY15–16 (R2014-0231/1), which was discussed by the Board on October 30, 2014. It is based on the World Bank's recent 2013–2018 Middle East and North Africa (MENA) Health, Nutrition and Population Strategy, which focuses on fairness and accountability as key priority areas for the World Bank's engagement in the region[12].** In line with the first pillar of the AS, the project would directly support the PA's efforts to strengthen institutions in order to efficiently manage public finances and ensure services to citizens: "The National Development Plan (NDP) prioritizes the development of a health insurance system to generate sustainable financing of the health sector" (paragraph 68, page 20). In addition, the first pillar of the AS highlights health expenditure as a key area of engagement that aims to strengthen public institutions that ensure services to citizens. The AS notes that "the proposed program will help create increased fiscal space that will allow the PA to generate enough financial resources to fund public services. Bank assistance will concentrate on revenue and expenditure management in general, with a special focus on improved management of health and electricity sector expenditures." In addition, the immediate needs resulting from the recent conflict in Gaza for additional health financing will be addressed. As such, the project is consistent with the World Bank Group's twin goals of ending extreme poverty and boosting shared prosperity and with MENA's Regional Strategy, supporting the pillars of ensuring economic and social inclusion and strengthening governance.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

10 Palestinian Central Bureau of Statistics (PCBS), Ramallah (2014). *National Health Accounts*
11 Paul Farmer. Haiti After the Earthquake. Public Affairs
12 Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa, The Word Bank Health, Nutrition and Population Sector Strategy for MENA (2013-2018); link: www.worldbank.org/mena/health-strategy

25. The Project Development Objective (PDO) is to support the Palestinian Authority in securing continuity in healthcare service delivery and building its resilience to withstand future surges in demand for effective healthcare coverage.

26. The proposed emergency operation will potentially impact several key priorities for the Palestinian health sector. First, the immediate needs resulting from the recent conflict in Gaza for additional health financing will be addressed. Second, the fiscal health of the health system will be strengthened by rationalizing OMRs, which are the main reason behind the arrears and deficit. These measures will pave the way toward increased donor confidence and thus financial support for effective health coverage in the medium term, while also supporting the Government's own sectoral organization and strengthening the MOH's ability to be the steward of the entire health sector, including NGOs and private facilities.

27. The proposed Project would support meeting the immediate and emergency needs of the Palestinian healthcare system by bolstering the PA's initiatives to provide basic health services. The fiscal health of the system will also be addressed by containing costs and improving equity and fairness in the distribution of limited resources. In addition, the project aims to support the MOH's efforts to rationalize the healthcare system to ensure the sustainability of its interventions. More specifically, the project proposes to develop a Referrals Reform Master Plan, which would include the roles of all stakeholders in the reform and how they can each fully implement their actions during the project. The project also proposes, in the first phase (during the project) to develop a roadmap to Universal Health Coverage (UHC); however, components of the UHC reform such as the Independent Purchasing Agency and Basic Package(s) of activities will be developed in the context of referrals first.

28. More specifically, the proposed Project aims to achieve the following key results:

(i) Immediate needs addressed, including provision of fuel, cleaning, and catering services for hospitals in Gaza.
(ii) The total cost of referrals reduced (compared to the current trend line).
(iii) Referral protocols and procedures for the ten costliest conditions defined and rendered operational.
(iv) Contracting arrangements initiated with healthcare providers.
(v) Strengthened public capacity to provide some referred services.
(vi) Autonomous Purchasing agency established, staffed, and operational.
(vii) A basic package of services for referrals defined and costed;[13] for GHI, packages for different beneficiary groups defined.

B. Project Beneficiaries

13 The GHI law stipulates that enrollees are entitled to a wide range of benefits including maternal and child health services, primary health care, prescription drugs and school health services. On the other hand, the GHI law does not explicitly include inpatient services within the benefits package. The explicit exclusions in the GHI law consist of expensive transplant operations with the exception of kidneys and corneas, *in vitro* fertilization services, prosthetics, eye glasses and cosmetic surgery. Lastly, the GHI stipulates that all health services from non-MOH service providers, namely hospitals located in East Jerusalem and in Egypt, Jordan and Israel, are included in the benefits package.

29. The project beneficiaries are the Palestinians in Gaza who are in need of immediate, emergency health services. In addition, the project will support populations in the West Bank and Gaza who benefit from the healthcare system and are the beneficiaries of the various GHI schemes. The Project will also support policymakers, health professionals, and technical staff within the MOH through the provision of capacity building, training, and technical assistance.

C. PDO-Level Results Indicators

(i) Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa and Rafedia[14] do not deteriorate or improve up to 10 percent compared to a baseline end-September, 2014 (trends in hospital utilization are a proxy for the impact of the project on access to health services).
(ii) The total cost of referrals reduced by 15 percent relative to baseline.
(iii) Gap in geographic equity for referral cost (between the West Bank and Gaza) reduced by 80 percent relative to baseline.

III. PROJECT DESCRIPTION

30. The focus of the proposed Project is to support the immediate emergency needs of the health sector. Secondly, the Project aims to strengthen the fiscal condition of the health system by rationalizing OMRs, which are the main reason behind the arrears and deficit. The project will support the development of functional arrangements for public health coverage and medical referrals, including capacity building to the MOH with a particular emphasis on strengthening resilience in the MOH's healthcare provisions in order to ensure the sustainability of these interventions. Overall, the Project's components, which address immediate sector needs (Component 1), rationalizing OMRs (Component 2), and supporting health coverage (Component 3), will deliver a clear set of actions that the Government can take to address the current health system crisis as well as respond to the needs of the population. The proposed Project aims to help the MOH to implement policy findings and recommendations from recent analyses, including a Public Expenditure Review, a Dual Practice study, Health Insurance analysis studies, and OMR studies supported by the World Bank along with several analyses conducted by other donors (e.g., the United States Agency of International Aid (USAID), World Health Organization (WHO), European Union (EU), UK Department for International Development (DFID), Italian Development Cooperation (IDC)-Italy, Swiss Development Cooperation (SDC)-Switzerland, Norwegian Agency for Development Cooperation (NORAD), and others) on clinical protocols, the contracting of hospitals, the Health Information System (HIS), and protocols of medical conditions.

A. Project Components

Component 1: Emergency and Rapid Response Window (US$2.0 million)

31. In the aftermath of the Gaza crisis, an enormous set of needs emerged due to health sector damages and losses and, therefore, there is a funding gap. Currently, there are serious disruptions

[14] These are the main and largest hospitals in Gaza and the West Bank.

in the healthcare system due to significant power outages and the lack of fuel for generators, which negatively impacts the daily operations of healthcare facilities and ambulance services. Additionally, due to the huge and cumulative debts of the MOH, providers for hospital cleaning and catering services have suspended their operations as of October 2014. The lack of sanitation, sterilization, and hygiene at hospitals has had severe consequences for public health and increased the risk of infections and outbreaks of communicable diseases.

32. This emergency window will help close a portion of this gap and fund much needed recurrent expenditures. Health sector facilities in Gaza are in great need of these resources, as they require adequate provisions of fuel and other basic necessities to ensure the operational continuity of hospitals under the direst circumstances, such as the prolonged power outages coupled with the MOH's budgetary crisis.

33. The aim of this component is to provide timely and targeted interventions to deal with urgent needs and thus help mitigate further deterioration in the delivery of essential health services; it aims to ensure the continuation of basic healthcare services at minimum acceptable levels and avoid such services from experiencing systemic collapse.

34. This component will provide support to the MOH for the delivery of essential health services through the financing of recurrent non-medical expenditures of MOH and health facilities. This approach may be usefully looked at as a complementary strategy to prevent any further collapse in health service provision and at the same time to minimize the cost of OMRs. It offers the opportunity to meet immediate and urgent needs, but it does not provide the necessary predictability of more sustained support that is needed in a protracted crisis.

35. This component covers the following expenditures: Non-medical recurrent expenditures (US$2 million): non-medical costs of operating and maintaining MOH facilities covering (i) fuel costs for hospital generators and ambulance services; (ii) hospital cleaning services and cleaning materials; and (iii) catering services for hospitals.

Component 2: Rationalizing Outside Medical Referrals (US$3.5 million)

36. The ability of the PA to respond to the current crisis is seriously hampered by its fiscal situation. The degradation in health infrastructure and the increase in health needs arising from the crisis are putting additional pressures on a medical referral system that is already in severe debt, and is inequitable and unsustainable. The aim of the project is to first mitigate the immediate impact of this situation on the health sector and, secondly, to take the actions necessary to improve the resilience of the system in the longer term in order to ensure the system's sustainability and resilience to future potential shocks.

37. To address the emergency situation, the project proposes to support the PA to institute immediate cost-cutting measures in order to improve efficiency in the current system without compromising access to needed and quality health services. Two short-term actions are proposed; the first is (i) Rationalizing Contracts with Outside Providers. More specifically, the Project will support the MOH to review and revise an initial set of contracts and arrangements with providers outside of the public system that account for a large portion of avoidable cost. In

addition, the second is (ii) Guidance notes for referrals will be developed to determine a clear set of rules for treatment and referral for selected health conditions, including indications for referral and treating hospitals.

38. In the short- to medium-term, a set of actions are proposed to ensure the sustainability of the referrals system specifically and the health sector generally. This includes the (i) Referrals Master plan, which will unite stakeholders working on different components of referrals reform toward supporting a common MOH plan. In addition, the (ii) Contracts with Outside Providers will involve the MOH rationalizing all contracts with providers outside the public system in the medium-term in order to ensure that services are purchased based on quality as well as on contracts that are fair and rational across a selected number of hospitals providing the services purchased. Lastly, there will be (iii) Health systems strengthening, which will involve strengthening the Referrals Information system (RIS) and the strategic purchasing of equipment to bolster the public provision of certain services.

Component 3: Supporting Health Coverage to Strengthen Sector Resilience (US$2.0 million)

39. Fragmentation and financial unsustainability of the health system have severely hampered the ability of the MOH to deal with the current crisis. Ensuring sustainability and building resilience entail immediate actions to rationalize coverage while improving quality.

40. Fragmentation of the healthcare system leads to poor quality of services, high OOP expenditures, especially in poor populations, and low accountability and transparency of payments to providers. The PA is committed to making changes to improve the resilience of the health system through the phased establishment of a national health coverage scheme that the project will support with extensive technical assistance activities. These changes will re-define changes in the financing, stewardship, and provision of roles at the MOH, strengthening the first two roles and gaining efficiency in the later by taking into account the relative comparative advantages of the private healthcare providers at the secondary and tertiary levels through the development of partnership arrangements and contracting out healthcare services.

41. While addressing immediate, emergency cost-drivers, the project will define a roadmap to UHC for the Palestinian territories with a detailed calendar and planned actions in order to enhance the supply capacity to deliver needed services, reducing system losses and ensuring better quality of services to targeted populations.

42. Areas to be covered include: (i) defining the enrollment criteria and options; (ii) specifying the benefit package of healthcare services, including the costing of services as well as a criteria to include and exclude services in the package; (iii) establishing provider payment options for primary and hospital care; (iv) developing strategies for covering the informal sector; and (v) establishing an independent pooling and purchasing agency to separate financing, pooling, and purchasing functions from service provision. This agency will be autonomous and staffed with qualified staff according to agreed TORs.

Component 4: Project Management and Capacity Building (US$1 million)

43. This component finances costs related to project management and capacity building efforts, including (i) short-term consultancies to support the management capacity of the MOH in the areas of procurement, financial management, and monitoring and evaluation; (ii) the provision of technical assistance and training to improve the capacity of the participating MOH units, cadres, and service providers; (iii) provision of essential equipment; (iv) project operating costs; and (v) external financial audits.

B. Project Financing

Lending Instrument

44. The Project is being processed as an Investment Project Financing (IPF), under paragraph 12 of Operational Policy (OP) 10.00 (Situations in Urgent Need of Assistance or Capacity Constraints), where the "Urgent need of assistance because of a natural or man-made disaster or conflict," which includes both "conflict-affected" and "post-conflict" situations, is required to help the MOH address its alarmingly high spending on OMRs despite the PA's serious budgetary constraints. Addressing system inefficiencies will therefore enable the MOH attend to the emergency needs in the PT, in particular after the recent conflict in Gaza which has substantially impacted the already compromised sector overall.

45. The project will be financed through a US$8.5 million Special Financing Grant from the Trust Fund for Gaza and the West Bank.

Project Cost and Financing

Project Components	Project cost (US$ million)	Special Financing (US$ million)	% Financing
1. Emergency and Rapid Response Window	2.0	2.0	100%
2. Rationalizing Outside Medical Referrals	3.5	3.5	100%
3. Supporting Health Coverage to Strengthen Sector Resilience	2.0	2.0	100%
4. Project Management and Capacity Building	1.0	1.0	100%
Total Costs			
Total Project Costs	8.5	8.5	100%
Front-End Fees			
Total Financing Required			

C. Lessons Learned and Reflected in the Project Design

46. The design of the project was informed by the lessons learned from the implementation of previous Bank engagements in the health sector, including the Emergency Services Support Program and a series of analytical and advisory services implemented over the past few years. Accordingly, the design of the proposed project has been kept simple, focusing on a few critical activities which are deemed achievable in a relatively short timeframe, will provide quick impacts, and will be in line with the Bank's previous technical assistance (TA) recommendations. These activities will also provide reliable information concerning on-the-ground realities and a

better understanding of the underlying causes of these conditions in order to inform the design of medium to longer term reform strategies.

47. The project also takes into account lessons learned from other similar projects in fragile and post-conflict countries, including: (i) ensuring a robust understanding of country context and dynamics; (ii) providing adequate funding and a road map for capacity building as well as expected activities upfront; (iii) remaining flexible in order to respond to the dynamic situation on the ground; and (iv) focusing on harmonization of donors' work relating to governance and reforms.

48. The introduction of new management systems and reform options should be undertaken incrementally at a pace that permits the institutional structure to absorb and integrate the new systems before moving to the next step. The project will support the implementation of relatively basic management systems and reforms, while postponing the introduction of more complex systems to a later phase.

49. A key lesson from working in the West Bank and Gaza is to keep in close coordination with other donors and to develop approaches to which other donors can contribute additional funding. In this project, there is room for other donors to finance similar complementary activities in parallel. Hence, special attention was given to ensuring that the activities included in the project are closely coordinated with and complementary to the inputs from the other donors in the sector, notably USAID, DFID, and WHO. A technical steering committee has been formed to oversee the technical aspects of project implementation and will keep all stakeholders informed of the implementation progress.

50. When introducing reforms, such as the contracting for tertiary services under an emergency-type operation, there is a need to assess capacity issues as well as the feasibility of the contracting mechanism used. Under the Third Emergency Services Support Project, which closed in 2011, contracts with local NGOs and private institutions providing tertiary healthcare services that could not be provided by public facilities were awarded competitively, following requests for proposals. However, there were deficiencies at the bidding stage where hospitals were asked to bid on selected treatment procedures, separating diagnostic and treatment services. This situation made it difficult for the MOH to continue using the same contracting mechanism when dealing with life threatening or emergency cases. Therefore, at the project's end, the MOH reverted to the old mechanism of awarding contracts on a direct contracting basis. The proposed Project aims to set proper and cost effective contracting arrangements, taking into consideration emergency situations, mobility and access restrictions, and quality assurance standards.

51. Under a complex emergency situation, it is beneficial to have the Task Team based in the field to ensure continuous dialogue, oversight, and monitoring. Likewise, close supervision and flexibility to respond to urgent needs and changing requirements through reallocation of resources are important to ensure that the program remains responsive to the emergency situation. To ensure close implementation support and effective project monitoring, the Bank team will be based within the West Bank and Gaza country office. This will enable clients to have easy access to the Bank team whereby implementation issues can be identified early on, and thus, the Bank will be able to respond quickly.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

52. The MOH will be the implementing agency responsible for project implementation and will have the primary responsibility for all technical, operational, and fiduciary aspects related to the project. The MOH's technical and implementation capacity was assessed by the Bank and deemed satisfactory to implement the project.

53. The Project will rely on the MOH's existing organizational structure, including the involvement of its various departments related to medical referrals, health insurance, procurement, and financial management. The various development partners engaged in health financing reforms (USAID, WHO, and DFID) will continue to play a prominent role in building the MOH's capacity to implement various elements of the envisaged reforms, including health system strategic planning, efficiency improvements, and the rationalization of health sector expenditures.

54. A Project Management Unit (PMU) comprised of a Project Coordinator, Procurement Specialist, Financial Management Specialist, and Administrative Assistant will be formed to help implement the project. A Management Information System (MIS) Specialist and a Public Health Specialist will also be recruited at a later stage of the project implementation. The PMU will be onboard prior to project effectiveness and will be responsible for: (i) management of the fiduciary aspects of the project, including financial, procurement, and disbursements; (ii) preparation of periodical project progress reports (technical, financial, and procurement) with inputs from the implementing entities represented in the technical steering committee; (iii) monitoring output, outcomes, and impacts of the project, and (iii) preparation of annual work plans and budgets for review and approval by the Steering Committee (SC). The PMU staff will be familiar with Bank fiduciary and implementation procedures and will closely coordinate efforts with MOF and other stakeholders involved in the sector.

55. A technical SC has been established to ensure full alignment of activities with the MOH's strategies and policies and to facilitate linkages between the various units within the MOH and also with MOF and service providers. The SC is comprised of key MOH officials, chaired by the Health Minister and includes the different entities that will be directly responsible for the implementation and supervision of the project. The committee will closely coordinate with key stakeholders including the World Bank, USAID, WHO, Norwegian Agency for Development Cooperation (NORAD), civil society organizations, and NGOs.

B. Results Monitoring and Evaluation

56. Overall project monitoring and evaluation will be the responsibility of the PMU. The PMU, supported by the various MOH departments, will manage data collection, aggregation and periodic reporting on the project's implementation progress, and will monitor closely the project's key performance indicators. The Results Framework includes project specific and core sector indicators (see Annex 1).

C. Sustainability

57. The financial sustainability of the healthcare system remains a challenge. The MOH financing gap is increasing, due to changes in GHI revenues and the uncertainty of international aid. Expenditures resulting from outside referrals have been increasing. Tax revenues have been falling resulting in a limited fiscal space through which to bridge the financing gap of the GHI. Given the macroeconomic conditions and fiscal constraints, these levels of spending were deemed unsustainable.

58. The PA will therefore, need to shift its policy to one that emphasizes cost containment, rationalizing the investments, introducing appropriate cost-containment and quality assurance measures, and strengthening the planning and management of scarce resources, including better coordination and sharing of resources with the private and NGO providers.

59. This project is expected to improve the overall fiscal sustainability of the sector through the implementation of efficiency and equity measures and through more effective and transparent processes. The MOH will also have a greater ability and capacity to ensure that these processes are implemented and monitored. This will therefore improve the overall technical stewardship over the health financing functions and ensure increasing cost-containment within the existing fiscal envelop.

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Risk Category	Rating
Project Stakeholder Risks	High
Implementing Agency Risk	
- Capacity	High
- Governance	High
Project Risk	
- Social and Environmental	High
- Program and Donor	High
Delivery Monitoring and Sustainability	High
Other	
Political	High
Overall Implementation Risk	High

B. Overall Risk Rating Explanation

60. The risk ratings are high because of the challenges faced in terms of the wider context of healthcare reform in the Palestinian territories. For instance, the needed health insurance reforms require legislative endorsements, coordination between the various stakeholders, and a stable environment that enables these reforms. The MOH also has an insufficient capacity to implement the reforms because of budget constraints, limited technical capabilities, and fragmentation of the healthcare system between the West Bank and Gaza. (See the Operational Risk Assessment Framework (ORAF) in Annex 4 for more details). However, it is important to note that despite these challenges, there is high-level support to undertake major health sector reforms, and the PA is indeed moving in this direction. Thus, the proposed project would provide needed support to the PA during this important window of opportunity for advancing healthcare reform in the territories. Additionally, because of the uncertainties created by the external environment and the risks inherent in operating with limited institutional capacity, the PA, assisted by the World Bank and development partners, needs to implement a detailed communications strategy. The strategy should be accompanied by a public information function that keeps the general public informed of the initiatives underway and manages expectations.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

61. The project components are directly and strongly aligned with the World Bank's twin goals of ending extreme poverty and boosting shared prosperity. Furthermore, they are directly aligned with the HNP Global Practice's orientation towards Universal Health Coverage—to ensure that all Palestinians obtain the health services they need without suffering financial hardship when paying for them.

62. Overall, the project components are by definition in the public sector. The emergency response covers immediate sector needs required for the functioning of the health system. It is the public sector's role to provide organization, rules, and stewardship for the insurance sector and for referrals. The project aims to reduce costs related to referrals while ensuring that the Palestinian population receives the tertiary services they need in a manner that is costed, prioritized, and based on clear rules. The project aims to achieve a 40 percent reduction from the trend-line (a 15 percent reduction from the 2013 baseline) in referral costs, resulting in cost-savings over the lifetime of the project of US$198 million over projected costs in the absence of the project. This projection is based on an assumption of limiting international referrals to conditions not treatable within the Palestinian system (with a clear gatekeeping function for the Palestinian centers of excellence), reducing unnecessary referrals, and rationalizing the contracting with all outside providers.

63. The World Bank has a long engagement in the health sector, globally and in the Palestinian territories, supporting the PA and MOH through technical assistance. The World Bank brings global experience and expertise in the field of health financing and health insurance, and is a

global leader in UHC. The Bank has unique expertise in coordinating the complex set of interventions that comprise the Government's plan for referrals and health insurance and can provide the technical and financial support required to achieve key program goals. This includes dialogue with the MOF to ensure that the program is adequately funded to ensure that the resources required to achieve targets are available.

B. Technical

64. Although the West Bank and Gaza (WBG) population enjoys a good overall health status relative to other countries at comparable levels of income, maintaining the level of healthcare in the face of a rapidly growing population, deteriorating economic conditions, and an uncertain political climate present a major challenge to the PA. Overall, health spending in WBG accounted for nearly 13 percent of the GDP in 2013—a very high spending rate for WBG's level of income—which may not be sustainable under the deteriorating economic conditions. Given the tight fiscal constraints in the medium-term, the PA is also unlikely to sustain the present pace of government service expansion. The PA will therefore, need to shift its policy to one that emphasizes cost containment and the improved management of scarce resources, including better cooperation and sharing of resources with the private/NGO sector. A series of short and longer term reform options have been laid out in order to achieve efficiency gains, ranging from improving the MOH contracting processes to adopting various cost containment strategies. At this phase, the proposed Project aims to tackle the short- to medium-term interventions while the longer term reform options will be deferred to the next phase of Bank assistance.

65. The Project design was guided by the country's priorities and includes: (i) support to selected vulnerable populations; (ii) development of a benefits package; (iii) development of enrollment criteria; (iv) development of payment mechanisms; (v) functioning of a purchasing autonomous agency; (vi) strategic investments and technical assistance for capacity building; (vii) improvements in the referral process in hospitals and strengthening healthcare networks; and (viii) support to the MOH efforts for the separation of their roles in purchasing and provision.

66. The Project will be complemented with parallel activities funded by donor partners. The PA acknowledges the importance of conducting health sector reforms to reduce system losses and increase equity, accountability, and quality of services. All these actions are expected to improve the health results of women, children, youth, refugees, and the poorest populations.

C. Financial Management

67. The MOH PMU will be in charge of managing the financial aspects of the Project in close collaboration with the MOF Financial Management (FM) team. The Project funds will be provided by the World Bank and disbursed through a new U.S. Dollar Designated Account (DA), opened by the MOF at the Bank of Palestine in Ramallah, West Bank and will be managed by the MOH PMU. More information on financial management and disbursements is included in Annex 3.

D. Procurement

68. Procurement of goods will be carried out in accordance with the "Guidelines: Procurement under the International Bank for Reconstruction and Development (IBRD) Loans and the International Development Agency (IDA) Credits" published by the Bank in January 2011 and revised July 2014, and the selection of consultants will be carried out in accordance with the "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" published by the World Bank in January 2011 and revised July 2014, the Grant Agreement and the Procurement Plan approved by the Bank. Non-medical recurrent operating expenditures to be financed under the emergency rapid response window and other project incremental operating costs shall be procured in accordance with MOH contracting and administrative procedures, acceptable to the Bank. "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants," dated October 15, 2006 and updated January 2011, shall apply to the Project. The overall responsibility for the implementation of project procurement will rest with the MOH, through the PMU, which will manage the procurement process, in coordination with the respective MOH departments. MOH procurement and contract management capacity, in particular for consultants' services contracts, is limited. Therefore, an experienced procurement specialist will be hired within the PMU to support the MOH in handling project procurement.

69. Given the nature of the project, which entails the interaction of various stakeholders, coordination and decision-making may become a challenge that may delay project procurement and implementation. Additional challenges may be imposed by the attendant technical complexity and capacity limitations in the targeted areas/fields as well as potential opposition by those benefiting from maintaining the status quo. Within this context, an adequate and realistic sequencing and prioritization of actions would be critical. A procurement plan dated December 10, 2014 for the first 18 months of project implementation was prepared and agreed with the Bank. It is summarized in Annex 3.

E. Implementation Support by the World Bank

70. The implementation support plan has been defined and confirmed during appraisal. The core task team, including the Task Team Leader (TTL), fiduciary staff, Information Technology (IT) Specialist, Country Economists, and Governance and Public Financial Management Specialist, are all based in the country office and therefore, close supervision and implementation support to the MOH will be ensured. In addition, full coordination and harmonization of efforts with all development partners will be conducted. The Bank will also provide continuous technical support through Headquarters (HQ)-based staff to deal with more specialized topics, such as health insurance reforms, costing and benefit packages, contracting mechanisms for medical referrals, and other related topics. Additionally, the technical assistance provided by the World Bank will continue to develop the MOH's institutional capacity to ensure sustainability of the proposed reforms. The implementation support plan is included in Annex 3.

F. Social

71. Health is considered a human right in the Palestinian territories. The right to healthcare is guaranteed for the entire population in the Palestinian Constitution.

72. Quality of services in the public sector is generally a major concern and priority, particularly in the Gaza Strip. High rates of mortality and infection in hospitals are coupled with low satisfaction among users. However, there are no effective grievance or redress mechanisms. Although responsiveness is perceived to be better in the private sector, little is known about quality of care and regulation of the private sector. In addition, partially driven by the blockade, there is a steady degradation of the Gaza health system and deterioration of the quality of care is increasing there. Health workers are unable to access continuous training education; maintenance of medical equipment is severely hampered by restrictions on importing spare parts; and electricity cuts make operations difficult and negatively affect the functioning of health facilities.

73. The MOH will likely encounter pressures when revising the current health insurance schemes including removing beneficiary households or individuals who will no longer be eligible for free health insurance. As of 2010, OOP expenditure accounts for approximately 40 percent of total health expenditures, which may further burden the marginalized and poor. In fact, the poorest groups bear a higher share of OOP expenditure compared to their total income and are at the greatest risk of impoverishment due to health spending. In addition, utilization of referral services is unequal across governorates and across the different insurance schemes, which suggests inequities in access to these services. These inequities are mostly related to the low performance of the health system due to its fragmentation, limited access and distances to health facilities, and other mobility restrictions.

74. The MOH acknowledges the social challenges in the sector, and it is making all necessary efforts with key stakeholders, including other PA ministries (e.g., the Ministry of Social Affairs and the Ministry of Labor), local NGOs, and developments partners, in order to ensure adequate coverage of the poor and equitable access within the health system. Additionally, the MOH will continue the consultation process with beneficiaries and civil society organizations in order to make sure that the healthcare system sufficiently covers the poor and marginalized as well as ensures equity within the system. The Project will aim to strengthen the implementation of its monitoring and evaluation framework and to guarantee equitable access to the healthcare system for all.

Gender Mainstreaming

75. Access to healthcare is limited for women in vulnerable communities. Restrictions on movement and on access continued to impede utilization of healthcare, more particularly for women in area C,[15] in the seam zone,[16] and in the Gaza Strip. The WHO tracks equity aspects for the medical referrals in Gaza on a monthly basis. There is evidence of unequal access to referrals by gender. The gender gap in Gaza in terms of OMRs is 59.6 percent for male patients versus 40.4 percent for female patients.[17] Besides, micronutrient deficiencies remain a concern, with

15 Area C is the portion of the West Bank under full Israeli civil and security control and covers over 60% of the West Bank.
16 The "seam zone" is the closed area between the Green Line and the separation barrier in which about 11,000 Palestinians currently reside.
17 WHO monthly report, October 2014.

high levels of anemia as well as vitamin A and D deficiencies, recorded for girls, boys, and pregnant women. 35.6 percent of pregnant women in Gaza suffered from anemia.[18] The MMR remains high due to delivery procedures, maternal nutrition, and poor quality of services.[19] Furthermore, the rate of caesarean sections has doubled in the last decade, reaching 20 percent. A recent study suggests that in the Palestinian territories, the risk of death from caesarean sections is 6 times higher than a normal delivery, due to suboptimal operating conditions, lack of training, poor follow-up and preventive care.[20]

76. The core sector indicator "Number of beneficiaries, percentage of which is female" has been added to the intermediate indicators and will be closely monitored under the project. This will be accompanied by a communications strategy on Universal Health Coverage that would be developed under the project, including series of consultation workshops with the various stakeholders. Additionally, a Grievance and Redress Mechanism (GRM) for OMRs and access to Healthcare will be developed and monitored under the project.

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G. Safeguards

77. No environmental or social safeguards are triggered.

H. Exceptions to or waivers of Bank policies

78. The Project does not involve any exceptions to or waivers of Bank policies.

18 UNRWA 2012

19 PCBS, On the Eve of the International Population Day, 2012, PCBS: Ramallah, Palestinian territories.

20 AbdulRahim, et al., *Maternal and* child *health in the occupied Palestinian Territory.* Lancet, 2009. **373**(9667): p. 967-977.

Annex 1: Results Framework and Monitoring

West Bank and Gaza: Health System Resiliency Strengthening Project

Project Development Objective (PDO): The Project development objective (PDO) is to support the Palestinian Authority in securing continuity in healthcare service delivery and building its resilience to withstand a future surge in demand for effective healthcare coverage.

PDO Level Results Indicators*	Core	Unit of Measure	Baseline	Cumulative Target Values**					Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (indicator definition etc.)
				YR 1	YR 2	YR3	YR 4	YR5				
Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa and Rafedia do not deteriorate or improve up to 10% compared to a baseline end-September, 2014		Percentage	Shifa occupancy: 89% - Rafedia occupancy: 85% Obstetrics Shifa:76% Rafedia: 94% Outpatient Shifa: 578,646 Rafedia: 163,262	Same ratio as baseline or improve up to 10%	Same ratio as baseline or improve up to 10%	Same ratio as baseline or improve up to 10%	Same ratio as baseline or improve up to 10%	Same ratio as baseline or improve up to 10% above	biannually	MOH/Shifa and Rafedia hospitals	MOH	Monitor trends in hospital utilization as a proxy for the impact of the project on access to health services
The total cost of referrals reduced by 15% (by end of the project) relative to baseline		US$m	144	150	152	145	135	120	biannually	MOH	MOH	Total value of referral cost
Gap in geographic equity for referral cost (between the West Bank and Gaza) reduced by 80 percent relative to baseline		Ratio of expenditure per population	1.7:1	1.6:1	1.5:1	1.35:1	1.27:1	1.15:1	biannually	MOH	MOH	Ratio
INTERMEDIATE RESULTS												
Intermediate Result (Component One): Emergency and Rapid Response Window												
Utilization rates (overall occupancy) in the hospitals of Shifa, Nasser Hospital		Percentage	Shifa occupancy: 89% - Nasser occupancy:	Same ratio as baseline or improve up to 10%	Same ratio as baseline or improve up to 10%	Same ratio as baseline or improve up to 10%	Same ratio as baseline or	Same ratio as baseline or improve up to 10%	biannually	MOH/Shifa, Nasser and European Gaza	MOH	Monitor trends in hospital utilization as a

and European Gaza Hospital improve by up to 10% or retain the same ratio compared to a baseline end-September, 2014			74% European Gaza Hospital: 79%				improve up to 10%	above		hospitals		proxy for the impact of the project on access to health services
INTERMEDIATE RESULTS												
Intermediate Result Indicators (Component Two): Rationalizing Outside Medical Referrals (OMRs)												
Referral protocols and procedures for the ten costliest conditions defined and rendered operational		Number (of conditions)	N/A	For 2 conditions	For 5 conditions	For 6 conditions	For 10 conditions	For 10 conditions	biannually	MOH	MOH	Number of conditions
A consolidated health information system (HIS) for referrals, billing and health insurance in both the West Bank and Gaza is fully operational		Text	0	Referrals and billing data bases linked for West Bank	Referrals and billing data bases linked for Gaza	Referrals, MOH finance and MOF have access to database in real-time	Web-based system operational in all hospitals taking referrals	Web-based system operational in all hospitals taking referrals	biannually	MOH departments: Referrals, Finance, and Health Insurance	MOH	Consolidated system
HIS operational in selected hospitals		Number of hospitals	0	1	2	4	6	10	biannually	MOH	MOH	System is operational
Health facilities constructed, renovated, and or/equipped	X	Number of health facilities equipped	0	2	3	5	5	5	biannually	MOH	MOH	Accumulated number of health facilities equipped
Direct project beneficiaries (no), of which female (%)		Number of users (%)	N/A	40%	43%	45%	50%	50%	biannually	MOH-PCDS//DHS	MOH	Utilization of services
Intermediate Result (Component Three): Supporting Health Insurance Reforms to Strengthen Sector Resilience												
New referral contracts negotiated with all outside providers		Accumulated number	0	20	<40	<40	Same <40	Same <40	biannually	MOH	MOH	Number of contracts renegotiated at the local level

Purchasing agency (either independent or part of the MOH) created, staffed, and made operational		Text	0	Completed	Functional	Functional	Function al	Functional	biannually	MOH/MOF/C abinet	MOH/MOF/ Cabinet	Completed all the arrangements and functions (implementing contracts)
People with access to a basic package of health, nutrition or reproductive health services	X	Percentag e	80	80	85	90	90	90	biannually	MOH/DHS	MOH/WHO//U NFPA	Number of people
Direct project beneficiaries (no), of which female (%)	X	Number and percentage	N/A	40%	42%	45%	48%	50%	biannually	MOH	MOH	Number and percentage
Intermediate Result (Component Four): Project Management and Capacity Building												
External audit (medical and financial)		Text	0	Established	Functional	Functional	Function al	Functional	biannually	MOH	MOH	
Health personnel receiving training	X	Number	0	100	150	200	300	500	biannually	MOH	MOH	Accumulated number of staff receiving training
Grievance and Redress Mechanism (GRM) for OMRs and access to Healthcare designed and fully operational by end of the project.		Text	0	Rapid Diagnostic Report on GRM prepared	GRM Manual Developed	GRM Database establishe d and piloted in two governora tes	GRM effective and scaled up to cover all MOH facilities	GRM fully operational	biannually	MOH	MOH	GRM system becomes fully operational by end of the project.
Communications Strategy on Universal Health Coverage (UHC) developed and consultation workshops with stakeholders conducted to promote the concept of citizens' engagement.		Text	0	Communic ations Strategy prepared	One consultation workshop conducted	One consultatio n workshop conducted	One consultati on worksho p conducte d	One consultation workshop conducted	biannually	MOH	MOH	At least one consultation workshop conducted annually and at least four cumulatively

Annex 2: Detailed Project Description

West Bank and Gaza: Health System Resiliency Strengthening Project (P150481)

The project seeks to support the Palestinian Authority (PA) in securing continuity in healthcare service delivery and building its resilience to withstand future surge in demand for effective healthcare coverage. This proposed project will support health sector initiatives led by the MOH to address the immediate needs of the health sector, including the proper functioning of hospitals and rationalizing the fiscal situation. This project will support improvements in public health expenditures through the establishment of sustainable regulatory, oversight, and institutional arrangements for referrals and healthcare coverage. These activities, along with the following phases of the Bank's engagement, with support from development partners, will continue to support the health sector in the Palestinian territories (PT) by focusing on scaling up the implementation of interventions to ensure sustainability while building up health sector resilience. More specifically, the project will finance the activities of four components, the main features of which are indicated below:

Component 1: Emergency and Rapid Response Window (US$2.0 million)

1. In the aftermath of the Gaza crisis, expected donor financing has not materialized in a timely manner and, therefore, there is a funding gap. Currently there are serious disruptions in the healthcare system due to significant power outages and the lack of fuel for generators which negatively impacts the daily operations of healthcare facilities and ambulance services. Additionally, due to the huge and cumulative debts of the MOH, providers for hospital cleaning and catering services have suspended their operations as of October 2014. The lack of sanitation, sterilization and hygiene at hospitals has had severe consequences for public health and increased the risk of infections and outbreaks of communicable diseases.

2. This emergency window will help close a portion of this gap and fund much needed recurrent expenditures. Health sector facilities in Gaza are in great need of these resources, as they require adequate provisions of fuel and other basic necessities to ensure the operational continuity of hospitals under the direst circumstances, such as the prolonged power outages coupled with the MOH's budgetary crisis.

3. The aim of this component is to provide timely and targeted interventions to deal with urgent needs and thus help mitigate further deterioration in the delivery of essential health services; it aims to ensure the continuation of basic healthcare services at the minimum acceptable levels and avoid such services from experiencing systemic collapse.

4. This component will provide support to the MOH for the delivery of essential health services through the financing of recurrent non-medical expenditures of the MOH and health facilities. This approach may be usefully looked at as a complementary strategy to prevent any further collapse in health service provision and at the same time minimize the cost of outside medical referrals. It offers the opportunity to meet immediate and urgent needs but it does not provide the necessary predictability of more sustained support that is needed in a protracted crisis.

5. This component covers the following expenditures: ***Non-medical recurrent expenditures (US$2 million)*****:** non-medical costs of operating and maintaining the Ministry of Health facilities covering (i) fuel costs for hospital generators and ambulance services; (ii) hospital cleaning services and cleaning materials; and (iii) catering services for hospitals.

Component 2: Rationalizing Outside Medical Referrals (US$3.5 million)

6. The ability of the PA to respond to the current crisis is seriously hampered by its fiscal situation. The degradation in health infrastructure and the increase in health needs arising from the crisis are putting additional pressures on the medical referral system, which is already in severe debt, is inequitable, and is unsustainable. The aim of the project is to first mitigate the immediate impact of this situation on the health sector and, secondly, to take the actions necessary to improve the efficiency and fairness of the system in the longer term as well as to ensure the system's sustainability and resilience to future potential shocks.

7. To address the emergency situation, the project proposes to support the PA in instituting immediate cost cutting measures and improving the efficiency of the current system, without compromising access to needed quality health services. The measures will additionally focus on rationalization and equity in order to ensure that available resources are shared among the Palestinian population in a manner that is fair and based on a transparent set of rules that are derived in a clear and evidence-based manner.

8. The immediate emergency actions to reduce the financial impact of referrals and limit corruption include:

(i) Contracts with Outside Providers (emergency context). The Project will support the MOH in reviewing and revising a set of current contracts and arrangements with providers outside of the public system. The focus will be on (a) providers outside of the national system to ensure that the set of procedures that will be compensated are well defined and (b) low-volume providers within the Palestinian national system to both ensure that the contracts are rational and to eliminate high-cost providers that are not needed. The project will generate a report based on available data and information and engage in immediate advocacy with the MOH, MOF, donor partners, providing facilities, and relevant national authorities to formalize the recommended actions. **(US$ 0.3 million)**

(ii) Guidance note for referrals. This note will be developed in order to establish a clear set of rules for treatment of and referral for selected health conditions, including ensuring that the referral process and hospital referred to are documented. The guidance note will cover: (a) a study of referral protocols by agreed conditions; (b) training of physicians and referrals committee members; and (c) the finalization and ratification of the referrals manual. **(US$ 0.5 million)**

9. In the short- to medium- term, a set of actions are proposed to ensure the sustainability of the referrals system in particular and the health sector more generally. Referral reform is a critical part of the health sector, and health insurance reform aims to increase the coverage of the

Palestinian population with better quality services, while ensuring financial protection, especially for the poorest. Rationalizing and ensuring the sustainability of the referral system involves increasing the efficiency of expenditures, reducing/eliminating expenditures to foreign hospitals, fostering systems that ensure equity and fairness in referrals, and addressing the underlying weaknesses in the public system leading to referrals, including quality and availability of services.

10. The short- to medium- term actions to ensure the sustainability and resilience of the referrals system include:

(i) Referrals Master Plan. The Referrals Master Plan will unite stakeholders working on different components of referrals reform toward supporting a common MOH plan. It will outline areas and strategies for reform, roles of development partners and stakeholders as well as targets and timelines. It will involve parallel development with several analytic pieces (e.g. Hospital Master Plan; cost-effectiveness study, etc.–see below for more details). The Referrals Master Plan will be developed in close consultation with stakeholders and key actors through hosting a multi-stakeholder consultative conference, and will be ratified and adopted by the MOH. **(US$ 0.1 million)**

(ii) Contracts with Outside Providers (rationalizing in the medium-term). In the medium-term, the MOH will need to rationalize all contracts with providers outside the public system to ensure that services are purchased based on their quality, and that contracts are fair and rational across a selected number of hospitals providing the services purchased. This will entail: (a) an assessment of all existing contracts where recommended referrals will be directed to national (public and private) providers on new contracting arrangements; (b) for a set of conditions, a study of referral volume by provider, absorptive capacity, quality, and geographical considerations; (c) a costing study to determine the cost of providing services in various settings; and (d) based on (a-c), a renegotiating of contracts with all service providers. **(US$ 1.3 million)**

(iii) Health systems strengthening. Tackling the underlying causes of referrals is a system-wide and long-term intervention. This project will focus on strengthening the Referrals Information System (RIS) and strategic purchasing of equipment to bolster the public provision of certain services. The RIS will aim to track all referrals through the process from request to billing. The RIS will additionally allow for interactions between outside providers and the relevant department/unit for the approval of procedures/expenditures beyond the original referral ceiling. The Project will aim to integrate the RIS into the existing health information system (HIS) as well as to strengthen the existing HIS where possible. The information system will have four main components: (a) linking the referrals database with the billing database; (b) computerizing and automating the referrals application and approval process; (c) linking providers and the approving unit for additional treatment/expenditures; and (d) linking the referrals department with the MOH finance department and MOF. The strategic equipment purchase component will entail a cost-effectiveness study to determine whether it is more efficient to provide services within the public system or to refer them to outside providers for the five costliest conditions; in addition, this study will shed light on the purchasing of equipment, training, and human resources support for select MOH facilities for the conditions that will be treated within the public sector **(US$ 1.3 million**).

(iv) **The following overlapping components will be developed under component 3 (Health Insurance):** (a) the creation of a purchasing agency/unit; (b) defining a basic package of services; (c) studies to evaluate the role of primary care strengthening; and (d) a study to evaluate pharmaceutical purchasing and provision.

Component 3: Supporting Health Coverage to Strengthen Sector Resilience (US$2.0 million)

11. Fragmentation and financial unsustainability of the health system have severely hampered the ability of the MOH to deal with the current crisis. Ensuring sustainability and building resilience entail immediate actions to rationalize coverage while improving quality.

12. This component has the main objective of improving the provision of services and supporting the MOH's efforts to separate its roles of financing, provision, and regulation. Setting the conditions for improving quality of service, accountability and results from the health system providers, these investments will ensure that quality health services are available to all, starting with the poor and vulnerable.

13. A well-organized public health insurance arrangement is needed to achieve the all-intended results defined by the MOH related to quality improvements, reduction of Out-of-Pocket (OOP) Expenditures, monitoring of results, and reduction of referral costs. These achievements will be possible due to improvements in the contracting process. The PA has decided to promote changes in the health system through a series of activities that the project will support through technical assistance and investments. These changes will basically re-define in the mid- and long-term the MOH's roles in financing, stewardship and provision strengthening. This requires the formation of two key task teams responsible for the purchasing and quality assurance roles: (a) an autonomous Purchasing Agency that will report to the MOH and MOF; and (b) an Accreditation and Technical Audit Unit, which will report directly to the MOH and will set the standards and protocols to be followed by the Purchasing Unit. The Terms of Reference (ToRs) of both teams/units will be prepared and available in coordination with the MOH and Donor Partners and will be available in the first quarter of 2015. The purchasing agency will be in charge of the contracting in and out of external and MOH providers, with a special focus on secondary- and tertiary-level clinics and hospitals.

14. Areas to be covered in the short-term include the following:
    (i) Defining the enrolment criteria and options;
    (ii) Defining the benefit package of healthcare services, including the costing of services as well as the criteria to include and exclude services in the package; and
    (iii) Establishing provider payment options for primary and hospital care.

15. The areas to be covered in the medium-term are: (i) strategies for covering the informal sector and (ii) establishing an independent pooling and purchasing agency to separate financing, pooling, and purchasing functions from service provision. This agency will be autonomous and staffed with qualified staff according to agreed ToRs and ready to function at the time of project effectiveness. These activities would lead to defining a roadmap to universal health coverage

(UHC) for the Palestinian territories with a detailed calendar and planned actions in order to enhance supply capacity to deliver services to the most needy with greater efficiency.

Table 2.1. Road Map of Key Activities for Health Coverage

Activity	**Year of implementation/** Completion	**Responsible and financier**	**Estimated Cost**
Analysis of fiscal space and fiscal financing	2014	MOH (Project funds)	100,000
National health accounts 2000–2012	2014	MOH (WHO)	N/A
Costing study for a selected number of hospitals	2015	MOH (Project funds)	200,000
Strengthening health economics' unit capacity	2015–2017	MOH (Project Funds)	200,000
Establishment and functioning of purchasing agency	Q1 2015	MOH (Project Funds)	700,000
Definition of benefit package	Q2 2015	MOH (Project Funds)	50,000
Hospital master plan	Q2 2015	MOH (WHO)	N/A
Accreditation Unit/quality assurance and auditing arrangements	Q3 2015	MOH (Project Funds)	500,000
Cost effectiveness study	Q4 2015	MOH (Project funds)	250,000
Contracting-in and -out of services by Purchasing Unit	2015–2018	MOH	N/A

Component 4: Project Management and Capacity Building (US$1.0 million)

16. This component finances costs related to project management, including (i) short-term consultancies to support the management capacity of the MOH in the areas of procurement, financial management, and monitoring and evaluation; (ii) the provision of technical assistance and training to improve the capacity of the participating MOH units; (iii) provision of essential equipment; (iv) project operating costs; and (v) external financial audits. The Project will use information and communications technology (ICT) when possible to enhance both outreach and the collection of information and data for monitoring and evaluation (M&E).

Annex 3: Implementation Arrangements

West Bank and Gaza: Health System Resiliency Strengthening Project

Project Institutional and Implementation Arrangements

Project administration mechanisms

1. The Project will rely on the MOH's existing organizational structure, including the involvement of its various line departments related to medical referrals, health insurance, procurement, and financial management. Development Partners that are engaged in health sector capacity building (i.e. USAID, WHO, and the UK Department for International Development, DfID) will continue to play a prominent role in supporting the MOH's reforms and improving its capacity to implement the envisaged reforms, including the separation of financing and provision roles, strengthening regulatory and public health functions, health system strategic planning, and other efficiency improvements as well as the rationalization of health sector expenditures.

2. High-level Government officials are keen on pursuing the key reforms envisaged under the project and committed to taking concerned actions to have them implemented. The MOH will be the implementing agency responsible for Project implementation and will have the primary responsibility for all the technical, operational, and fiduciary aspects related to the Project. The MOH's technical and implementation capacity was assessed by the Bank and it was recommended to carry out a series of activities to strengthen its capacity to implement the Project. Therefore, a Project Management Unit (PMU) will be installed and composed of technical experts on fiduciary and procurement aspects as well as technical knowledge to ensure a satisfactory project implementation.

3. A PMU comprised of a Project Coordinator, Procurement Specialist, Financial Management Specialist and Administrative Assistant will be formed to help implement the project. A Management Information System (MIS) Specialist and a Public Health Specialist will also be recruited at a later stage of the project's implementation. The PMU will be onboard prior to project effectiveness and will be responsible for: (i) management of the fiduciary aspects of the project, including financial, procurement, and disbursements; (ii) preparation of periodical project progress reports (technical, financial and procurement) with inputs from the implementing entities represented in the technical steering committee; (iii) monitoring outputs, outcomes and impacts of the project; and (iv) preparation of annual work plans and budgets for review and approval by the SC. The PMU staff will be familiar with Bank fiduciary and implementation procedures and will closely coordinate efforts with the MOF and other stakeholders involved in the sector.

4. A technical Steering Committee (SC) has been established to ensure full alignment of the project's activities with the MOH's strategies and policies and to facilitate linkages between the various MOH line units, MOF and service providers. The SC will be chaired by the Minister of Health or a designee of the Minister of Health, and comprised of

officials directly related to project implementation and supervision. More specifically, the SC is comprised of the director of the MOH international cooperation department, the director general of health insurance, the director of the medical referrals unit, the director general of financial affairs, the director general of hospitals, the director of procurement, as well as representatives from the MOF and PMU unit. The PMU will act as a Secretariat of the SC. The SC will meet on a monthly basis to: (i) plan and approve project activities and action plans, (ii) review project progress reports compiled by the PMU with inputs from the various entities, and (iii) advise on improving the implementation of various activities when necessary. The Committee will be assisted by local and international consultants, as needed, and will closely coordinate with key stakeholders including the World Bank, USAID, WHO, NORAD, civil society organizations and NGOs.

Overall Role of the PMU

5. The PMU, in coordination with the relevant MOH departments and technical units, will have the following responsibilities:

i. Prepare annual work plans and budgets, in coordination with the relevant MOH technical departments, before the start of the fiscal year and submit them to the SC for review and approval.

ii. Define, monitor and evaluate specific project activities to be undertaken under each subcomponent and ensure their coordination and integration with the relevant entities by assisting, as needed, in tasks, such as preparing TORs. The PMU will prepare tender documents and Requests for Proposals (RFP) and will manage the procurement process.

iii. Prepare semi-annual progress reports based on information provided by the MOH Departments/Technical Units responsible for implementing project activities, summarizing the status of project implementation (including explanations for deviations from agreed-upon implementation plans, constraints and corrective measures to be taken), financial status, and major outputs.

iv. Develop and maintain a project information system which would consolidate reports received from the MOH departments and generate quarterly progress reports, which will be submitted to the SC for review and action.

v. Set up all technical and operational aspects of project accounting and implementation (i.e., ensure that funds are available in the relevant accounts as required to meet payments for project expenditures and ensure maintenance of project accounts as well as timely preparation of interim evaluations and financial statements; etc.).

vi. Prepare and monitor annual project procurement plans and manage the procurement process of goods and services, assist in the selection of consultants and specialists, provide input to consultant TORs, oversee consultant contracts, and arrange for the calling of bids, the evaluations, and awarding of contracts related to the project.

Project reporting mechanisms

6. Project reporting arrangements will include the following:

a. *Semi-annual or calendar semester progress reports.* Semi-annual progress reports will monitor and evaluate project progress with information on the progress made under the various

project components and project monitoring indicators. This report shall be furnished to the Bank not later than forty-five *(45)* days after the end of the period covered by such a report.
b. *Interim Unaudited Financial Reports (IFRs).* Interim Unaudited Financial Reports are to be prepared by the MOH every quarter through project closing date of June 30, 2020. These reports shall be furnished to the Bank not later than forty-five *(45)* days after the end of each quarter.
c. *Annual audited project financial statements.* Audited project financial statements are to be prepared on an annual basis and shall be furnished to the Bank no later than six months after the end of each year.
d. *Completion Report.* The Implementation Completion Report of the Project is to be completed and submitted not later than six months after the closing date of the Project.

Financial Management, Disbursements, and Procurement

Financial Management (FM)

7. An FM assessment was carried out to determine whether the Project has in place an adequate financial management system as required by the World Bank under OP/BP 10.02. The FM Assessment Questionnaire was completed during Project appraisal.

Organization Structure for Project Management:

8. The overall implementation of the Project will be through a Project Management Unit (PMU) under the Ministry of Health (MOH). The PMU will be responsible for managing the project on behalf of the client. The PMU will consist of four key personnel: Project Coordinator, Procurement Officer, Administrative Assistant, and Financial Officer who will be based in the finance office of the MOH. Other personnel from the MOH's directorate, as needed, will assist the PMU members in various aspects of project implementation. The PMU will coordinate with other institutions involved in the project, i.e., primary healthcare centers and the Medical Referrals department, among others, in the preparation and implementation of the Project. The PMU will manage the technical aspects of the Project and will be responsible for all fiduciary aspects.

Institutional and implementation arrangements:

9. The PMU is the primary unit responsible for the overall coordination and monitoring of the project with support from the MOH. The PMU, under the direction of a Project Coordinator will be responsible for the day-to-day implementation of the project, including carrying out procurement, disbursement activities, maintaining a sound financial management system through MOH and facilitating technical assistance. MOH is responsible for the financial management of financing as well as its overall coordination.

Assessment of existing FM arrangements at the MOH

10. The Bank reviewed the existing systems and internal controls of the MOH to assess the adequacy of accounting system, procedures, and controls and determine how these can be used and relied upon for the proposed project's financial functions. The MOH has a unit responsible for monitoring and supervision of donor projects. They do not have experience in the Bank's Guidelines and policies on disbursement and Client Connection. The MOH finance department has qualified staff and experienced accountants, though a Financial Officer will be appointed in the PMU who will coordinate payments from the Designated Account (DA) as well as the replenishment of the DA.

11. INFORMATION SYSTEMS. The system currently used by the MOH and MOF (the Bisan system) will be configured through the opening of a separate cost center that will be used to account for, record, report and monitor the project accounts and generate the project financial reports.

12. PROJECT FINANCIAL MANAGEMENT ARRANGEMENTS. The MOH/PMU will follow the tax regulations issued by the PA. The MOH/PMU will ensure that project financial management, including accounting functions and reporting activities, will utilize the MOH's accounting system (Bisan) that suits the project's components. The availability of data from the accounting system will help the MOH/PMU focus on meeting project management information needs.

13. FINANCIAL CONTROL. Financial control for the MOH is the responsibility of the MOF financial controllers stationed at the MOH. According to the MOF financial controller mandate, all project activities implemented by line ministries have to be reviewed and cleared by the financial controller based in that line ministry. This will include the Project as well. The Financial Controller's function is important to ensure that Project activities are in compliance with the Implementation manuals and donor guidelines as well as in compliance with internal control mechanisms.

INTERNAL AUDIT. The internal audit function is also centrally established at the MOF, with a mandate to cover all line ministries and public entities, including the MOH. The MOF's internal audit function is under way to be fully functional. The Bank will continue the discussion with the MOF to continue building the capacity of the internal audit function at the MOF and MOH. The internal auditor will ensure that the processes and procedures of the whole MOH are properly applied. The internal audit reports will also be submitted to the MOH chairman.

14. ACCOUNTING PERIOD. The Project will use the January–December accounting period of the Government.

15. PLANNING AND BUDGETING. The MOH, through the Project Finance Officer, will prepare the annual budget based on the procurement plan. This budget will be generated from the accounting unit and will be monitored regularly. The Finance Officer will compile the project's budget and will also provide its requirements to the MOH to incorporate in the

yearly budget requirement (government contribution) for submission to the MOF. The first budget report will be prepared prior to the first request for replenishment.

16. PMU STAFF AND TRAINING. There will be training required for the Finance Officer in the PMU since the staff is inexperienced in World Bank projects. This Finance Officer will be provided with an orientation and training on the Bank's guidelines concerning Interim Financial Reports (IFRs), audits, and disbursements. Additional training from the Bank FM team will be provided to the PMU throughout the project's implementation as needed. The recruitment of this Finance Officer, based on the agreed TOR among the various parties, MOH/PMU, and cleared by the World Bank, has to be completed prior to the first replenishment request.

17. RECORD MANAGEMENT. The files will be kept in MOH for three years from the closing date, after the last audit of the project. The management of records under this project would provide a paper trail on which the accounting system is based, along with verification of financial transaction. For each financial transaction, an individual record would be created. Generally, records management would include:
    a. clearly defined procedures for creating and maintaining records;
    b. adequate back-up arrangements;
    c. storage of financial records under lock and key, and safe from environmental risks (e.g. fire and water damage); and
    d. easy access for authorized personnel only.

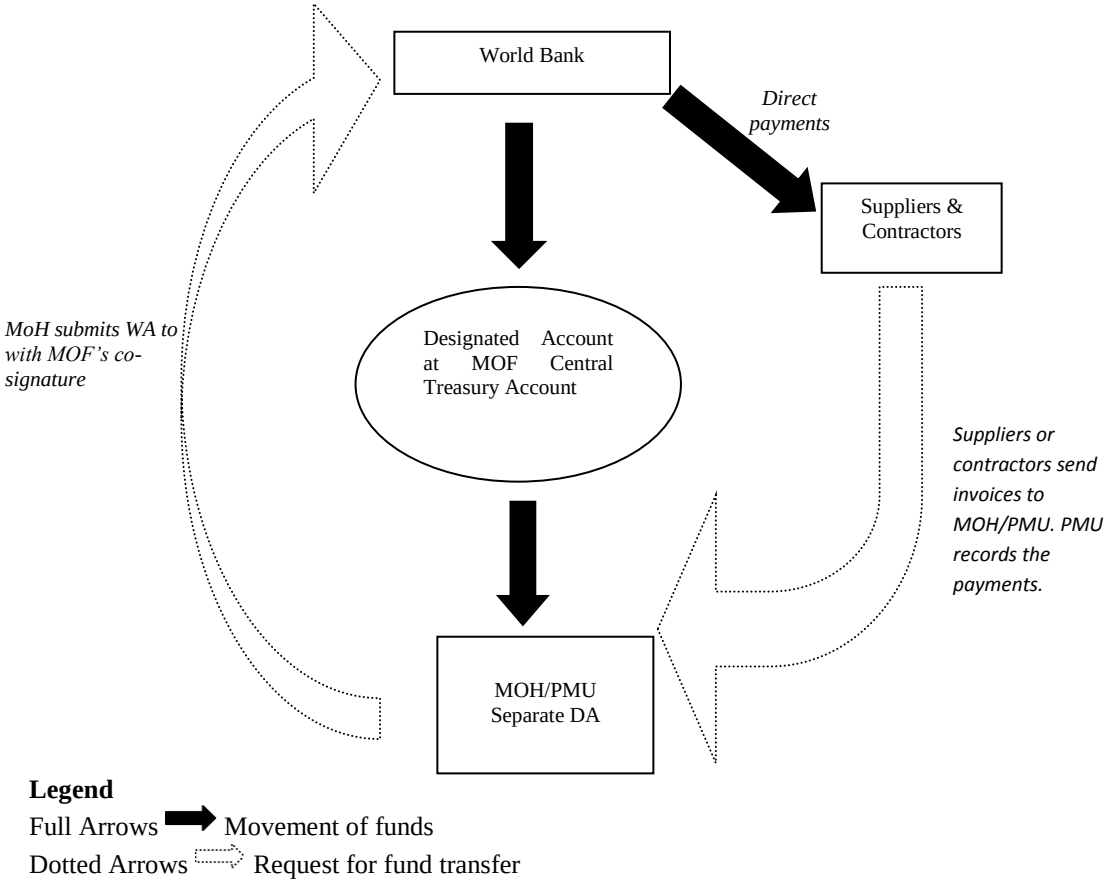
18. The IFRs formats where developed and agreed upon by Project negotiations.

A. SOURCES AND FLOW OF PROJECT FINANCING:

19. Financing of the proposed Project will be by Bank financing through a Grant from the Trust Fund for the West Bank & Gaza to be disbursed through a Designated Account opened by the MOH at the Bank of Palestine and managed by the MOH. The proposed grant will finance all Project activities in the amount of US $8.5m.

20. FLOW OF FUNDS. The Bank financing will be a Grant from the Trust Fund for the West Bank and Gaza to be disbursed through a Designated Account (DA) denominated in USD which will be opened by the MOF at the Bank of Palestine (Nablus) and managed by the MOH. The MOH will prepare a detailed quarterly budget (disbursement plan), according to which the ceiling of the DA will be defined, to facilitate the availability of funds necessary for on-time project implementation. The DA will be used for an initial deposit and replenishments from Bank resources which will be deposited and used in financing project components according to the approved budget, the Grant Agreement, and Project Appraisal Document. The same arrangements will be implemented for any project expenses in Gaza i.e., verification of the expenses will be done centrally by the PMU at the MOH and funds will transferred from the DA directly to suppliers or contractors through the banking system in the West Bank. No funds will be managed from Gaza.

21. The PMU will prepare the Withdrawal Applications (WAs) with the related supporting documents, signed by the Project Coordinator as designated signatory. The WAs are submitted to the MOF for review and signature of the MOF designated signatory. The diagram below shows the flow of funds.



Reporting Requirements

22. FINANCIAL REPORTING. The PMU/MOH will manage the project activities of the proposed project; and they will be responsible for consolidating and processing all reimbursement claims, as well as the submission of quarterly IFRs (45 days after the end of each quarter). The Finance Officer will be responsible for producing a full range of (i) financial statements and reports, including sources and uses of funds, Designated Account reconciliation statements, cash forecast, Statement of Expenditures comparing actual and planned expenditures by component, etc., (ii) a listing of all contracts showing amounts committed and disbursed under each, and (iii) a fixed assets register of regularly updated and verified assets.

Auditing arrangements, accounting, and auditing standards

23. AUDITING ARRANGEMENTS. The MOH will engage an external independent auditor, acceptable to the Bank, to perform the annual audit of the project's accounts and issue a management letter. The yearly external audit report shall encompass all of the project's activities and shall be in accordance with internationally accepted auditing standards and will be submitted to the Bank within six months after the end of the audit period.

24. The annual audit report of the project's accounts shall include an opinion on the project financial statements and the designated account transactions as well as give an opinion on whether expenditures reimbursed are eligible for Bank financing and are reflected on the project financial statements. The auditor will also be asked to prepare a management letter identifying any observations, comments and deficiencies in the system and controls that the external independent auditor considers pertinent and shall provide recommendations for their improvements. The external auditor should be acceptable to the Bank and their ToR will be prepared and submitted for the Bank's no objection, at least 9 months prior to the end of the project's fiscal year. The external auditor shall be engaged not later than seven months after project effectiveness. Audit costs will be financed by the Project.

25. According to the World Bank policy on access to information issued on July 1, 2010, the audit report with audited financial statements of the Project will be made available to the public.

Inherent Risks

26. INHERENT RISKS. The most recent PEFA conducted in 2013 indicated that there were improvements in the public financial management system but that significant challenges remain. In the most recent Development Policy Grant (DPG) operation (VI), the risk was assessed as "**High**". The last issued financial statements by the government are from 2010. However, efforts are underway to develop and enhance the Public Financial Management (PFM) system, including government accounting, internal auditing and external auditing.

27. The Bank has been working closely with other donors to assist the Government in its public financial management reforms. For the proposed Project, the MOH will handle the project's financial management and accounting system with a Finance Officer and the engagement of an independent qualified private audit firm, acceptable to the Bank for the yearly audit of the project.

Risk Analysis and Mitigation

28. CONTROL RISKS – PROJECT LEVEL. The Project is exposed to potential risks involving the MOH/PMU staff assuming the authority and responsibility for every aspect of the project, thereby exposing it to possible risks of collusion and corruption. The risk level is assessed as "**High**". To mitigate this risk, (i) all payment orders will be signed by the Project Coordinator, MOH Finance Officer, and MOF Financial Controller at the MOH, (ii) the Project Coordinator will certify that the services have been rendered before the payments

are made by the MOH, (iii) regular interim financial reports will be presented by the MOH/PMU, and (iv) the MOH will open a separate general ledger in its accounting system to separately account for the Project funds and expenditures. In addition, the complete segregation of duties among MOH/PMU staff will exist, i.e., the functions of implementing and overseeing will not reside with the same MOH/PMU staff. The project financial statements will be audited by an external private auditor, acceptable to the World Bank. Taking into account the above mentioned mitigating measures, the Control Risk at the Project Level is assessed as "**Substantial**" after mitigating measures.

29. CONTROL RISKS – IMPLEMENTING AGENCY (IA) LEVEL. Control risk for the implementing agency is assessed as "High" before mitigating measures due to the lack of experience in the MOH in implementing World Bank projects. However, an "acceptable FM policies and procedures" manual will be issued prior to the first disbursement to indicate the accounting process and procedures for the funds. This manual will include detailed roles and accountability, as well as guidelines for sound financial control environments. The internal controls will also be discussed in this manual, identifying the signatories for payments and withdrawal applications (WAs), documentation, record-keeping, etc. Taking into account the above mitigating measure, the Control Risk for IA is assessed as "Substantial".

30. OTHER RISKS. The issue of recruitment and retention of local qualified procurement and finance staff can pose a problem. To mitigate this, the PMU will engage staff who are experienced in procurement, project management, and financial management, with appropriate job descriptions. The detailed assessment of risks and corresponding mitigating measures (MM) are discussed in the Table below.

Table 3.1. ASSESSMENT OF RISKS AND MITIGATION

TYPE OF RISK	RISK RATING	RISK RATING AFTER MM
Inherent Risk	High	Substantial
Control Risk – Project Level	High	Substantial
Control Risk – IA Level	High	Substantial
Overall FM Risk	**High**	**Substantial**

Readiness for Implementation

31. The MOH has prepared an FM Policies and Procedures Manual, covering accounting, reporting, auditing arrangements, funds flow, documentation, payment processes, and internal controls. There will be a new financial management system set up in the MOH for this Project. In order to be ready for implementation the following must occur, (i) the PMU Finance Officer has to be recruited, (ii) the Project's accounting and financial management

system has to be set-up, the (iii) Designated Account with the Central Treasury Account at the Bank of Palestine has to be opened, and (iv) formatted IFRs should be developed.

Legal

32. The legal documents should ensure that all the requirements related to the Financial Management System are covered as follows:

Financial Management; Financial Reports; Audits

33. The Recipient shall ensure that a financial management system is maintained in accordance with the provisions of Section 2.07 of the Standard Conditions.

34. The Recipient shall ensure that interim unaudited financial reports for the Project are prepared and furnished to the World Bank not later than 45 days after the end of each quarter, covering the quarter, in form and substance satisfactory to the World Bank.

35. The Recipient shall, upon the World Bank's request, have its Financial Statements for the Project audited in accordance with the provisions of Section 5.09 (b) of the Standard Conditions. Each such audit of the Financial Statements shall cover the period of one fiscal year of the Recipient. The audited Financial Statements for each such period shall be furnished to the World Bank not later than six months after the end of such period.

Disbursement Arrangement

36. The following table specifies the categories of Eligible Expenditures that may be financed out of the proceeds of the Financing ("Category"), the allocations of the amounts of the Financing to each Category, and the percentage of expenditures to be financed for Eligible Expenditures in each Category:

Category	Amount of the Financing Allocated (expressed in USD)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Goods, consultants' services, training and operating costs	6,500,000	100%
(2) Operation and Maintenance Expenditures for Health Facilities	2,000,000	100%
TOTAL AMOUNT	**8,500,000**	

37. The proceeds of the Grant will be disbursed in accordance with the disbursement guidelines as outlined in the Disbursement Letter and in accordance with the Bank Disbursement Guidelines for projects. The requests for payments from the grant account will be initiated through the use of WAs either for Direct Payments or Replenishments to the Designated Account. Authorized signatories, names, and corresponding specimens of their signatures will be submitted to the Bank prior to the receipt of the first replenishment application.

38. Designated Account (DA)**.** To facilitate project implementation and make timely payments, MOH will open a USD DA under the Central Treasury Account at the Bank of Palestine (Ramallah) which will be managed by the MOH. The MOH will be responsible for submitting the WAs with appropriate supporting documentation for expenditures incurred. Deposits into and payments from the DA to pay contractors, consultants, suppliers and others will be made in accordance with the provisions of the Disbursement letter.

39. Direct Payment Method. In addition, the direct payment method to suppliers for goods and services may be used. The Disbursement Letter will stipulate the minimum application value for direct payment and special commitment procedures as well as detailed procedures to be complied with under these disbursement arrangements.

Supervision Plan

40. The first supervision plan would take place within three months of effectiveness to ensure that the financial management system put in place is operating according to plans. A Project Supervision Plan should ensure review of the following information, which should be readily available:

(i) Financial forecasts for the life of the project broken down by appropriate period, from which the annual budgets for the project should be developed.
(ii) A procurement plan, including the activities and processes associated with the project (for instance, arrangements and processes to secure the services of consultants).
(iii) The format and content of project financial reports and the auditing arrangements.
(iv) Review of annual audited financial statements and management letters as well as timely follow up on issues raised by the auditor and review of SOEs if needed.

41. The mission should evaluate the progress of the development of interim financial reports, the consultants' work and other related FM issues, i.e., designated account, internal control, work and document flow, etc. The mission would conduct a random review of the designated account, IFRs, compliance with the financial covenants, disbursements, financial record management, and changes in procedures related to IFRs, etc. After the first supervision, there should be two supervision missions a year at a minimum.

42. Governance and Anti-corruption: Fraud and corruption may affect the project's resources, thus negatively affecting the outcomes. The World Bank financial management specialist developed an integrated understanding of possible vulnerabilities and set actions to mitigate

the risks. As a result, the above proposed FM arrangements and mitigating measures are expected to address, to a reasonable level, the risks of fraud and corruption that are highly likely to have a material impact on the project's outcomes.

Agreed ACTIONS

43. THE FOLLOWING ACTIONS WERE AGREED UPON:

TABLE 3.2: AGREED ACTIONS

AGREED ACTIONS REQUIRED PRIOR TO THE FIRST REPLENISHMENT REQUEST
1. TOR and Recruitment – PMU/MOH to recruit the Finance Officer (FO) for the Project to handle the accounting and financial management system of the Project; TOR for the FO has been prepared and agreed upon with the Bank and the position has been advertised; the FO, once recruited, will be trained on the Bank's FM policies.
2. Project accounting system – PMU/MOH to develop accounting books and the formatted IFRs. Format of IFRs has been agreed upon during negotiations.
3. Audit TOR – PMU/MOH to prepare and submit the TOR of the auditor to the Bank for clearance.

Procurement

44. *Country System*: As part of the PA's efforts to reform and modernize its public procurement system with the aim of improving accountability, integrity, and transparency of the system, in addition to preventing corruption and increasing opportunities for the private sector, a new Public Procurement Law (PPL) and implementing regulation, consistent with internationally accepted practices, were enacted and recently came into effect. The new PPL and regulation, which applies to all public procurement entities, lays down a sound institutional and organizational set-up for public procurement; provides comprehensive provisions on procedural matters; sets out provisions on transparency and accountability; establishes a complaint/dispute review mechanism; and provides for routine dissemination of information on public procurement through a single portal procurement website. National Standard Bidding Documents for various types of public procurement, including goods, works, and consultancy services are being prepared and will be issued for use by all procuring entities by December 2014. Other components of the procurement system envisaged by the PPL (e.g., complaint mechanism, single portal), are also expected to be put in place within the coming few months. The Bank team will assess the components of the country procurement system that may apply to the project, as they become available.

45. Procurement of goods will be carried out in accordance with the "Guidelines: Procurement under IBRD Loans and IDA Credits" published by the Bank in January 2011 and revised July 2014, and the selection of consultants will be carried out in accordance with the "Guidelines: Selection and Employment of Consultants by World Bank Borrowers"

published by the World Bank in January 2011 and revised July 2014, the Grant Agreement and the Procurement Plan approved by the Bank. Non-medical, recurrent operating expenditures to be financed under the emergency rapid response window and other project incremental operating costs shall be procured in accordance with MOH contracting and administrative procedures, acceptable to the Bank. "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants," dated October 15, 2006 and updated January 2011, shall apply to the Project.

46. The overall responsibility for the implementation of project procurement will rest with the MOH, which would act as the main counterpart to the Bank for all procurement aspects of the project. The PMU will manage the procurement process, ensuring the involvement of the respective MOH department in all steps of the procurement process. It would ensure that project procurement is carried out in accordance with the Grant Agreement and the Procurement Plan. The MOH departments will be responsible for contract management including the supervision, review, and approval of consultants' deliverables and the receipt/inspection and acceptance of goods, and for advising the PMU on the release of payments to the consultant/supplier in accordance with the signed contract.

47. A procurement capacity and risk assessment of the MOH was carried out as part of the Project's preparation. The assessment evaluated the institutional capacity of the MOH to implement procurement for the project following Bank Guidelines as well as evaluated procurement risks and made recommendations on mitigation measures for efficient procurement under the project. Below is a summary of the identified procurement risks and mitigation measures:

48. Procurement Risks:

i. MOH procurement and contract management capacity, in particular for consultants' service contracts, is limited, and it is unable to meet project procurement requirements.
ii. Lack of proper coordination and interaction of various stakeholders may cause procurement and project implementation delays.
iii. Decision-making and implementation may be challenged by the attendant technical complexity and capacity limitations in the targeted areas/fields, as well as potential opposition by those benefiting from maintaining the status quo.
iv. Further deterioration of the political situation may limit competition and discourage participation by qualified international consultants with specific expertise in the targeted fields.

49. Mitigation Measures:

i. A procurement specialist, with detailed knowledge of the Bank's procurement and consultants' guidelines and expertise in consultancy services contracts, will be hired within the PMU to provide support to the MOH procurement staff in handling project procurement.

ii. Procurement and contract management training will also be provided to the PMU and MOH procurement and other staff.
iii. The project implementation structure and the detailed responsibilities of the various entities shall be defined, and an adequate and realistic sequencing and prioritization of actions shall be adopted.
iv. To ensure project readiness for implementation, draft Terms of Reference for key studies and technical assistance packages to be implemented in the first year shall be prepared by negotiations.
v. The Bank team will maintain a close follow-up and quality control of procurement/contract management matters during project supervision to ensure the efficiency of procurement decisions.

50. The overall procurement risk rating for the project is **High**.

Procurement Plan

51. Consultants' services constitute the major type of procurement to be carried out under the project. These would include a number of studies that would inform the envisaged reforms and other technical assistance packages that would facilitate targeted improvements in the performance of the health system, as well as PMU staff. In addition, the project will finance improvements to the respective information systems (e.g., referral information system) through the provision of software, hardware, training and support services. Based on the outcomes of the studies to be implemented in the first year, the project may also finance in later years the purchase of equipment and training for select MOH facilities, and conditions to be treated within the public sector.

52. Under the emergency rapid response window, the project will contribute to the financing of non-medical recurrent operating expenditures, including: fuel costs for hospital generators and ambulance services, hospital cleaning services, and catering services for hospitals. The allocation from the project is only an increment of the actual needs (monthly fuel needs is estimated at 600,000 liters (approx. ILS 4 million), cleaning cost is estimated at ILS 700,000 per month, and catering cost at ILS 700,000). These supplies and services are procured centrally by the MOH on an annual or bi-annual basis for the benefit of the public hospitals and facilities and payments are made directly by the MOH to suppliers/service providers against monthly invoices, supported by inspection and acceptance reports, endorsed by the respective hospital. The MOH contracting and administrative procedures in place were assessed and found acceptable and shall apply to these costs.

53. For each contract to be financed under the project, the different procurement and consultant selection methods, estimated costs, prior review requirements, and time frame will be agreed between the MOH and the Bank project team in the Procurement Plan (PP). A procurement plan dated December 10, 2014 for the first 18 months of project implementation was prepared and agreed with the Bank during appraisal, and is summarized below. The PP will be updated at least annually or as required to reflect the actual program implementation needs.

54. Given the emergency nature of the project, the following simplified procurement procedures for goods and selection procedures for consultants' services shall apply:

A. Goods

i. Direct Contracting. Direct contracting for the procurement of goods (as per paragraph 3.6 (a) and (e) of the Procurement Guidelines) may be used to extend an existing contract or award new contracts. For such contracting to be justified, the Bank should be satisfied that the price is reasonable and that no advantage could be obtained by further competition.

ii. Shopping. Shopping in accordance with paragraph 3.5 of the Procurement Guidelines may be used for procuring readily available off-the-shelf goods of values less than US$200,000. The

PMU shall solicit at least three price quotations[21] for the purchase of goods to formulate a cost comparison report.

B. Consultants' Services

i. Single-Source Selection. Single-source selection of consulting firms and individuals (paragraphs 3.10 (b) and 5.4, respectively, of the Consultant Guidelines) may be used only if it presents a clear advantage over competition for the required consulting services.

ii. Advertising/Shortlists For assignments that are estimated to cost less than US$100,000, advertisement is not mandatory as long as a shortlist of at least three qualified firms is established.

55. Summarized Procurement Plan

I. General

1. **Project Name:** Health System Resiliency Strengthening Project

2. **Period covered by this procurement plan**: first 18 months

II. Goods

1. **Procurement Methods and Prior Review Thresholds**: Procurement Decisions subject to Prior Review by the Bank as stated in Appendix 1 to the Guidelines for Procurement:

Category	Method of Procurement	Threshold (US$ Equivalent)	Prior Review Threshold (US$ Equivalent)
Goods	ICB	No threshold	All contracts
	NCB	<500,000	First contract
	Shopping	<200,000	First contract
	Direct Contracting	No threshold	All contracts

2. **Summary of the Procurement Packages planned during the first 18 months after project effectiveness:**

21 The PMU shall use the sample request for quotations for goods, which is currently being used under other Bank-financed projects.

Goods:

1	2	3	4	5	6	7	8
Ref. No.	**Description**	**Estimated Cost US$ in thousands**	**Procurement Method**	**No. of lots**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Estimated Bidding Documents (BDs) issue date**
1.	PMU office equipment and furniture	30	S	2	No	Prior	Q1/2015
2.	Independent Purchasing Agency- office equipment and furniture	50	S	2	No	Post	Q4/2015
3.	RIS/HIS hardware	150	NCB	2	No	Prior	Q2/2016
4.	Strategic equipment to health facilities	500	ICB	multiple	No	Prior	Q2/2016
	Total	**730**					

III. Selection of Consultants

1. **Selection Methods and Prior Review Thresholds**: Selection decisions subject to Prior Review by Bank as stated in Appendix 1 to the Guidelines Selection and Employment of Consultants:

Category	Selection Method	Threshold	Prior Review Threshold
		(US$ Equivalent)	**(US$ Equivalent)**
Consulting Services Firms	QCBS/QBS	No threshold	First contract selected under each of the two methods and thereafter all contracts above $200,000
	FBS/CQS/LCS	<200,000	First contract selected under each of the three methods
	Sole Source	No threshold	All contracts
Individuals	IC	No threshold	First contract and thereafter all contracts above $100,000
	Sole Source	No threshold	All contracts

2. **Short list comprised entirely of national consultants**: Short list of consultants for services, estimated to cost less than $300,000 equivalent per contract, may be comprised entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

3. Consultancy Assignments with Selection Methods and Time Schedule:

1	2	3	4	5	6
Ref. No.	**Description of Assignment**	**Estimated Cost US$ in thousands**	**Selection Method**	**Review by Bank (Prior / Post)**	**Estimated Request for Proposals (RFP) issue date**
1.	Emergency review of contracts with outside providers	300	QCBS	Prior	Q1/2015
2.	Development of guidance note on referrals (including manual and protocols)	500	QCBS (multiple)	Prior	First in Q1/2015
3.	Development of referrals master plan	100	IC	Prior	Q2/2015
4.	Technical assistance for rationalizing the contracting arrangements for outside referrals (including: assessment of existing contracts, a study of referral volume by provider, quality and geographic location, a costing study of selected hospitals, etc.)	1,000	QCBS (multiple)	Prior	First in Q2/2015
5.	Business analysis and design of necessary improvements to information systems (RIS, HIS, etc.)	50	IC	Post	Q3/2015
6.	Implementation (software development, training, support, etc.) of information systems' improvements (including integration of RIS, HIS, billing database, etc.)	500	QCBS	Prior	Q2/2016
7.	Analysis of fiscal space and fiscal finances	100	CQS	Prior	Q1/2015
8.	Strengthening the capacity of Health Economics unit	300	IC (multiple)	Post	First in Q3/2015
9.	Technical Assistance for the establishment and functioning of Purchasing Unit and the Accreditation and technical audit unit	1,200	IC (multiple)	Prior	First in Q1/2015
10.	Defining of basic package of service and enrollment criteria	100	IC	Prior	Q2/2015
11.	Cost-effectiveness study	250	QCBS	Prior	Q4/2015
12.	PMU Staff (Project Coordinator, Procurement Specialist, FM Specialist, Admin Assistant, etc.) (4 years)	600	IC (multiple)	Prior	Q4/2014
13.	Financial Audit (4 years)	40	LCS	Prior	Q4/2015

	Total	**5,040**			

Procurement Supervision

56. The Bank's prior review thresholds were set based on the existing procurement capacity and the identified procurement risks. In addition to prior review, the Bank will carry out at least two supervision missions per year. A post procurement review of contracts which are not subject to the above prior review requirements shall be conducted once a year. The procurement post reviews should cover at least 20 percent of contracts subject to post review. Complete procurement documentation for each contract, including Request for Proposals (RFPs)/bidding documents, advertisements, proposals/bids received, proposal/bid evaluations, letters of acceptance, contract agreements, securities, related correspondence, etc., will be maintained by the MOH-PMU in an orderly manner, readily available for audit.

Technical Aspects

57. As a result of the economic and political situation in the West Bank and Gaza (WBG), the health sector managed by the PA is under severe stress. There are severe financial imbalances in the MOH General Insurance scheme and inefficiencies in MOH spending on the wage bill, pharmaceuticals and outside referrals. The Government Health Insurance (GHI) program is operating at a loss since there is no actuarial link between beneficiary contributions and the actual costs of the benefits. In recent years, public sector health spending on salaries, drugs and outside medical referrals (OMRs), especially referrals to overseas health providers (in Egypt, Israel, and Jordan), has also ballooned, causing considerable concern among MOH and MOF officials. Despite these challenges, the MOH is committed to undertaking fundamental reforms in the health sector and has highlighted health financing issues, including health insurance, as high priority areas for the PA.

58. The financial sustainability of tertiary care services (and of the health system as a whole) depends on carefully balancing between funding and coverage. Although the MOH has demonstrated a firm commitment to reforming OMRs, a more comprehensive reform plan is needed to tackle deeper institutional issues that include short-, medium-, and long-term policy reforms. A number of areas related to the current OMR system needs to be addressed in order to improve the equity, efficiency, and sustainability of the system. For the contracted tertiary healthcare services, the MOH will need to develop stringent criteria for prioritizing services that should be outsourced, including measures of cost-effectiveness, efficiency, and quality of care. Contracts should include quality standards and appropriate medical audits to ensure adherence to those standards as well as prospective case-based payments, rather than fee-for-service or simple price and volume contracts, in order to improve the incentives for performance. The benefit package is currently very generous for those covered, potentially encouraging overuse of services and unnecessary services. Services provided tend to be hospital-focused, while most observers would note that primary care could be strengthened and provide more care. Gatekeeping is not yet in place to improve allocative efficiency. This is especially important as the population transitions in terms of disease profile, moving from an infectious disease profile

to increasingly include non-communicable diseases (NCDs). There are few incentive mechanisms in place, such as capitation, global budgets, or per case admission payment models, which could improve both technical and allocative efficiency as well as equity.

59. Currently, public hospitals receive only line-item budgets and physicians are more or less on salary with some modest bonus schemes. Out-of-pocket payments (OOPs) policy could be more carefully designed to discourage unnecessary services and overuse of services, while at the same time safeguarding the poor and setting financial protection limits on key services with high social priority, such as disease prevention, vaccinations, and Primary Healthcare. There are also challenges on the supply side. Primary care is well established, relying on UNRWA and the NGOs, especially for the refugee population; nevertheless the infrastructure, training, improved incentives and organizational reforms are still needed at the primary healthcare level. Hospitals are marked by a large number of empty beds and poorly distributed beds, except a few, and levels of technical efficiency may be constrained by civil service rules. The hospital sector would benefit from measures relating to organizational reform such as managerial autonomy or corporatization, and within from more flexibility in terms of staffing and management. Related to the vision for the sector will be important issues regarding the governance of the sector and role of the Ministry of Health. Should the MOH continue to be involved in "everything" from financing to delivery, human resources, regulation, etc., or should it focus on areas of comparative advantage such as primary healthcare, public health, quality, and regulation and medical education.

60. The immediate challenge for the PA is to address excessive referrals while ensuring equitable access to appropriate and needed care for populations throughout the West Bank and Gaza. The PA has identified health sector reform as a major priority, with the future aim of adopting universal health coverage, while acknowledging that it must first focus its efforts on cost containment of the current health sector system. The MOH will need to define clear rules for referrals for each condition and will need to train health professionals in these revised regulations. New sets of incentives and disincentives for adherence to regulations should be formulated. Within this reform, the roles of the referral committees should be reevaluated and the role of the Inspector General's office in supervision should be strengthened. Two key evaluations will be needed. The first is a costing study that will support the renegotiation of contracts for services with outside providers. The second is a cost-effectiveness (or cost-benefit) analysis that will allow the MOH to strategically plan the provision versus the contracting of tertiary services. These reports will also feed into reforms concerning the definition of the benefit package for OMR and for the eventual health insurance reform. A key component of reforming OMR will be putting in place an agency responsible for strategic purchasing of services from outside providers. The responsibility of this agency will be to negotiate contracts and enter into agreements with outside providers for the provision of tertiary services. In addition, a number of donor partners have committed to supporting the PA in its OMR reform agenda, including USAID and DFID. The reform agenda around OMR is large and complex and will require coordinated and complimentary efforts from key stakeholders. The proposed project will focus on these areas; the Bank's team will guide the process, providing the necessary technical assistance to the MOH in order to undertake these important interventions.

Environmental and Social (including safeguards)

61. The Environmental Category is **"C".** The proposed project mainly focuses on technical assistance and institutional capacity building activities. It does not include financing of civil works; thus, no environmental or social safeguard issues are anticipated.

Social

62. Health is considered a human right in the Palestinian territories. The right to healthcare is guaranteed for the entire population in the Palestinian Constitution.

63. Quality of services in the public sector is generally perceived to be low, particularly in the Gaza Strip. High rates of mortality and infection in hospitals are coupled with low satisfaction of users. However, there are no effective grievance or redress mechanisms. Although responsiveness is perceived to be better in the private sector, little is known about quality of care and regulation in the private sector. Partially driven by the blockade, there has been a steady degradation in the Gaza health system, and deteriorations in the quality of care are increasing. Health workers are unable to access continuous training education; maintenance of medical equipment is severely hampered by restrictions on importing spare parts; and electricity cuts make operations difficult and negatively affect the functioning of health facilities.

64. The MOH will likely encounter pressures when revising the current health insurance schemes including removing beneficiary households or individuals who will no longer be eligible for free health insurance. As of 2010, out-of-pocket (OOP) expenditure accounts for approximately 40 percent of total health expenditure, which may further burden the marginalized and poor. In fact, the poorest groups bear a higher share of OOP expenditure compared to their total income and are at the greatest risk of impoverishment due to health spending. In addition, utilization of referral services is unequal across governorates and across the different insurance schemes, which suggests inequities in access to these services. These inequities are mostly related to the low performance of the health system due to its fragmentation, limited access due to distances to health facilities, and other mobility restrictions.

65. The MOH acknowledges the social challenges in the sector, and it is making all necessary efforts with key stakeholders, including other PA ministries (e.g., the Ministry of Social Affairs and the Ministry of Labor), local NGOs, and developments partners, in order to ensure adequate coverage of the poor and equitable access within the health system. Additionally, the MOH will continue the consultation process with beneficiaries and civil society organizations so as to make sure that the healthcare system sufficiently covers the poor and marginalized as well as ensures equity within the system. The Project will aim to strengthen the implementation of its monitoring and evaluation (M&E) framework and to guarantee equitable access to the healthcare system for all.

Gender Mainstreaming

66. Access to healthcare is limited for women in vulnerable communities. Restrictions on movement and access continue to impede their utilization of healthcare, particularly women in area C[22], the seam zone,[23] and the Gaza Strip. The WHO tracks equity aspects for the medical referrals in Gaza on a monthly basis. There is evidence of unequal access to referrals by gender. The gender gap in Gaza in terms of outside medical referrals is 59 percent for male patients versus 41 percent for female patients (WHO monthly report, August 2014). In addition, micronutrient deficiencies remain a concern, with high levels of anemia, as well as vitamin A and D deficiencies, recorded for girls, boys and pregnant women. 35.6 percent of pregnant women in Gaza suffered from anemia (UNRWA 2012). The Maternal Mortality Ratio remains high due to delivery procedures, maternal nutrition and poor quality of services.[24] Furthermore, the rate of caesarean sections has doubled in the last decade, reaching 20 percent. A recent study suggests that in the Palestinian territories, the risk of death from caesarean sections is 6 times higher than a normal delivery due to suboptimal operating conditions, lack of training, poor follow-up, and preventive care.[25]

67. The core sector indicator "Number of beneficiaries, percentage of which are female" has been added to the intermediate indicators and will be closely monitored under the project. This will be accompanied by a communications strategy on Universal Health Coverage that would be developed under the project, including series of consultation workshops with the various stakeholders. Additionally, a Grievance and Redress Mechanism (GRM) for OMRs and access to Healthcare will be developed and monitored under the project.

Monitoring & Evaluation

68. As indicated above, overall Project monitoring and evaluation (M&E) responsibilities are the responsibility of the PMU. The PMU, supported by the MOH's Health Information Center, Medical Referrals, Health Insurance, and Finance Departments will manage data collection, aggregation and periodic reporting on the Project's implementation progress and on meeting the PDOs and key performance indicators.

69. The PMU team will maintain a simple M&E system for data collection, as well as output and outcome monitoring, in order to ensure proper monitoring, reporting, and evaluation of the project-funded activities. Gender-sensitive monitoring will be ensured through disaggregation of data when relevant.

22 Area C is the portion of the West Bank under full Israeli civil and security control and covers over 60% of the West Bank.
23 The "seam zone" is the closed area between the Green Line and the separation barrier in which about 11,000 Palestinians currently reside.
24 PCBS, On the Eve of the International Population Day, 2012, PCBS: Ramallah, Palestinian territories.
25 AbdulRahim, et al., *Maternal and* child *health in the occupied Palestinian Territory.* Lancet, 2009. 373(9667): p. 967-977.

70. The PMU will prepare Semiannual Progress Reports, covering progress in the implementation of project activities and providing an update on the Results Framework Indicators (see Annex 1). Two years after Project effectiveness, a midterm review (MTR) of the Project status, achievement of results, management performance and lessons learned will be conducted by the World Bank Team in collaboration with the PMU, and Development Partners. This review will be used to identify performance improvement opportunities and to prepare a revised action plan to guide implementation during the remaining life of the Project.

Role of Partners

71. During Project preparation, the World Bank consulted with Development Partners (DP) working in the health sector who demonstrated a strong interest in coordinating efforts with the Bank to rationalize health sector expenditures and institute important reforms on health sector financing and provision of care. A greater emphasis was placed on improving the health sector's efficiency, quality and standards of care, and improving the MOH regulatory capacity with a clear separation of roles in financing and provision. Lessons learned from previous Bank projects and DP activities were considered in the design of the proposed Project.

72. A review of health sector performance and discussion of new sector challenges during Project implementation will be discussed with the health sector's key players during the regular Health Sector Working Group meetings, including a thematic sub-sector working group on medical referrals. This in turn will ensure harmonization of efforts and open opportunities for potential joint efforts and further engagements in the health sector.

Annex 4: Operational Risk Assessment Framework (ORAF)

West Bank and Gaza: Health System Resiliency Strengthening Project (P150481)

Project Stakeholder Risks	**Rating**	**High**		
Description: Insufficient funds to provide the level of benefits and salaries deemed necessary by the Palestinian Authority (PA) could adversely affect client, Bank, and development partner (e.g., the United States Agency for International Development—USAID and the United Kingdom Department for International Development—DFID) relationships. Insufficient progress to contain healthcare costs and to rationalize the role of the Ministry of Health (MOH) could also negatively affect stakeholder relationships.	**Risk Management:** • A number of development partners, including USAID and DFID, have committed to supporting the PA in its Outside Medical Referrals (OMR) reform agenda. • The PA is working to coordinate complimentary stakeholder efforts since the reform agenda for both OMR and Universal Health Coverage (UHC) is large and complex. • The PA is seeking additional funds from the World Bank and other development partners. • The Bank and development partners will monitor the PA's budget through the budget support operation (to which the Bank and other development partners contribute), which contains certain policy triggers to monitor the budget reforms. • The PA is engaging in additional technical assistance operations with the World Bank and other development partners.			
	Resp: Bank/Development Partners/PA	**Stage: Implementation**	**Due Date : June 30, 2020**	**Status: In progress**
Implementing Agency Risks				
Capacity	**Rating:**	**High**		
Description: The MOH's overall institutional capacity is limited in the areas of monitoring and evaluation (M&E), auditing, procurement, and financial management. Quality of services in the public sector is a major concern and priority, which puts pressure on the public sector to provide OMRs.	**Risk Management:** • The Bank and a number of development partners, such as USAID and DFID, are providing complementary support to the government in health management, M&E, and other key areas to strengthen the Ministry's institutional capacity. More specifically, this capacity building includes hiring external consultants and expertise for the project management unit as well as upgrading the management information system (MIS). • One of the aims of the project is to help improve the quality of care through the provision of technical assistance including capacity building at the primary healthcare (PHC) level, such as training medical personnel, developing clinical guidelines, and upgrading the clinical MIS. Through this investment, a patient satisfaction survey is being considered, which will establish the baseline indicators at the PHC level of patient satisfaction with the quality of care.			
	Resp: PA/MOH	**Stage: Implementation**	**Due Date : June 30, 2020**	**Status: In progress**
Governance	**Rating:**	**High**		
Description: The MOH faces governance challenges. The health sector in the Palestinian territories is fragmented,	**Risk Management:** • This investment will support the Ministry's capacity to oversee the existing health systems in the			

especially since the seven-year split between the West Bank and Gaza, which constrained the Ministry's capacity to regulate the system. The MOH lacks the human resources and technical capacity to formulate healthcare policies, regulate the health sector, enforce the implementation of existing regulations, and oversee compliance with regulations.	Palestinian territories and enhance the Ministry's accountability. • The project will complement the Ministry's efforts to standardize the health sector regulations, rationalize expenditures, and ensure consistent compliance with regulations across the Palestinian territories, as outlined in the Palestinian NDP 2014 to 2016, which emphasizes that the PA aims to achieve "more effective, efficient, and transparent management of the allocation of public finances… [and] more effective delivery of and equitable access to public services." In addition, the MOH has also demonstrated its commitment to this area by preparing the technical referral guidelines related to heart catheterization, including the training of physicians in this procedure.			
	Resp: PA/MOH	**Stage:** Implementation	**Due Date : June 30, 2020**	**Status: In progress**
Project Risks				
Design	**Rating:**	**High**		
Description: Reforming OMRs and GHI constitute a major undertaking and require serious commitment from the PA as well as strong leadership at the MOH to implement these reforms.	**Risk Management:** • The Palestinian Government has demonstrated a firm commitment to reforming the healthcare system, giving top priority to the reduction of referral costs and the rationalization of universal health coverage. The project will build on the efforts of the MOH—with the support of other development partners—in developing explicit guidelines for standardizing procedures related to medical referrals.			
	Resp: PA/MOH	**Stage:** Implementation	**Due Date : June 30, 2020**	**Status: In progress**
Social & Environmental	**Rating:**	**High**		
Description: There are no environmental risks, but as for social risks, there will likely be pressure in terms of ensuring that the healthcare system sufficiently covers the poor and marginalized as well as ensures equity within the system. As of 2010, out-of-pocket (OOP) expenditure accounts for approximately 41% of total health expenditure, which may further burden the marginalized and poor. In fact, the poorest groups bear a higher share of OOP expenditure compared to their total income and are at the greatest risk of impoverishment due to health spending. In addition, restrictions in mobility hinder access to care in the Palestinian territories, particularly in Gaza.	**Risk Management:** • The MOH will need to make coordinated efforts with key stakeholders, including other PA ministries (e.g., the Ministry of Social Affairs and the Ministry of Labor), local NGOs, and developments partners, in order to ensure adequate coverage of the poor and equitable access within the health system. • The project will aim to strengthen the M&E framework to ensure equitable access to the healthcare system for all groups.			
	Resp: PA/MOH	**Stage:** Implementation	**Due Date : June 30, 2020**	**Status: In progress**
Program & Donor	**Rating:**	**High**		
Description: The PA has been unable to close the increasing financing gap for the healthcare system because of changes in GHI revenues, the uncertainty of international aid, and the increasing expenditures for OMRs (which are a result of continuing shortages that push the MOH to refer the patients it is unable to treat to outside facilities). Recent estimates suggest	**Risk Management:** • The PA will need to adjust downward health costs and payments to match its available funds. The PA will continue to receive budget support from the Bank and development partners through the Palestinian Reform and Development Plan, provided that they adhere to the reform agenda and fulfill the policy triggers for cost containment under the DPG. • The MOH has attempted to contain costs and improve service delivery in recent years,			

that these OMRs now comprise over 40% of the public spending in health and have resulted in accumulated unpaid bills to outside providers of over NIS100 million (US$30 million) to East Jerusalem hospitals in 2013.	introducing two National Strategic Health Plans (2014–2016 and 2011–2013) that promote public health measures (e.g., smoking cessation, road safety, cancer screening, etc.) to tackle the growing burden of non-communicable diseases and to reduce public spending on specialty referrals. • The Bank's ongoing Public Expenditure Review provides short-, medium-, and long-term policy options that would assist the PA in achieving efficiency gains in health expenditures.			
	Resp: PA/MOH/Bank/ Development Partners	**Stage:** Implementation	**Due Date : June 30, 2020**	**Status: In progress**
Delivery Monitoring & Sustainability	**Rating:**	**High**		
Description: The MOH has a weak M&E framework and lacks an oversight and auditing mechanism to enforce regulations and ensure the quality of healthcare. With the re-engagement of all development partners, there is a need for the harmonization of efforts and a serious commitment from all key stakeholders to enable the MOH to adhere to its reform agenda. The heavy reliance of the PA on international aid also requires the steady flow of assistance from the Bank and development partners in order to ensure project sustainability.	**Risk Management:** • The complementary efforts of development partners have helped the MOH identify key priority areas, have aligned their support with the health sector strategy, and have avoided the duplication of donor efforts. • The MOH has taken some initial steps toward reforms with the Bank and development partners. For instance, the MOH is working on developing a web-based system (currently being piloted in five Israeli hospitals), which will facilitate the tracking of approved referrals and bills from hospitals by connecting them at the central level and also connecting the MOH with external providers. In addition, the MOH has started on the uniform coding of diagnostics-related groups as well on the auditing process to review the financial claims from Israeli hospitals. The project will continue to build on these efforts. • The MOH has highlighted UHC and reforms to the GHI system as top priorities and has sought technical expertise in undertaking these efforts. The project will help implement this vision and establish this health insurance entity. • The PA will continue to receive budget support from the Bank and development partners, conditional on their adherence to the reform agenda and fulfillment of the policy triggers under the DPG.			
	Resp: PA/MOH/Bank/ Development Partners	**Stage:** Implementation	**Due Date : June 30, 2020**	**Status: In progress**
Other: Political	**Rating:**	**High**		
Description: The envisaged reforms for health insurance are politically sensitive and complex, which calls for a strong commitment and political will from the PA, MOH, local community, and development partners. The MOH needs a supporting legislative framework to enable them to endorse and implement the reforms. However, the MOH might face resistance to implement legislative changes and reforms in this particular area.	**Risk Management:** • The Bank will have to work closely with the MOH by putting in place an agency responsible for the strategic purchasing of services from outside providers and by providing technical assistance to develop actuarial modeling and cost-benefit analyses in order to garner public support, maximize the benefits of the proposed reforms, and mitigate the potential costs of the reforms (particularly to any potential losers of the reforms). Component 3 of the project will tackle this issue by providing the Ministry with best practices as to how to move forward with the reforms.			
	Resp: Bank/MOH	**Stage:** Implementation	**Due Date : June 30, 2020**	**Status: In progress**
Overall Implementation Risk Rating: High				
The overall risk rating is high because of the challenges faced in terms of the wider context of healthcare reform in West Bank and Gaza. The Ministry of Health has				

insufficient capacity to implement the reforms because of budget constraints, limited technical capabilities, and fragmentation of the healthcare system between the West Bank and Gaza.

Annex 5: Implementation Support Plan

West Bank and Gaza: Health System Resiliency Strengthening Project

1. **The Project will be implemented by the Palestinian Ministry of Health (MOH) through the Project Management Unit (PMU).** The PMU will report to the Project Steering Committee (SC). The MOH is legally responsible for coordinating health policy and programs in the Palestinian territories (PT). The PMU will be responsible for carrying out the proposed Project and managing the contracts of the Purchasing Unit and Accreditation Unit in coordination with the procurement unit of the MOH. The PMU will be responsible for ensuring that the Project's technical aspects are executed in a timely manner as defined by the grant agreement.

2. The PMU will provide technical advice to the MOH authorities on all aspects concerning the project related to the functions of financing, provision, and regulation of providers. The PMU will be supported by the MOH's financial management and procurement units to manage the finances and procurement for all resources and provide support to all executing units involved in Project implementation.

Strategy and Approach for Implementation Support

3. The design of the Implementation Support Plan for the proposed Project builds on the experience and lessons learned from the Bank's previous engagements in the health sector. The aim is to align the required implementation support with the Project's key risks and expected results. The Plan will be updated every six months to account for progress made in the implementation of the Project. It includes a consideration of implementation risks, the strategies and actions aimed at mitigating those risks, a detailed schedule summarizing the required supervision missions, and a summary of the required efforts and resource commitments by the Bank to ensure successful implementation.

4. The strategy and approach for Implementation Support is characterized by an important staff presence in the field and great flexibility to provide support from experts in more specialized fields. A significant level of Bank staff effort is necessary to meet the implementation challenges, especially during the first two years. The Bank team comprises the appropriate skills mix and experience, including staff both from the Country Office and from Headquarters (HQ) in Washington, as required for the successful implementation of the Plan.

5. The core task team including the Task Team Leader (TTL), fiduciary staff, the Information Technology (IT) Specialist, Country Economists, and Governance and Public Financial Management Specialist are all based in the country office and therefore, close supervision and implementation support to the MOH will be ensured. In addition, full coordination and harmonization of efforts with all development partners will be conducted. The Bank will also provide continuous technical support through HQ-based staff to deal with more specialized topics, such as health insurance reforms, costing and benefit packages, contracting mechanism for medical referrals, and others. In addition, the technical assistance provided by the World

Bank will continue to develop the MOH's institutional capacity to ensure the sustainability of the proposed reforms.

6. Partnership arrangements between the development partners and the Bank are significant. The development partners (e.g., USAID, DFID, WHO) and the Bank remain committed to providing the necessary technical expertise to support the medical referrals reform process and to build the MOH's capacity in the area of contracting tertiary healthcare services, health management information systems (HMIS) and institutional capacity building.

7. The Bank is well-placed to provide technical assistance (TA) based on the institution's worldwide experience in improving the efficiency of the health systems and health insurance reforms.

Focus	Skills Needed	Resource Estimate: Number of staff weeks and trips	Partner Role
Policy Reform (including medical referrals and health insurance). Fiduciary aspects (ensuring proper contracting and procurement of services, proper management and utilization of funds)	Overall experience in design and implementation of effective and efficient health system projects. Technical knowledge of defining and costing basic benefit packages, contracting with outside providers, health insurance reforms, health economics, and cost benefit analyses.	US$120,000 annually 50 weeks, and two semi-annual supervision and implementation support missions for HQ-based staff. With Bank team in the field, the project is under continuous supervision.	USAID and DFID provide significant funding and TA in capacity building, technical training, contracting, preparation of technical and referrals guidelines, and Management Information System.

II. Skills Mix Required

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Overall experience in the design of effective health systems. Health Economists, Experts in health	40 weeks	At least two semi-annual supervision missions for HQ-based staff.	As most of the team is based in the field, the project is under continuous supervision.

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
insurance reform with technical knowledge on health management information systems, and contracting of tertiary healthcare services. Team Leader: good technical skills, procurement skills and financial management skills.			

III. Partners

There are several international organizations that provide health services in the Palestinian territories. The following table represents the main development partners engaged in the area of Outside Medical Referrals, capacity building and Health Information System.

Table: Development Partners involved in OMRs, HIS and TA activities

Body/Organization	***Objectives and Major Activities***
USAID	**Title:** Palestinian Health Sector Reform and Development Project **Aim:** Building a functional health sector to meet priority health needs **Themes:** Governance, service delivery, procuring medical equipment and commodities, and capacity building. **Collaborators:** MOH, NGOs, community-based organizations, educational institutions **Additional Areas of Work:** HIS, Intra-health • **Flagship Palestinian Health Project – September 2008-November 2014:** the project focused on the roll out of the electronic Health Information System (HIS) to MOH Hospitals and targeted NGO facilities. The project worked with MOH counterparts to install HIS in 8 MOH hospitals (Rafidia, Qalqilya, Alia, Palestinian Medical Complex, Beit Jala, Jericho, Jenin, and Salfit. Installation of the same HIS has been initiated in Makassad Hospital in East Jerusalem. The HIS has 26 modules and can be used as both client registration and as a management tool. The project provided the MOH the open License system and provided the infrastructure, training, and hardware. *USAID hopes to continue to support the roll out of HIS in the remaining MOH hospitals in the future.* • **Intrahealth (Palestinian Health Capacity Project - PHCP), US$15 million– April 2013-March 2018:** This project is designed to assist the MOH in strengthening the oversight and management of the Medical Referrals from secondary to tertiary care. The cornerstone of the approach is a strong partnership with the MOH from the start of the project that supports their leadership in the development, implementation and oversight of a strategy for strengthening the

Body/Organization	*Objectives and Major Activities*
	health workforce and meeting the five project objectives related to governance, workforce planning, development, management and quality assurance (e.g., licensing and certification). The project also works closely with another USAID project that has designed the Referral Tracking web-site that is currently in the demonstration phase with the MOH, MOH and one Israeli hospital and has drafted Model Contracts for Provision of Care for Patients Insured and Referred by the PA. The 4 pillars of the PHCP strategic approach include: Clinical Reform (Referral Protocols, Diagnostic Related Groups (DRG), Continuity of Care; 2 - Management systems reform (streamline referral unit audit & control processes/skills, Use of electronic systems website) 3- Fiscal Reform (Managed contracts with external hospitals, DRG based contracting) 4- Improve quality of health services (licensing and accreditation, raising standards in education/training, ensure access to information) • **Augusta Victoria Hospital (AVH), US$2.9 million – April 2013-2016:** The cooperative agreement was designed to support the AVH efforts to establish a bone marrow transplantation program, which the MOH has identified as a priority, especially given the high external referral costs. The project supported the purchasing of equipment and training nurses and allied health staff in accordance with accreditation requirements and international standards. • **St. John Eye Hospital, US$2.1 million – April 2013-March 2016:** The goal of this grant is to improve eye healthcare of vulnerable Palestinians who live in marginalized areas of the West Bank and to increase eye care awareness through conducting mobile clinics, surgical treatment in cases of preventable blindness, and educational sessions. The project includes the installation of the HIS at St. John Eye Hospital and its satellite centers to improve efficiency and functionality. • **Caritas Baby Hospital, US$2.1 million – April 2013-March 2016:** This grant was established to implement HIS at the Caritas hospital, and procure a Pulmonary Function Test machine to improve Cystic Fibrosis diagnosis and care for children in the West Bank.
EU	**Title:** Mental health and psychological support in the West Bank and Gaza Strip (phase 2) **Aim:** increase accessibility, quality and acceptability of mental health services in the West Bank and Gaza. **Themes: Service delivery** **Financing:** East Jerusalem Hospitals (EJH) arrears: EUR 13 million disbursed in 2013 + EUR 13 million in mid 2014 (+ an additional EUR 2.5 million before the end of 2014).WHO/Mental health : EUR 1.5 million over 3 years (mid-2012 to mid-2015)
WHO	**Title: Technical Assistance and Capacity Building to the MOH** Collaborated with the MOH to develop the national health strategy 2014-2016 and progress underway for a Hospital Master Plan for the West Bank and East Jerusalem. Completed assessment in PHC and Hospital Services. Introducing WHO Package of Essential NCD services (PEN) in PHC. Progress underway to introduce the Family Practice model for PHC. Supporting MOH to strengthen mental health services at policy and strategy level, service provision at secondary and tertiary levels, and integration of mental health into PHC. Implementing the Patient Safety Friendly Hospital Initiative in MOH hospitals. Collaborating with MOH on developing emergency preparedness plans in governmental

Body/Organization	*Objectives and Major Activities*
	hospitals. Also collaborating with MOH to address humanitarian needs in health sector including assessment and reconstruction after Gaza attack in summer of 2014. WHO implementing project to support EJHs and EJH Network including components to improve quality through accreditation and strengthen the Network. WHO also implementing project to establish a national public health institute in the PT. Also, WHO implementing project to advocate right to health, including monitoring referrals and permits and access to health services.
DFID UK	**Title: Technical Assistance and Capacity Building to the MOH in the area of OMRs** Facilitation of a referrals workshop, at MOH request, bringing together a leading cardiologist from the UK and cardiologists from the Palestinian public and private sectors, together with the MOH Deputy Minister, and some donor representatives. The workshop aimed to establish the basic outline for a revised referrals policy, using cardiac care as a pilot area. Guidelines were drafted to reflect the findings of the workshop, approved by MOH and distributed to all MOH cardiac catheterization-referring doctors. Also at MOH request, a temporary additional staffer was hired to assist the MOH in analyzing referrals and dealing with Israeli hospitals, at the Referrals Department in Ramallah.

Annex 6. Sectoral and Institutional Context

West Bank and Gaza: Health System Resiliency Strengthening Project

1. **The health system in the Palestinian territories has two distinguishing features:** (i) it operates in a context of political instability and conflict under Israeli control, undermining effective system governance; and (ii) its financial viability is severely constrained by its dependence on donor funding, which is subject to fluctuations based on political considerations. These features, in conjunction with the recent war and resulting emergency situation as well as the chronic mobility restrictions imposed by Israel, pose many challenges for the Palestinian health sector, including areas related to health outcomes, effective service delivery, access to health services, quality of care, human resources for health development and capacity, fiscal sustainability, governance and accountability, investment planning and management, and creation of a long-term vision and strategy for the development of the health sector.

2. **The recent conflict in Gaza (July – August 2014) greatly compromised an already weakened health sector.** The blockade on Gaza and frequent closure of the Rafah crossing since June 2013 has resulted in severe shortages of medicine, medical equipment, spare parts, fuel and clean water. The salaries of some staff working in Gaza hospitals[26] have not been paid since March 2014 and, furthermore, severe shortages of drugs, with close to half of the drugs to be provided by the Ministry of Health (MOH) to the largest hospital in Gaza, Al Shifa hospital, not being available undermined the provision of health services. In addition, the restrictions on transportation resulted in a shortage of medical equipment and spare parts, as well as fuel for generators, which were crucial to ensuring the uninterrupted functioning of hospitals, given the frequent electricity outages.

3. **The impact of the conflict was particularly pronounced in the health sector in Gaza.** The incursion, which started on July 7**,** 2014 lasted for 51 days[27]. The conflict has resulted in 2,145 deaths and 11,231 injuries in Gaza, with a significant proportion of those who lost their lives and incurred injuries being Palestinian children and the elderly[28]. Medical institutions, staff, equipment and supplies have undergone extremely difficult conditions. It is worth noting that the increase in injuries and trauma patients also led to a shortage of emergency medicines, medical equipment, and spare parts. This shortage of several critical emergency medicines such as pain killers, anesthetics, and saline solutions restricted the facilities' ability to provide care. In addition, there was a shortage of psychotropic medicines to treat relapses of post-traumatic stress disorder and anxiety in the general population. The ongoing shortages in medicines, medical equipment and spare parts will continue to hinder the continuity of service delivery and management of life-threating chronic diseases such as cardiovascular disease, cancer, chronic respiratory disease, and diabetes, in the period following the de-escalation of the conflict.

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26 A total of 5,355 Gaza staff were directly hired by the de facto authorities in Gaza prior to the consensus government and have not yet been integrated as PA's civil servants.

27 Health Cluster in the Occupied Palestinian Territory. (September, 2014). *Gaza Strip Joint Health Sector Assessment Report*. Gaza: Health Cluster.

28 World Health Organization. (September 5, 2014*). Situation Report #11 covering period August 29 and September 5, 2014*. Gaza: WHO. Retrieved from http://www.moh.ps/attach/768.pdf on September 12, 2014.

4. About 58 percent of all health facilities in Gaza were damaged during the conflict. It is estimated that during the height of the conflict, 59 out of 129 public health facilities, corresponding to about 46 percent, were unable to provide services, 11 out 31 hospitals (about 25 percent) and 48 out of 97 primary healthcare centers (about 49 percent) were closed. This translated to about a nine percent reduction in available bed capacity. The disruption in service delivery resulted in about an 81 percent decrease in elective surgeries in July 2014. The Shifa and Nasser Hospitals reported increases in neonatal mortality.

5. **The shutting down of checkpoints severely restricted the ability of facilities to refer patients for treatment at outside hospitals.** Prior to the recent incursion, referral patients were facing considerable difficulties due to mobility restrictions. During the conflict, crossings in Egypt and Israel were both shut down, which exacerbated already constrained access to care in hospitals in East Jerusalem, the West Bank, and Egypt. As a result, referrals steeply dropped and in July only 580 referrals, corresponding to about only 32 percent of all requests were issued, and in August, only 839 referrals (about 45 percent of all requests were issued.

6. **US$12.6 million in essential medicines and medical supplies were mobilized by the international community to date in order to support the health system.** In addition, three health working groups, including (i) Mental health and psychosocial services, (ii) Foreign medical teams coordination working group led by International Medical Corps, and (iii) Disability working group, to help support the health needs of the population.

7. **Restrictions in mobility hinder access to care.** Israeli Authorities hinder the movement of Palestinians between and within Gaza and the West Bank. In the latter, movement is restricted via checkpoints, military orders, policies, and practices. In Gaza, there are only two exits for patients to reach hospitals outside of the Gaza Strip. When Palestinians are referred to specialized hospitals in East Jerusalem, Israel, or Jordan, they are required to apply for an Israeli-issued permit to access healthcare. Applications are submitted through the Palestinian General Authority of Civil Affairs office, which submits them to the Israeli Liaison Office and receives the response. Children under 18 years old must be accompanied by a first-degree relative with a valid permit. The application processes hinder access in two dimensions. First, the procedures often result in significant delays in receiving treatment. Second, not all permits are approved.

Health Status

8. **Remarkable progress has been made in improving child and maternal mortality.** Between 1990 and 2010, the maternal mortality ratio (MMR) has decreased from 90 per 100,000 live births in 1990 to 64 in 2010, lower than the Middle East and North Africa (MENA) average of 74 in 2010 (UN, 2013; World Bank, 2013a). Furthermore, the territories perform better in terms of improving child health compared to the MENA region as a whole: the under-5 mortality rate (U5MR) has been halved from 43.1 per 1,000 live births to 22 between 1990 and 2011, lower than the MENA average of 26.1 in 2011. In addition, the infant mortality rate was 13.5 per 1,000 live births in 2012.

9. **Notwithstanding these important improvements, the Palestinian territories are unlikely to reach Millennium Development Goal (MDG) 4.** The reasons for this relatively

slow decline include deterioration in health conditions and changes in the causes of death. For instance, some of the main causes of death among infants and children shifted from diarrhea and infectious diseases to prematurity and low birth weight (13.4 percent of all deaths) as well as congenital defects (16 percent of all deaths). However, pneumonia and other respiratory disorders remain leading causes of death (34 percent of all child deaths). Deterioration in access to health services due to the Palestinian-Israeli conflict is also another key reason for the slow decline.

10. **There are significant regional disparities in child mortality indicators.** The Palestinian Family Health Survey (PFHS) showed that the Infant Mortality Rate (IMR) and Under-5 Mortality Rate (U5MR) have persistently been higher in Gaza compared to the West Bank over the last decade, with the mortality gap widening for both indicators. The PFHS estimated that the IMR in Gaza was 20.1 per 1,000 live births between 2005 and 2009, which is higher than the IMR in the West Bank, which is 18.1 per 1,000 live births. In the same period, the U5MR was 26.8 per 1,000 live births in Gaza, compared to 20.9 in the West Bank. Moreover, child mortality also varies depending on the type of residency. The IMR and U5MR are higher in rural areas and camps, compared to urban centers across the territories. The IMR and U5MR were the highest in refugee camps (20.9 and 26 per 1,000 live births, respectively), followed by rural areas (20.8 and 25.9 per 1,000 live births, respectively), and the lowest in the urban centers (18.2 and 22.4 per 1,000 live births, respectively)[29].

11. The Palestinian territories are going through an epidemiologic transition, with a rising burden of chronic diseases—mainly cardiovascular diseases, diabetes, and cancers. In 2012, heart disease was the leading cause of death in the West Bank, causing 31.2 percent of all reported deaths. Cancers, when combined together, were the second leading cause of death, accounting for 13.7 percent of all deaths, followed by cerebrovascular diseases (12.2 percent), infant diseases and prenatal conditions (9.2 percent), and diabetes mellitus (6.4 percent).

Health Facilities and Human Resources

12. **The World Health Organization estimates that about 58 percent of all health facilities in Gaza were damaged in the recent conflict.** Several health facilities were hit, resulting in deaths of patients and health workers. Of 32 hospitals in Gaza, one hospital (Al Wafa Medical Rehabilitation NGO Hospital) was destroyed; 17 hospitals reported damages in various degrees; and seven hospitals were closed due to incurred damages or security concerns as of August 27, 2014. In addition, 13 of the currently functioning hospitals operate despite reported damages. Several primary healthcare centers were also hit during the conflict. Of 58 primary healthcare clinics in Gaza, 5 MOH clinics in Shaja'yia, Fukhari, Khuzaa and Wadi Gaza districts, one NGO clinic (Palestinian Red Crescent) in Sheik Ajleen district and one Palestinian Military Medical

29 PCBS.(2013). *Palestinian family health survey: Monitoring the situation of children and women.* Ramallah: Palestinian Central Bureau of Statistics.

Services (PMMS) clinic in Al Twam district were destroyed. In addition, 14 ambulances were destroyed and 33 were partially damaged[30].

13. **The Palestinian territories (PT) have a pluralistic service delivery model. A complex amalgam of service providers operates in the Palestinian territories.** The public sector, comprised of the MOH and the PMMS, is the main service provider. The MOH has a network of 460 primary healthcare centers (PHCCs, 404 in the West Bank and 54 in Gaza in 2012), and 25 hospitals (12 in the West Bank and 13 in Gaza). The PMMS focuses largely on primary healthcare services through 23 PHCCs (16 in the West Bank and seven in Gaza) and provides secondary and tertiary care services in three hospitals located in Gaza. Non-governmental Organizations (NGOs) have historically played an important role in service delivery, especially in providing tertiary, ambulatory and rehabilitative care services. In 2012, NGOs operated 206 PHCCs (140 in the West Bank and 66 in Gaza) and 33 hospitals (19 in the West Bank and 14 in Gaza). UNRWA plays a critical role in providing services to registered refugee populations, mainly through primary healthcare clinics; UNRWA operates 61 PHCCs (41 in the West Bank and 20 in Gaza) and one hospital in the West Bank. Finally, there are 17 private hospitals, all located in the West Bank. Overall, the private sector in the PT is limited and mainly provides maternal and child health services. The distribution of PHCCs and hospitals does not match the population size in the governorates (e.g., compared to the West Bank, Gaza is under-served). Furthermore, hospitals and health centers in the Palestinian territories suffer from a lack of new technologies, outdated equipment, and a shortage of health personnel. In 2012, the number of physicians per 10,000 people in the population was 20.2 across the territories (compared to 27.1 in Jordan and 36.5 in Lebanon). The number of nurses per 10,000 people was also low compared to its neighbors (46.6 in Jordan and 29.1 in Lebanon). Furthermore, the Palestinian territories suffer from acute shortages in certain sub-specialties (e.g., oncology).

Health Financing and Financial Protection

14. **Total health expenditure in the territories is among the highest in the world**. Total health expenditure increased from 8.3 percent of GDP in 1995 to 12.3 percent in 2012. In the period following the Second Intifada, the overall health expenditures continued to increase and averaged at 11.5 percent between 2000 and 2007. In 2008, it reached 14.3 percent of GDP (the highest level in the last decade). Although total health expenditure has slightly declined since then, it remains high. In 2012, it stood at 12.3 percent of GDP. This is significantly higher than the MENA average of 4.6 percent, and it surpasses the overall health spending of many advanced economies, such as France and Austria (11.7 percent in France and 11.5 percent in Austria in 2012)[31] (See Annex 7 for further information on health financing in the Palestinian territories).

30 Ibid.

31 However, this comparison should be interpreted with caution because the Palestinian territories are not a sovereign state, and as such, they do not have several typical line expenditures (e.g., military), which means that by definition the total health expenditure as a share of GDP is expected to be high. Furthermore, the territories pay significantly high prices for outside medical referrals and pharmaceuticals, which inflate overall health spending.

15. **Out-of-Pocket (OOP) spending is the main source of health financing**. In 2012, households' OOP expenditure accounted for 39.8 percent of total health expenditure, followed by general government spending (38.7 percent), non-profit institutions serving households (18.3 percent), and other external sources (0.9 percent). A 2006 study indicated that more than 13% of individuals fell into poverty and another 13 percent fell into extreme poverty due to healthcare expenses. The general impoverishment of the population makes it vulnerable to healthcare expenditure, and the scarcity of high quality government health services makes them more prone to going to private, more expensive health providers. Expenditures on medications and due to chronic conditions, exacerbated by the lack of prevention and poor primary care, are a major contributing factor. The poorest groups bear a higher share of OOP expenditure compared to their total income and are at the greatest risk of impoverishment due to health spending.

16. **The health system has a segmented financing model incorporating both tax-based and premium-based financing for different segments of the population who receive healthcare through a myriad of public and private profit and not-for profit providers.** There is no separation of functions in the Palestinian health system: the MOH is payer, provider, and regulator of the health sector. The MOH receives its revenue from tax revenues and external donors and investors, and it delivers health services in government facilities through cost-sharing under the Government Health Insurance (GHI) scheme. The MOH also purchases tertiary care for services abroad when the needed medical services are not available in the territories.

17. **The GHI scheme, administered by the MOH, provides health insurance coverage to seven population groups and acts as the last resort for the uninsured**. The benefits package is comprehensive and includes maternal and child health services, primary healthcare (PHC), and prescription drugs; in addition, it covers services purchased from non-MOH providers such as East Jerusalem Hospitals or hospitals operating in neighboring countries (e.g., Egypt, Jordan, and Israel). The GHI revenue collection mechanism is highly fragmented. The composition of GHI enrollees has witnessed significant changes in the last decade, with an increase in the number of non-contributing members. As a result, GHI revenues have been increasing at a much slower rate than the number of GHI enrollees. Between 2009 and 2012, GHI revenues have increased by about 32 percent, whereas the number of GHI enrollees increased by about 47 percent, reaching almost 167,000 people.

18. **Financial sustainability remains a challenge.** The MOH financing gap is increasing due to changes in GHI revenues and the uncertainty of international aid, coupled with rising expenditures. Furthermore, public expenditures on salaries are on the rise. On several occasions during the past two years, public sector health workers working in Gaza were not paid their salaries on time[32] or they only received partial payments. It is estimated that salary arrears are about US$38 million. Pharmaceutical expenditure is also rising, despite acute shortages in essential drugs. In 2013, pharmaceutical expenditures accounted for 47 percent of non-salary public expenditures. Expenditure on drugs has shown large fluctuations, increasing by 29 percent between 2010 and 2011, mirroring, and partially driving, the increase in overall public

32 These include Gaza staff, totaling 5,355, who were hired by the de facto authorities in Gaza prior to the consensus government and have not yet been integrated as PA's civil servants. The estimated monthly wage bill of those employees is ILS 14.7 million.

expenditure on health. The Ministry of Health pays relatively high prices for pharmaceuticals, as pharmaceutical companies actor in the cost of delayed payments in their pricing.

Annex 7: Health Financing in the Palestinian territories (PT)

West Bank and Gaza: Health System Resiliency Strengthening Project

1. **Health expenditure is increasing** (Table 1). Total health expenditure more than tripled in the last decade from US$126 million in 2000 to US$1.3 billion in 2012. In this period, public spending on health almost quadrupled from US$126 million to US$488 million and out-of-pocket (OOP) spending increased from US$152 million to US$502 million. Expenditures of non-profit institutions serving households (NPISH) also increased in the last decade from US$90 million to US$231 million. In addition, private insurance enterprises spent about US$231 million in 2012, increasing from US$90 million in 2000. Palestinians living abroad also contribute to health financing, increasing from US$7 million to US$11 million in 2012. OOP spending continues to surpass public spending on health.

Table 1: Trends in health financing, in millions US$, Palestinian territories, 2000-2012

Health Spending	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total*	384	372	386	417	528	557	624	684	894	959	1,075	1,201	1,262
Public*	126	114	125	153	212	214	222	243	328	346	390	424	488
OOP*	152	154	134	151	193	190	215	293	328	403	440	518	502
Private insurance enterprises*	10	8	8	8	10	12	15	14	29	13	27	18	29
Non-profit institutions serving households (NPISH)*	90	89	98	98	109	121	134	114	189	168	196	228	231
Palestinians living abroad*	7	6	21	7	5	20	38	21	20	29	23	13	11
Health expenditure per capita (current US$)	125.9	118.4	119.7	125.8	155.0	158.9	172.8	183.9	233.6	243.7	265.5	288.1	293.9

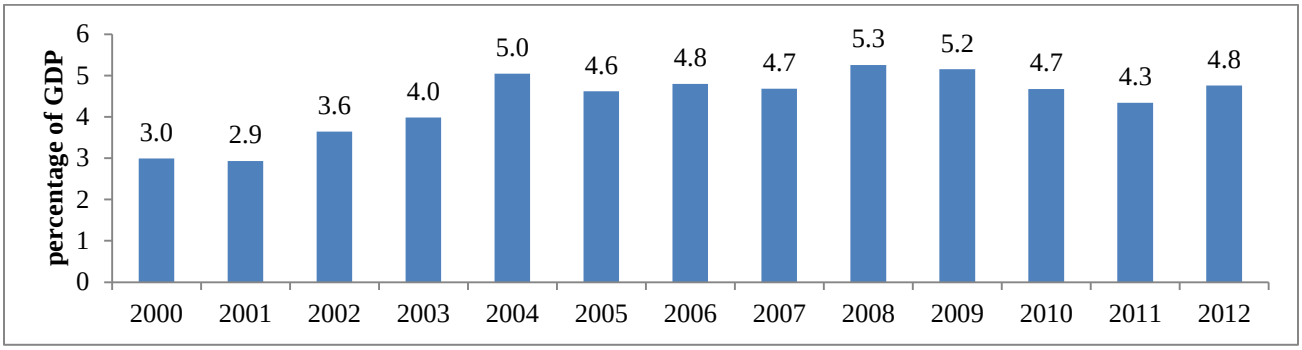
Source: PCBS&MOH, 211, 2012, 2014

2. **Total health spending in the PT as a share of GDP is among the highest in the World.** Despite the slight decline in total health expenditure as a share of GDP in recent years, the overall health spending in the PT is among the highest in the World, surpassing health expenditures in many advanced economies, such as France and Austria. However, this comparison should be interpreted with caution because the PT, not being a sovereign state, does not have several typical line expenditures (e.g. military), which means by definition the total health expenditure as a share of GDP is expected to be high. Furthermore, the PT pays significantly high prices for outside medical referrals and pharmaceuticals, which inflates overall health spending. Finally, the Israeli restrictions and their implications on planning, management, and population mobility significantly hinder the efficiency of the system, increasing the cost per unit of health purchased.

3. **Public spending on health as share of GDP has increased over the last decade.** Public spending on health increased from three percent of GDP in 2000 to 4.8 percent in 2012, higher

than the Middle East and North Africa (MENA) average of 2.6 percent and lower-middle income country (LMIC) average of 1.7 percent of GDP in 2012.

Figure 1: Public spending on health as percentage of GDP (%), Palestinian territories, 2000-2012



Source: Authors calculations based on PCBS & MOH, 2010, 2012, 2014 [31-33]

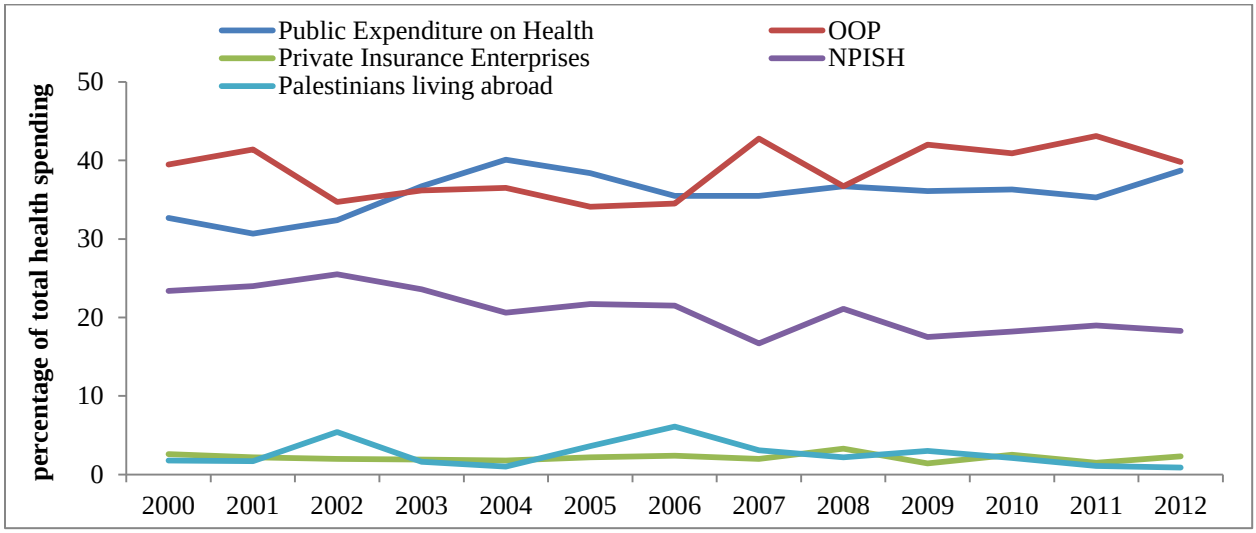
4. **Public spending on health relies heavily on increasingly unpredictable donor funding.** Over the past decade, the PA has benefitted significantly from external aid provided by the international community. Notwithstanding, aid flows have shown large fluctuations, particularly depending on the political economy considerations. After peaking at 30 percent of GDP in 2006, external support declined to 15 percent of GDP in 2010 and nine percent in 2012. In the short-term, donor aid is projected to decline further to 8.6 percent of GDP between 2014 and 2018. The heavy reliance on donor funding is a significant challenge for the Palestinian health sector and the unpredictable nature of the aid flow hinders the MOH's ability to prepare and implement medium- and long- term health reforms and plan allocation of resources. Furthermore, the MOH faces the risk of running high arrears given that donor funding is an important means of covering recurrent expenditures.

Sources of Funding

5. **The PT mobilizes resources from public, private, non-profit institutions and Palestinians living abroad.** Private spending of Palestinian households on health constitutes a significant proportion of total health spending; in 2012, households' out-of-pocket spending accounted for a percentage of total health expenditure higher than many countries in MENA (e.g., Jordan: 28.5 percent, Tunisia: 35.5 percent) and the overall MENA average of 35.5 percent. High OOP spending indicates that Palestinians are not protected from financial shocks due to health events. The public sector, comprised of central, state and local government units, as well as social security funds administered by these units, is the second main source of health financing; in 2012, public health expenditure represented 39 percent of total health expenditures. Public funds for health are generated through general taxes raised by the Ministry of Finance (MOF) and the Government Health Insurance scheme. NGOs serving households across the Palestinian territories also play a role in health financing; in 2012, 18 percent of total health spending was mobilized by non-governmental organizations (NGOs). NGOs can be categorized in three broad categories: (i) those providing services to businesses (e.g., chamber of commerce); (ii) those operating in partnership with the public sector (e.g., government owned hospital); and (iii) those providing services directly to the households, such as charities, trade unions, professional unions, churches, and privately financed aid organizations. In addition to these

actors, private insurance enterprises account for two percent of total health spending and funds from Palestinians living abroad account for less than one percent. Over the last decade, as NGO expenditures on health have declined, public expenditures have increased to fill the gap.

Figure 2: Sources of health financing as a share of total health spending, Palestinian territories, 2000-2012



Source: PCBS & MOH, 2010, 2012, 2014

6. **MOH spending has more than doubled in the last decade** (Table 2)**.** Following the Second Intifada, MOH spending showed a two-year contraction from US$95 million in 2000 to US$88 million in 2002. Between 2003 and 2013, it increased from US$122 million to US$286 million, an increase of 134 percent, though there has been a small decrease between 2012 and 2013.

Table 2: MOH expenditure, Palestinian territories, 2010-2013

(in US$ millions)	2010	2011	2012	2013
Recurrent Salary Expenditure	91	159	164	176
Recurrent Non-Salary Expenditure	104	97	129	108
Pharmaceutical Expenditure	50	48	70	47
Medical Referrals	46	40	49	52
Other	8	9	10	9
Capital Investment Expenditure	2	1	1	1
MOH expenditure as % of GDP	2%	3%	3%	3%
Total MOH Expenditure	197	257	295	286

Source: MOH, 2014

Government Health Insurance

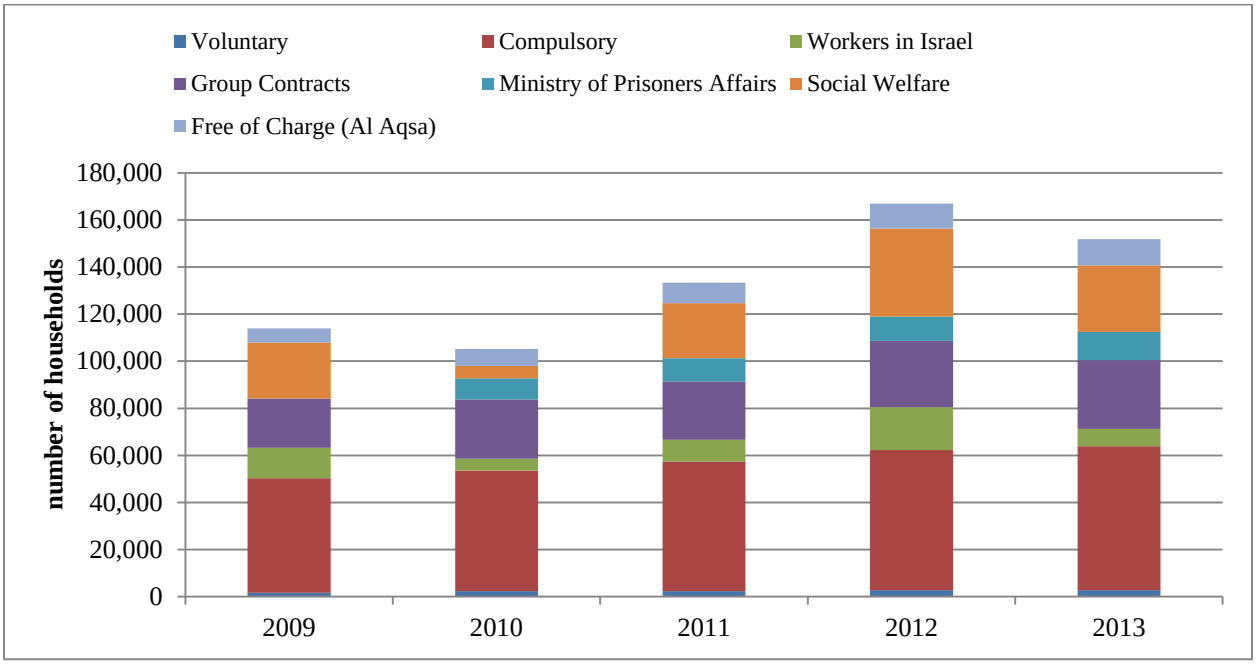
7. The Government Health Insurance (GHI) scheme was established in 1994 in order to provide health insurance coverage to the Palestinian population. Administered by the Ministry of Health, the GHI provides coverage to seven population groups: (i) public sector

employees on a compulsory basis; (ii) private individuals and households on a voluntary basis; (iii) Palestinian workers residing in Israel on a compulsory basis; (iv) businesses and employers (contract groups); (v) eligible Palestinians through the Commission of Detainees and Ex-Detainees Affairs; and (vi) social hardship cases. In addition to these population groups, the MOH acts as the insurer of last resort through the Al-Aqsa scheme and all Palestinians residing in Gaza are covered by the GHI scheme free of charge (MOH, 2014). All Al-Aqsa enrollees must be identified as "unemployed" by the Ministry of Labor. The benefits package is comprehensive and includes maternal and child health services, primary healthcare, prescription drugs, as well as services purchased from non-MOH providers such as East Jerusalem Hospitals or hospitals operating in neighboring countries (e.g. Egypt and Israel).

8. **The number of non-contributing GHI enrollees increased in the last decade compared to the number of contributing members, damaging the scheme's finances.** In 2013, approximately 151,873 households in the West Bank were covered by one of the health insurance schemes (increasing from almost 114 thousand households in 2009). This corresponds to about 804,926 out of 2,719,112 people who had health insurance coverage in 2013 in the West Bank[33] (approximately 30 percent of the population residing in the West Bank). In 2000, the majority of GHI enrollees were public employees covered on a compulsory basis, followed by contract groups, and workers in Israel. Between 2000 and 2007, the number of Al-Aqsa enrollees (non-contributing members) increased while the number of insured Palestinian workers in Israel declined significantly, impacting the Ministry of Health's capacity to collect revenues in order to finance GHI expenditures. The decline in the number of insured Palestinian workers in Israel continued between 2009 and 2012 from almost thirteen thousand families to seven thousand. Consequently, the share of Palestinian workers in Israel as percentage of overall GHI enrollees declined from 11.3 percent to 4.8 percent. Concurrently, the number of Al Aqsa enrollees almost doubled between 2009 and 2012 from about six thousand families to eleven thousand families. In 2013, Al Aqsa enrollees represented about 7.4 percent of all GHI enrollees, compared to 5.2 percent in 2009. On the other hand, the number of GHI enrollees covered by the Social Welfare declined considerably from about thirty seven thousand families to twenty eight thousand between 2012 and 2013. In 2013, public sector employees accounted for 40.3 percent of all GHI enrollees, followed group contracts (19.2 percent), hardship cases receiving social assistance (18.6), and workers in Israel (4.8 percent)[34].

33 The average household size in the West Bank in 2013 was 5.3 people in 2013 (MOH, 2014).
34 MOH. (2014). Annual Health Report 2013. Ramallah: Ministry of Health

Figure 3: GHI enrollees by type, West Bank, 2009-2013



Source: MOH, 2009-2014

Note: (1) The MOH Annual Report does not contain data from the Gaza Strip. (2) All population in Gaza Strip are covered by the GHI scheme for free (MOH, 2014).

9. **The GHI revenue collection mechanism is highly fragmented, which undermines the Ministry of Health's ability to collect revenues.** A large proportion of the GHI revenues are firstly pooled by the MOH. The MOF deducts the contributions of the public sector employees automatically from their salaries and makes annual transfers from the Ministry of Social Affairs (MOSA) budget to the GHI pool in order to cover the contributions of the social hardship cases. The MOF also receives the contributions of the Palestinian workers in Israel through the Israeli Authority on a monthly basis. In addition, those who are enrolled in the GHI scheme on a voluntary basis pay their contributions to the health directorates every six months or once a year. The contributions of contract groups are received collectively through employers either on a monthly or yearly basis.

Table 3: Government Health Insurance Contributions

Beneficiary category	Monthly premium	Collection system
1. Compulsory	5% of the basic salary—with a minimum amount of NIS 40. The minimum amount is not applied to retired people.	Automatically deducted from the salary and transferred from the MOF to the GHI account.
2. Voluntary	NIS 75 per family and NIS 50 for any individual.	To be paid to one of the health directorates in the West Bank or to the post offices in Gaza monthly, every six months, or yearly.
3. Workers in Israel	NIS 75 per month—the Israeli Authorities deduct NIS 93 and reimburse only NIS 75	The Israeli Authority pays the premiums (NIS 75) to the

	for GHI. Workers should have to pay NIS 93 but have not paid since November 2000.	Palestinian MOF on a monthly basis.
4. Contracts[1]	5% of the overall salary with a minimum amount of NIS 50 and a maximum amount of NIS 75.	Payments are made collectively through the employers on a monthly or yearly basis.
5. Special Hardship Cases	NIS 45 per month per family.	The MOF is making transfer payments from the MOSA budget to the MOH account for all beneficiaries once a year.
For all categories	Premiums for additional dependents: NIS 5 per month for each additional dependent.	Amount is included in the monthly premiums.

[1] This group includes workers registered in the labor union employed in the Palestinian territories.
Source: MOH 2006.

10. For various services provided by MOH facilities, the insured have to contribute fixed co-payments. Those include drug co-payments (NIS 3 per item, NIS 1 for children), laboratory co-payments (NIS 1/NIS 6 per test depending if for routine or culture test), co-payments for X-rays (NIS 2/NIS 18 depending if normal or colored), ultra-sounds (NIS 6), CT-scans (NIS 50), ECGs (NIS 9), and co-payments for services in referral facilities (non-governmental services and services abroad).[35] There are a number of other treatment co-payments for non-MOH facilities, but they have not been enforced since the beginning of the economic crisis in 2000. Furthermore, there appears to be no empirical or actuarial basis for the numbers provided for premium contributions, floors, ceilings, dependent premiums, copays, etc.

Table 4: Government Health Insurance Co-payments for Treatment in Non-Ministry of Health Facilities

Service type	Category of Insured	Co-payment
Outside the MOH in the West Bank and Gaza	• Compulsory insured	5%
	• Social Cases	10%
	• Voluntary insured (continuous payments more than five years)	10%
	• Voluntary insured (continuous payments but less than five years)	20%
	• Voluntary insured (2 to 6 months)	25%
Emergency services	• Voluntary insured (less than 2 months)	35%
Exceptional cases referred by the	• All insured	5%

35 Exemptions for co-payments are cancer treatment, dialysis and kidney transplantations for children, communicable and infectious diseases and blood diseases (like Hemophilia and Thalassemia).

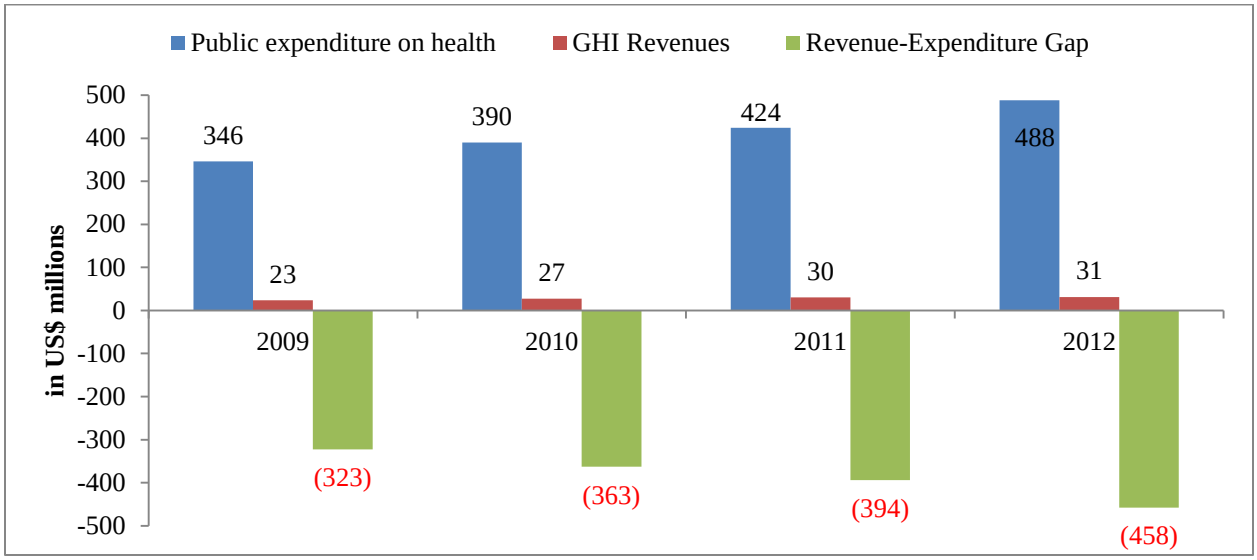
President		
Operations like artificial joints, Cesarean sections, bolts, mineral plates, heart beat regulators, arteries support, artificial valves	• All insured	25%

Source: MOH 2006.

11. **The GHI revenues have been increasing, but at a rate slower than the increase in the number of GHI enrollees, thus increasing the financial gap of the GHI.** The GHI revenues have increased from US$23.5 million in 2009 to US$30.7 million in 2012 and US$33.4 million in 2013 (which is still less than US$35 million collected in 2000) while, during the same period, the number of GHI enrollees increased by 33 percent and reached 151.8 thousand families in the West Bank. It should be noted that between 2012 and 2013, the number of households covered by the GHI declined from almost 167 thousand to 152 thousand in the West Bank. It is estimated that in 2013, approximately 850 thousand Palestinians residing in the West Bank had been covered by the GHI. Between 2009 and 2013, the GHI revenues generated by the contributions of public sector employees increased from about US$12.4 million to US$18.8 million but, despite this increase in contributions, the proportion of public sector employees as share of total GHI revenues declined from 53.1 percent to 47.3 percent. Contributions from contract groups also increased from US$3.8 million to US$5.5 million and the proportion of contributions from contract groups as share of total GHI revenues has increased slightly from 16.2 percent to 16.5 percent. Contributions from those who are receiving social assistance also increased from US$2.8 million in 2009 to US$4.3 million in 2012, but declined to US$3.9 million in 2013. Contrary to these trends, contributions from voluntary enrollees continued to account for only a very small portion of the total revenues, slightly decreasing from 1.7 percent to 1.5 percent between 2009 and 2013. In addition to contributions of enrollees, copayments are an important part of the GHI revenues. Between 2009 and 2013, copayments increased from US$3.9 million to US$5.8 million. This increase in the total copayment was mirrored by the increase in the proportion of copayments as share of total GHI revenues from 16.9 percent to 17.5 percent (MOH, 2014).

12. The imbalance between the GHI revenues and public expenditures on health is growing. GHI scheme was originally designed to provide additional funding for the MOH expenditures. In 2000, public expenditure on health was US$125 million while GHI revenues reached US$35 million. By 2009, the public expenditure on health reached US$346 million, while GHI revenues declined to about US$23 million. Since 2009, the GHI revenue and public expenditure on health has been widening as the GHI revenues have not been able to match the increase in public expenditure on health. In 2012, public expenditure on health reached about US$ 488 million and GHI revenues were around US$31 million, undermining the sustainability of the health financing.

Figure 4: GHI revenue and public health expenditure gap, Palestinian territories, 2009-2012



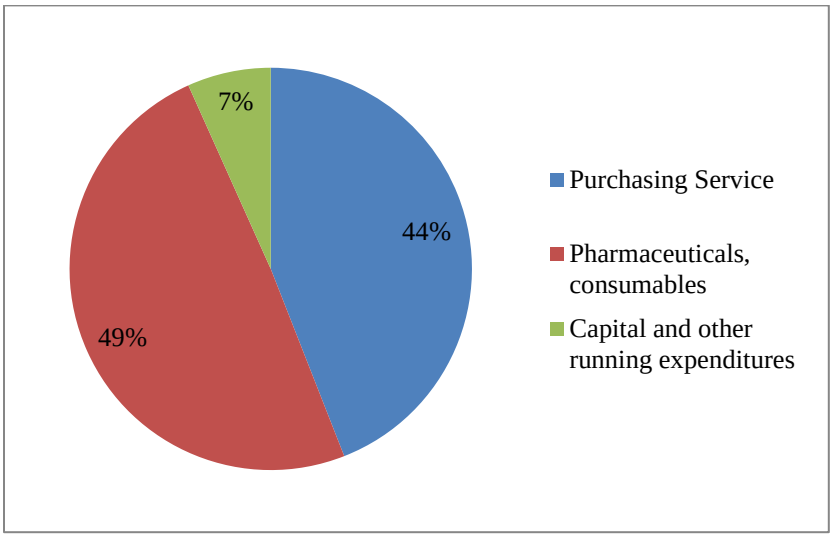
Source: MOH, 2009-2014

13. GHI expenditures have been increasing rapidly exacerbating the already constrained fiscal position of the MOH. GHI expenditures, as a percentage of the total health expenditures, were 5.2 percent in 2000 and fluctuated between 6.2 percent and 4.7 percent until 2005. Starting from 2005, they have increased steadily and reached 15 percent of total health expenditures in 2010. This sizable increase in the GHI expenditures adds additional pressures to its already constrained fiscal position.

14. **In 2013, the arrears corresponded to more than half of the MOH's spending.** The MOH reported that in 2013, arrears due to spending on pharmaceuticals, consumables, referrals, capital and other running expenditures reached about US$193 million, corresponding to about 54 percent of the MOH's actual spending[36]. More specifically, almost half of the MOH arrears, excluding salaries, were due to spending on pharmaceuticals and consumables. Arrears due to referrals represented about 44 percent of MOH arrears, excluding salaries, and reached about US$85 million. Lastly, arrears from capital and other running expenditures were almost US$13 million.

36 This calculation is based on expenditure figures reported in the MOH Annual Health Report 2013. The MOH's total expenditure in 2013 used for this calculation differs from the figure listed in Figure 5 due to the aforementioned inconsistencies between different reports. The team decided to use this figure in order to maintain internal consistency of the calculation.

Figure 5: MOH arrears, Palestinian territories, 2013



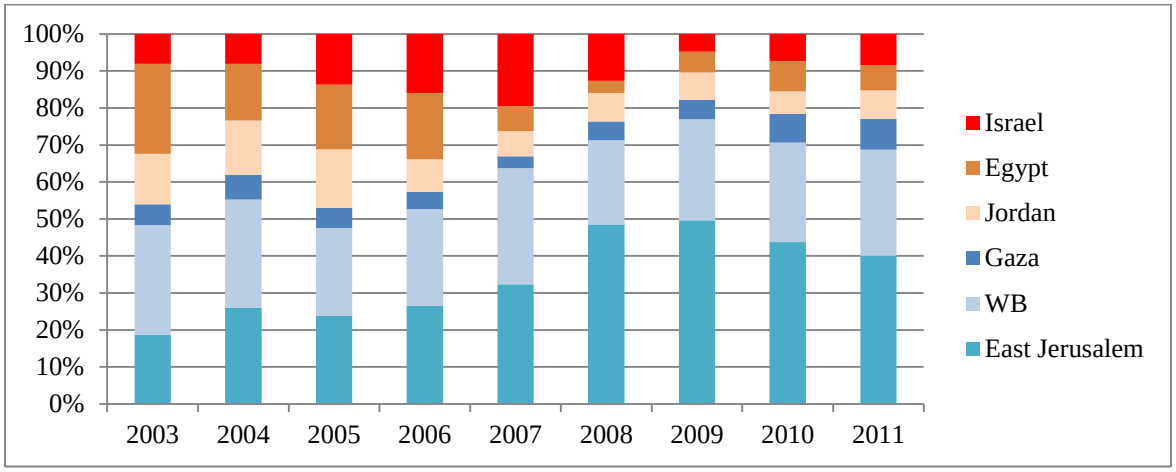
Source: MOH, 2014

Annex 8: Outside Medical Referrals in the Palestinian territories (PT)

West Bank and Gaza: Health System Resiliency Strengthening Project

1. **The lack of availability of certain treatments, medications, medical staff, equipment and infrastructure has resulted in a referral system** where a large volume of patients requiring tertiary-level care are referred to a mix of private (for profit) and non-profit service providers outside of the public health system. In the last decade, the number of outside referrals increased drastically from 8,123 in 2000 to 61,635 in 2013. Patients are referred to service providers within the West Bank and Gaza, hospitals located in East Jerusalem, or neighboring countries including Egypt, Jordan, and Israel. Until recently, Jordan was among the top destinations for referrals, especially from the West Bank. However, due to significant delays in payments in recent years, Jordan has almost halted receiving Palestinian patients.

Figure 1: Destination of outside referrals by region and country, 2003–2011



Source: World Bank, 2014

2. **There are differences in the rates of referrals across governorates.** In 2011, the referral rate was 14.9 per 1,000 population in the West Bank and 11.3 per 1,000 population in the Gaza Strip. In the West Bank, the highest referral rates were observed in Jericho and Ramallah (28 and 18 per 1,000 population, respectively), Bethlehem (15.6 per 1,000 population) and Hebron (13.9 per 1,000 population). In the Gaza Strip, the highest referral rate in 2011 was in Gaza City with 31.9 referrals per 1,000 population. Several factors contributed to these differences, including local supply of tertiary services, location of public hospitals, and how *the source of referral* was defined. For example, referrals from Gaza are not differentiated by patients' residence. Referrals from both the West Bank and Gaza are sent to a large number of facilities (79 overall). This spread across providers and regions is highly inefficient, increasing the administrative cost of managing patient transfers and provider bills.

3. **Non-communicable diseases are the leading reasons for outside medical referrals** (Table 1). The PT are experiencing an epidemiological transition with a rising burden of non-communicable diseases (NCDs). In 2013, patients suffering from tumors accounted for 15.6

percent of all referral cases (15.2 percent in the West Bank and 16.6 percent in Gaza). Ophthalmology and internal medicine cases represented about 7.6 percent (7.7 percent in the West Bank and 7.1 percent in Gaza) and 6.5 percent (7.9 percent in the West Bank and 3.0 percent in Gaza) of all referrals respectively. In addition, 10 percent of all patients were referred outside to receive an MRI scan (11.4 percent in the West Bank and 4.9 percent in Gaza) and 5.8 percent were sent for cardiac catheterization (6.2 percent in the West Bank and 4.7 percent in Gaza).

Table 1: Top 10 procedures for outside medical referrals, West Bank and Gaza, 2013

West Bank		Gaza	
Procedure	**% of all referrals**	**Procedure**	**% of all referrals**
Tumors	15.2	Tumors	16.6
MRIs	11.4	Atomic scans and nuclear medicine	7.1
Internal medicine	7.9	Ophthalmology cases	7.1
Ophthalmology cases	7.7	Orthopedic surgery	6.9
Child diseases	6.4	Child diseases	6.3
Cardiac catheterization	6.2	Urological cases	6.3
Renal/ kidney cases	5.3	Cardiology cases	6.0
Urological cases	4.8	Blood diseases	5.3
Rehabilitation	4.1	Neurological surgery	5.2
Gynecology and child delivery	3.7	MRIs	4.9

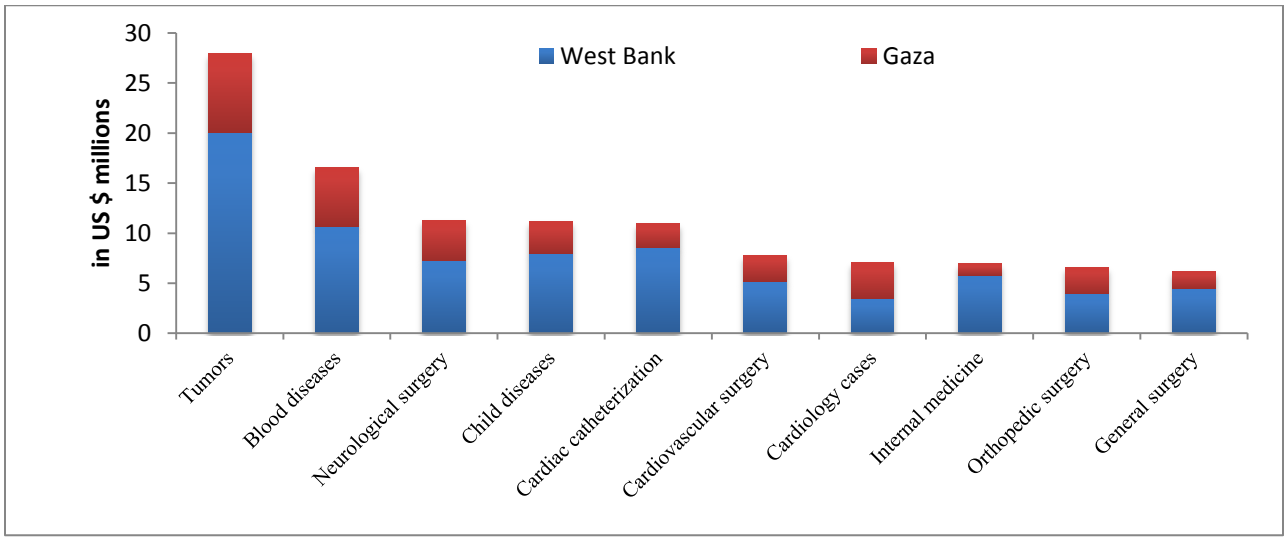
Source: MOH, 2014

4. **Referrals account for about 40 percent of non-salary public spending on health.** Between 2000 and 2013, expenditure on referrals increased from about US$8 to US$144 million, corresponding to about 40 percent of non-salary public spending in health and resulting in accumulated unpaid bills to outside providers of over US$30 million.

5. **The West Bank spends 2.5 times more on referrals than Gaza.** The geographical distribution of expenditure on referrals has seen a shift in the recent years. In 2009, the cost of referrals was US$75.7 million, US$49.4 million of which was incurred by the West Bank and US$26.3 by Gaza. Since then, while spending associated with outside referrals increased both in the West Bank and Gaza, it has grown about 74 percent more rapidly in the West Bank than Gaza between 2009 and 2013. In 2013, the cost of referrals from the West Bank reached 2.5 times higher than the cost of referrals from Gaza (US$102 million in the West Bank and US$42 million in Gaza). It is not entirely clear why referral expenditures in the West Bank and Gaza have been diverging in the recent years due to lack of sufficient data.

6. **Non-communicable diseases account for the majority of referral expenditures** (Figure 2). The cost of referrals associated with tumors has been increasing. It rose from US$16 million in 2009 to US$28 million in 2013 (US$20 million in the West Bank and US$8 million in Gaza), corresponding to 19 percent of overall referral expenditures. The referral expenditure due to blood diseases is also high and more than tripled between 2009 and 2013 from US$5 million to US$16 million, representing 11 percent of the overall referral bill. Neurological surgery accounts for seven percent of the total referral expenditures.

Figure 2: Top 10 costliest referral procedures, Palestinian territories, 2013



Source: MOH, 2014

7. **Israeli hospitals represent a high cost burden relative to the number of patients treated.** In 2013, Jerusalem hospitals, despite being the top destination for outside medical referrals (44 percent of referral cases in 2013), accounted for 34 percent of overall referral expenditures while Israeli hospitals saw 13 percent of referral cases but represented 33 percent of the total referral expenditures. Israeli hospital fees are deducted directly from Palestinian tax revenue and procedures are often added or changed without Palestinian authorization. The MOH is currently planning an audit of Israeli medical referrals to recuperate charges that may have been improperly levied by these hospitals or at the point of deduction.

8. **The average cost of referrals per patient differs significantly across referral destinations.** In 2013, the average cost of referral per patient was around US$2,355. More specifically, the average cost of referrals per patient was the highest in Israel, standing around US$5,858 and in Jordan around US$4,203. It is not clear why average prices in these two destinations are higher compared to other providers, and further research in this area is needed to understand these cost drivers. The average cost of referrals from the West Bank was around US$ 2,315. Referrals to Egypt from the West Bank in 2013 was a major cost driver, accounting for about eight times higher than the average cost of referrals. The cheapest destination for referrals from West Bank in 2013 was Jerusalem hospitals. The average cost of referrals per patient from Gaza was slightly higher than from the West Bank. The costliest destination for referrals per patient was Israel and the cheapest was Egypt.

Table 2: Average cost* of referrals per patient by destination, in US dollars, 2013

Average cost of referrals per patient by destination, in US dollars, 2013			
Destination/ Origin of referral	**West Bank**	**Gaza**	**Total**
Jordan	4,633	2,594	4,203
East Jerusalem	1,618	2,518	1,818
Israel	7,288	4,264	5,858
Egypt	19,880**	935	1,147
West Bank	1,904	2,282	1,944
Gaza	-	1,411	1,411
Total	2,315	2,458	2,355

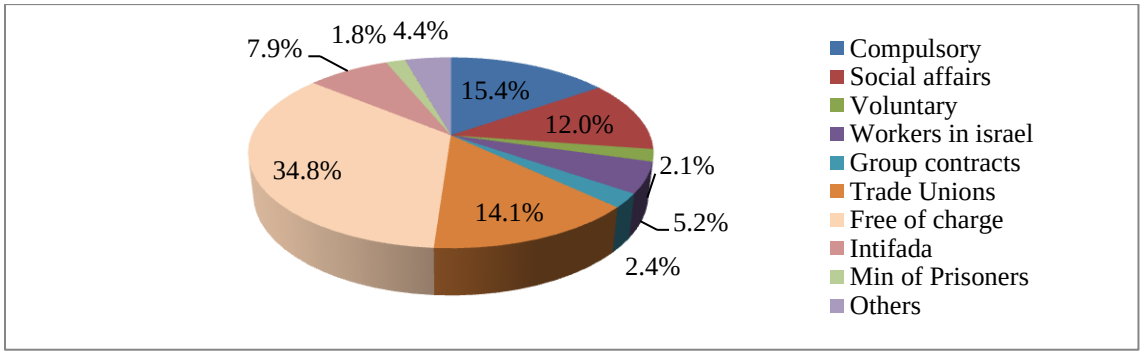
Source: MOH, 2014

*The figures in the table indicate the cost per patient and are calculated by a simple average of dividing the total cost of referrals to a destination to total number of patients referred to that destination. These figures do not take into account the complexities of cases or procedures conducted.

**There were 32 referrals from the West Bank to Egypt in 2013. The >20-fold difference between the per-capita cost in referrals to Egypt between West Bank and Gaza is further suggestive of potential corruption in the referrals system.

9. **A large proportion of referral services are used by the enrollees of the non-contributing health insurance scheme.** The referral system caters to all Palestinians seeking care in the public sector regardless of their insurance status with the government bearing the cost of referrals (i.e. one can easily join the GHI at a small fee and have access to the referral system). In 2011, 35 percent of all outside medical referrals were used by the enrollees of the non-contributing health insurance scheme[37] and eight percent were used by the members of the Al-Aqsa scheme. The enrollees of the compulsory health insurance scheme, public sector employees and their dependents, represent 15 percent of all referral cases. In addition about 14 percent of all referrals were used by members of trade unions (Figure 3). This composition of utilization of referrals by insurance scheme has important consequences for the financial sustainability of both referrals and the GHI system as a whole.

Figure 3: Utilization of referral services per insurance scheme, Palestinian territories, 2011



Source: World Bank, 2014

37 The MOH acts as the last resort for the uninsured through the Al-Aqsa scheme.

Referral System Challenges

10. A recent World Bank study (2014), which looked at the appropriateness of referrals, found that outside medical referrals, a heavy burden on the PA's finances, were the consequence of several distinct but inter-related problems operating at different levels. At the level of the referral system itself, the most important challenges are the following:

a. ***Process***: The referral system is based on a bureaucratic pre-authorization system, coupled with weak or non-existent auditing system. Furthermore, the referral process is fragmented across several levels, departments and steps, and lacks transparency due to the absence of explicit guidelines for standardizing procedures or rules for decision making. Referrals depend heavily on the personal opinion of individual professionals and authorization of referrals is carried out on a case-by-case basis[38]. Information pertaining to referrals is recorded independently at each step in an unstandardized manner, impacting the quality of record keeping.

b. ***Purchasing and contracting:*** the existing system and processes for selecting and contracting outside providers is inefficient and leaves room for significant distortions. Furthermore, it does not ensure a reasonable level of control, which reflects its large and unexplained variations in price and billing values; no consistent cost information is used on which to base price negotiations or reimbursements.

c. ***Access:*** difficulties are faced by most patients needing referral to tertiary hospitals in neighboring countries or even within the PT due to the restrictions imposed by the occupying authorities; differences in coverage and access across population groups affect the equity dimension of the referral system.

d. ***Sustainability:*** the financial burden posed by outside referrals has been growing rapidly over the years and appears unsustainable under the current political and economic context; referrals are likely to continue growing if serious action is not taken to control them.

e. ***Equity:*** utilization of referral services is unequal across governorates and across the different insurance schemes, which suggests inequities in access to these services; these inequities are mostly related to access distances and restrictions on mobility, but also to the design of the GHI system.

These challenges compounded by the broader level of the health system challenges, including:

a. ***Quality and effectiveness of care at all levels:*** while many outside referrals are for complex, tertiary treatment of non-communicable diseases, prevention and control of these diseases at the primary and secondary care levels is quite weak. In addition, the quality of care at government facilities as perceived by patients and the population at large is very low.

38 It is worth noting that the MOH has, to its credit, shown a strong willingness to tackle these issues and taken some recent steps including reforms of the referral approval process whereby 3 committees now oversee referrals by sub-region.

b. ***Weaknesses, inefficiencies, and gaps in the design and operation of the health system*** as a whole, including the concentration of nearly all functions within the Ministry of Health, and the conflicting views on the role of the private sector, among others.

11. ***A severe imbalance between the limited resources available to fund the public system and the open-ended service coverage***, which translates into a problem of sustainability that affects not only the referrals but the health system as a whole (and most governmental and social activities in the PT). This issue was not resolved by the establishment of a national health insurance system, and to a great extent results from design and operation flaws in the insurance system.

Annex 9: Palestinian territories Health System Overview				
Macro-fiscal Indicators		**Value**	**Year**	**Source**
1	Gross domestic product (at current prices, US$ million)	10,254.6	2012	PCBS, 2014
2	Unemployment rate (%)	26.3	2014	WB, 2014
3	CPI inflation rate (period average)	2.8	2012	IMF, 2013
4	Public revenues (as % of GDP)	20.2	2012	IMF, 2013
5	Public recurrent expenditures and net lending	34.4	2012	IMF, 2013
6	Overall public finance balance (as % of GDP)	-16.5	2012	IMF, 2013
Indicators for MENA Health National Policy (HNP) Sector Strategy		**Value**	**Year**	**Source**
	Health Status			
1	Malnutrition prevalence, height for age (% of children under 5)	11.8	2007	WDI, 2013
2	Mortality rate, under five (per 1,000 live births)	22.6	2012	WDI, 2013
3	Maternal mortality ratio (per 100,000 live births)	28	2011	WHO, 2013
	Financial Protection			
4	Health expenditure total, (per cent GDP)	13	2012	PCBS, 2014
5	Out of pocket health expenditure (OOP), (% total expenditure on health)	37	2011	WHO, 2013
6	Health expenditure, public (% of government expenditure)	10	2011	WHO, 2013
	Overarching environment: Labor force, environmental, and voice and accountability			
7	Physicians (per 1,000 people)	2.08	2011	WHO, 2013
8	Nurses and midwives (per 1,000 people)	1.82	2011	WHO, 2013
9	Improved water source (% population with access)	81.8	2011	WDI, 2013
10	Improved sanitation facilities (% of population with access)	94.3	2011	WDI, 2013
11	Voice and accountability Index*	-1.02	2012	WGI, 2013
General health sector indicators				
1	Population, total	4,046,901	2012	WDI, 2013
2	Population growth (annual %)	3	2012	WDI, 2013
3	Population ages 0-14 (% of total)	40.7	2012	WDI, 2013
4	Population ages 15-64 (% of total)	56.4	2012	WDI, 2013
5	Population ages 65 and Above (% of total)	2.9	2012	WDI, 2013
6	Age dependency ratio (% of working-age population)	77.3	2012	WDI, 2013
7	Fertility rate, total (births per woman)	4.1	2011	WDI, 2013
8	Life expectancy at birth, total (years)	72.8	2011	HNP Stats, 2013
Top 5 Causes of Mortality and Morbidity (DALYs)				
1	Preterm birth conditions	104,575	2010	IHME, 2010
2	Unipolar depressive disorders	69,792	2010	IHME, 2010
3	Congenital anomalies	52,059	2010	IHME, 2010
4	Low back and neck pain	51,934	2010	IHME, 2010
5	Cerebrovascular diseases	48,568	2010	IHME, 2010
Governance Indicators				
1	Human Development Index	110/187	2012	HDI, 2013
2	Corruption Perception Index			
3	Rule of Law Index*	-0.46	2012	WGI, 2013
4	Political Stability and Absence of Violence*	-1.94	2012	WGI, 2013
5	Government Effectiveness*	-0.75	2012	WGI, 2013
6	Regulatory Quality*	0.11	2012	WGI, 2013
7	Control of Corruption*	-0.78	2012	WGI, 2013
Note: * denotes estimate of governance measured on a scale from approximately -2.5 and 2.5. Higher values correspond to better governance.				

Data is from World Development Indicators - WDI (2013); Health, Nutrition, Population (HNP) Stats (2013); World Health Organization - WHO NCD Profiles (2011); WHO EMRO Data Observatory (2013); Institution of Health Metrics (IHME) GBD Study Data (2010); Human Development Index - HDI (2013); Transparency International - TI(2013) and Worldwide Governance Indicators - WGI(2013); International Monetary Fund Staff Report (2013); World Bank Economic Monitoring Report to Ad-Hoc Liaison Committee (2014).

Annex 10: Economic Analysis

West Bank and Gaza: Health System Resiliency Strengthening Project

A. Introduction

1. The economic analysis of the proposed project focuses on three key areas: (i) justification for public sector provision; (ii) the project's development impact; and (iii) the World Bank's comparative advantage and value added.

2. The proposed project has three components: (i) addressing immediate sector needs; (ii) rationalizing outside medical referrals (OMRs); and (iii) supporting health coverage. All three components are directly and strongly aligned with the World Bank's twin goals of eliminating poverty and boosting shared prosperity and furthermore directly aligned with the HNP Global Practice's orientation towards Universal Health Coverage to ensure that all Palestinians obtain the health services they need without suffering financial hardship when paying for them.

3. The Palestinian territories (PT) lag in key indicators related to millennium development goals (MDGs). For example, 90 per 10,000 live births in 1990 to 64 in 2010[39]. Although the value is less than the regional average[40], it is more than twice the target value of 22.5, despite less than one percent of the total deliveries in the PT occurring at home in 2010 and more than 99 percent of women receiving antenatal care (at least four visits) during pregnancy. Birth delivery procedures and the quality of services are partly responsible for the high mortality ratio[41]. Similarly, despite reductions in child mortality, MDG 4 will not be reached. The under-five mortality rate decreased from 43.1 in 1990 to 22.0 per 1,000 live births in 2011. This decline[42], however, remains far from the MDG 4 target of only 14 child deaths per 1,000 live births and the Palestinian territories had the smallest reduction in this rate compared to all Arab countries[43]. Moreover, aggregate indicators mask important disparities – particularly geographic disparities – in the PT. For example, anemia prevalence is 31.9 percent of women who come for antenatal care visits in Gaza and 15.4 percent of women in the West Bank; the highest rates being in Jericho and Al-Aghwar governorate (50 percent), and in Khan Younis (55.9 percent)[44].

4. The general impoverishment of the population makes it vulnerable to healthcare expenditure, and the scarcity of good quality government health services makes them more prone to going to private, more expensive health providers[45]. Expenditures on medications and due to chronic conditions, exacerbated by a lack of prevention and poor primary care, is a major contributing factor. Furthermore, the poorest groups are at greatest risk of impoverishment due to

39 UN, 2013
40 The UN region 'Western Asia' includes Bahrain, Iraq, Jordan, Kuwait, Lebanon, Occupied Palestinian Territory, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, United Arab Emirates, and Yemen.
41 PCBS, 2012
42 UN, 2013
43 Abdul Rahim, 2009
44 PCBS, 2011
45 Mataria, 2010

health spending; the poorest income deciles bear a higher share of out-of-pocket (OOP) expenditure compared to their total share of income.

5. The impact of the Gaza conflict has had a severe impact on the health sector. The conflict has resulted in 2,145 deaths and 11,231 injuries in Gaza, with the significant proportion of those who lost their lives and incurred injuries being Palestinian children and the elderly. Increase in injuries and trauma patients has led to a shortage of emergency medicines (e.g. pain killers, anesthetics, saline solution), medical equipment and spare parts, hindering continuity of service delivery and management of chronic diseases such as cardiovascular disease, cancer, chronic respiratory disease and diabetes.

6. Human resources and health sector planning are key issues contributing to high referrals and high OOP expenditures in the PT. While the PT has a very high number of physicians and dentists per 10,000 people relative to MENA countries, they lack facilities, equipment, drugs, and rare specialties. Furthermore, the distribution of health centers does not match the population distribution, and facility planning does not take the private or NGO sectors into account. Hospital beds sit empty at many specialized hospitals wards whereas others, such as the ICU and ER are overburdened. Referrals from primary care do not work and the population uses the ER of hospitals as the first entry into primary care. Unnecessary tertiary care is draining already depleted resources.

7. The proposed Project components provide a set of activities to address immediate sector needs and improve quality and efficiency in health expenditures as well as management and policy-making capacity at all levels of the system, including supporting sectoral planning and supporting coordination of donor community actions. The rationale for public intervention is demonstrated by the current inequities in health outcomes between the West Bank and Gaza and between urban and rural areas, which are matched by inequalities in quality and access to health services. Although addressing disparities is an issue of social justice, there are considerable economic benefits as well, at both the individual-level, through impacting productivity, employment, and OOP expenditures and at the population-level, through impacts on costs to governments and business.

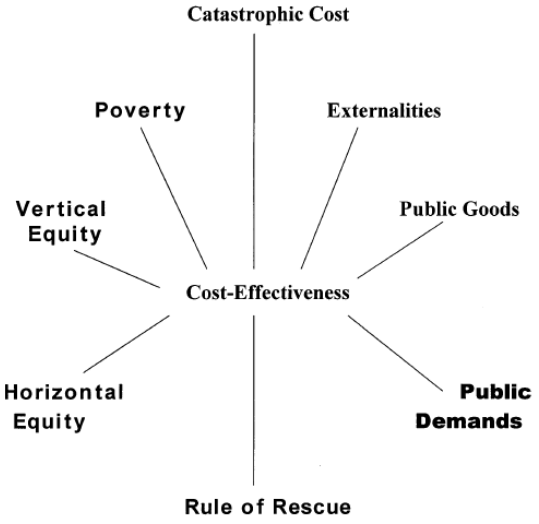
B. Public Sector Justification

8. Market failures in the health sector and the case for public intervention and financing have been well established starting as far back as 1965 with Kalarman's[46] analysis. There are at least 9 criteria related to public intervention in the health sector[47]: economic efficiency criteria (public goods, externalities, catastrophic cost, and cost-effectiveness), ethical reasons (poverty, horizontal and vertical equity, and the rule of rescue), and political considerations (especially demands by the populace) (Figure 1).

46 1. Klarman HA. (1965). The case for public intervention in financing health and medical services. Med Care.;3:59–62.

47 Philip Musgrove (1999). Public spending on health care: how are different criteria related? Health Policy 47 207–223

Figure 1: Nine criteria for public intervention in the health sector



Source: Musgrove Health Policy 47 (1999) 207–223

9. The project exemplifies the criteria in Figure 1. Equity is an important consideration with geographic differences in key health outcomes and gender and geographic differences in referral rates. Related is the issue of poverty; the rule of rescue applies to the population in need of tertiary services, particularly for life-saving conditions. Furthermore, the public has strong demands for quality services and expectations that have been set by wide coverage for nearly all services but coupled with poor quality and lack of service availability in the public sector. Catastrophic cost is additionally important with over 40 percent of healthcare costs in the PT financed by out-of-pocket (OOP) expenditures. The market is not able to deal with these issues related to sectoral strategy and organization effectively.

10. Overall, the project components are by definition public. It is the public sector's role to provide emergency relief as well as organization, rules and stewardship for the insurance sector and for referrals. However, for the latter, the private sector has an important role to play: NGO and private hospitals are an important part of the sector and their capacity should be included in the sector strategy and their services purchased based on clear rules regarding quality and price. Furthermore, there are important externalities of improving health and reducing disparities in health, for example economic impacts discussed below which are not considered in the market price of health provision.

B. What is the project's development impact?

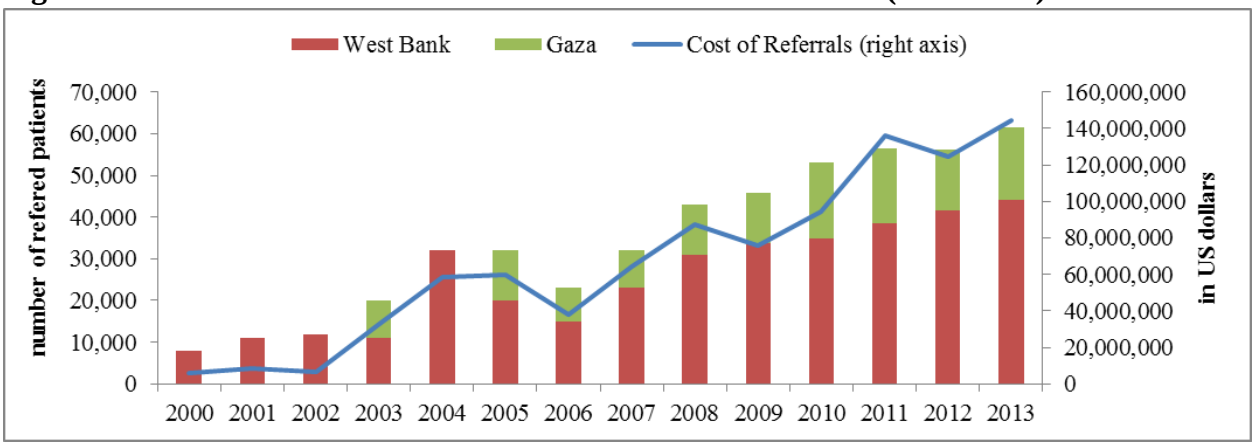
11. By addressing immediate emergency needs in Gaza, the project aims to ensure the continuation of basic healthcare services at minimum acceptable levels and avoid such services from experiencing systemic collapse. Furthermore it aims to mitigate potential severe consequences for public health from increasing the risk of infections and outbreaks of

communicable diseases. This approach may be usefully looked at as a complementary strategy to prevent any further collapse in the provision of health services and, at the same time, to minimize the cost of outside medical referrals.

12. The project aims to improve the equity and efficiency of OMRs and address longer term sustainability by focusing on planning, strategy, purchasing, and process. Currently access to, and efficiency of, the referral system is limited as a result of prolonged waiting times (exacerbated by the political situation) and the presence of too many outside providers (some with very few cases). Weaknesses related to purchasing and contracting include unclear criteria for the selection of providers, too many providers, weak contracts that are unrelated to clear criteria, weak information-management, and close to nonexistent monitoring. Overall, the system is characterized by a highly bureaucratic process with limited data linkages, weak controls and reviews, and no auditing.

13. The project aims to reduce costs related to referrals while ensuring that the Palestinian population receives the tertiary services they need in a manner that is costed, prioritized, and based on clear rules. The cost and volume of referrals has been rising (Figure 2). These rising costs have led to a large amount of accumulated arrears for the MOH (US$55 million in 2011) and financial difficulties for hospitals providing contracted services. For example, Jordan no longer receives referrals due to unpaid arrears. Overall costs, accumulating to 40 percent of the operating budget, are threatening the sustainability of the health sector.

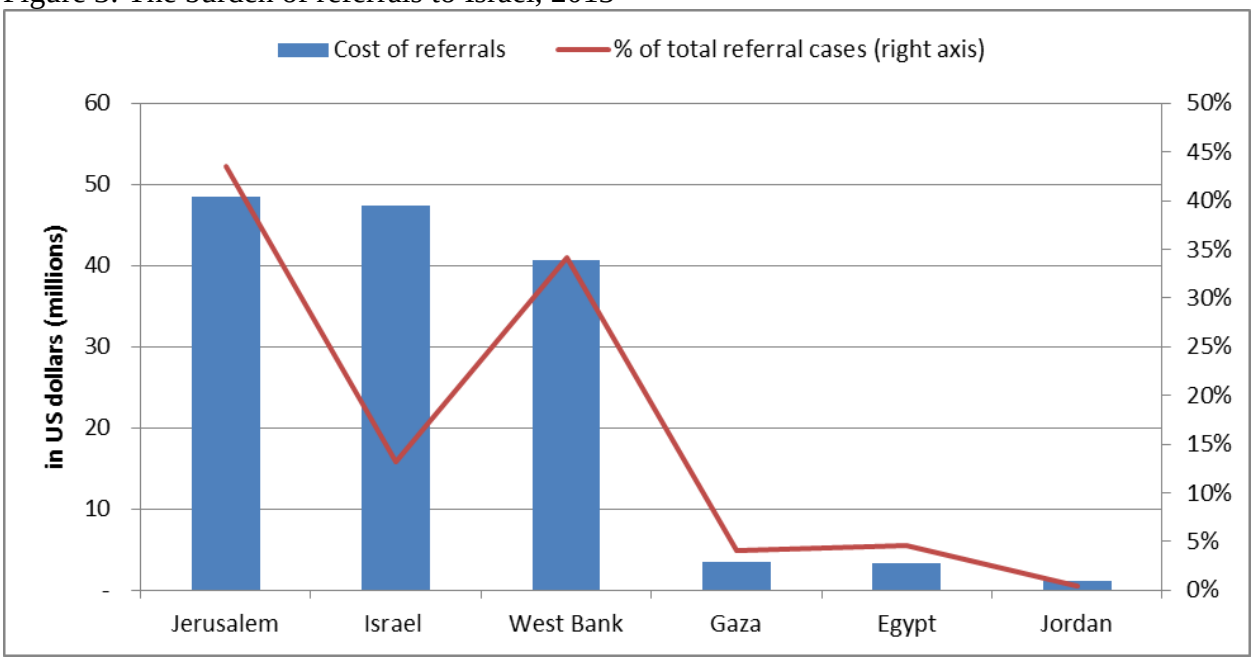
Figure 2: Volume and Costs of referrals in West Bank and Gaza (2000-2013)



Source: Author's calculations from MOH Data

14. A key driver of costs is referrals to Israeli hospitals. Israeli hospitals have 13 percent of referrals but 33 percent of the total cost (Figure 3). By comparison, East Jerusalem Hospitals have 44 percent of referrals with 33 percent of the cost. A recent audit by the USAID indicates that some 55 percent of billing by Israeli hospitals are unauthorized or older than the 90 day validity date) and recommends that all cardiac procedures, blood tests, other laboratory investigations, and kidney and liver transplants currently referred to Israeli hospitals– and, eventually, bone marrow transplants– should be done within the Palestinian system. Furthermore, Israel deducts claims directly from Palestinian tax revenue with little oversight or accountability.

Figure 3: The burden of referrals to Israel, 2013

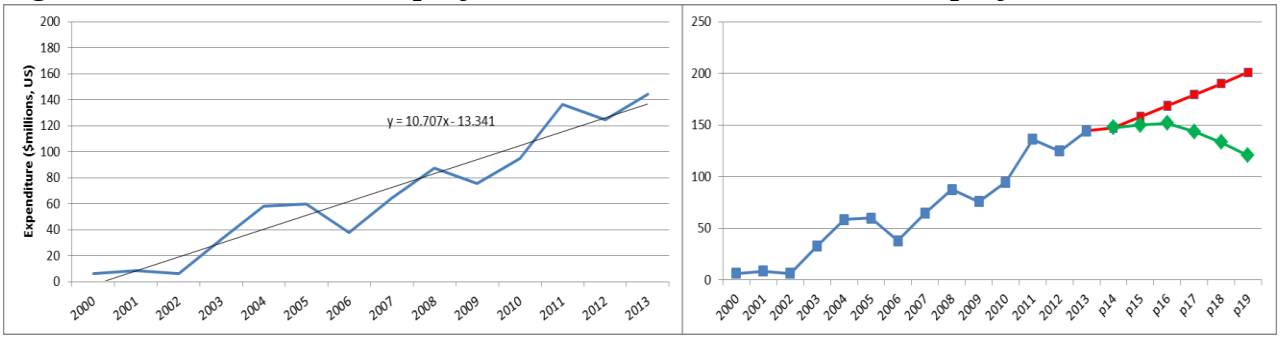


Source: Author's calculations, MOH referral data

15. The system is weak and needs reform: there is extremely poor recordkeeping and referring facilities, receiving facilities, and the referral committees do not follow required OMR procedures. Clinical summaries are insufficient or were missing from more than 70 percent of the files, and the exact reason(s) for the referrals were missing from more than 90 percent of the files. Out of the remaining cases about 40 percent of the referrals were not justified.

16. Through (i) reduction of unnecessary referrals through clear rules and guidelines; (ii) reduction of referrals to Israel; and (iii) renegotiating current contracts and elimination of unnecessary facilities, it is estimated that the project can achieve a 40 percent reduction from the trend-line (a 16 percent reduction from 2013 baseline) in referral costs (Figure 4). This entails a five percent reduction (from trend-line) in 2015, 10 percent in 2016, 20 percent in 2017, 30 percent in 2018 and 40 percent in 2019, resulting in a cost-savings over the lifetime of the project of US$198 million over projected costs in the absence of the project.

Figure 4: Historical costs and projected costs in with and without the project

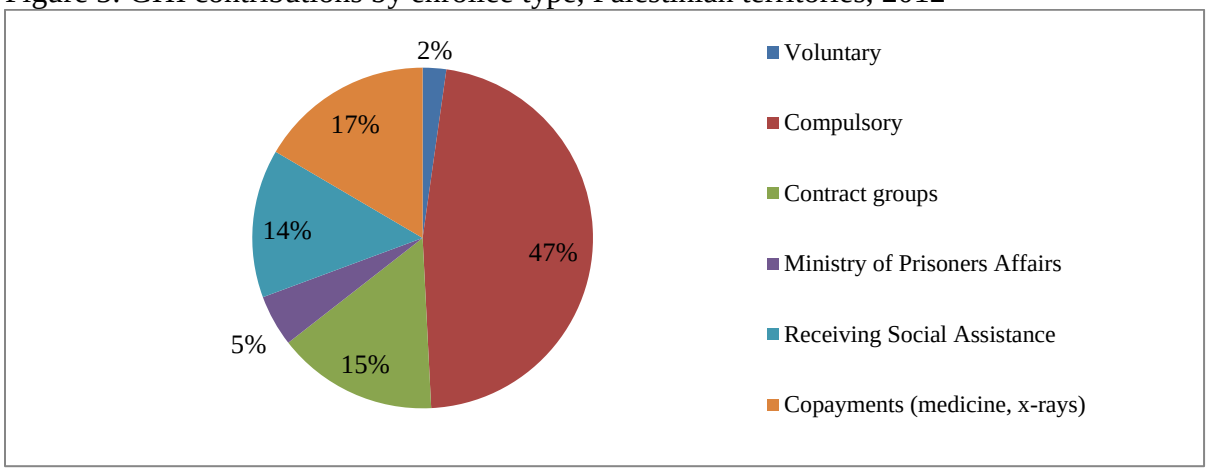


Note: Red – projected trend-line based on linear regression; Green – projected costs with project

17. The referrals system is inequitable. There is tremendous pressure on the system by individuals to have the highest quality treatment in Israel for certain procedures that are not classified as emergency or could have been treated locally. The government, to its credit, has taken a series of concrete measures to address this issue, but more work is yet to be done. Referrals from the West Bank were 2.5 times higher in cost than from Gaza, despite only having 1.5 times more in terms of population and the fact that the capacity is much lower in Gaza due to the Israeli blockade. Furthermore, the utilization proportion of referral services relative to the population is higher for males (1.39 per 1,000 population) than for females (1.23 per 1,000 population), and the difference is larger in Gaza (33 percent higher among males) than in the West Bank (4.3 percent higher among males). The system has led to corruption in where referrals are sent, brokers facilitating referrals to Israeli hospitals, and rent seeking at all levels. All of these factors pose challenges for social cohesion and the integrity of Palestinian institutions.

18. The project will focus on designing a roadmap towards universal health coverage, including defining a basic package of services and the creation of an autonomous purchasing agency. The separation of functions has been shown in a variety of settings to greatly increase the efficiency of health expenditures. The number of non-contributing GHI enrollees increased in the last decade compared to the number of contributing members, damaging the scheme's finances; the number of non-contributing GHI enrollees increased compared to the number of contributing members, damaging the scheme's finances

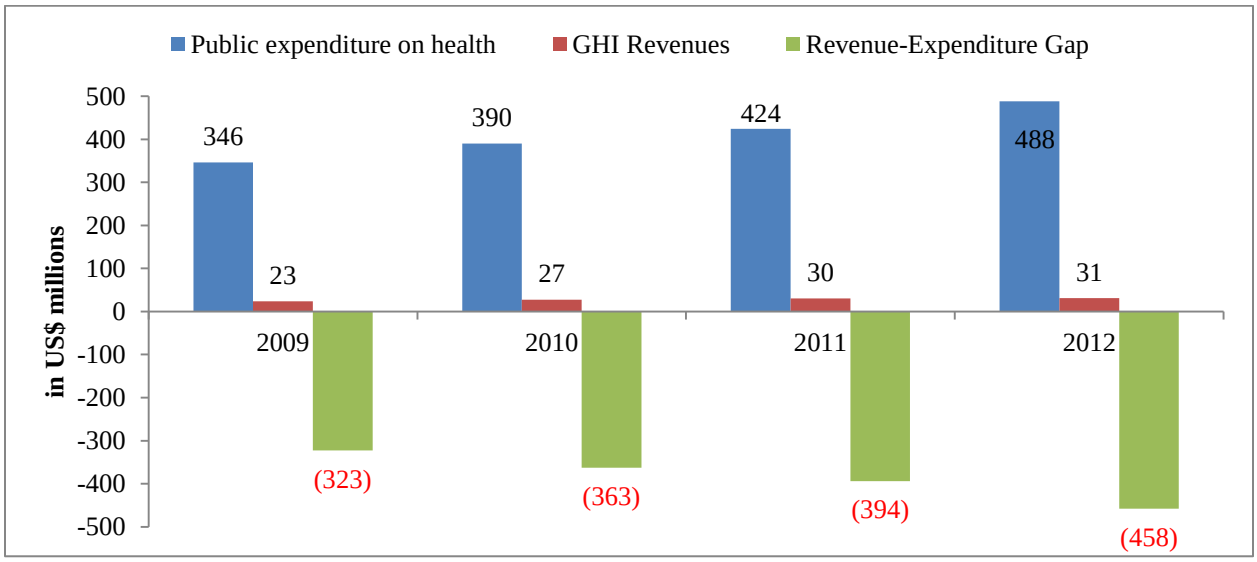
Figure 5: GHI contributions by enrollee type, Palestinian territories, 2012



Source: MOH, 2013
Note: Contributions of Palestinian workers residing in Israel not included.

19. GHI revenues have been increasing, but at a rate slower than the increase in the number of GHI enrollees, thus increasing the financial gap of the GHI (Figure 6). The GHI scheme was originally designed to provide additional funding for the MOH's expenditures. In 2000, public expenditure on health was US$125 million while GHI revenues reached US$35 million. By 2009, the public expenditure on health reached US$346 million, while GHI revenues declined to about US$23 million. Since 2009, the GHI revenue and public expenditure on health has been widening as the GHI revenues have not been able to match the increase in public expenditure on health. In 2012, public expenditure on health reached about US$ 488 million and GHI revenues were around US$31 million, undermining the sustainability of the health financing.

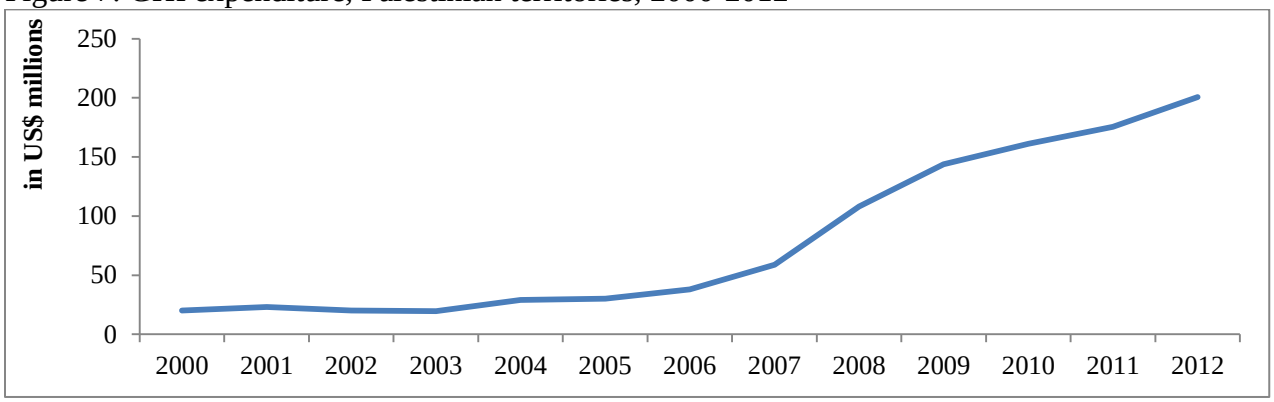
Figure 6: GHI revenue and public health expenditure gap, Palestinian territories, 2000-2010



Source: WB, PCBS, 2010

20. The GHI expenditures have been increasing rapidly exacerbating the already constrained fiscal position (Figure 7). GHI expenditures, as a percentage of the total health expenditures, were 5.2 percent in 2000 and fluctuated between 6.2 percent and 4.7 percent until 2005. Starting from 2005, they have increased steadily and reached 15 percent of total health expenditures in 2010. This sizable increase in the GHI expenditures adds additional pressures to the already constrained fiscal position.

Figure 7: GHI expenditure, Palestinian territories, 2000-2012



Source: PCBS & MOH, 2011, 2012, 2014

C. What is the World Bank's value added?

21. The World Bank (WB) has a long engagement in the health sector, globally and in the PT, and is seen by the PA as a trusted partner in addressing the current emergency situation. The WB has been supporting the PA and MOH through technical assistance, including for health insurance, dual practice, medical referrals, and public expenditure reviews. Furthermore, the World Bank brings global experience and expertise in the field of health financing and health insurance. Overall, in health, the World Bank's comparative advantage is in systems building and strengthening. The Bank's health sector strategy is focused on supporting countries to create health systems that deliver results for the poor and that are sustainable. This includes leading in the multi-sectoral actions taken in health and functions related to financing, management, and insurance in national health systems.

22. The Bank has unique expertise in coordinating the complex set of interventions that comprise the Government's plan for emergency relief, referrals, and health coverage. The Bank provides strong technical expertise and project design and management. The information system reform involves many actors and systems across the health sector and, as such, is strongly aligned with the Bank's comparative advantage in systems strengthening. The World Bank can provide the technical and financial support required to achieve key program goals. This includes dialogue with the MOF to ensure that the program is adequately funded to ensure resources required to achieve targets are available. It also includes mobilizing trust funds and other sources for technical assistance in identified target areas.