Guidelines for the COnstruction of Palestinian Plan for Health For health Care Development

Rita Giacaman, 1990

Introduction

The health of a population is an inseparable part of the existing social structure and therefore must be considered within this specific historical and political context. Improvements in health are known to be closely linked with the struggle for liberation, for self determination, and for social equity. In Palestine, this strugge is an integral part of the larger struggle on the global level.

Thus any intervention in the health field must be part of an overall strategy for development for the country as a whole. In our context, an interdisciplinary and invetive approach is necessary in order to create an appropriate model for health care adapted to the needs in our specific situation. This must be based on a comprehensive analysis of the health situation and the political and economic structure that it is a part of.

Adapting uncritically the Western biomedical model of medical care is not necessarily the most effective approach to health care development. The Western biomedical approach sees the body as different parts of a machine. When one part breaks down, you treat it with drugs and technology to repair it. This view of health overemphasizes curative medicine, relies on specialist doctors, depends on high technology, is by necessity urban-based, and disregards the social origins of disease. **Medicine, technology and drugs should be applied in a beneficial way depending on the needs of society**. Medical care is not a commodity to be bought and sold on a world market. It is a process of social relationships.

It is important to analyze the health conditions of the Palestinian population as well as the health services available. These two separate phenomena have an inluence one upon the other, but certainly the presence of other determinants is essential. In the developed world it was not onvestments in health care that determined improvements in the level of health. In fact, a historical analysis of 19th century England illustrates that nutritional deficiencies and poor living conditiosn were responsible for the prevalence and severity of infectious diseases and that the impressive decline in illness and death during this period resulted primarily from improved living standards, nutrition

and hygiene.

However, economic growth alone does not assure improvements in health conditions of a population, as was illustrated in the 1970's in Brazil with its psurt in economic growth. During this period of economic expansion, the standard of living of the majority of the population declined, and the infant mortality rate increased. If economic growth does not improve the living standards of the poor, it will not affect positively the health conditions of the society.

In the Palestinian context, the following principles must be taken into consideration when planning for health care development:

1. That health is sociall constructed. That is, health status is determined not only by the presence or absence of medical services, but also by political, economic, social and cultural phenomena related to society at large.

2. That the right to good health, good nutrition, good housing, access to clean water, a healthy environment and the right to education are basic human rights. As such, they should be available to all sectors of the population.

3. That the differences in health status among the population can be tremendous, and, therefore, priority groupings must be identified, especially those that are biologically and sociall disadvantaged.

4. That consequently, planning for the delivery of health services in the area must take into consideration building a strategy aimed at fulfilling the majority of people's needs, focusing on priority and target groups, and informed by clinical data and research that can elaborate the basic health problems in the area and the particular health problems of the identified priority and high risk groups.

5. That health planning must also take into consideration the input of various types of human resources available in the country today, including doctors, nurses, village health workers, pharmacists, epidemiologists and researchers, medical social workers, rehabilitation workers, diagnosticians and others.

6. That planning for health must also encompass the views and apsirations of the communities for which the planning is envisaged.

A Brief Description of Health Conditions

Health conditions of the Palestinian population living in the West Bank and Gaza Strip can be characterized as follows:

1. A

Available Health Services

The health services infrastructure of the West Bank and Gaza is subdivided into three distinct and almost completely independent sectors: the governmental sector, controlled by the Israeli Authorities, UNRWA, which caters to the needs of refugees in the area and the Palestinian sector. The Palestinian sector is in turn subdivided into the charitable society, the popular health movement and the private/fee for service sub-sectors. It is this sub-division within the health services infrastructure that forms the main impediment to the coherent and rational development of health services in the area.

The Hospitals

In total, there are 21 hospitals operating in the West bank and 8 in the Gaza Strip. Of those, 8 hospitals in the West Bank are operated by the Israeli Authorities, and the rest by the non-governmental sector. In the Gaza Strip, 3 hospitals are operated by the Authorities and 1 privately.

Overall, there are approximately 1.4 beds per 1000 population in the West Bank and 1.2/1000 in the Gaza Strip[1]. Regional variations are substantial, ranging from 3.4 beds/1000 people in Jerusalem to 0.45/1000 in Jenin. As an index of service availability - but not accessibility - the hospital bed/population indicates that hospital services continue to be very low compared to what is available in

[1] These figures rely on field research and testing, as figures published by the Authorities are known to be over-estimates of the actual services available in the country

Israel -6.1/1000 for the same period. This ratio also compares unfavorably with the objective of 3/1000 bed coverage fixed by the World Health Organization for the area.

Hospital services in the area are poorly developed. Governmental hospitals suffer from increasingly deficient budget allocations, are inadequately staffed, stocked and administered. They continue to lack what is considered essential services by the World Health Organization. This deteriorating has taken place as the costs of hospital care have risen systematically over the years of occupation. As for the Palestinian operated hospitals, those have continued to develop throughout the 1970's and 1980's as a matter of necessity, where, gradually, a shift in responsibility for both hospital and primary care, from governmental to non-govenrnmental health and medical care institutions took place. However, Palestinian operated hospitals face persistent problems: major fund raising problems as they must continually seek financial assistance from outside the country, absence of a coherent medical and health care policy leading to erratic and uncoordinated developments between and within hospitals, absence of needed specialties and management problems as major examples. In addition, non-governmental hospitals face restrictions imposed by the Authorites on building and expansion - one of the major problems that Maqassed Hospital faces today is space restrictions - and the acquisition of permits to establish new facilities. Added to these problems are sharp and continuous increases in the workload that have come as a result of the shift of the patient population away from governmental services to private ones, all leading to the overloading of the non-governmental hospitals without the availability of sufficient financial, technical and managerial support.

Another important problem that the hospital services face is the problem of accessibility, where the majority of these services are located in the centre of the country, leaving the peripheral rural areas especially starved for care. Such a problem arises because of many factors, including the fact that, in the absence of a state structure interested in the welfare of people, decisions regarding the establishment of services are made without due consideration to the overall needs of the population, to the needs of priority and target groups and to cost effectiveness. Thus an overall vision for the country's secondary care needs continues to be abscent, and creating the vacuum within which irrational and unrealistic ideas are implemented.

Primary Health Care

Primary care services include curative clinics, maternal and child health care centres, elements of dental care programmes and diagnostic aids. There are approximately 500 primary care clinics and services operating in the West Bank today and around 60 in the Gaza Strip. A substantial proportion - about 40% of those clinics have been established after 1987, where 97% of those are operated by non-governmental organizations. Thus a clear shift in responsibility for the primary health care sector from governmental to non-governmental organization has taken place in the latter part of the 1980's. One can clearly see this trend by noting that in 1967 72% of primary health care services were operated by the Jordanian government, when in 1992, 30% only are operated by the Authorities.

Overall, it is estimated that there is about 1 clinic per 2500 persons in the West Bank and 1/1500 in the Gaza Strip. It is critical to note here that the variability in quality and quantity of services in these centres is substantial, where many of these services are unable to fulfil people's basic health needs. Many of these services tend to be restricted to the presence of a doctor and some medications. Up to 20% of these centres lack even the most basic sanitary facilities such as latrines, sinks and soap and towels. Over a third do not have any form of institutional supervision, leading to substantial variations in the delivery of services and the lack of standardization. Over 50% do not offer basic services such as pre-natal and post natal care, well baby clinic services and simple screening programmes. Because of this concentration on curative care and the relative neglecto f preventive care , the patient loads in these clinics tend to be low, leading to closure of clinics a few months after they have been opened. The lack of continuity of care is a crucial factor contributing the the inability to fulfil people's basic health needs and assist in a serious way in improving people's health status Thus much can be done in the area of upgrading these existing services and focusing their activities on target and priority groups, where service delivery can be based on rational planning and cost effectiveness.

Another problem that primary health care faces is that of accessibility. While many of the existing primary health care schemes offer their services at low cost, they are geographically unequally distributed, in favor of the centre of the country and urban areas, at the expense of villages and the peripheral parts of the country, most notably the northern part of the West Bank, excluding Nablus and the Southern part, including the Hebron District. A similar problem is noted for the Gaza Strip, where the majority of services are concentrated in Gaza city, at the expense

of the rest of the Strip.

Supporting Services

Those consist of mobile clinics and ambulances, pharmacies, laboratories, diagnositc centres, geriatric and rehabilitation services.

There are about 170 pharmacies, 41 laboratories and 26 diagnostic centres in the West Bank, other than those found in hospitals and secondary care centres. These services are usually provided on a fee for service basis, although increasingly, they are being provided by non-governmental organizations operating health services. In the Gaza Strip, there are 110 and pharmcies of which 60 are found in Gaza City and the rest scattered all over the Strip. Only one diagnostic centre is in operation in the Strip and 3 officially registered laboratories with qualified personnel operating them. A numerous other ventures operate within the context of physicians' private practices, without the presence of the necessary qualified staff.

These services are generally concentrated in the centre of the country, where 73% of the pharmacies and 91% of the laboratories in the West Bank, for instance, are located in urban areas. Thus the problem here is one of urban and regional bias. These facilities are often found inadeuate and unclean; staff is generally ill prepared for the type of work performed, specialties are often absent and quality control and proper supervision are serious problems to contend with. Overall, a serious attempt is needed to place these service on the map of health care provision locally and attempt to upgrade them to meet the minimum required standards of care.

The proliferation of rehabilitation institutions and services has been profoundly affected by the state of emergency that followed the beginning of the Uprising. Since that time, consciousness regarding the need of the disabled at large grew and developed. Today, at least 60-70 institutions are providing rehabilitation-physiotherapy services in the West Bank and Gaza Strip. The majority of these institutions are found in the West Bank urban locales and central area. Many conflate rehabilitation with biomedicalization, institutionalization and physiotherapy. Important elements of rehabilitation such as counseling, social work, educational services, community participation and social integration activities are often missing from programmes altogether. The tendency is towards building institutional services. While such services are needed, if developed without the necessary developing in community based rehabilitation projects, those might end up

coming in the way of ultimately re-integrating the disabled into society. Thus great attention must be paid to the need to develop rehabilitatio services within communities and to assist the disabled in organizing themselves for social action before embarking further on building institutional rehabilitation in the area.

Geriatric institutions are almost solely shelters for the elderly and the destitute. There are at least 23 such institutions operating in the West Bank and 3 in the Gaza Strip. These institutions cater to not more than 10% of the elderly population in the country. These services are generally known to be of very low standard, lacking programmes geared towards the alleviation of the problems of residents, many lacking basic hygiene and sanitation and on the whole inadequately operated. Yet, in the meanwhile, the bulk of the geriatric population continue to live within the community, often completely unattended by special home services for the elderly - such as medical, social, pscyhological and enterntainment services - and sometimes alone. With the increasing incorporation of women into the labour market, old people are becoming a burden on the family, and as they grow older, their needs become more and more difficult to fulfil. Given these facts and the fact that the geriatric population in this country is growing in relation to the rest of the population, it is worthwile to seriously examine the ways in which this population can be served, at least cost, and within the context of the community.

Human Resources

Those consist of physicians, nurses, pharmacists, dentists, laboratory technologists, village health workers, medical technicians, nutritionists, epidemiologists and researchers, medical social workers and counselor, among others.

At the moment, only the classical medical and paramedical specialties are available in the country. Doctors and nurses are by far the most available human resource in health. In the West Bank about 1200 physicians are currently registered and work in the area. In the Gaza Strip, of about 800 registered doctors 400-500 are estimated to be actually working in the Strip. Thus the physician to population ratio is about 11/10000 for the area, contrastic sharpy with 33/10000 for Israel and 24/10000 in Jordan for the latter parts of the 1980's. About half of the doctors of the West Bank and 67% of those in the Gaza Strip work in the hospital sector, and the rest are divided between institutional primary health care work,

private practice and educational and managerial positions.

The rate of specialization among physicians is very low, with only 14% of the total working in the West Bank and 30% in the Gaza Strip - where specialization options are available in Egypt for Gazans, but not necessarily for West Baners. Many specialties are either completely lacking or do not fulfil local need, especially in the areas of pathology, psychiatry, epidemiology and the various strands of community and public health, gastroenterology and family practice.