Health Sector Reform: Review of Concepts and Critiques
And
An initial Review of the Palestinian Setting
2000

Following is an introductory review of the limited literature available to us here at Birzeit at the time of its writing, September- October, 2000. It is neither an exhaustive discussion of the subject nor an elaboration of its different facets. Rather, it is a simple attempt to put together available information in ways that can help our group to begin working on the subject, having started from a somewhat different information base. An initial systematic review may help us also to begin to raise questions pertaining to what is taking place in our health systems at the country level. This is necessary so that we can open up discussions of health sector reform at the Arab World level, and the ways in which we can influence current transformations in favor of equity in reproductive health care and health service provision.

The aim of this review is threefold:

1. To elaborate what is meant by reform in the health sector, beginning with structural adjustment, then health sector reform (HSR), and finally Sector Wide Approaches to Development (SWAPs), including the principal elements of what such reform means in general, both at the policy level and in management terms.
2. To review some of the available international critiques of these approaches to health sector development that are available to us, and assess their relevance to the development of a local approach to understanding the events taking place in the Arab world, as well as their similarities and differences.
3. To assess the stages that the different Arab countries have reached in the adjustment/reform framework, and attempt to place Palestine on its map.

Perhaps the best way to begin this review is by outlining Hilary Standing's account of the evolution of the reform discourse worldwide, and integrate the views and experiences of others as we go along.

Standing begins by noting that health sectors have all along been undergoing constant changes, so health sector reform (HSR) is really nothing new, but a 'moving target'[1]. What makes HSR different is that reform has been associated recently - the last 20 years or so - with a particular set of ' policy prescriptions' that target institutional and financial reforms, a type of reform that is largely, although not solely, donor led.

She correctly points out that HSR has different meanings in different settings. While 'the drivers of reform', that is international aid, are often the same, the reform options vary from country to country.

[1] Standing, H**., Gender Inequalities and Health Reforms: An Analysis and Review of Policy Issues**, draft chapter kindly shared by the author, IDS, UK, 2000,

She then outlines the inception of this particular reform movement beginning with structural adjustment programmes, then the Bamako initiative, the HSR and finally Sector Wide Approaches (SWAP)[2]. Structural adjustment came in the 1980's as a result of economic crises and state failures (mostly in the developing world, in my opinion), and as a response to this by the IMF and the World Bank. Standing places the Bamako initiative of 1987 as a response of UNICEF, WHO and African health ministers to the crisis in the health sector and the need to protect the most vulnerable. But she does not elaborate on the nature and causes of this crisis in this presentation, although she acknowledges the importance of identifying the economic, political, demographic and epidemiological 'drivers' of reform in different countries in another presentation[3].

Here, Macrae, Zwi and Birungi's account is very useful, in that he contextualizes the health crises in the developing world, notably in Africa[4]. Their view thus is integrally linked to the rise of nation states in the developing countries in the latter part of the 20th century. I would like to add here that the rise of developing world nations came rather late in modern history, and was associated with the rise of nationalist movements against colonialism since the beginning of the 20th century, with successive waves of liberation struggles and state formations. This is certainly true of the Arab World as well in that during the aftermath of World War One and World War Two, we have witnessed the rise of various nation states the way we know them today. Those had not really existed as such in the pre-World War One period. This does not only hold true for Palestine, but also Syria, Lebanon and Iraq, as examples.

Macrae et al's analysis of Uganda, for instance, identifies the health system there as essentially 'inherited' from the colonizers and concentrating on curative care. The expansion of the health system in the 1960's (post-independence), reinforced a pre-existing curative bias, where attempts to introduce Primary Health Care (PHC) only occurred later. But those were interrupted by successive conflicts, contributing to real reversals in health gains made during the 1960's[5]. That is, their view is that governmental health services faced a double burden: inherited colonial systems, coupled with distortions of conflict, both of which need to be taken into account when examining ways in which to develop health systems in post conflict situations. Thus the inclusion of conflict and instability in the formula of reform, challenging 'paradigms of relief and development' is also very important and insightful. As they

[2]Standing, H., ibid, page 2 of the document contains a simple to understand and useful chronology of institutional and financial reforms, putting together the broader picture of the change of reform policies over time.

[3]Standing, H., **Gender Impact of Health Reforms - The current State of Policy and Implementation**, Paper presented to the ALAMES Meeting, Havana, Cuba, 3-7th July, 2000, and kindly furnished by the author, p.1.

[4]Macrae, J., Zwi, A. and Birungi, H**., A Healthy Peace? Rehabilitation and Development of the Health Sector in a Post-Conflict Situation, the Case of Uganda,** Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, 1995.

[5] Macrae, J. et al… ibid, pp.IX-X.

correctly maintain, development seen as ' a linear, necessarily progressive process, defined primarily in terms of economic growth' is quite problematic, limiting the approaches of current international aid agencies to both relief and development. In essence, they argue that relief and development must be conceptually and organizationally separate, especially in conditions where improvement in security does not lead to absolute peace (the case in the Arab world, Palestine?). They further maintain that existing models of reform are not necessarily appropriate in conditions of transition to the 'post-conflict' state, as current models are linked to all sorts of pre-conditions, such as strong state structures, rational action in policy making, measures designed assuming long term peace and security, availability of minimum national and household resources, and complementarity between the concepts of rehabilitation and reform that may or may not be present in a particular post-conflict state [6]

One would immediately add here that, consequently, the structural conditions within which health systems developed and the constraints imposed by a particular setting must have an impact on the way in which reform can or cannot proceed, calling for the need for great flexibility in approaching reform in a particular setting, and raising serious question regarding universal policies often adopted by international aid agencies that are not 'contextualized'. This is Standing's view as well, although differently expressed.

However, what Macrae et al's elaboration also implies differing stages of post conflict that countries are undergoing, and the need to examine the historical evolution of health systems in the pre independence period to allow for an adequate, relevant and effective development of reform policies. In addition, their inclusion of the historical colonial framework opens the space for a discussion of colonialism in relation to health crises as also linked to external causation, rather than only related to internal conflict and states of war. To me, this historical contextual view also implies a need at the Arab World Level to examine the ways in which the colonial period and other types of conflicts (in Lebanon: the civil war, in Jordan: War with Israel, in Palestine, continued occupation cum minimal autonomy, in Egypt: previous war) influenced the shaping and development of health systems in each of these countries separately. There is a need to understand the constraints and problems faced during the nation state period, and during conflict periods, leading to an understanding of today's influence of both central governmental approaches to health sector development as well as the role of international aid agencies in shaping and determining the health systems of the future.

More, in the case of Palestine, colonization in the form of military occupation (internal colonialism?) and the current situation of bantustanization or cantonization[7] continues to be a crucial component determining the shape, ailments,

[6] Macrae, J., Zwi, A. and Forsyythe, V., Post-Conflict Rehabilitation: Preliminary Issues For Consideration by the Health Sector, Department of Public Health and Social Policy, London School of Hygiene and Tropical Medicine, 1995, pp. VII-XI.

[7] As it stands today, Area A , cities and urban areas, is controlled by the Palestinian Authority; Area B, villages, is in the process of being handed over, and Area C, the bulk of the West Bank is to remain

and distortions of the developing Palestinian health system, including the recent evidence of beginning collapse. One needs to only examine how, de facto, two health systems that are governmentally operated have arisen during the past 5 years (one for the Gaza Strip and another for the West Bank), to understand the depth of the influence of continued colonial effects on attempts to system build during the Palestinian Authority period. Yet, current reform policies do not appear to take this important fact of continued colonization into consideration, probably based on the idea that soon, a peace process will lead to the signing of a peace treaty, and all will be well after that. Yet, evidence suggests otherwise, and indicates that the Palestinian setting is far from a post conflict one, but one that appears to take the contours of a chronic protracted conflict that will take years to resolve, even if a peace treaty is signed. Within such a context, how can we re- examine reform, especially reform dictated by international aid? And how do we go about rationalizing the process, given this important omission?

The other point that directly emanates out of our discussion here is the essential need to stage possible reform each country has undergone separately, as each stage has its own characteristics, imperatives, and constraints. Such an analysis or staging is crucial for the elucidation of policies and plans related to particular stage. An understanding of each stage in the process of reform yields rational expectations as to how to influence policies and plans from the gender perspective, if at all. This is where I find a discussion of the Reich Applied Political Analysis for Health Policy Reform [8] and mapping probably premature for some countries, as if the beginning of our work is right in the middle of a process, instead of at its legitimate and essential beginnings. What I have from Reich, if this is what has been discussed with the RHWG regional, is a tool, a piece of software, allowing for a computer assisted political analysis. This software allows for an assessment of ' policy content, the major players, the power and policy positions of key players, the interests of different players, and the networks and coalitions that connect the players'[9]. Although potentially very useful for us and others, it is merely an application, and cannot substitute for historical and systems analysis first. Reich himself acknowledges this and other potential problems with the software by pointing to the need to have quality data when using this tool, and by pointing out to the vulnerability of the tool to 'garbage in garbage out'[10] . He then concludes by also acknowledging that political data often require 'judgment and interpretation', meaning, for our purposes, the need to first analyse our setting adequately and then begin to use the tool, carefully and rationally rather than mechanically. It is then that this tool could be potentially very powerful.

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under Israeli control. This effectively means the Israeli ability to block flow and movement to and from these areas at any time. In addition, all exits from the West Bank and Gaza Strip continue to be controlled by the Israelis. Any movement between the West Bank and Gaza Strip requires approval by the Israeli military.

[8]Reich, M., **Applied Political Analysis for Health Policy Reform**, Current Issues in Public Health, 1996, Reich, M., and Cooper, D., Policy Maker, Computer-Aided Political Analysis: Improving the Art of the Feasible, Versions 2.2.

[9]Reich. M., ibid, p.3.

[10]Ibid, p.5.

Going back to Standing's chronology, HSR developed in the late 1980's and early 1990's focusing primarily on public sector reform (governmental) and governance (problematic concept), efficiency/effectiveness, controlling governmental expenditures and essentially managerial aspects for cost containment purposes. In another article, she examines from a gender perspective the effects of HSR and its major elements as put forth by Cassels. Cassels elements of HSR include: the improvement of the performance of the civil service, decentralization, improving the functioning of national ministries of health, broadening health functioning options, introducing managed competition and working with the private sector [11]. According to Standing, this HSR approach was developed/espoused by the World Bank, the United States and the United Kingdom. It is interesting to note that this initiative for reform apparently began first in the developed world, and trickled down to the developing world in various forms, but notably driven by international aid agencies. (It sounds like, if it is good for the UK, it must be good for you!)

Strikingly absent from the discourse of HSR is a focus on essential policy analysis issues related to and governing reform, that are so crucial for the Arab World context, perhaps especially Palestine. Also absent is an analysis of preconditions for the implementation of such policies, in addition to the absence of a globalization and north south discourse that can contribute to our understanding as to partially why developing world governments are unable to cope. And how do we place the Arab World into the globalization cum conflict with Israel context?

In the meager literature that is available to us, we find that inadequate conceptualizations of health policies that do not take into consideration historical and socio-political structures is noted; priorities of health policies related to equity and ethical considerations are identified as insufficient or missing, in addition to what seems to be a fixation on the managerial instruments without due consideration to the need for structural and political changes to govern HSR implementation , all identified as causing the exacerbation of the conditions of the poor (and women are among the poor) , and the insufficient success and even failure of reform[12]. Such international descriptions then, warn against swallowing HSR whole. They call for a starting point for our regional work rooted in analysis first and a broad perspective of what is taking place in the specific country and the Arab World at large. In addition, they are a call for the elaboration of how HSRs in the different countries have had an impact on reproductive and women's health.

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[11] Standing, H., Gender and Equity in Health Sector Reform Programmes : A Review**, Health Policy and Planning**, 12(1), 1997, pp.1-18.

[12] See for instance, Gauld, RDC, The Development and Implementation of Health Policy: New Zealand and Hong Kong Compared, Journal of Health and Social Policy, 8(3), 1997, pp.67-78, Ivanovska, L, Ljuma, I., Health Sector Reform in the Republic of Macedonia, **Croatian Medical Journal**, 40(2), 1999, pp.181-9, Jayasinghe, KS, De-Silva, D., Mendis, N. Lie, RK, Ethics of Resource Allocation in Developing Countries: The Case of Sri Lanka**, Social Science and Medicine**, 47(10),1998, pp.1619-25, Chaulet, P., After Health Sector Reform, Whither Lung Health?, **The International Journal of Tuberculosis and Lung Disease**, 2(5), 1998, pp.349-59, Healy, J., McKee, M., Health Sector Reform in Central Asia and Eastern Europe: The Professional Dimension, Health Policy and Planning, 12(4), 1997, pp. 286-295.

SWAPs developed in 1997 and are currently taking shape in different countries according to Standing. Swaps pertain to a new approach to development assistance, where assistance is viewed as a partnership with national governments, defining priorities within a macroeconomic and institutional (?) framework. Here, it seems that donors have coordinated approaches to health sector funding where donor give money in return for a voice in the development of the national sectoral strategy as a whole, and not only that of health. This is a good start, as health strategies cannot be divorced from overall developmental ones. Yet here, there seems to be a continuation of the classical HSR agenda focusing on management of systems and ministries, and setting clear priorities for the public sector. At the same time, there is an acknowledgement of the importance of ' national ownership of reforms.

It is not clear at all what this means in real life in Palestine, and perhaps in other Arab Countries, and who is meant when ownership is discussed .It is as if one can have consensus on priorities because the interests of different groups in society are the same, or that all 'stakeholders', as the frameworks put it, have agreed on a bare minimum agenda of priorities and needs. It is as if societies are not divided horizontally and vertically, leading to widely differing needs, aspirations and power positions within the decision making apparatus! Collective ownership, in the case of Palestine, with very rare exceptions, means the power of those in charge. Lumping different groups together into 'community', for instance not only omits the needs of women, but also often lead to increasing the power of those in charge, and those are usually elder men. For, after all, patriarchy and seniority are the basis of leadership in the Arab World.

Swap also acknowledges the demand side of reform, and not only the supply side. Moreover, attempts are made to include a wide range of 'stakeholders' in negotiating strategic plans for the health sector, including, I add, the necessary civil society institutions and NGO's. Yet when the structural basis of the political domain does not and cannot allow for genuine participation, when the analytical basis for priority listing for health policy development is absent, when the ethical and equity arguments are not even part of the discourse, save perhaps as lip service in response to donor aid pushes and pulls, and when the managerial instruments required to affect even minimal changes are absent, attempts at SWAP to development can turn into a tragi-comedy.

Consequently, in Palestine, we have had these seemingly non-stop Mickey Mouse sessions of strategic planning that every agency and the other engaged us in for 2-3 years, with the Dollars as the carrot, and with little coordination and some serious competition among the international agencies themselves. The process took place in form, but not in content, without adequate regard to the need for the fulfillment of preconditions before this potentially very useful exercise could be attempted. In our context, the pre-conditions include: a public/general view of/and agreement on what kind of Palestine we want for ourselves (we have lost the space for such discussions since the PA arrived), an overall development plan emanating out of that, a clear, ethical, equity based priority setting process by the MOH delineating the course of the process of negotiations (noted elsewhere in the developing world)

and limiting excessive biomedical interference that constitutes the natural bias, a genuine strategy that emanates out of these constraints, and then the strategic planning sessions. The way the process took shape in Palestine is that quick, dirty and non-comparable information was collected and collated. Yet data collection appeared to have no bearing on the process because the collected information was not linked to the process: it was not utilized to inform, prioritize nor steer the discussions! A hoopla process of consultation was then initiated, costing quite a bit of money in a resource constrained environment, entailing inviting every health person and his brother in the north, center, south and Gaza asking for needs but being given back demands, with the dollar sign in the eyes. Thus the process turned into a shopping list, maybe a wish list, swaying in between different conceptual terrains: the biomedical equipment and things variety coming out of the demand wish list of the health profession here, and the necessary reproductive health (meaning population control, really), management related projects and tools such as job descriptions and guidelines, and mental health priorities, imposed by international aid agencies' dollars. So disconcerted and so disheveled was the process that I cannot even begin to analytically read the national health plan for content analysis purposes. I am not even sure it can be read that way. It may well be destined to remain on the shelf [13].

While it is not so clear what institutional really means, a term of apparent integral importance to the SWAP orientation, the argument in the SWAP's to development focuses on the need to develop and strengthen the public sector (rightly perhaps) so that it is better able to meet basic needs. This in itself is an important position to take, especially if we hold that, ultimately, it must be governments that are responsible for the health of the population. If to not protect, provide and safeguard, what are governments for then?

The principal question here is: how can international aid assist in the process of governmental system strengthening without obliterating the needed space for operation and the independence of civil society institutions and NGO's working in health especially, so crucial for the generation of information for policy, model building , mobilization and advocacy purposes. This space for operation is important for other domains that link to health, such as the domain of women, disability rehabilitation, social support, human rights and democratization, all part and parcel of the formula for citizenship and human rights. How does one arrive at a balance between governmental support and and the intellectual and operational space for pluralism and democracy to grow in the process of nation building?

We in Palestine have seen the extreme form of the governmental strengthening and partnership approach in some instances, notably with agencies filtering western governmental aid locally. We now have a situation where there is an increasing number of international aid agencies insisting on donating development funds to

[13] I as well as various others working at the Institute of Community and Public Health, as well as partners from the NGO, UNRWA and governmental sectors as well as our alumni have all participated in this process repeatedly, and recognize the problems. See Palestinian National Authority, Ministry of Health, National Strategic Plan, Palestine, 1999-2000.

NGO's, universities and research centers only with governmental approval, and even though special budget lines are reserved for assisting NGO's, in addition to assistance donated to government. Such an extreme form fails to note the importance of the necessity of independent work in the health care sector that is free of governmental approval and sometimes dubious decision making regarding funding (especially in cases where governments are accused of corruption, favoritism and when immediate ultimate priorities pertain to either obtaining as much money from international aid to cover the operating expenses of the public sector or the national political domain and peace agreements, as opposed to the systems development for the needs of the majority one). It is not clear at all here, even within the context of original, non-extreme framework, why funding need not be freed and directed to NGO's, as long as the general NGO framework of operations is compatible with general governmental strategies for development. Such an independent, un-obstructed type of work is at the core of the NGO role, indeed the role of civil society institutions. Indeed, it is they that are able to yield both policy information as well as models of health care that the public sector traditionally is not able to produce, yet needs in order to move forward. As it stands, such a stance also pits government against NGO's in that it reduces the issue to an attempt of each to bring money into its own institution rather than that of the other. Is this healthy for system building? Is this healthy for reform in partnership?

There are some real problems entailed in the main concepts underpinning this framework, even in the non-extreme form. The assumption it seems here is that aid to different actors must fall in line with governmental plans and policies. The assumption also here is that such policies and plans are equitable, gender sensitive, have been developed first and foremost with a clear priority setting process in ethical ways, engaging the different groupings within society in a genuine and well directed manner, and focused on system development, rather than, say, power politics, corruption. Etc. The other assumption underlying this approach is that the public sector employs technocrats for the purposes of strategic planning who are knowledgeable, well trained, and with experience, and have an allegiance to the development of the public sector and the common good. Evidence in Palestine points to the contrary, with, for instance, 67 directors general in the Ministry of Health having been appointed by a presidential decree, and according to the testimony of high officials in charge (the deputy Minister of Health) not only have no role and exhaust substantially the health care budget through their salary remunerations, but are also hampering growth and development as well).

Finally, the SWAP framework also assumes a policy environment conducive of inter and intra-sectoral collaboration, and a managerial structure within the public sector that ensures the adequate and smooth operation of such collaboration. Again, evidence in Palestine points to the contrary, where so often, the hurdles we face in dealing with specific health issues entail not merely inter-sectoral collaboration within the public sector (say, between education and health) but also at the intra-sectoral level as well (for instance, the case of the women's health versus the primary health care Departments at the MOH, the case of school health and the Department of Pediatrics, the case of environmental health and medical waste

disposal). In all these cases, we have encountered serious impediments pertaining to problematic approaches to the management and containment of disease and its prevention, serious managerial structural problems prohibiting intra-sectoral collaboration within the MOH and between the MOH and that of education, environment and social welfare, among others, an amazing level of budgetary and other forms of extreme centralization (only the President can in effect move things forwards, budgetary and otherwise), serious budgetary constraints and budgetary allocation problems, inequitable distribution of resources, extremely low staff morale, inadequate supervision, and extremely restrictive job definitions, when available, that fundamentally come in the way of any reform, despite the money and the pressure of international aid, among other problems. In other words, while funders push reform in the absence of a genuine Palestinian strategy for development, the administrative instruments to implement such reforms are still lacking, in addition to a policy environment (and the political will) that is not conducive to serious PA attempts at influencing change, and with donors turning a blind eye to failures and to corruption, precisely because the development aid agenda at the moment is placed at the service of the political dimension : signing a peace treaty with Israel). It must be added here that the lack of coordination and the competition among donors have only increased the problems encountered in attempts to forge inter and intra-sectoral collaboration, with vertical donations to vertical programmes making matters in fact worse for the MOH itself, as the Minister and his deputy constantly raise as a constraint hampering their work. Examples include the highly competitive terrain of family planning, five mental health plans developed by five different international donors, three parrallel attempts at management restructuring within the MOH by three separate international donors and no real coordination between them, and others).

As has been found elsewhere in the developing world, we have what is called in the literature a situation of 'operational collapse'[14], coupled with what is called 'state budgetary crisis' emerging in the last 2-3 years, and becoming quite obvious in the year 2000. What clearly testifies to this beginning collapse are the public health workers and school teachers and university students strikes of the year 2000, among other indicators of the seriousness of the situation. Yet these diagnoses appear to have been placed on the shelf for now, as the imperative of signing peace agreements with Israel are at the moment paramount.

Standing also notes that gender analysts are particularly critical of adjustment programs as those relate to women's further deprivation in real ways, especially given women as the caretakers and producers of health care, other than them being consumers.. By not recognizing the sexual division of labor, and the non-market work of women, health outcomes of adjustment, reform, etc have direct and indirect ill effects on women and women's health. Charging user fees and cost recovery reduces access; cutting on governmental health expenditure has an impact on women workers, the mostly female labor force of the health sector; removal of food

[14] Arroyo, LJ, The Autonomization of Public Hospitals and its Consequences on Health Care Demand, Lima, **Revista Panamericana de Saludad Publica**, 6(5), 1999.

subsidies has most impact in poor households, and on women and children; demographic transitions with an increasing number of elderly people mean more caretaking roles for women and increasing their burdens, all with consequent ill effects on women's health and wellbeing.

Other critiques focus on children as well as other excluded and deprived groups Yet others focus on class, where cost recovery is found to have a negative impact on the poor, especially those who need free services. It is maintained that, without a holistic approach to reform, micro-reforms produce both micro-efficiency and systemic inequity, where impact of effectiveness of services for the population served is omitted[15].

Finally, Standing notes that the major aim of adjustment policies in general is to reduce public expenditure, with serious impact on the social sector. According to the literature I have managed to collect, a sizeable proportion of efforts to reduce public expenditure in the health sector fall on drugs, with claims of irrational drug use, and attempts to construct rational drug policies and essential drug lists. Drug supply systems have been cited in the literature as constituting a major element of public health policy design, notably in Africa[16]. In Palestine, the current common knowledge is that about 30% of the health care budget is consumed by medications. We also know from our work that drugs are indeed used quite irrationally, but that the availability of basic medications especially at the primary care level continues to present a serious problems to those seeking governmental health care services (work in progress, Khatib , R. et al)

At the same time, an investigation that we conducted during the past two years at the Institute (Khatib et al.) revealed clearly that drugs per se take up about 10% of the health budget, while an additional 20% is taken up by diagnostics, chemicals and laboratory materials. Every attempt was made to argue for the separation of these two items, knowing fully well the problems of limited supplies of basic medications at the primary care level, but we failed. The percentage continues to be quoted in a way that misconstrues reality. That is, attempts are being made currently in Palestine to rationalize drug use, which is an honorable step. However, the focus seems to be almost solely on cost containment and reduction to the exclusion of a good examination of the expenditures at the level of diagnostics and laboratory tests and chemicals. In a situation where essential drugs are in fact not readily available at all to the population seeking public health care services, the question arises of why the PA and the World Bank are so obsessively working with medications, to the exclusion of the 20% budgetary expenditure consumed by chemicals and diagnostics? The question here is: why is the overall expenditure on these materials not separated into its constituent parts, as such separation might lead to very

[15] Arroyo, Lj, op.cit., Bloom, G., Xingyuan, G., Health Sector Reform: Lessons from China, Social Science and Medicine, 45(3),1007, pp.351-60.

[16] Falkenberg, T., Tomson, G., The World Bank and Pharmaceuticals, Health Policy and Planning, 15(1), 2000, pp.52-8.

different conclusions, priority listing for cost reduction, and courses of action than the one currently being taken?

Finally, perhaps what is most problematic in these frameworks is the absence of the concept of citizenship and what it entails from the discourse of adjustment historically and up till the SWAP's. What is citizenship if it is not about social rights, and not only the political rights that Palestinians are aspiring to achieve.? And what are social rights if not health, education, food and shelter as a bare minimum? Whose responsibility is this sector? Is not citizenship about a social contract between state and citizens defining rights and responsibilities? Where is the basic human right of health in the formulae of adjustment? In the Palestinian setting, such a discourse is a crucial component of all discourses, as omitting it, as is the case here, means effectively that we are quickly losing citizenship before we even achieve it!
For the RHWG purposes, unless we raise this particular issue as a core concept within our discourse, the chances are that women and women's health will take the brunt. For it is women who are the producers of health care - as mothers and caretakers of the disabled and the elderly; it is women whose work is omitted from the economic formulas of adjustment, so cost containment is highly likely to mean more burdens added to an already burdened life; it is women, the invisible voices, who need special health care especially because of biological - reproductive - roles but also an inequitable sexual division of labor and all its ramifications on social relations and health; and it is women who appear to be the focus of aid fertility control policies rather than society at large..

References

Adams, OB, Hirschfeld, M., Human Resources for Health, Challenges for the 21st Century, **World Health Statistics Quarterly**, 51(1): 28-32, 1998.

Almeida, C., Travassos, C., Porto, S., Labra, ME, Health Sector Reform in Brazil: a Case Study of Inequity, **International Journal of Health Services**, 30(1): 129-62, 2000.

Alvarez, RC, Zelmer, J., Standardization in Health Informatics in Canada, **International Journal of Medical Informatics**, 48(1-3):13-8, 1998.

Battistella, R., Health Services Reforms: Political and Managerial Aims, an International Perspective, **International Journal of Health Planning and Management**, 8(4), 265-274, 1993.

Blaise, P., Dujardin, B, de-Bethune, X., Vanderbergh, D., Centralized Purchasing of Essential Drugs, a Priority for the Health Care Systems of Developing Countries, **Sante**, 8(3):217-26, 1998.

Bloom, G., Xingyuan, G., Health Sector Reform: Lessons from China**, Social Science and Medicine**, 45(3):351-60, 1997.

Buchan, J., Hacock, C., Rafferty, AM, Health Sector Reform and Trends in the United Kingdom Hospital Workforce, **Medical Care**, 35(10) 143-50, 1997.

Cassels, A., Aid Instruments and Health Systems Development :An Analysis of Current Practice, **Health Policy and Planning**, 11(4), 354-368, 1996.

Chaulet, P., After Health Sector Reform, Wither Lung Health**, The International Journal of Tuberculosis and Lung Disease**, 2(5):349-59, 1998.

Falkenberg, T., Tomson, G., The World Bank and Pharmaceutical, **Health Policy and Planning**, 15(1), 52-8, 2000

Gauld, RDC, The Development and Implementation of Health Policy: New Zealand and Hong Kong Compared, **Journal of Health and Social Policy**, 8(3): 67-78, 1997.

Healy, J., McKee, M., Health Sector Reform in Central and Eastern Europe: the Professional Dimension, **Health Policy and Planning**, 12(4):286-295, 1997.

Ivanovska, L, Ljuma, I., Health Sector Reform in the Republic of Macedonia, **Croatian Medical Journal**, 40(2):181-9, 1999.

Jayasinghe, KS, De-Silva, D., Mendis, N., Lie, RK, Ethics of Resource Allocation in Developing Countires: The Case of Sri Lanka, **Social Science and Medicine**, 47(10):1619-25, 1998.

Jayasinghe,KSA, De-Silva, D., Mendis, N., Lie, RK, Ethics of Resource Allocation in Developing Countries: The Case of Sri Lanka**, Social Science and Medicine**, 1998, 47(10), 1619-1625, 1998.

Macrae, J., Zwi, A., Birungi, H., **A Healthy Peace? Rehabilitation and Development of the Health Sector In A Post Conflict Situation, the Case of Uganda**, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, 1995

Macrae, J., Zwi, A., Gilson, L., A Triple Burden for Health Sector Reform: Post Conflict Rehabilitation in Uganda, **Social Science and Medicine**, 42(7):1095-1108, 1996.

Macrae, J., Zwi, S., Forsythe, V., **Post Conflict Rehabilitation: Preliminary Issues for Consideration by the Health Sector**, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, 1995.

Mills, A., Hongoro,C., Broomberg, J., Improving the Efficiency of District Hospitals: is Contracting an Option? **Tropical Medicine and International Health**, 2(2):116-26, 1997.
Oreskovic, S., New Priorities for Health Sector Reform in Central and Eastern Europe (Editorial), **Croatian Medical Journal**, 39(3):225-33, 1998.
Reich, M., Applied Political Analysis for Health Policy Reform**, Current Issues in Public Health,** 1996.
Sauerborn, R., Nitayarumphong, S., Gerhardus, A., Strategies to Enhance the Use of Health Systems Research for Health Sector Reform, **Tropical Medicine and International Health**, 4(12): 827-35, 1999.
Standing, H., Gender and Equity in Health Sector Reform Programmes: A Review, **Health Policy and Planning**, 12(1):1-18, 1997.
Standing, Hilary**, Gender Inequalities and Health Reform: An Analysis and Review of Policy Issues**, Draft Chapter kindly forwarded by Author, Institute of Development Studies, Sussex University, England, 2000.
Van Den Heever, AM, Private Sector Health Reform in South Africa (Editorial), **Health Economics**, 7(4):281-9, 1998.
Wilkinson, D., Tuberculosis and Health Sector Reform: Experience of Integrating Tuberculosis Services into the Districty Health System in Rural South Africs, **The International Journal**