Case Study

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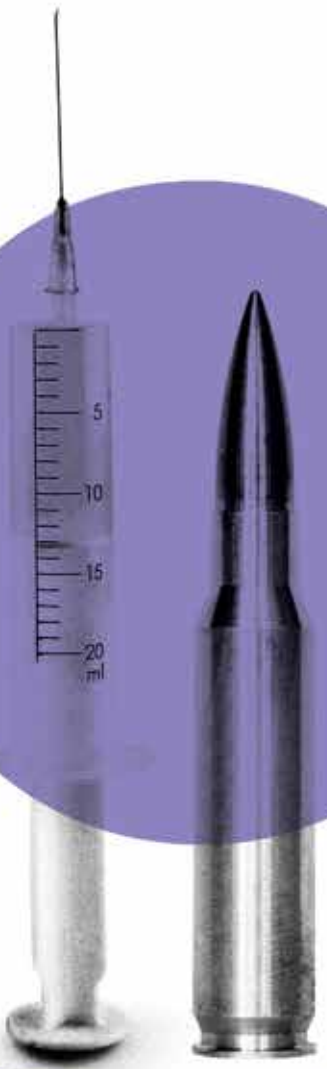

A Health System Under Siege: Ensuring Equity Across the Continuum of Care in the Occupied Palestinian Territories

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Introduction

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The views expressed in this case study are those of the author and do not necessarily reflect the official opinion of ISGlobal.

Access to efficient and timely health care services remains a formidable challenge within the context of violence and warfare. Although the magnitude of armed conflicts has decreased globally following the end of the Cold War, intramural violence remains entrenched within many countries, compromising the health status and welfare of the population at large (Leaning and Guha-Sapir, 2013). The public health challenges that ensue as a result of a complex network of instability -economic, political, and societal- and a subsequent breakdown of basic health services, have had devastating effects upon afflicted populations. The impact of both direct (eg. combat wounds, food scarcity) and indirect (eg. increased risk of communicable disease transmission, detrimental psychological health conditions) health consequences are experienced and exacerbated, leading to an increase in mortality and morbidity rates in conjunction with a 'destructive impact on the national economy and infrastructure [and] on social cohesion (Geneva Declaration on Armed Violence and Development, Chapter 2: 2006)'. Ensuring equity is at the heart of service provision in these areas therefore presents as a significant challenge for health systems and providers in the many different settings devastated by conflict.

The Palestinian situation, although no exception to this global struggle, presents an especially challenging case to providing and sustaining access to often basic health care, primarily as a consequence of the chronic volatile social and political milieu (Rahim et al, 2009; Matthews, 2012). Sixty years of continuing conflict and forty years of Israeli occupation has subsequently created many displaced and refugee populations, increased discrimination and marginalisation, and considerably jeopardised the continuum of care across the population. The presence of occupational authority has meant that the mercurial state of institutional, political, economic, and environmental structures within the occupied territories (oPt) are almost entirely vulnerable to the external operations outside of the control of the Palestinian Authority (PA). This lack of basic security inherent to this region, as to many other conflict areas, presents a fundamental underlying threat inhibiting efforts to effectively implement an integrated and equitably-led health system, and exposes the intrinsic challenges to providing effective, responsive and continuous care.

"The population of Palestine has suffered incomparable hardship, injustice, discrimination, eviction, displacement, illegal settlements of Palestinian lands, isolation, war, and terror"
(Rawaf et al, 2010)

Since the onset of the second *intifada* -one of the 'longest and bloodiest episodes of the Israeli-Palestinian conflict' from 2000-2005, in which

Palestinian resistance groups fought against Israeli occupation -the state of health care within the oPt has been increasingly precarious (Manekin, 2013): evidence highlights limited progress with regard to infant, under-5 and maternal mortality rates in particular (standard indicators of health status and progress), that have 'changed little since 2000 (Matthews, 2012)' and remain considerably high in comparison to rates in neighbouring countries, particularly with regard to Israel to which there is notably disparity between these rates (Figure1).

Developing a co-ordinated approach to targeting these rates is further hampered by the development of 'two de facto health systems' in the West Bank (WB) and the Gaza Strip (GS), as a consequence of the protracted conflict between both the governments of Israel and Palestine, and between the central Palestinian political parties themselves, [a] point that seems to be missed by donors and…reform policies' (Giacaman et al, 2003). Indeed, the injection of almost $9 billion in international aid has not been channeled into promoting development in this sector, but has instead 'fuel[led] the growth of a health care complex that is crowded by public and private providers connected in loose opaque networks' (Stefanini and Pavignani, 2010), creating further disunity to an already fragile system.

Intended as an essential overview rather than an extensive analysis of a situation of profound complexity, this paper will first explore how the structure of the health care system presently affects equity across the territories; will then look to how this structure explicitly affects access to health services within the WB; and will finally examine the present state of health and provision in the GS, and the major challenges ahead for future health equity and development.

Figure 1
Infant and under-5 Mortality Rates, and Maternal Mortality Ratios Across the Occupied Territories and its Neighbouring Countries within the Levant

	Infant Mortality Rate (per 1,000 live births)	Maternal Mortality Ratio (per 100,000 live births)	Under-5 Mortality Rate (per 1,000 live births)
Palestine*	**WB: 22.9 / GS: 28.8**	**64 (upper limit: 150)**	**23**
Israel	3	7 (Upper limit: 10)	7
Lebanon	7	25 (upper limit: 45)	9
Syria**	13	70 (upper limit: 110)	15
Jordan	18	63 (upper limit: 110)	19

Mortality Ratio:
the number of women who die during pregnancy and childbirth, per, 100,000 live births.

Mortality Rate:
the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates.

Mortality Rate:
the number of deaths in the first year of life, per 1,000 live births during the same period.

Source: World Bank, 2012; WHO et al Report, 2012

** Figures presented for the occupied territories are often deemed to be 'improbable low estimation(s)' (Rahim et al, 2009: 970), primarily due to the paucity of reporting, analysis, and organisation of documentation within the Ministry of Health, attributable, in part, to institutional weaknesses within government-run hospitals themselves (Abdo et al, 2009: 10; Imam et al, 2012). Caution must therefore be taken when interpreting these indicators and such gaps may under-represent the true gravity of this situation.*
*** These figures are representative of the status of healthcare prior to the current conflict in Syria, and thus do not reflect the present state of health conditions/health provision.*

A Fragmented System

The current structure of health care across the occupied territories is one that is largely disconnected, insecure and principally reliant upon external financing. Following the end of the six-day Arab-Israeli war of 1967, which culminated in Israel's annex of the West Bank and the Gaza Strip, there has been a significant military presence within these territories: extensive violence and struggle has continuously surged within this region, both between Palestinian and Israeli forces, as well as internal conflict between warring Palestinian political factions themselves (*Hamas*, now operating within the GS since 2007, and *Fatah*, claiming jurisdiction within the WB). Although an independent Palestinian Ministry of Health was established as a result of the Oslo Accords in 1993[1], the economic vulnerability and insecurity of the Palestinian Liberation Organisation's (PLO) internal budget, as a result of years of deficit, jeopardised the fiscal and physical security to this transition, and did not result in the proposed 'parallel distribution of power': Israeli authorities still controlled border crossings/closures (and thus volume and type of imports/exports), and provision of basic infrastructure and commodities (eg. building permits, water and sanitation) (Marton, 2011). As a result, the health care system has remained in a tenuous state, and is managed between a multitude of providers, each administering different levels of care to various factions of the population across the regions (Abu-Zaineh and Mataria, 2010).

'The health care arena is territorially, institutionally, organizationally and culturally fragmented [and consequently] is a constellation of health service delivery systems'
(Stefanini and Pavigiani, 2010)

This convoluted state of segregation has meant that the establishment of a harmonised and integrated Palestinian health care system has been severely challenging, and engendered a state of 'de-development' within the health care sector (Pavignani and Riccardo, 2011). Four central providers currently operate across the territories: Ministry of Health (MOH), providing for the majority of the population; UNRWA, that provides services to Palestinians of specific refugee status; various NGO's and private sector organisations (Rawaf et al, 2010; Giacaman et al, 2009). The disunity between these has indubitably led to significant 'gaps' in accessing health care, and exacerbated inequities across the oPt: proficient and accessible perinatal care is significantly lacking across both the WB and the GS; chronic shortages in medicines and apparatus are prevalent, particularly in government-run facilities; and increasingly high treatment costs have prevented many from accessing often the most basic of health care needs.

Moreover, the territorial segregation of the Palestinian regions has given rise to the absence of a cohesive health information system, the effect of

1 A 1993 signed agreement- 'essentially an agenda for negotiations'-by Israeli Prime Minister Yitzhak Rabin and then PLO leader Yassar Arafat. The agreement outlined the transfer of authority to the PLO in five central areas (education, social welfare, health, tourism, and taxation), and initiated a platform for the development of PLO control over areas in both the WB and Gaza (Shlaim, 2005). An independent Ministry of Health was thus established at this time.

which has been misplaced, fragmented or incomplete, and unreliable data, resulting in limited efforts to target, manage, and efficiently address these gaps. This lack of rigour in data collection has also meant that reliable mortality and morbidly estimates are extremely 'problematic', and as such limits 'the capacity [of the system as a whole] to plan and assess performance' (Mataria et al, 2009: 1210). Of particular concern is the fact that little data is available pertaining to health care in the GS since its split from the WB and, commonly, information accumulated within the WB is misconstrued as being illustrative of the oPt as a whole: often the situation in Gaza is considerably more damaging. This further reinforces the need to purposively develop a framework targeting a more unified approach to managing health care across the territories to more concretely establish where persistent gaps exists and where greatest need lies.

Health under Occupation: Access to Health Services in the West Bank

Regressive Financing

The nocuous effect that the fragmentation of the health sector has had across the occupied territories is manifested within the regressive financing system currently in place that has placed a significant fiscal burden upon an already indigent populace. Restrictive conditions imposed by external forces across the oPt has significantly impeded economic activity and development across the two regions, making it increasingly difficult to implement long-term strategies to bolster the internal economy and strengthen public-sector facilities endorsed by the PA. However, evidence also elucidates fraudulent activities within the central Palestinian administration itself, in addition to the 'political polarisation' between the West Bank and Gaza Strip, as playing a central role in the creation and sustainment of an inefficient and inequitable structure of health financing (Chene, 2012). With no competent autonomous agency to both impartially monitor the activities of PA members, and hold venal affiliates accountable for deprave offences, reports of internal corruption (fiscal and administrative) are somewhat extensive and the actions of those involved in managing the MOH are, seemingly, contributing to the preservation of a 'plethoric, underperforming public health care system, which provides an excess of health services of modest quality, and disregards its policy and regulation functions' (Pavignani and Riccardo, 2011). This has, in turn, fostered a culture of dependence within the PA: reliance on financial support from external sources to sustain public services has both hampered the development of an independently-managed health agency, and fashioned one that often has to concede to the specific, and often disparate, conditions stipulated by various donor agencies (ibid).

Consequently, although the PA extended its Government Health Insurance Scheme (GHI) following the second *intifada* to cater for those sects of the population most affected by this conflict (covering both inpatient and outpatient services mainly within MOH facilities, and also subsidising payments for specific medications), the expansion of this scheme has not been matched by an increase in resource provision (either technical and material) due to the extensive debt burden acquired by the PA over the last few decades (Mataria et al, 2010). The weak position of the MOH to commit to financial investments to maintain and strengthen the GHI has meant that little can be done to protect poorer individuals from adverse health care payments. Many of the poorest individuals are often required to pay high routine treatment costs through private/NGO providers: an enormous 40.5% of the total health care cost is financed through out-of-pocket payments (a structure that does not take inter-households' 'contributive capacities' into consideration), a factor that has had detrimental effect to a region where approximately 27.5% of

the population are unemployed (though in Gaza this is cited to be much higher at 34.5%) (Abu-Zaineh et al, 2011; Mataria et al, 2009).

'Reports [have] clearly confirmed the 'pro-rich' regressive nature of the current healthcare financing structure, with lower-income population groups bearing a higher burden of healthcare expenditure...although the worse off appeared to have a greater need for all levels of health care...access to and utilization of all levels of health care emerged as significantly higher for the better off'
(Mataria et al, 2010)

This most regressive and debilitating form of health care financing has also meant that the prevalence of 'catastrophic' payments[2] has increased (Mondal et al, 2010), and 'stresses the high burden [of these] among the most economically worse off classes' (Abu-Zaineh et al, 2008). Although, where available, the MOH-run hospitals are the most affordable health care service, chronic deficiencies in resources and appropriately trained staff, in conjunction with restrictions on opening times (some cannot operate 24hrs), has forced people to access alternative, more costly providers of care, adversely affecting their income status and pushing them further into poverty (Abu-Zaineh et al, 2009).

Within the present context of a deteriorating economy and the uncertain condition of resources, the structure of health financing needs to be re-evaluated to ensure a pro-poor approach. Stipulating contributions based on ability-to-pay criteria (following a vertical equity model[3]) could perhaps be one way of doing this, as well as considering to develop the use of community-based insurance schemes appropriate to this context through an *ex-ante* model of financing (taking into account other important features of 'societal capital' -extra-community networks, solidarity, and regional state-society relations- that must be considered alongside economic status) (Mladovsky and Mossialos, 2008). Such innovative mechanisms are essential to more concretely attempt to address and reduce unnecessary financial burdens experienced amongst those most vulnerable within this population.

Regional Inequities

A further consequence of this disjointed nature of health care delivery is the markedly inequitable distribution of services across the WB (Rahim et al, 2009; Matthews, 2011; MOH Report, 2012). Exogenous factors pertaining to tensions between the Israeli and Palestinian administrations have created clear topographical divisions across this area, split both by the segregation of Palestinian and Jewish settlements and by a 'comprehensive system of restrictions of freedom of movement' (UN OCHA Report, 2011): the multitude of military checkpoints (over 600) presently spread across the entire of the WB, numerous and often sporadically placed roadblocks, and a 707 km separation wall, that runs along the border of the WB, the presence of which has isolated many towns and villages and effectively trapped them in state of solitude.

It is the populations of these rural areas that face particularly devastating circumstances in relation to accessing health care facilities. In Area C of the WB for example (Fig.2) -an area under full Israeli control, comprised of Israeli settlements and many herding/Bedouin Palestinian communities- those Palestinians residing here (approximately 180,000) considerably suffer unequal access to health care, largely due to restrictions

2 Health care expenditure is considered 'catastrophic' if it surpassed a certain percentage of other household resources. (Mataria et al, 2010). In Mataria et al's study in the oPt, this was if health care payments exceeded '10% of household resources, or 40% of resources net of food expenditures' (ibid: 393).

3 Vertical equity models predicate that individuals earning higher incomes should pay a larger percentage of tax into a pooled system. It aims to redistribute income in society and reduce inequitable financial burdens placed upon poorer individuals (Abu-Zaineh et al, 2008).

of the PA in being allowed permission to build any health facilities, and the communities themselves denied consent to construct any buildings in this area. The 'restrictive and discriminatory' nature of this permit system denies many here any right to even build a permanent home: in 2012 alone, 540 Palestinian structures (165 of which were of residential status) were destroyed as a consequence of a lack of Israeli-issued permits', from which 815 people were displaced and destitute, many of who were children (UN OCHA Report, 2013). This deplorable situation has forced many to often reside in makeshifts tents or caves for prolonged periods, exposed to the external threats of both extreme climate conditions and violence from neighboring settlements. With little access to running water, no mains electricity, and no sewerage, these communities are amongst the 'most vulnerable areas in the WB': over 70% of the population are not connected to the water network and depend upon tankered water, at a considerable cost; water consumption is often as low as 20 litres per capita per day, just one-fifth of that recommended within WHO guidelines, and 57% of the Palestinian population here are deemed to be food insecure, even after received aid contributions (FAO et al Report, 2012). Given the increasingly high need across this area and the palpable dearth of facilities, NGO-managed mobile clinics are relied upon to provide for basic health needs, though, given the context in which they are set, these are often infrequent, under-resourced, limited in capacity, and subject to cease operating at any given time (Batniji et al, 2009).

"Many live in caves which are poorly ventilated and often have mould on the walls and ceilings. Such conditions lack even a semblance of dignity (...) Families are exposed to rain and frost in winter and to very high temperatures in summer posing serious health concerns, particularly for the most vulnerable, children and the elderly"
(UN OCHA, 2010)

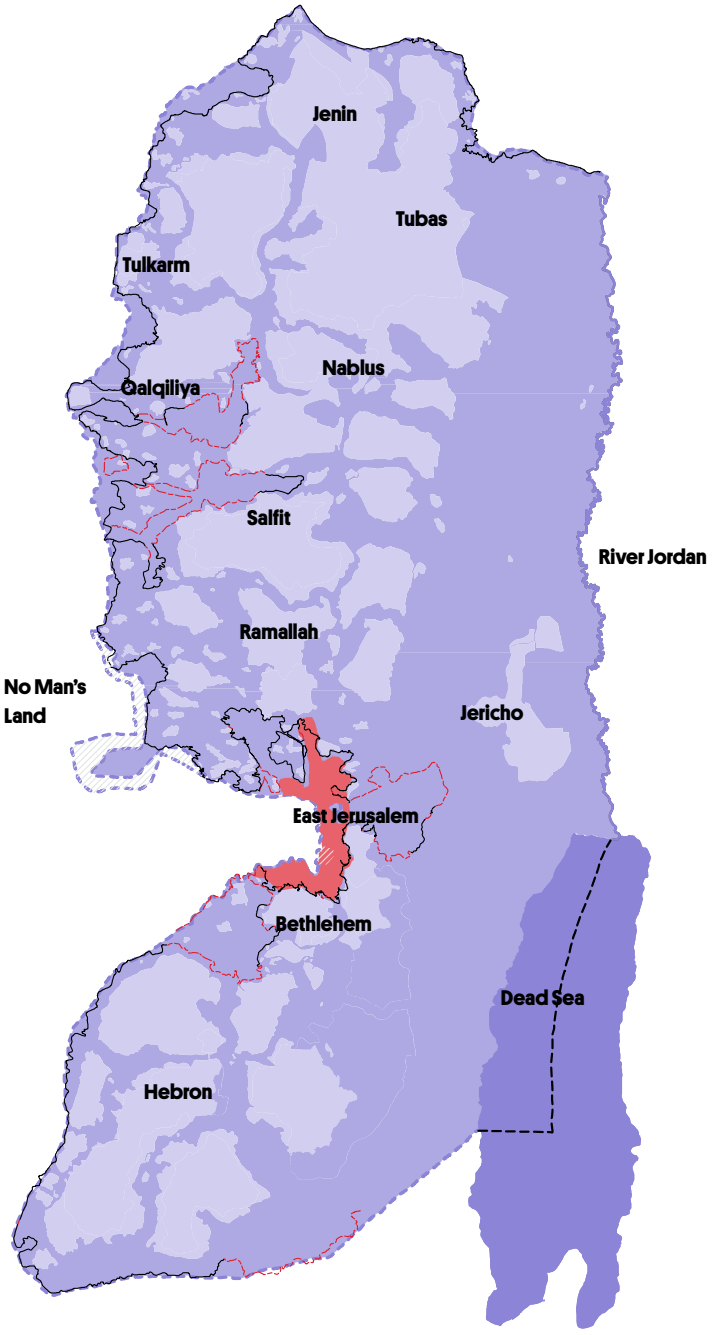
Moreover, the Separation Wall (under construction since 2002 for purported security measures) has isolated many regions and caused further disruption to both building health facilities, and accessing those nearby (WHO and UN OCHA Report, 2010). The estimated 11,000 Palestinians currently living within the 'seam zone' (between the Barrier and 1949 Armistice Line[4] as shown in Fig. 2) are significantly impacted by this: health facilities here are scarce, and the six NGO-managed facilities in nearby East Jerusalem- the central providers of primary, secondary and tertiary care for the majority of the Population in the WB- are 'virtually out of reach' for these Palestinians due to strict permit restrictions, and the cost incurred in using these services (Batniji et al, 2009). The stringent requirement for visitor permits for any personnel ingoing to these insulated areas often prevents medical teams, ambulances and mobile clinics from entering the region (WHO and UN OCHA Report, 2010). Subsequently, services that were being provided by an UNRWA-managed mobile team in Barta'a- the most populated of these regions with 5,600 residents- have been 'suspended' (ibid).

Such profound disproportionalities within the distribution of services across providers continues to exacerbate health disparities across the WB, with these isolated regions suffering significant deprivation and adverse health effects. Developing a coordinated approach integrating both 'inter-providers and inter-sectors' could help to both target and manage the necessary healthcare needs of even the hardest-to-reach population within Area C, and help to alleviate, in part, some of the pervasive environmental barriers blocking health care developments within these areas (Abu-Zaineh et al, 2011).

4 The 1949 Armistice Line (established after the 1948 Arab-Israeli War) was intended to set the border between Israeli and Palestinian settlements, the legitimacy of which is still a much contested issue to date.

Figure 2
Maps Displaying the Location of Area C

Map A



BORDER
- International Border
- Green Line
- Israeli Unilaterally Declared Municipal Area of Jerusalem

BARRIER
- Constructed / Under Construction
- Planned

OLSO AGREEMENT
- Area (A), (B)
- Area C & Nature Reserves

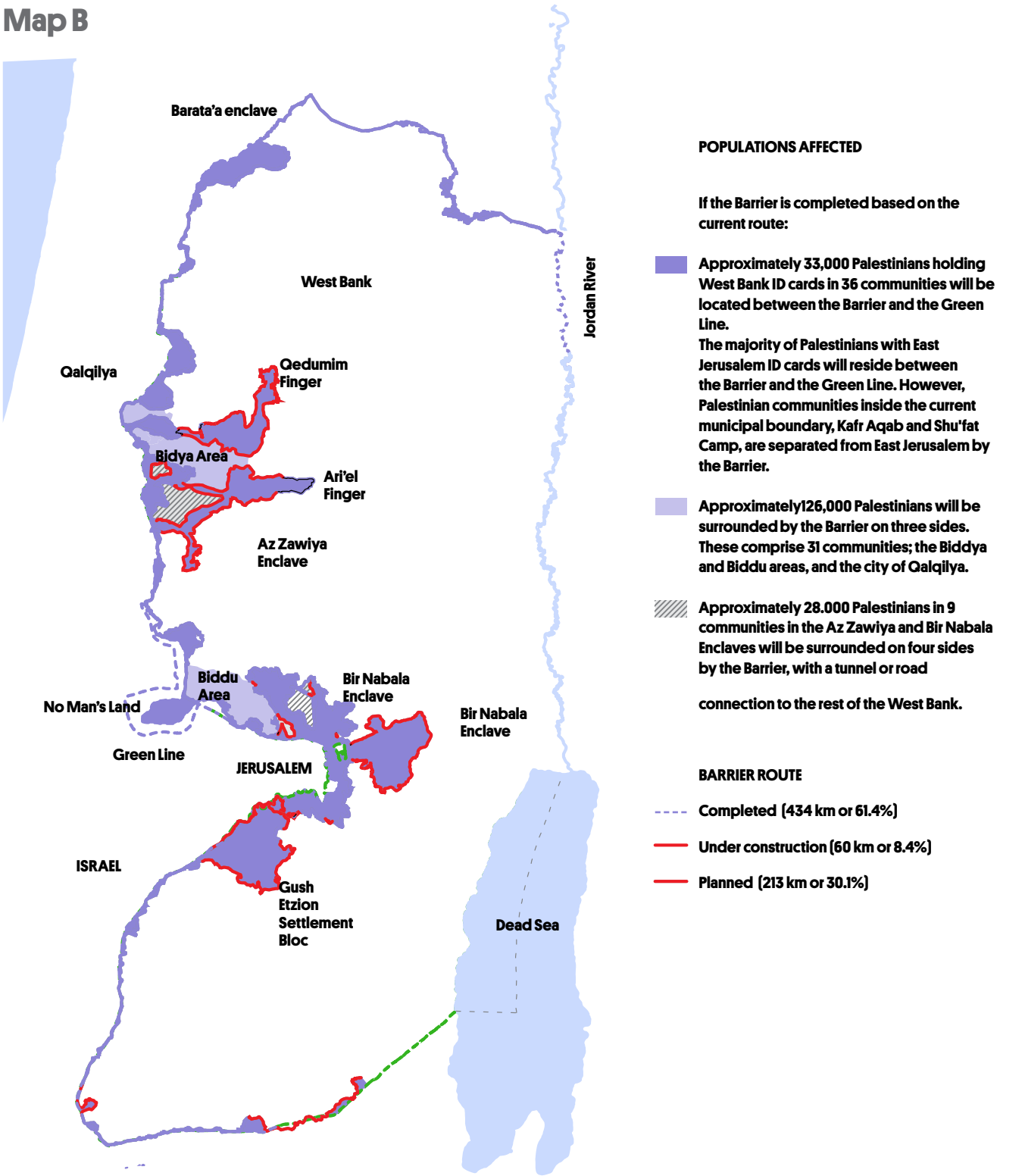
OLSO INTERIM AGREEMENT

2. Area A: Full Palestinian civil and security control
Area B: Full Palestinian civil control and joint Israeli-Palestinian security control
Area C: Full Israeli control over security, planning and construction

Source: UN OCHA, 2011

Figure 2

Map B



Source: UN OCHA, 2010

A Land under Siege: Availability of Services in the Gaza Strip

Institutional Deficiencies and Chronic Shortages

The most prevalent of health inequities across the occupied territories, however, persist within the Gaza Strip, one of the most densely populated regions in the world. The majority of the 1.7 million inhabitants reside in refugee camps and are subject to a protracted state of economic, social and environmental degradation: 44% are food insecure and 38% are living in a state of poverty[5], the effects of which have created extensive and multifarious health consequences and thus an increasing demand for health services. The provision of health services, however, has become increasingly precarious since the split from the West Bank and the internal and external pressures that have ensued. The 'intensified' land, air and sea blockade from Israeli forces, enforced in 2007 when *Hamas* (deemed an 'extremist' organisation and thus unfavourable within predominantly Western donor circles) took administrative control within the GS, continues to stifle its economic development (UN OCHA Report, 2012). Consequent restrictions on imports and exports, in conjunction with the termination of many channels of donor aid to the GS, has limited all spheres of infrastructure, greatly disrupting health service access and delivery and proving detrimental for Gaza's survival and development.

One of the most devastating aspects of this is the chronic shortages in medicines and apparatus across the whole of the GS: at the end of 2013, the WHO reported that 30% of medicines listed on the 'essential drugs list' and 50% of medical disposables were at zero stock levels across the territory (WHO Report, 2013). Although UNRWA (an exclusive agency created for the purpose of assisting Palestinian refugees specifically) remains the main provider for primary health services, the health ministry in the WB is still responsible for supplying medicines and medical equipment for the ministry-run hospitals and clinics within the GS. The geographical discord across the oPt, and the ensued lack of coordination and communication between the two regions, has caused prevalent delays and reductions in the transfer of resources, and medicines received are often expired or out of date (UN OHCHR Report, 2011). Of further concern is UNRWA's purported deteriorating economic status (an accrued state of 'financial crisis' since 2008) that has led to substantial disruption in the delivery of care, and compromised the future stability of service provision. Although the majority of the population depend upon their services (basic care is provided free of charge), the reliance on voluntary contributions to the agency from donors increases its vulnerability to financial strain: only 40% of its total budget was financed in 2011 resulting in the revocation of 30% of services, particularly health initiatives across the GS (Save the Children and Map Report, 2012). The adverse health consequences caused by

5 According to the International Labour Organisation, the poverty rate across Palestine is 25.8%, whilst in Gaza it is significantly higher at 38.8% (2013: 13).

such severe deficiencies are rife: patients face disruptions to ongoing medical treatments, critically compromising health status, and infection control is nearly absent given that many disposables are used and reused, greatly increasing the risk of cross-contamination. Moreover, due to limitations of electricity and water supplies, health facilities struggle to keep life-saving equipment operating and maintained- hospitals often depend upon 'back up generators' as a central electricity source (many of which cannot be maintained properly as difficulties are faced trying to import spare parts and new apparatus), and of the little water that is available, 90% is unsafe to drink due to contamination in the central aquifer (UN OCHA Report, 2010; UNRWA Report, 2013).

What is further unsettling to this already sombre situation is the alternative patients are presented with to gain the service they are unnecessarily denied in this environment: expensive and unpredictable treatment within the private sector across the oPt or within neighbouring countries (Abu-Zaineh and Mataria, 2010). It is estimated that at least 1,000 people are referred for costly specialised treatments outside of the GS each month for conditions that are largely exacerbated by the pernicious environment in which people are living within (considerably from non-communicable diseases such as cardiac complications, diabetes related ailments and kidney conditions), and with a strict permit system in place that can incite both delays and denials, gaining access to treatment is not guaranteed, and incurs considerable costs to both the MOH and to the patient (WHO Report, 2010). With so many of the Gazan population trapped within a state of poverty, the repressive nature of this system both perpetuates existing health and financial and weakens the potential for any initiative aimed at strengthening the capacity of the internal system as a whole.

Maternal and Child Health

With this in mind, those most vulnerable to these adversities are women, children and those suffering with chronic conditions. Considering the high fertility rate (4.57 per woman) and the subsequent young demographic of the population (46% of the population are aged 0-15), the need for comprehensive and stable access to maternal and child health services in this region is imperative (Mahmoud, 2013). Moreover, conditions originating in the perinatal period have been identified as a leading cause of under-5 mortality in this region at an immense 50.8% (WHO Report, 2012).

The aforementioned blockade on the GS continues to bear dire consequences upon the sustainability of perinatal existing services throughaforementioned disruptions to service delivery, causing significant gaps in the continuum of care and keeping mortality rates high and largely unchanged over the last decade (Matthews, 2011; Mahmoud, 2013). Infrastructural disruptions and restrictions have fuelled a lack of evidence based practices and protocols for safe intra- and post-partum care, and subsequently engendered long term damage to key apparatus (eg. incubators and CT scanners) that are consequently often out of use for prolonged periods. An additional concern within this is the safe storage and maintenance of fundamental medicines, such as the refrigeration of essential vaccines (crucial for neonates), as well as protracted deficits in the supply of essential disposables (such as syringes, sutures, exchange transfusion sets for neonates) (McGirk, 2011; Save the Children Report, 2012), and consequent re-use of disposable equipment and increased risk of cross-infection.

Consequently, the prevalence of conditions such as septicemia (bacterial infection in the blood stream) is a leading cause of infant death in the oPt (affecting approximately 1/3 of newborns) with frontline hospital health care workers cited as the 'strongest link in the chain' in inciting and preventing infectious transmissions (Gupta et al, 2008; Petroudi, 2009; MOH Report, 2012; Riccardo et al, 2011). Moreover, anaemia amongst children and pregnant women, and stunting rates (a result of chronic malnutrition) of children under 5 have increased considerably: approximately 50% of infants and young children under two years of age in both the WB and the GS suffer from iron deficiency anaemia, a condition related with inappropriate feeding practices for infants and young children, and evidence attests to a high prevalence (39.1%) of anaemia among women attending antenatal clinics (WHO, 2012). Further, although no formal research has yet taken place, UNICEF cites that increased nitrates and chlorides within the water supply (six times the rate of that stated within the WHO guidelines) pose a significant risk to infant mortality and morbidity in this region (UN OCHA Report, 2010), fuelling the risk of additional health complications and increasing the need for more comprehensive and accessible service delivery across the vicinity.

Gaining sustained and affordable access to critical medicines and medical supplies thus remains a palpable challenge to these more vulnerable cohorts within the GS. In light of the substantial predictions for Gaza's population growth rate -from a current total of 1.7 million to 2.6 million by 2020- the demand for comprehensive health services will considerably escalate, and such current challenges will become more deeply entrenched (UNRWA Report, 2012). If this situation is to improve, it is imperative practicable initiatives are established and encouraged by all providers of care through increased communication and interlinked efforts, targeted at all stages of delivery. A framework advocating a coordinated effort to warrant entry of necessary medicines and equipment into the region, and innovative strategies to improve infrastructural requirements, needs to be more concretely addressed to allow for efficient and sustainable health services, and is critical to ensure those most vulnerable do not continue to disproportionally suffer.

Conclusion

Establishing and sustaining an equitable approach to health care within a context of conflict remains a profound challenge facing both inter-country health authorities, and the global health community at large. Although the occupied territories faces many of the corresponding salient concerns that are encountered within other countries experiencing this kind of instability, it represents a particularly unique case as a consequence of its protracted state of military occupation in conjunction with its inter-geographical and political segregation. The prolongation of this conflict between its various actors has stifled the development of an independent and co-ordinated health care system across the territories; continual reliance on external funding resources has entrenched a dependent and fragile economy, induced institutional deficiencies, and exacerbated economic disproportionalities. The amalgamation of these factors within this convoluted environment perpetuates a system that adversely impacts upon secured health provision for many sectors of the Palestinian population.

In the West Bank, the regressive financing system and the prevalence of out-of-pocket payments presents a major barrier to acquiring different health care services, the impact of which has been a deeper impoverishing effect upon the poorest parts of the population. Although the issue of financing is a much more intricate matter, it is clear that elements of the GHI need to be re-examined, and investment to prompt further research to explore 'innovative financial mechanisms' to alleviate disproportionate fiscal restrictions (Abu-Zaineh et al, 2008). Long-term sustainability however will depend upon the financial stability of the MOH and the PA itself. Moreover, the distribution of health services in the WB, firstly, stresses the disunity and lack of communication between providers that intensifies regional disparities; secondly, highlights the prominent socio-economic divisions constraining access to many health services; and thirdly, accentuates the effect of the governmental budget deficit on the wider cycle of poverty faced by the majority of the populace. In conjunction with this, further pertinent challenges pertain to the present environmental barriers that are not only outside of the jurisdiction of the health sector alone, but also largely out of the control of the PA. These physical obstacles have put the lives of individuals in unnecessary danger and further marginalise many regions and communities. Imminent objectives need to focus efforts upon implementing and actively sustaining a harmonised health information system, to allow for regional scarcity of health care provision to be identified, and suitable distributive planning of services to be more efficiently applied to evade unnecessary imminent and future mortality/morbidity.

Across the Gaza Strip, the crippling economic and environmental conditions as a result of the military blockade, and internal and external political struggle and donor scepticism as a result of political impasse, bears extraordinary consequences for Gaza's inhabitants. Economic stagnation and consequent rising unemployment and poverty rates has both increased immediate and long term health needs whilst, at the same time, causing severe disruption to procuring medicines and apparatus and crippling the internal infrastructure. Having to access expensive and unpredictable treatments and services in neighbouring countries has exacerbated inequity in accessing health care, both internally between different income-groups, and between the GS and the WB themselves. Enduring a political tension that is not expected to stabilise in the immediate future, the situation in the GS demands more purposive, adn integrated reform, forged through increased and sustained dialogue between providers to recognise where gaps persist and collaboratively devise the foundation for a more efficient and equitably led system.

Abating the adverse effects of these barriers to accessing necessary health care, however, is markedly contingent upon the mercurial political relations provoked by this state of conflict. A collaborative effort to further stimulate research and encourage innovative, practical measures from all actors involved within this sphere (both local and international) needs to be encouraged and enforced, if there are to be any tangible improvements to accessing this care across the territories. Unless the wider political situation is more definitely addressed, this accrual of barriers will persist and, together with the other prejudicial restrictions, further incite increasingly precarious consequences for much of the population of the occupied territories.

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