

# Declining Governmental Health Service



# Provision in the West Bank

**15 November 2006**  
**ICRC**



**ICRC**

<b>1. Introduction</b> .....	<b>3</b>
<b>2. Aim</b> .....	<b>3</b>
<b>3. Methodology</b> .....	<b>3</b>
<b>4. Finding: declining MOH hospital services</b> .....	<b>4</b>
<b>5. Some analysis</b> .....	<b>7</b>
<b>6. Conclusion</b> .....	<b>11</b>

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# 1. Introduction

The International Committee of the Red Cross (ICRC) increased its assistance activities as a response to the increasing health needs that resulted from the suspension of funding imposed on the Palestinian Authority (PA) by the Quartet and Israel. In particular, the ICRC supported four hospitals and 30 Primary Health Care centres (PHC) of the Palestine Red Crescent Society (PRCS), and paid the salaries of PRCS medical staff. In addition, the ICRC has sought to alleviate serious gaps in the drugs and disposables Ministry of Health (MoH) sectors.

In August, the ICRC initiated a process of support to all the MoH surgical hospitals by providing drugs and disposables to the Central Medical Stores (CMS) in Gaza and the West Bank (WB). These drugs specifically target emergency life-saving treatments.

The PA health staff went on strike on 23 August in protest for not having received their salaries for six months. In Gaza, the strike has not been supported as widely as in the WB and health services there are functioning at approximately 80%.

The European Union (EU), under the Temporary International Mechanism (TIM), provides social allowances equivalent to a percentage of health workers' salaries since July. It has extended this support until the end of 2006. However, health workers request that all retrospective salaries be paid in full before they return to work.

Access of the population to hospitals and Primary Health Care (PHC) clinics is now severely compromised.

## 2. Aim

This report attempts to capture the situation that prevails today in all MoH West Bank hospitals as well as the consequences of the suspension of funding and the health sector strike have had and continue to have on the population.

## 3. Methodology

ICRC health teams visited ten surgical MoH hospitals between 22 September and 11 November. In addition, all PRCS hospitals, the sole UNWRA Hospital, and selected private and charitable hospitals were also visited in order to understand where patients go to receive essential hospital services today. The report presents a qualitative account based on observations and interviews with hospital staff. Quantitative analysis compares 2005 hospital activities and activities since the onset of the strike. While the MoH has provided some statistics, the limits of its contribution is indicative of the system's breakdown. Whenever MoH statistics could not be obtained, the ICRC sought to obtain the relevant information directly from concerned hospitals. It cross-checked this information with whatever had been received from the MoH.

A clear limitation is the report's focus on hospitals. However, so as to also capture the situation prevailing in PHCs, all interlocutors were asked questions about available and functioning primary health care facilities.

## 4. Findings: declining MOH hospital services

The Strike Syndicates gave instructions on a series of dates for the strike. This has resulted in a gradual decline in service provision in both hospital and PHC governmental sectors.

### 23 August

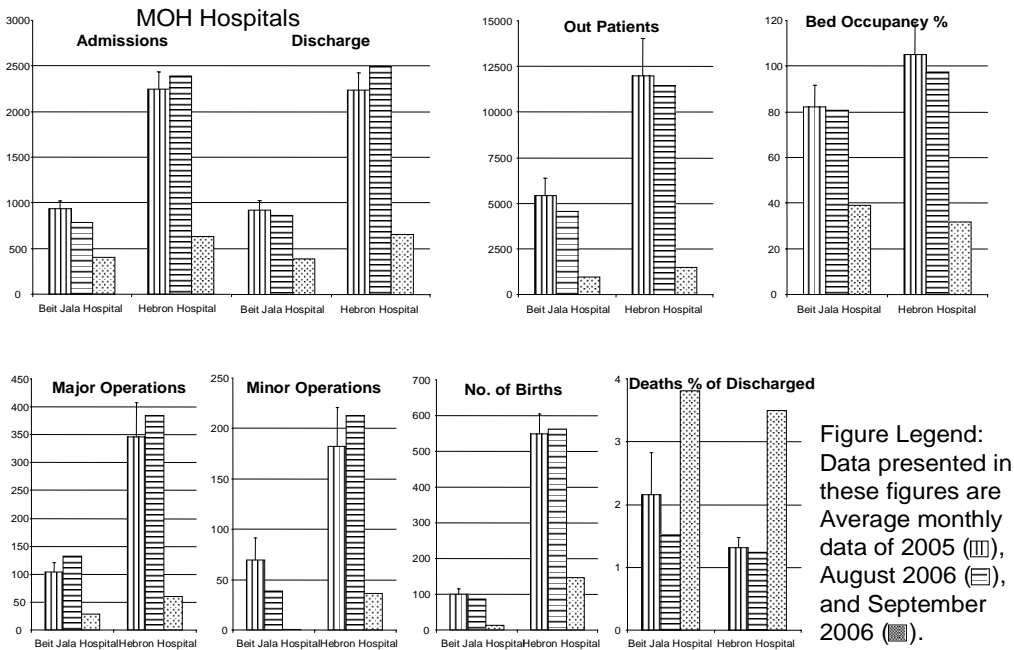
- Out Patient Departments (OPD) close;
- Elective surgery stops;
- Life-saving emergencies are admitted to hospitals;
- PHC close. Some weeks into the strike PHC clinics are still open every other Wednesday to dispense drugs to selected chronically ill patients. Immunizations are performed every other Saturday in the same clinics.

### Mid September

- Normal maternity services stop. Normal deliveries at late stage (cervix dilated 5 to 6 centimetres or above) are admitted;
- All elderly and chronic patients are discharged;
- Specialized services (oncology, haemodialysis) continue to function in major referral hospitals.

Figure 1 hereunder illustrates the decline in hospital services in two MoH hospitals:

**Figure 1: Representative data on the effect of the strike on MoH hospital activities in September 2006**



## **15 October**

- Only top-level life-saving emergencies are admitted.
  - Top-level emergency admissions are at the discretion of the health professional receiving the patient. Some hospitals appear to have a looser approach to strike regulations than others;
- Only on-call staff is permitted in the hospitals.
  - The patients who do attend governmental hospitals receive treatment with minimum staffing levels. This can alter the provision of safe treatment.

## **7 November**

- The Syndicate instructs hospital emergency rooms to close and to stop accepting maternity patients;
- Remaining PHC services close.

## **Additional findings**

- Staff transport to and from hospitals is problematic given the staff's reduced ability to pay for transportation. Coping mechanisms such as use of ambulances, staff grouping, and sharing of traveling expenses occur;
- Contractors without payment provide food to the hospital patients and staff on duty on a credit basis. In some hospitals, the community provides additional support;
- Staff is present in all emergency rooms (ER), however some ERs have their lights turned off and their doors closed. Emergency equipment is locked away in one hospital;
- All but one ER visited are empty of patients. On one occasion, an emergency case came in and the staff reacted quickly.

## **Staff threats and insecurity**

- Four out of ten hospitals were threatened by relatives and patients over patients being turned away from hospitals;
- High tensions among staff exist in some hospitals. These arise over the category of top emergency cases allowed for admission. No clear definition of "top level emergency" is made available to the staff;
- Relatives damaged one PRCS ambulance when a patient was denied admission.

## **Drugs, disposables, equipment and maintenance**

- Sufficient supplies of drugs and disposables were available in all hospitals as the activities were very low. When specific emergency items are needed, ambulances referring patients pass by the Central Medical Store (CMS) in Ramallah. The CMS has not delivered supplies since the strike began;
- Six hospitals report problems with maintenance and repair of equipment. In many cases, spare parts are unavailable, or technicians are not present to make regular repair or urgent maintenance. In one hospital, the staff reports a problem with a ventilator in use in the morning; in the afternoon during the ICRC visit, no technician has yet arrived;
- In most hospitals, electricity and fuel for generators is available. However many hospitals raise concerns over the availability of fuel for heating over the winter months;
- Community support is instrumental to keep some hospitals functioning.

## Where do patients go to receive hospital care?

- The majority of patients do not present themselves at the hospital as they are aware of the strike;
- Not all patients are able to go to private health providers as the fees charged create a financial barrier. A few interlocutors mention that 70% of the population lives beneath the poverty line<sup>1</sup>;
- According to interlocutors, typical fees charged in the charitable sector range from<sup>2</sup>:
  - USD 70 to 156 for a normal delivery.
  - USD 300 to 700 for a caesarian section.
  - USD 4.7 to 11.7 for private consultation.
  - Some providers reduced their prices and some increased them.
- Some charitable hospitals and clinics have only a license for obstetrics, gynecology and pediatric patients, but not for over-night stays, internal medicine or surgery;
- The majority of interlocutors mention that there is no real increase in the private sector hospital admissions (these charge higher fees than the charitable/NGO hospitals);
- All PRCS hospitals demonstrate a significant increase in workload in their respective departments and overall bed occupancy rate.

**Figure 2: Representative data on the effect of the strike on the PRCS hospital activities**

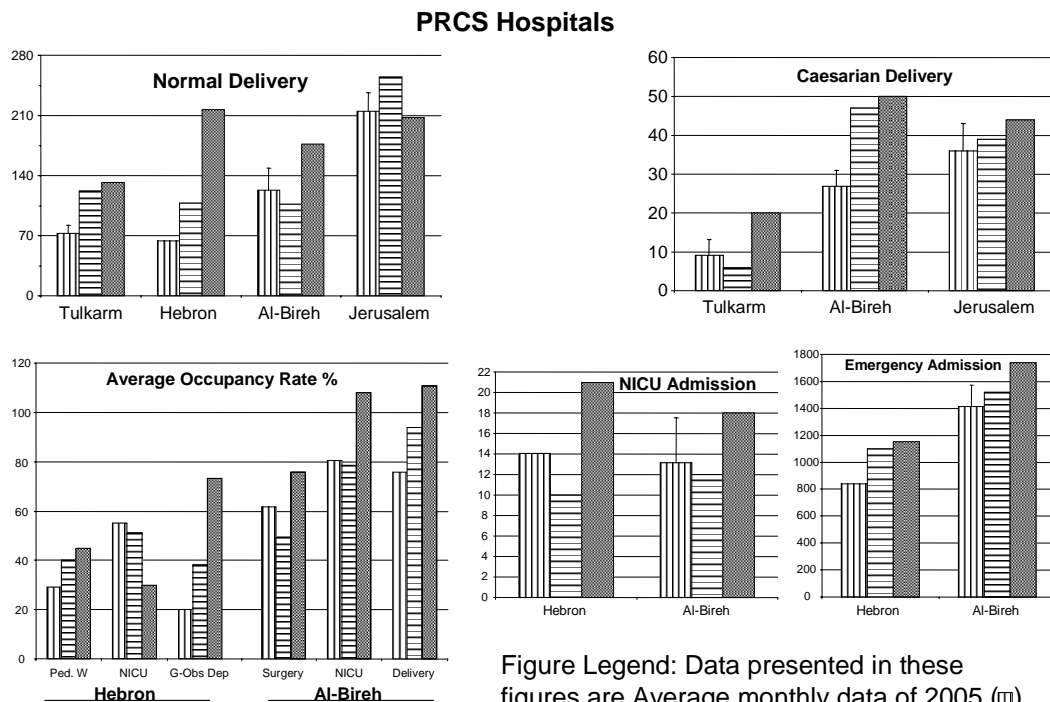


Figure Legend: Data presented in these figures are Average monthly data of 2005 (□), August 2006 (▨), and September 2006 (■).

<sup>1</sup> The poverty threshold in Palestine is 117 USD / month

<sup>2</sup> Currency rate used: 1 USD = 4.288 ILS

## Protection issues

- In one district, private hospitals receive some weapon-wounded cases as they were not considered as emergencies by the governmental hospital. Examples given included gunshot wounds and a child with humerus fracture;
- Patients in need of accessing alternative health care are further restricted by checkpoints and the West Bank Barrier.

## Comments

- Smaller hospitals are dependent on major referral and specialist hospitals;
- In two districts the MoH hospital is the sole hospital;
- In all areas, only MoH hospitals provide service free of charge; however, some charitable hospitals have treated patients coming from MoH hospitals at reduced or waived fees;
- Most hospitals are clean, some are run down; most are ready to receive emergency patients;
- Some ICRC contacts are concerned about the health of patients on lists for elective surgery since some of those lists were already over two years old when the strike started.

# 5. Some analysis

Background information on the provision of health services before the strike commenced.

*Note: figures are inclusive of the West Bank and Gaza.*

## MoH

- Serves a population of approximately four million (2.7 in WB), Operates over 60% of the PHC facilities, over 60% of all beds in general hospitals and 47% of all maternity beds. **The PA MoH covers approximately 65 % of general health needs;**
- 35,000 people are admitted into hospitals every month, of which 23'000 (64.5%) are admitted into MoH hospitals;
- 85,000 people receive specialized out-patient care in hospitals every month, out of which 62'000 (73.5%) in MoH hospitals;
- 11,000 people undergo surgical operations every month, of which 8'000 (72.5%) in MoH hospitals;
- 9,000 women deliver babies of which 5'000 (55%) in MoH hospitals and PHC facilities (WHO 2006)<sup>3</sup>.

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<sup>3</sup> WHO (2006), Addressing the health situation in the occupied Palestinian territory, WHO, June 2006

## NGOs

- NGOs provide 31% of beds in general hospitals and 26% of maternity beds. UNWRA manages 1.8% of hospital beds and 2% of maternity beds;
- NGOs account for 11.7% of health services used by Palestinian households<sup>4</sup>;
- The rate of use of NGO health services in the WB is 13.3%. Consistent with MoH's data: NGOs account for 30% PHC services and 31% hospital beds (MoH 2003)<sup>5</sup>;
- NGO health services in particular seem to be largely used by households enjoying higher income levels;
- Private hospitals provide the remaining maternity beds (approximately 20%);
- Combined UNWRA, PRCS, and NGO's make up 35.5% of service provision;

## Some general points and predictions

- Hospitals with the highest in-patient numbers contain the functioning specializations: oncology, haemodialysis, thalassaemia;
- Some emergency patients are denied access to emergency services;
- Normal deliveries take place in hospitals and are usually assisted. While an increase in deliveries is noted in PRCS hospitals and some charitable hospitals, it is unlikely that these hospitals can and will receive the total numbers normally arriving to the governmental hospitals. Some interlocutors mention women accessing private clinics where unsafe conditions prevail (compared with hospital care) or forced to rely on home deliveries with little or no experienced assistance available. It can only be predicted that such practices will lead to an increase in maternal and child morbidity and mortality;

It is estimated that 4,500 women have had to look at alternative maternity services since the strike started;

- An increase in the mortality rate has been recorded at two MoH hospitals in September (from 2.1%-3.7% in one hospital and 1.3%-3.6% in the other);
- While waiting lists were already in place for elective surgeries, strike-induced delays will predictably cause some cases to become emergencies, increasing the morbidity and mortality risk;
- Patients are altering their perception over need and demand for healthcare.

ICRC contacts consistently mentioned that:

- Patients are staying at home until the last minute;
- Patients arrive to the hospital more acutely ill than before;
- Some patients avail themselves of alternative health services: traditional medicine, private clinics, prescriptions over counter;
- Patients who cannot pay prefer not to lose face by being turned away at private clinics;
- It is too premature to determine if there is a change in morbidity and mortality patterns inside the hospitals. It is also very difficult to determine if there is a change in morbidity and mortality patterns in other hospitals (NGO, PRCS, private).

<sup>4</sup> Bisan Center for Research and Development (BCRD)(2006), The Role and Performance of Palestinian NGO's, BCRD, April 2006

<sup>5</sup> MoH (2003), Health Management Information Systems Annual Report, MoH 2003

However, one charitable hospital has increased its rate of caesarean sections versus normal deliveries by 100% during the month of September (220 normal deliveries and 59 caesarean sections, as compared to an average of 120 normal deliveries and a 13% caesarean section rate before the strike);

- All outpatient departments are closed, routine monitoring of chronic illness has stopped, antenatal care and postnatal care has stopped. Such routine monitoring and health prevention and promotion services will predictably increase morbidities and mortalities eventually;
- It is not possible that NGO's, UNWRA and the PRCS combined can fully substitute for the MoH hospital services (insufficient beds, insufficient capacity, focus on OBGYN and paediatrics). The inability of many patients to pay the NGO and PRCS fees is a deterrent;
- New instructions from the labour unions on 7 November have deteriorated further the provision of remaining services:
  - Hospitals and the existing PHC services (vaccinations and selected chronically ill drug dispensing) are virtually closed
  - In-patient figures in ten governmental hospitals in the WB<sup>6</sup> have declined steadily from 223 on 7 November to 144 on 12 November, a stark 18.5 % of the average inpatient numbers for the month of November 2005

**Figure 3: In-patient numbers from 7 November compared with November 2005 average**

#### Hospital In-Patients

DATE	7 Nov	8 Nov	9 Nov	11 Nov	12 Nov	Av IP in November 2005
Amira Alia	57	36	30	24	20	185
Rafidia	19	17	15	12	20	142
Khalil Suliman	17	14	8	0	0	103
Jericho	20	7	5	6	6	24
Ramallah	63	61	57	54	70	132
Al Hussein	35	25	22	27	23	98
Salfit	8	1	2	0	1	8
Qalqilya	1	1	0	3	3	6
Yatta	3	1	0	3	1	14
Thabet Thabet	?	7	5	5	?	67
	<b>223</b>	<b>170</b>	<b>144</b>	<b>134</b>	<b>144</b>	<b>779</b>

- Some staff is present despite closed hospital doors and signs posted;
- The few patients who present themselves to the hospitals with life threatening conditions are either treated or transferred to private and charitable hospitals;
- Provisions are being made to have existing inpatients transferred to the private and charitable sectors. They will allegedly receive financial compensation at a later date;

<sup>6</sup> The focus of this analysis is on the ten governmental hospitals with surgical capacity only.

- This will close the governmental hospitals completely.

### MoH Clinics

- Over time a reduction in the current estimated 98% immunization coverage predictably will occur. The Palestinian territories may see a reoccurrence of preventable diseases;
- Regular monitoring and follow up has not occurred for chronically ill patients (including type 2 diabetics, cancer patients, patients under dialysis, renal treatment, metabolic diseases etc). Since the latest labour unions instructions, there is no free service provided to these patients;
- All antenatal care services and postnatal care services have been stopped. This predictability will result in an increase in undetected 'at risk' pregnancies.

### Broader Public Health Issues

- No births and no deaths are registered;
- Routine strategies to support public health are affected;
- Water is not routinely tested, it is not known if chlorination activities are ongoing, no reports on water safety are written;
- Food inspectors are not working;
- Public health inspectors are not conducting routine surveillance;
- Autumn and winter will increase the numbers of respiratory tract infections, pneumonias etc, conditions which currently have very restricted access to hospitals and no access to governmental clinics.

### Three Case studies

Some health workers interviewed observe that patients are arriving increasingly late to the charitable hospitals. This is due to inability to pay. "We are dying because of poor socioeconomic status" said a man interviewed for the report.

#### Case one:

After a home delivery, the newborn was admitted to a private hospital after developing breathing problems. The baby was treated and taken out of the hospital against medical grounds hours later. The family could not afford to pay the hospital fees. A day later, the baby was returned to the hospital in breathing distress. The baby suffered respiratory arrest and developed brain damage. The baby spent a few days in the hospital and was discharged with a feeding tube. The family did not have to pay. However, days later the baby was readmitted after aspirating (milk went into lungs) days previously. The baby died.

#### Case two:

Two pregnant women were turned away from the emergency department; they arrived back to the emergency department hours later. Both had developed complications during this waiting time. Both had emergency caesarean sections. Both babies died.

#### Case three:

A 75-year-old woman died 15 minutes after she was denied access to the emergency department.

# 6. Conclusion

The current strike will undoubtedly result in a large proportion of the West Bank population suffering from reduced access to essential health care, including primary health care (ante natal care, postnatal care and vaccinations) and curative care (life saving emergency cases and all chronically ill). The poor will be the most severely affected, given that health care is now available only for a fee in the private and charitable sector.