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Healthcare in the times of increased adversity: changes in out-of-pocket payments, treatment seeking behaviours, and public-private mix in the Gaza Strip.

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PhD in Global Public Health Policy

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Declaration

I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, in any previous application for a degree. Except where stated otherwise by reference or acknowledgment, the work presented is entirely my own.

Majdi Ashour

Date

To the soul of my father, Mohammed Ashour.

“NO HARM BEFELL THE LAND.

THE HORSE WINDS BLEW, THE HYKSOS BLEW, AND THE TATARS BLEW, MASKED OR UNVEILED.

ALL IMMORTALIZED THEIR NAMES WITH SPEAR OR MANGONEL TREPUSHE ... AND DEPARTED.

NONE OF THEM DEPRIVED APRIL OF ITS HABITS: THE FLOWERING OUT OF STONES OR THE BELLS OF LEMON BLOSSOMS; NO HARM BEFELL THE SAND NO HARM, NOT A HARM AFTER THEY LEFT.

AND LAND, LIKE LANGUAGE, IS INHERITED.”

MAHMOUD DARWISH

THE TRAGEDY OF NARCISSUS: THE COMEDY OF SILVER

Abstract and Lay Summary

Aims and Objectives of the Research

This thesis aims to increase understanding of changes in access to and affordability of healthcare in the Gaza Strip, especially after socioeconomic conditions began to deteriorate in the territory with the start of the first intifada in 1987. This aim is addressed by studying changes in three key areas: (i) the extent and distribution of out-of-pocket payments for health-related products and services; (ii) household experiences of care-seeking in the mixed health system; and (iii) the nature of the mixed (public / private sector) health system in the Gaza Strip.

Data and Methods

Investigation of these phenomena, and changes in them, have been pursued through quantitative and qualitative methods. In relation to area (i), a secondary quantitative analysis of 11 repeated rounds of the Palestinian Expenditure and Consumption Survey (PECS) between 1996 and 2017 was conducted. In relation to area (ii), 29 qualitative interviews with 33 householders were completed. In relation to area (iii), review of academic and grey literature, complemented by 17 key informant interviews in the Gaza Strip, was undertaken.

Results

Out-of-pocket payments were broadly stable between 1996 and 2017. The incidence of catastrophic health expenditures increased in 2017, driven by a significant decrease in household budgets. However, the socioeconomic distribution of out-of-pocket payments, and of catastrophic expenditures, have changed over time after 2007, with the burden shifting to richer population groups. Although out-of-pocket payments and their catastrophic burden were not high by international standards, their impact on poverty were consistently very high, indicating that paying out of pocket was able to push the near-poor into extreme poverty.

The consistent relatively low levels of out-pocket payments reflect the continuous reliance on publicly-provided healthcare among most people, which is complemented by incidental use of private sector among those who can afford. The change in the socioeconomic distribution of out-of-pocket payments after 2007 has occurred in parallel to the emergence of an environment conducive to the growth of private sector.

There has been a rise in the number of private hospitals and their activities in the context of overstretched and underfunded government hospitals. This suggests that the change in the socioeconomic distribution of out-of-pocket payments resulted from a re-configuration of the health system into more social stratification.

Conclusion

This research provides new understanding of the changes in the scale, share, composition, burdens, and socioeconomic distribution of out-of-pocket payments, and connects the results of this analysis to the changes in healthcare-seeking experiences and to the incipience of a socially stratified mixed healthcare system in the Gaza Strip.

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List of Abbreviations and Acronyms

ALOS	Average Length Of Stay
ANOVA	Analysis of Variances
CHE	Catastrophic Health Expenditure
CMS	The Church Mission Society
COICOP	Classification Of Individual Consumption by Purpose
CPI	Consumer Price Index
CTP	Capacity to Pay
DHS	Demographic and Health Survey
FHP	Financial Health Protection
GHI	Government Health Insurance
GHS	Government Health Services
HMIS	Health Management Information System
HPBS	Healthcare Providers and Beneficiaries Survey
HRH	Human Resources for Health
IPL	International Poverty Line
MCH	Maternal and Child Health
MMR	Mixed Methods Research
MoH	Ministry of Health
MoSA	Ministry of Social Affairs
NGO	Non-Governmental Organization
NHP	National Health Plan
NIS	New Israeli Shekel
NPM	New Public Management
OOPP	out-of-pocket payments on health-related products and services
oPt	The occupied Palestinian territories
OR	Odds Ratio
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PECS	Palestinian Expenditure and Consumption Survey
PFHS	Palestinian Family Health Survey
PFM	Public Financial Management
PHC	Primary Health Care
PHIC	Palestinian Health Information Centre
PLO	Palestine Liberation Organization

PMICS	Palestinian Multiple Indicator Cluster Survey
PMS	Police Medical Services
PNIPH	Palestinian National Institute of Public Health
PPP	Purchasing Power Parity
UHC	Universal Health Coverage
UNRWA	UN Relief and Works Agency for Palestine Refugees in the Near East
USD	United State Dollar
USAID	United States Agency for International Development
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization

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Chapter 1

Introduction and background

1.1 Introduction

The Gaza Strip emerged as an artificial geopolitical entity during and after May 1948, when the British mandate of Palestine ended, the State of Israel was declared, and the Palestinian Nakba (catastrophe) began. Since 1948, the Gaza Strip has endured a protracted political conflict and extreme socioeconomic adversity. The displacement of more than 200,000 Palestinian refugees into the Gaza Strip resulted in its population increasing by 2.5 times within months (Cheal, 1988). This increase in the population size in the Gaza Strip alongside the loss of the Strip's grazing hinterland, national trade links, and employment prospects, had severe negative consequences for its economy (Roy, 1995, p.75). This led Sara Roy, a Harvard University scholar who has been studying the Gaza Strip since the 1980s, to describe the birth of the Strip as "wrenching and traumatic" (Ibid). Egypt controlled the Gaza Strip following the Nakba but without annexing it, ruling it as a closed, separate territory (Azoulay and Ophir, 2012, p.163). Egypt initially considered its mission to the population to be humanitarian (Feldman, 2008, p.187) and did little to alleviate the harsh economic conditions there (Azoulay and Ophir, 2012, p.163).

The Israeli army raided the Gaza Strip frequently after 1948 and inflicted high losses of human lives. Every year during the early 1950s, approximately 500 Palestinians were shot on sight and killed (Roy 1995, p.69). During the Suez crisis in November 1956 the Israeli army occupied the Gaza Strip; it withdrew in March 1957, only as a result of American pressure. During the Israeli army's short-lived occupation of the Gaza Strip it inflicted devastating human losses: more than 1200 Palestinians were killed out of a population of 330,000 (Filiu, 2014 a, p.105). With Israel's withdrawal from the Gaza Strip in March 1957 a UN Emergency Force (UNEF) was established to monitor military activity and the Egyptian military administration was re-established. A decade of tranquility and some amelioration of the economic situation followed (Roy, 1995, pp.84-91).

Following the Israeli re-occupation of the Gaza Strip in 1967, the Israeli policies aimed to ensure its inseparability from Israel by integrating the Gazan local market and its labour force into the Israeli economy (Roy, 1995, pp.147-150; pp.209-252). Israel allowed Gazans to enter into Israel and through it to the West Bank (Hass, 2002). The integration of the Gazan local economy into the Israeli market and the employment of Palestinians from Gaza in Israel contributed to increasing the levels of income and employment among Gazans. This increase led to limited individual prosperity, which existed side by side with the under-development of the local economy (Roy, 1995, p.110).

In December 1987, the first Palestinian intifada (uprising) in the Gaza Strip triggered a change in the way that Israel dealt with the occupied Palestinian territories (oPt) and their populations, especially those in the Gaza Strip. Following the start of the first Intifada, in 1988 the Israeli army imposed the requirement for the possession of an annually renewed magnetic card for anyone wishing to travel from the Gaza Strip to Israel, and in 1991, after the first Gulf War, Israel started to impose closures on travel between the oPt and Israel (Hass, 2002). Additionally, the Israeli attitudes towards Gaza changed after the Intifada. This was expressed clearly by the late Israeli Prime Minister Yitzhak Rabin just before his famous handshake with Yasser Arafat, president of the Palestine Liberation Organization (PLO), in Washington DC, when the Declaration of Principles was signed by the two parties. Rabin lamented, stating: “If only it [Gaza] would just sink into the sea” (Hass, 2014).

The signing of the Oslo Accords between Israel and the PLO in 1993 did not improve the situation. Rather, the closure of the Gaza Strip by Israel and Egypt has continued, and the Gazan economy has been shifted from being integrated within the more affluent Israeli market to being more separated from it (Roy, 2007, pp.102-122). This separation has led to soaring unemployment and high levels of poverty among Gazans. The separation of the Gaza Strip from the West Bank as well as from Israel has led to financial adversity for most Gazans. These were amplified after the start of the second (al-Aqsa) Intifada in September 2000, and even further with the implementation of the Israeli Unilateral Disengagement from the Gaza Strip in September 2005.

The electoral victory of Hamas¹ in 2006 and its seizure of power in 2007 were used by Israel as a pretext to intensify the isolation of the Gaza Strip and to impose spatial violence and economic sanctions, which were supplemented and punctuated by repeated military assaults (Winter,2016). Following the changing paradigm in dealing with the oPt, two different political-economic models emerged in the West Bank and in the Gaza Strip (Roy, 2021, p.51). The model that emerged in the Gaza Strip was characterized by “siege, isolation, collective punishment and economic subjection, with a leadership strengthened by the occupation but unable to do anything to address it” (Roy, 2021, p.51).

Knowledge about the healthcare system in the Gaza Strip is sketchy. No study has reported empirical research assessing the trajectory of healthcare services. Despite the Gaza Strip’s distinct history, it has been consistently neglected by Middle East scholars, who have treated it as an analytical annex to the West Bank (Roy, 1995, p.3). Additionally, as indicated by Pavignani and Riccardo (2013, p.30-31), the inadequacy of the available information has made the exploration of Gaza’s healthcare system challenging; they urged the study of Gaza in more detail than has been done previously without diluting its specific features in national sketches that might hide these features. Challand (2018) recommended avoiding short-term analyses and instead making historic investigations a priority when studying Palestine and Palestinians. As far as I am aware, there has been no empirical health policy and health system research study that has used a historical approach to study healthcare in the Gaza Strip.

My thesis therefore takes the point in time when the paradigm that determined the way Israel dealt with the Gaza Strip after the first Palestinian Intifada in 1987 changed and when the lives and socioeconomic conditions of the territory’s populations started to deteriorate, in the early 1990s, as a starting point to trace possible changes in certain interrelated aspects of the healthcare there. The changes in healthcare are assessed by tracing changes in out-of-pocket payments for health-related products and services, people’s experiences when interacting with the

¹ Hamas is the Arabic acronym of the Islamic Resistance Movement

healthcare delivery system, and changes in the pattern of the private-public mix of healthcare delivery and entitlement to healthcare.

The research described in this thesis explores changes in healthcare services in terms of (i) paying for them and being protected from the financial consequences of their use; (ii) experiencing an interaction with them (mainly in terms of use and payments); and (iii) the availability and development of a private-public mix of healthcare, and the rights and entitlements to healthcare services.

Next I will present the rationale for selecting the three aspects of healthcare used in my research to explore changes in healthcare that have been the consequences of changes in the economic and political situation in the Gaza Strip. I will then present details of my research questions and the data used to address them, as well as the interdisciplinary nature of my research. I will go on to provide more detail about the particularities of the Gaza Strip by presenting background accounts about the place and its people, their histories, demographic and health characteristics, and the configuration of the local healthcare system. I will then outline the structure and content of this thesis and provide a brief summary of each chapter. Finally, I will highlight the potential contributions of the research reported in this thesis.

1.2 The rationale for the three-pronged approach

My research project explores the changes in interrelated aspects of healthcare in the Gaza Strip during the past three decades (1987-2017) when Israeli policy and attitudes have changed and the socioeconomic situation of Gazans has deteriorated. The changes in healthcare are pursued through tracing the changes in household expenditure on health-related products and services, in their interactions with the healthcare system, and in the evolution of the public-private dichotomy of healthcare and entitlement to healthcare services in the Gaza Strip. In the following subsections, I provide the rationale for choosing a three-pronged approach to investigate the changes in healthcare. My choice of these three interrelated aspects of healthcare is based on the rationales presented below, reflecting the globally growing interest in Universal Health Coverage (UHC). It is set against the background of the limited evidence about Financial Health Protection (FHP), access to healthcare, and the development of public and private healthcare services in the Gaza Strip.

1.2.1 Financial Health Protection (FHP) and Universal Health Coverage (UHC)

In its World Health Report in 2000, the World Health Organization (WHO) recognized three distinct goals for any healthcare system: (i) promoting good health, (ii) responding to population expectations, and (iii) assuring fair financial protection from the risk of ill health (WHO, 2000). Measures to estimate the ability of healthcare systems to protect the population from financial consequences of accessing healthcare services and paying for them are not new. Berki (1986) published an article on catastrophic medical expenses, in which he discussed the implications of out-of-pocket payments for poor families in the United States of America (USA), and acknowledged previous work that has tackled the catastrophic expenses since the 1970s. The Indicators of FHP have been further developed since then through the work of Wagstaff and van Doorslaer (2003), and since the WHO introduced its “capacity to pay” approach, based on non-subsistence effective income, as a threshold to measure catastrophic health expenditure (Xu et al., 2003). However, the measurement of FHP gained momentum after the adoption of UHC by the 58th World Health Assembly (WHA) in 2005, when it called on countries to further develop health financing systems that guarantee access to necessary services and to provide protection against financial risk (WHA, 2005). Furthermore, the subsequent unanimous endorsement by the United Nations (UN) General Assembly on 13 December 2012 through a resolution in which it urged countries to accelerate progress towards UHC gave the measurements of FHP further thrust.

The WHO approached UHC through three overarching dimensions: the coverage of services, population, and the cost of services, towards achieving full universal coverage of these three dimensions (WHO, 2008; WHO, 2010). Beside these three dimensions of UHC, it is considered to be legally anchored in the right to health (Ooms et al., 2013; Abihiro and De Allegri, 2015). It has been argued that focusing on financing is necessary but inadequate to guarantee equitable and quality healthcare (Sengupta, 2013). The Global Health Watch, which is considered by Kapilashrami and Schrecker (2018) to be “an alternative to the better known and better funded annual outputs of the World Health Organization and the World Bank”, has contested the meaning of UHC (People’s Health Movement et al., 2017, pp. 73-95).

While the Global Health Watch acknowledges the recognition by the WHO officials of the importance of the equity, quality and efficiency of healthcare under the formally adopted slogan of UHC, it has pointed out that World Bank (WB) economists simply refer to UHC as synonymous with universal FHP (Ibid, p.74). The Global Health Watch has further illustrated that the WB, with its economic mindset, has been behind the current UHC agenda (Ibid, pp. 75-89). Given the WB access to ministries of finance and its staff expertise in measurement, it has an advantage over the WHO in leading the UHC agenda (Tichenor and Sridhar, 2017). It is interesting to note that the USA, where there has never been universal access to healthcare, has the highest voting power in the WB and its sister Bretton Woods' institution, i.e. the International Monetary Fund. Hence, the key message of Tichenor and Sridhar (2017) is that the expanded role of the WB in global health creates tension between its mandate and the right to health, which is central to UHC. Furthermore, the voting power of states is concentrated in the global north, especially among the ex-colonial or neo-colonial countries and states. This can result in the global south, where universal access to healthcare is lacking, being more disadvantaged in the global health agenda.

Nonetheless, FHP is useful when it is accompanied by guaranteed access for people to equitable and quality healthcare that respects the right to decent healthcare when it secures their dignity and guarantees their social protection. FHP is assessed based on out-of-pocket spending on healthcare through identifying and calculating Catastrophic Health Expenditure (CHE) and the impoverishing effects of out-of-pocket payments incurred by households (O'Donnell et al., 2008, pp.203-220; Wagstaff, 2009). CHE occurs when OOPPs exceed a predetermined fraction of household financial resources available to spend on health-related products and services in a given period, usually one year (Wagstaff, 2009; O'Donnell et al., 2008; pp. 203-205). Households are classified as impoverished by OOPPs if their financial resources had been above the poverty line before spending on health-related products and services but became below this line after incurring OOPPs (O'Donnell et al., 2008; pp. 213-215; Wagstaff and van Doorslaer, 2003). In addition to CHE and impoverishment due to out-of-pocket payments, there have been innovations in measuring FHP (Wagstaff and Eozenou, 2014; WHO and WB, 2021).

Out-of-Pocket expenditure incurred by households is the most important source of financing for healthcare systems in most developing countries (WHO, 2010), and

the occupied Palestinian territories (oPt) are no exception. The Palestinian Central Bureau of Statistics (PCBS) and the Palestinian Ministry of Health (MoH) have provided estimates of the National Health Accounts for the oPt. According to these National Health Accounts, the share of household out-of-pocket expenditure as a proportion of Total Health Expenditure in the oPt between 2000 and 2018 ranged between 35.8% in 2008 and 44.8% in 2015, and the share of Government Expenditure on healthcare ranged between 31.7% in 2001 and 47.7% in 2010 (PCBS and MoH, 2020). However, these National Health Accounts, which provide the shares of different contributors to the Total Health Expenditure in the oPt, do not provide the breakdown of these shares between the West Bank and the Gaza Strip. Internationally, there is a clear positive relationship between the share of out-of-pocket outlays as a proportion of the Total Health Expenditure and the incidence of catastrophic and impoverishing household expenditure (Xu et al., 2007; WHO, 2010).

Evidence about out-of-pocket payments across different household strata can help to identify the population groups most affected by the financial burden of ill health and most in need of financial protection (Chhun et al., 2015, p.1). Similarly, evidence about the changes in these payments can provide insights into the effects of new policies, political changes, and/or changes in the socioeconomic environment on the ability of the healthcare system to protect people from the financial burden of healthcare. In the case of the Gaza Strip, assessing changes in out-of-pocket payments could help in understanding the effects of socioeconomic and political changes on the changes in the ability of the local health system to protect people from the financial risk of seeking healthcare.

No study has yet assessed either the burden of catastrophic and impoverishing out-of-pocket payments on health-related products and services or how this burden is distributed within the population in the Gaza Strip. Although there are some studies that have tackled FHP in the oPt, they have focused on the national picture or compared this national picture with the situation in neighbouring countries. Mataria et al. (2010) recognized the importance of catastrophic and impoverishing out-of-pocket payments in the Palestinian context. They measured their incidence and intensity using a series of five Palestinian Expenditure and Consumption Surveys (PECS) conducted by the PCBS in 1998 and 2004-2007 (Ibid). These showed that the incidence of catastrophic health expenditure in the oPt almost doubled during the

period from 1998 to 2007. They indicated that 12.5% of households were pushed into deep poverty by out-of-pocket payments (Ibid).

Beside the analysis of PECS carried out by Mataria and his colleagues, other publications have used the PECS data in 2010 to report on the financial consequences of out-of-pocket payments in Egypt and Jordan, compared to those in Palestine (Rashad, 2014; Rashad and Sharaf, 2015), and to determine the factors that affected CHE in Egypt and Palestine (Rizk and Abou-Ali, 2016). They show that out-of-pocket payments exacerbated household living standards severely in Egypt, and that their disruptive effect was relatively modest in Jordan and Palestine. While one fifth of households in Egypt were pushed into financial catastrophe and four percent of them entered severe poverty due to out-of-pocket payments, the incidence of CHE was 2.7% in Jordan and 6.7% in Palestine, and only 0.1% of the households in both Jordan and Palestine were pushed into deep poverty due to out-of-pocket payments (Rashad, 2014). CHE in these three countries is mainly a problem for better-off households (Rashad and Sharaf, 2015). Consistent with the conclusions reached by Rashad and Sharaf (2015), the results of the analysis carried out by Rizk and Abou-Ali (2016) suggest that rich households in Egypt and Palestine were more likely to incur CHE than poor households. Additionally, the probability of incurring financial catastrophe due to out-of-pocket payments in both countries was higher in rural areas and in households with elderly members (Rizk and Abou-Ali, 2016).

Notwithstanding the use of the PECS data to estimate and report indicators of FHP, this use has focused on the national aggregate average for the oPt, and has not assessed indicators of out-of-pocket payments and FHP separately for the Gaza Strip.

Additionally, evidence about the financial consequences of out-of-pocket payments in fragile and conflict-affected settings is limited. In her review of evidence about health financing in conflict-affected settings published between 2000 and 2011, Witter (2012) indicated that very little work had been published on equity and access, including household payments, affordability and use of health services in these settings. Seven years after the publication of the review carried out by Witter (2012), Bertone et al. (2019) updated it to reflect on what had changed in terms of the knowledge base and gaps. They found that out-of-pocket payments in fragile and

conflict-affected settings had received limited attention in the publications reviewed (Bertone et al., 2019).

My research therefore explores the magnitude and burden of out-of-pocket payments during a period that witnessed a change in the socioeconomic and political landscape in the Gaza Strip.

1.2.2 Access² to healthcare and healthcare-seeking behaviours

Using out-of-pocket payments to assess FHP has its own limitations. High out-of-pocket payments may deter some people from using health services (Wagstaff, 2009). Additionally, the consequences of medical illnesses include direct and indirect financial losses, such as selling assets, losing time, borrowing from relatives and friends, and other coping strategies (McIntyre et al. 2006; Russell, 2005; Sauebborn et al., 1996; O'Donnell et al., 2008). Household budget surveys, which are customarily used to assess the catastrophic and impoverishing effects of out-of-pocket payments, inquire about household expenditure on commodities and services, including household expenditure on healthcare and on the purchase of health goods and commodities. However, these household budget surveys do not usually inquire about either the use of healthcare services or about the adaptation mechanisms used to overcome financial barriers resulting from payments for healthcare.

The approach used to assess financial protection through the identification of catastrophic and impoverishing out-of-pocket payments ignores two important issues: the agency used by people and adaptive preferences. The agency of individuals and households is concerned with the action taken by them to overcome their conditions. Some examples of the agency exerted by individuals and households to avoid high out-of-pocket payments are: changes in healthcare seeking behaviour, self-medication, the use of the entitlements of other people to access healthcare services,

² Access to healthcare is a broad term. It is concerned with enabling people to command appropriate healthcare resources to preserve and to promote their health. The USA Institute of Medicine defined access as the “timely use of personal health services to achieve the best possible outcome” (Millman, 1993, p.4). Gulliford et al. (2002) suggest that access to healthcare is a complex concept, which should be assessed on at least four dimensions: (i) the availability of resources and services, (ii) utilization of services and barriers to access, (iii) relevance and effectiveness of services, and (iv) equity.

etc. Adaptive preference is the deliberate or reflexive process by which people adjust their expectations and aspirations when trying to cope with deteriorating changes in their living conditions. Amartya Sen has highlighted the issue of adaptive preference in his reflection on freedom, wellbeing and development:

‘The deprived people tend to come to terms with their deprivation because of the sheer necessity of survival, and they may, as a result, lack the courage to demand any radical change, and may even adjust their desires and expectations to what they unambitiously see as feasible’ (Sen, 1999, p.63).

The issue of adaptive preference does not only relate to discussions on wellbeing. It can also have some direct links with discussions of individuals’ and households’ adaptation to their changing conditions in order to overcome high out-of-pocket payments. In particular, it seems that the avoidance or prevention of high out-of-pocket payments may happen in conjunction with adaptive preference. An example would be when households or individuals change their healthcare-seeking behaviours by moving from more to less expensive healthcare providers but also from a provider with better quality services to a provider with lower quality services or services of questionable quality (where the cost is low but the quality is also low) in order to cope with a recent job loss or low income or wealth. By moving to less expensive health services, individuals and households certainly decrease their out-of-pocket payments and increase their ability to cope with job loss or with a reduction in their income or wealth (or capacity to pay), but this to the detriment of some elements of the quality of the health services they receive and at a possible cost to their health and wellbeing.

Out-of-pocket payments for healthcare are numeric outcome variables that do not provide insights into the process of these developments. Furthermore, although multivariate analysis might give some insights into differences in the occurrence of catastrophic and impoverishing household out-of-pocket payments among different groups of the population, it cannot provide clues as to the process and factors that determine payments for healthcare or in relation to being trapped in health-related catastrophe and poverty. Financial ability to pay for healthcare is an important factor. Nonetheless, there are several factors that influence decisions regarding whether or not to spend money on healthcare and therefore possibly regarding experiencing

financial difficulties as a result of making out-of-pocket payments. It is impossible to determine whether payments or non-payments for healthcare are due to financial ability to pay for healthcare services, the price of healthcare, or other factors, such as the perceived quality of healthcare services, the availability of other providers, or even the stigma associated with using specific health services (Russell, 1996).

Notwithstanding the importance of knowledge about access to, and seeking healthcare and treatment options used by the population, the evidence about the experience of individuals and households when they seek healthcare services and when paying for them is piecemeal. It covers only certain points in time, not the whole period during which changes occurred in the Gaza Strip after the onset of the first Palestinian Intifada in 1987.

The evidence available about access to healthcare in the Gaza Strip indicates that users of healthcare have relied mainly on services provided by public providers, namely the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and the Ministry of Health (MoH), and have supplemented this reliance by using private healthcare services. This evidence is based on surveys carried out by health research institutions (Lennock and Shubita, 1998) and PCBS (PCBS, 1997a; PCBS, 2001a), a few qualitative research articles (Lewando-Hundt et al., 1997; Beckerleg et al., 1999), and one research article about the determinants of healthcare use in the Gaza Strip (Abu-Mourad et al., 2008).

The survey reported by Lennock and Shubita (1998, p.39) indicates that most respondents reported that they used publicly-provided healthcare, while some used a mixture of public and private providers for the same health-related conditions, such as pregnancies and chronic diseases. Similar to what was reported by Lennock and Shubita (1998), the majority (61.1%) of deliveries that occurred within five years of the Health Survey conducted by the PCBS (1997a) took place in public facilities of government hospitals (36.4%) and UNRWA maternity facilities (24.7%), while 25.9% took place in private for profit practices, and 4.1% at home (PCBS, 1997a).

Lewando-Hundt et al. (1997) reported how they used the data for their research project, which aimed to evaluate and improve Maternal and Child Health (MCH) care, and compare manual and computer software analysis of qualitative research. This provides useful insights into the healthcare-seeking behaviours of Palestinian women

in the Gaza Strip just one year after the establishment of the PA. The research indicates that women were able to exercise considerable choice in clinic use, as they used a number of health services besides the government or UNRWA Primary Health Care (PHC) centres (Lewando-Hundt et al., 1997). The majority of interviewees reported that the government or UNRWA PHC centres were their first resort when seeking care, and that their choice of healthcare providers was dependent on their social and economic conditions (Lewando-Hundt et al., 1997). Although few women reported that they never consulted private doctors, these doctors were highly regarded, as their examination and diagnostic skills, equipment, prescribing habits and communication were considered superior to those of doctors working in government and UNRWA facilities, even though the actual doctor may have been the same person (Lewando-Hundt et al., 1997).

Research combining observations, group interviews, and questionnaire-based data has indicated that users of healthcare services are heavy consumers of medicines (Beckerleg et al., 1999). Doctors who work under the pressure of heavy workloads in MCH centres tend not to examine their beneficiaries and to be under pressure to prescribe drugs for their reported symptoms (Ibid). Users of healthcare services purchase additional medicines from private pharmacies to treat their minor illnesses (Ibid). Users in prosperous neighborhoods buy medicines prescribed by private doctors (Ibid). The users of PHC services access them very frequently, and the frequent access to these services is associated with different dependent variables (Abu-Mourad et al., 2008), including an older average age of users, poor living conditions, being outside the labour force, poor self-rated health status, and being smokers (Ibid).

Although the available evidence can provide some useful insights about access to healthcare in the Gaza Strip, the evidence is limited and covers only certain points of time. It lacks full coverage of the whole historical period that spans the decades that followed the start of the 1st intifada in 1987. My research explores the changes in the experience of individuals and households when accessing healthcare services in the Gaza Strip, especially after 1987.

1.2.3 Evolution of the public-private dichotomy of healthcare services

Although developing countries are heterogeneous, the nature of the public-private dichotomy of healthcare in these countries was determined by the introduction of western allopathic medicine during colonial rule or nation-state-building. Western medical care was initially provided for the colonial elite and those employed directly by them (Manderson, 1987). Subsequently this care was extended to those whose ill health might jeopardize the interests and welfare of the colonists (Ibid). During the late period of colonial control in these countries, healthcare was organized mainly through networks of public facilities. In the early years following independence, healthcare was provided based on the same pattern used during the colonial control. For example, healthcare in the Arab countries following independence was provided mostly by the public sector and sometimes by voluntary, charitable, and religious associations (Kronfol, 2012). However, it was largely limited to urban populations.

Many post-colonial states in developing countries attempted to extend healthcare services to all of the population (Sen and Koivusalo, 1998). Nonetheless, the success of these attempts was not even. In some countries allied with the Soviet Union, such as Egypt, free access to healthcare under the authoritarian regime of military leadership was constitutionally granted to the population during the rule of Nasser in the 1960s and this was reflected in the state ownership of all of the core functions of the healthcare system (Fouda and Paolucci, 2017; Saleh et al., 2014). However, dual-practice among health professionals has been common in Egypt, leading to the dominant role of the private sector in ambulatory healthcare settings (Berman and Cuizon, 2004). Additionally, in the mid-1970s, the second president of Egypt, Anwar Sadat, aimed to reduce the dominant role of the state in the country's economy and to reorient it towards private initiatives and investments (Saleh et al., 2014). Resource allocation in India during the 1960s favored professional elites and the democratically elected governments did not put real pressure on the class in power, resulting in the growth of private healthcare (Qadeer, 1994). Accordingly, by the 1970s, modern medical care had not been made accessible to all Indians and the poor among them became disappointed with the inadequate or non-existent basic healthcare services (Ibid).

The recession of the global economy at the end of 1970s led the global south to enter into a debt crisis. This debt crisis, combined with the structural adjustment, led states in the global south to invest less in the public sector (People's Health

Movement et al., 2017). The reduction of investment in publicly-provided healthcare services resulted in shortages of necessary supplies and medications, low salaries for health professionals, and poor maintenance of public facilities (Fouda and Paolucci, 2017; Saleh et al., 2014). Accordingly, the quality of publicly-provided healthcare services became compromised.

The endorsement by many states of the Alma Ata declaration, which called for comprehensive Primary Health Care (PHC), was considered an opportunity to expand publicly-provided healthcare in developing countries. The declaration of Alma Ata emphasized the responsibility of states' governments for the health of their people and considered that this responsibility could only be fulfilled by the provision of adequate health and social measures (WHO, 1978). Accordingly, the declaration provided new momentum to extend and expand publicly-provided healthcare services in the global south. However, this momentum was challenged by the adoption of selective approaches to the provision of healthcare services (Magnussen et al., 2004), and the decade that followed the declaration was a missed opportunity to expand publicly-provided healthcare services and to extend them to disadvantaged groups of the population in the Global South.

Economic liberalism dates back to 1776 when Adam Smith authored his work "The Wealth of Nations", which advocated a minimal role of the government in the economy as a prerequisite for trade development. This liberal view dominated the global economic attitude until 1930, when Keynesian approaches were suggested in response to the global economic crisis, the promotion of a mixed economy that promoted the private sector while simultaneously emphasizing the role of the state in regulating it. While the Keynesian economic model prevailed after the 1930s, the neoliberal theories introduced by Friedrich Hayek and Milton Friedman started their ascendance during the 1970s, especially after the 1973 oil crisis. These theories gained further thrust when Margret Thatcher stated during her electoral campaign that there was: "No such thing as society". Her electoral triumph and the formulation of the new administration of Ronald Reagan, who became the 40th president of USA from 1981 to 1989, marked the official adoption of these neoliberal economic policies. **[For a brief history of neoliberalism see for example Harvey (2007)]** Even before the fall of the Berlin wall, Francis Fukuyama, who was the deputy director of the USA State Department's policy planning staff, authored an article in which he argued that the end

of the Cold War and the triumph of the west was a bold victory of economic and political liberalism and demonstrated the “total exhaustion of viable systematic alternatives to western liberalism” (Fukuyama, 1989). Three years later, after the collapse of the Soviet Union, he extended his article and published a book, in which he contended that humanity had reached the end of its evolution (Fukuyama, 1992). This contention can be considered the promotion of the USA-style system as the only correct political system and the notion that all countries should inevitably follow its system of government.

The ascendance of neoliberalism in the political and economic domains was associated with increased involvement of the WB in global health and with a shift in its focus to health system strengthening in Low Income Countries (LIC) and Low Middle Income Countries (LMIC), and ex-Soviet Republics. Although the WB has shifted its involvement in global health from population and disease control programmes to healthcare system strengthening since the 1970s, the landmarks of this shift started with the publication of the WB agenda to reform the financing of health services in developing countries in 1987 and its World Development Report in 1993. This shift was accompanied by an emphasis on the reduced role of publicly-provided healthcare services and the greater role of the private sector in the provision of healthcare.

In its agenda to reform the financing of health services in developing countries, The World Bank advocated the introduction of user fees at government health facilities to address resource allocation, inefficiency, and inequity (WB, 1987). Research findings on the effects of user fees suggest that the fees failed to provide the gains advocated by the WB agenda (Yates, 2009), and that they became a barrier to access to healthcare for vulnerable populations (Russell and Gilson, 1997; Jacobs and Price, 2004), leading many countries to later remove them (Yates, 2009). Besides advocating the introduction of user fees, the WB agenda to reform the financing of healthcare services promoted the use of private non-government resources in the provision of healthcare (WB, 1987).

The World Development Report, which was published by the WB in 1993, proposed (i) cuts in the public budget spent on healthcare services, (ii) shifting curative care to the private sector, (iii) the introduction of cost-recovery mechanisms in public hospitals, (iv) defining packages of essential clinical and public health interventions,

and (v) tackling poverty through structural adjustment policies, education and women's empowerment (Qadeer, 1994). Hence, the global health agenda, led by the WB before the beginning of the third millennium, emphasized the importance of including private healthcare, the reduced role of publicly-provided healthcare services, and selective and essentialist approaches to providing healthcare in developing countries. The promotion of an increased role for private healthcare and a diminished role for publicly-provided healthcare services, and a focus on essential packages of basic healthcare interventions have continued and been advocated by many international and national stakeholders during the past two decades.

The tendency towards the growth of the private sector and the diminished role of publicly-provided healthcare services has not been limited to developing countries. Even in developed countries, where there has been universal access to healthcare for a long time, there has been a tendency towards the growth of private healthcare and a slowdown in the government spending on public healthcare services (Hellowell, 2018).

Out-of-pocket health spending is any spending incurred by any household member when purchasing a health good or using a health service to receive any type of care, provided by any type of provider, for any type of disease, illness or health condition, in any type of setting; and it includes formal and informal expenses directly related to the cost of seeking care (WHO and WB, 2021). Hence, out-of-pocket payments can be incurred at both private and public settings that require healthcare payments. Although some out-of-pocket payments for health-related products and services can be paid as users' fees, most of these payments are for goods and services purchased or used at private healthcare settings. Whether or not out-of-pocket payments for healthcare are incurred by users depends on the type of healthcare facilities used, as the use of public facilities typically involves less out-of-pocket payments than the use of private facilities, since publicly provided healthcare services are subsidized by the state (Alam and Mahal, 2014). The use of private healthcare services leads users to incur more out-of-pocket payments.

The negative role of private healthcare is not limited to the occurrence of out-of-pocket payments. It can also be considered a threat to health equity³ and the quality of healthcare⁴, as well as the right to it. Private sector involvement in the delivery of healthcare has not been properly regulated or managed, resulting in threats to the equity and quality of healthcare. Mackintosh et al. (2016) suggested that a large and dominant formal private healthcare sector excludes poor people from sources of care. The limited evidence about the performance of the private sector has made it difficult to determine in what services and activities the private sector might have a comparative advantage over publicly-provided healthcare services (Clarke et al., 2019). Despite this limited evidence, it has been suggested that private providers tend to perform better than the public sector in terms of user satisfaction, but the technical qualities of private healthcare are inferior to those of publicly-provided healthcare services (Morgan et al., 2016). Chapman (2014), who explored the potential compatibility of privatizing health services with commitments to human rights, considered that the division of the provision and the financing of healthcare in the public and private sectors poses significant issues for the realization of human rights in mixed healthcare systems. Nonetheless, the statement made by Horton and Clark (2016) that "...private is not going away" is apt and correct. Accordingly, it is important to study private healthcare within mixed health systems.

While there is information about publicly-provided healthcare in the Gaza Strip that can be traced over a reasonable period of time, knowledge about the private sector is very scant. Public providers of healthcare in the oPt, namely the MoH and UNRWA, consistently disseminate reports about their activities and programmes and the services they deliver in their healthcare facilities. Private healthcare providers, which are an unquestionable constituent of the health field in the oPt, have been inadequately-studied (Pavignani and Riccardo, 2013, p18). This research project therefore explores the development and evolution of the private and public dichotomy

³ The WHO defines Health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically" (Solar and Irwin, 2010, p.12).

⁴ The WHO defines quality of healthcare as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes" (WHO, 2020, p.8).

of healthcare and entitlement to healthcare in the Gaza Strip. This exploration is pursued by following trends in the provision of public and private healthcare services and possible changes in policies, practices, attitudes and the environment that could have contributed to these trends.

To sum up this section of this introductory and background chapter, I have attempted to emphasize the substantive importance and interconnectedness of FHP and out-of-pocket payments, access to healthcare services and healthcare-seeking behaviours, and the significance of tackling the public-private dichotomy of healthcare. Additionally, I have demonstrated that there is a very limited knowledge about these three aspects of healthcare in the Gaza Strip. In addition to the substantive importance of each of these three aspects of healthcare and to the limited knowledge about them, they are linked to each other. Financial Health Protection (FHP) is measured by assessing the magnitude and the burden of Out-Of-Pocket Payments (OOPPs) for health-related products and services, including their catastrophic burden and their impacts on household poverty. OOPP is defined as any spending incurred by a household when any member uses health goods or services to receive any type of care, provided by any type of provider, for any type of health-related conditions in any type of setting (WHO and WB, 2021, p.2). Consequently, incurring OOPP requires the use of a health goods or services. Thus, the use of health goods or services is tightly linked to the occurrences of OOPP, and the second could be the result of the first. Although OOPPs can be spent to receive care provided by any type of provider, including both private and public, the use of public facilities typically involves less OOPPs than the use of private facilities, since publicly provided healthcare services are subsidized by the state (Alam and Mahal, 2014). This suggests the salience of understanding the availability, role, and development of both private and public healthcare for understanding the use of and the payments for health-related goods and services in mixed health systems. Accordingly, this research will attempt to address these three aspects of healthcare during the period when the Gaza Strip started to experience changes in the way that Israel dealt with it and its population, i.e. after the start of the first Palestinian Intifada in 1987.

1.3 Thesis overview

Here I will present the research questions addressed in this research project and summarize the work that I have conducted to address these questions. I will conclude

this overview by clarifying the area of this research project and emphasising its interdisciplinary nature.

1.3.1 Research questions

This exploratory research project uses a combination of quantitative and qualitative research methods to explore the changes in healthcare services in the Gaza Strip and their ability to protect Gazans, and specific groups among them, from the financial burden of accessing these healthcare services. The project further explores people's experience with the healthcare system in terms of the use of and payment for healthcare, especially after the onset of the first Palestinian Intifada in 1987; and the development of the public-private healthcare dichotomy, and possible changes in people's entitlement and rights to healthcare.

More specifically, this research project seeks to answer the following three overarching research questions, and the subsequent subsidiary research questions related to each of these three main research questions:

- (i) What changes were there in the ability of the local healthcare system in the Gaza Strip to protect the population and its different socioeconomic groups from the magnitude and burden of out-of-pocket payments related to healthcare during the period from 1996 to 2017?
- (ii) What changes were there in the experience of Palestinians in the Gaza Strip in terms of accessing and paying for healthcare, especially after the start of the first Palestinian Intifada in 1987?
- (iii) How did the conflict, policies, actions and inactions, and contextual factors affecting the healthcare system impact on the development of the public-private-public mix of healthcare services and their intersection, and on changes in people's entitlement to healthcare services?

1.3.2 Data sources

In order to answer the above research questions, this project draws on four sources of data:

- 1- The series of 11 rounds of the Palestinian Expenditure and Consumption Survey (PECS), which were carried out by the PCBS in 1996-1998, 2004-2007, 2009-2011, and 2011. (*For the 1st main research question*)
- 2- Thirty eight recorded hours of semi-structured interviews that I carried out in the Gaza Strip between mid-September 2016 and the end of September 2017. The interviewees were 33 men and women who lived in 29 different households. A life history approach was used to capture each individual household's historical experience of healthcare, mainly after the onset of the first Palestinian Intifada in 1987. (*For the 2nd main research question*)
- 3- Literature and documents related to healthcare in the Gaza Strip including the development of the private–public mix and the trajectory of entitlement to healthcare services. (*For the 3rd main research question*)
- 4- Approximately 15 recorded hours of semi-structured interviews that I carried out with 17 health actors. These actors included four current officials at the Palestinian MoH in Gaza, two previous Palestinian Ministers of Health, one academic who worked for various international health projects, one political and Non-government Organization (NGO) activist who had a pivotal role in establishing health committees in 1970s and 1980s, and 9 managers at various (secular and Islamic) NGOs in Gaza. These interviews were intended to corroborate and supplement the documents and literature reviewed. (*For the 3rd main research question*)

1.3.3 Area of study and its interdisciplinary nature

As indicated above, this research is about the Gaza Strip and it addresses the changes in interrelated aspects of its healthcare system. The Gaza Strip was selected as an area of research based on two factors: my experience and expertise, the limited knowledge base on Gazan healthcare, and my ability to access interviewees. Regarding the first factor, I worked in the fields of medical practice, public health, and health research in the Gaza Strip for more than 20 years. With regard to the second, until recently Gaza has been generally neglected by researchers and academics and has been appended to research on the West Bank or on Palestinian refugees.

Subsequently, studying healthcare in the Gaza Strip qualifies this research as a contribution to Palestinian and Middle Eastern Studies. Moreover, the belligerent

history of Gaza and its tumultuous current affairs mean that this research is tightly connected with studies of conflict-affected settings. Similar to other studies conducted in the field of health policy and health systems research (Gilson, 2012, p. 21), the appeal of this research is interdisciplinary. It encompasses various academic disciplines, including health economics and health financing policies, social sciences, historical trajectories of healthcare systems, and health systems in conflict-affected settings.

1.4 Background

As far as this thesis is related to the historical perspectives of healthcare in the Gaza Strip, below I provide some background about this tiny territory. First I provide some background about Gaza before the emergence of the Strip as a recognized territory. I then discuss the evolution of the Gaza Strip after 1948 through presenting the trajectory of the conflict and economic situation of the Strip throughout different political regimes that controlled it and throughout salient periods.

1.4.1 Gaza before the Strip

The title of the Gaza Strip is derived from the name Gaza, which is an ancient city that formed, alongside four other city-states, a “pentapolis”, which transformed south-west Canaan into Philistia in the twelfth century BC (Masalha, 2018, p.120; Filiu, 2014a, p.5). Gaza was at the crossroads of empires and trade between Asia and Africa and its location determined its position as a garrison city. The belligerent history of the city is attributed to its geographic location (Roy, 1995, p.14). The control of this ancient city was a key issue in the rivalry between powers that established themselves in the Nile Valley and the Levant. It was not possible to conquer Egypt from the eastern Mediterranean without relying on Gaza and it was a crucial forefront for any invasion of the Levant from Sinai (Filiu, 2014a, p.2). Martine A. Meyer, a nineteenth-century-born historian and theologian, noticed that “.. as long as the centre of history remained in the Mediterranean world, the fate of nations was mirrored in that of this solitary city”(Meyer, 1907, p.4). One example of Gaza’s strategic importance is its role during the Egyptian campaign of Alexander the Great. After three unsuccessful attempts by Alexander of Macedon to take the city, his army imposed a siege on Gaza in 332 B.C.

and eventually the city was taken by the Macedonian army (Filiu, 2014a, p.7). Following the takeover of the city, all of those suspected of having fought were slaughtered and their families were sold into slavery; the army of Alexander of Macedon was allowed to proceed securely south into Egypt (Ibid).

Similar to what happened in ancient times, the British led “Egyptian Expeditionary Force” was initially unsuccessful in its two battles to capture Gaza, but the British eventually triumphed over the Ottoman army in the third battle of Gaza and entered the city (Filiu, 2014a, pp. 36-7). This enabled the British to conquer Palestine after their entry into Gaza on 9th November 1917, the same day that the British Press published the text of the letter that had been sent by the British Foreign Secretary Arthur Balfour to the Zionist leadership (Ibid). Balfour, who was the Chancellor of the University of Edinburgh between 1891 and 1930, wrote in his capacity as the British Foreign Secretary to affirm that “His Majesty’s government views with favour the establishment in Palestine of a national home for the Jewish people” (Perugini, 2022; Filiu, 2014a, p.38).

The British mandate of Palestine started in 1920 and was approved by the League of Nations in 1922. Although early waves of Jewish immigration to Palestine started before the British conquered the country, they increased during the mandate period; the presence of Jewish immigrants was strengthened and a separate Jewish community emerged in Palestine (Roy, 1995, p.33; Pappé, 2006 a, p.93).

Based on the previous Ottoman divisions, the British divided Palestine into Districts; Gaza was part of the Southern District. It later took the name of Gaza, and constituted almost half of the area of Palestine under the British Mandate (Filiu, 2014a, p.40; Roy, 1995, p.45). Gaza District was divided into Gaza and Beersheba Sub-Districts; the area of the latter constituted 92% of the total area of the District and the former the remaining 8% (Roy, 1995, p.45). Gaza City was the administrative centre of both Gaza District and the Gaza Sub-Districts. The battles of Gaza between the British and the Turkish armies traumatised the city and reduced its size. One third of its buildings were destroyed and the majority of its 42,000 residents fled the city or were killed (Roy, 1995, p.46). It was not until 1931 that the population of the city reached 17,480 residents (Ibid). During the period of the British Mandate of Palestine,

the Gaza economy was largely agrarian with pre-capitalist organization and limited employment diversity, and there was a lack of structural transformations (Ibid). Gaza was the poorest region of Palestine. Gaza district had the lowest productivity ratios for key crops, and the municipal expenditure in Gaza was extremely low, equalling GBP 0.26 per capita compared to 0.64 in Jerusalem and GBP 0.88 in Jaffa (Roy, 1995, p.50).

One of the policy objectives of the British Mandatory Government of Palestine was to improve the economic conditions of the country, and this policy was shaped by the colonial power to secure its military control and to maintain the status quo of the country (Roy, 1995). Gaza's important position as the administrative centre of both the Gaza District and Sub-District during the mandate of Palestine, and its hosting of one of the three major British military bases in Palestine during the second World War contributed to increasing the number of clerical jobs, and availed many Gazans of employment in construction and services; some social changes in terms of increased population growth and relative reductions in child mortality were also observed (Roy, 1995). However, the economy of the indigenous Arab Palestinians benefited less from the policies of the British Mandate in comparison to the Jewish community in Palestine. Some of the peasants were pauperized by some of the class transformations, and Gaza's economy, despite some changes, remained agrarian. Gaza's economy was characterized by underdevelopment, and although some prosperity did accrue to the Gaza area during the Mandate, economic development did not (Roy, 1995; Pappé, 2006 a).

During the period of the British Mandate, Palestine underwent very crucial demographic, social, economic, and political transformations that have contributed to the destiny of the country. Immigration contributed to increasing the size of the Jewish minority, from 11.14% in 1922 to one third of the population of Palestine by 1947. On 29th November 1947, the UN General Assembly passed a resolution in favour of the partition of Palestine between the Jewish community and the Palestinian Arabs. While the Zionist leadership of the Jewish community accepted the partition, the Palestinian leadership and the Arab states rejected the resolution. The British forces withdrew from Palestine at midnight on 14th May 1948 and the State of Israel was declared on the same day. Even before the proclamation of the State of Israel in May 1948, the

Jewish militia had started the ethnic cleansing of Palestine (Pappé, 2006b, pp.80-86). Thousands of refugees from Yafa reached Gaza in April 1948 (Cheal, 1988). The Arab armies entered Palestine following the declaration of the State of Israel; the first Arab Israeli war started, and the Arab armies were defeated (Pappé, 2006a, p.135). The Israeli army captured 78% of the territory of Mandated Palestine. Palestinians refer to the events that followed 1948, which entailed immeasurable losses being endured by them, when more than three quarters of them were forcibly displaced and their society lost its cohesion, as Nakba (Filiu, 2014 a, p.71). The literal meaning of the Arabic word “Nakba” is Catastrophe.

1.4.2 Emergence of the Gaza Strip

Before May 1948, the Gaza Strip had no territorial demarcation and was mainly part of the Gaza Sub-District. The demarcation lines of this area were made only after a series of armistices between Egypt and Israel, and the area later became known as the Gaza Strip. The Gaza Strip and the West Bank are the parts of Palestine that were under the British Mandate, which were not incorporated into the State of Israel after the events of 1948. The Gaza Strip constitutes only 1.4% of the area of Mandated Palestine, and the West Bank constitutes some 20%. While the West Bank was annexed by Jordan and the people living there were granted Jordanian citizenship, Egypt did not attempt to annex the Gaza Strip; instead, it preserved its Palestinian identity. Gaza is a rectangular coastal enclave, situated on the south eastern coast of the Mediterranean Sea. It is bordered by Israel to the north and east, and Egypt to the south. It encompasses an area of approximately 365 square kilometres, where more than two million Palestinians currently live, making it one of the most densely populated areas in the world. Figure 1-1 provides an illustration of the Gaza Strip's location. The geographic position of this small-sized Strip, the limited material resources available to it, and the nature of its populations and the political regimes that controlled it after 1948 have all shaped its characteristics. In the following subsection, I provide details of the political regimes that controlled the Strip and the salient periods in its historical evolution since 1948.

Figure 1-1: Map of the Gaza Strip



1.4.3 Historical trajectories of the Gaza Strip Early years (1948-1957):

In 1948, the Gaza Strip was flooded by the influx of more than 200,000 displaced Palestinians who joined the 80,000 people who originally lived in the area (Cheal, 1988). The area of the Gaza Sub-district was dispossessed of its grazing zone and was reduced in size from more than 1000 square kilometres to some 360 square kilometres (Roy, 1995). The local community, Egyptian military and civilian institutions

and international bodies provided humanitarian assistance to the displaced population (Cheal, 1988).

The UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) was established in December 1949 to provide assistance to Palestinians who were displaced into the Gaza Strip and other places (Ibid). Since beginning its operations, the UNRWA has amalgamated its humanitarian mission with development (Takkenberg, 2009). It has provided shelter, food assistance, basic medical assistance and basic education (Ibid). Additionally, it has provided vocational training and education, and primary healthcare and subsidies for hospital services, and aims to create job opportunities (Ibid).

Notwithstanding the humanitarian relief provided to the refugee population, the living conditions in the Gaza Strip have been very difficult, especially during the decade that followed the Nakba. The Egyptian military administration of the Strip dealt with the population in a repressive way and did little to ameliorate their vulnerability and their extremely difficult financial and living conditions, and between 1948 and 1951 the Egyptian army prevented Palestinians from travelling (Roy, 1995). Israeli forces raided the Gaza Strip and treated the Gaza population brutally during the first seven years that followed the establishment of the State of Israel. Every year, the Israeli army killed on average 500 Palestinians on the border between the Gaza Strip and Israel (Roy, 1995). This led Filiu (2014 b), who counted 12 wars in Gaza from 1948-2014, to consider these incidents a second war that followed the first Arab – Israeli war in 1948.

Second period under Egyptian Military Control (1957-1967):

Following Nasser's nationalization of the Suez Canal, France and the UK, along with Israel, launched a joint military operation, whereby Israel occupied the Gaza Strip for more than four months, from early November 1956 until early March 1957. The toll of this brief Israeli occupation was heavy and terrible on Gaza's population of 330,000, whereby Israeli Forces killed more than 1200 Palestinians (Filiu, 2014 a, p.105).

The ten years that followed the short-lived Israeli occupation in 1956-1957 brought greater Egyptian attention to the needs of Gazans (Roy, 1995, pp.84-91). Economically, the commercial and service sectors flourished after 1957, and this led to more employment opportunities and benefited the merchant class, while the refugee

population and Gaza's lower classes remained poor and continually dependent upon the UNRWA and other sources of external aid. Politically, the Egyptian administration not only preserved the national identity of Gaza and its population, but also promoted Palestinian nationalism (Roy, 1995, pp.65-73). In fact, Gaza remained under the Egyptian control a Palestinian space but without Palestinian sovereignty (Feldman, 2008). However, Egypt treated its opponents in a repressive way and looked at those who were not directly affiliated with it suspiciously; tough measures to restrict the freedom of the press and assembly were in place continuously in Gaza, as they were inside Egypt itself (Roy, 1995, p.72).

Gaza under the Israeli occupation (1967-1987):

The second Israeli occupation, which began on 8th June 1967, sparked a new period in the Gaza Strip. The years that followed the Israeli occupation witnessed active resistance in which schoolgirls as well as Fedayeen (armed guerrilla fighters) were involved (Roy, 1995). This resistance was confronted by harsh Israeli measures to repress the population and to eliminate the presence of Fedayeen. This led Filiu (2014 a, pp.125-145) to name the period that directly followed the Israeli occupation “the four years’ war”.

The political repression of the population was complemented by a set of economic and social policies and practices to pacify the Gaza Strip and foster the Israeli control over it. One aspect of these policies and practices was the integration of the weak Gazan indigenous economy into the dominant Israeli economy (Roy, 1995). This integration, especially the integration of the cheap and unskilled or semiskilled Gazan workforce into the Israeli labour force, required free passage of people and goods between the Gaza Strip and Israel. Israel did not officially revoke the possession of Gazans’ permits in order to leave their Strip to enter Israel or to pass through it into the West Bank until the mid-1980s (Hass, 2002). However, Gazans, similar to the Palestinians in the West Bank, were in practice allowed to leave their places of residence to go to Israel from the early 1970s, when Israel officially granted West Bankers general exit permits (Ibid). The integration of Gaza’s local economy within the Israeli economy contributed to improvements in the levels of employment and income, and subsequently to “limited individual prosperity” rather to a development of the Gazan economy (Roy, 1995, p.138). This integration of Gaza’s

economy contributed to its de-development, a term coined by Roy (1995) to characterize the unique economic situation in the Gaza Strip.

Until the first Palestinian Intifada, Israel maintained the position that it would never withdraw from the Gaza Strip. This integration of Gaza's economy was not based on economic motives; instead, it was predicated on political imperatives to control the population and pacify them, and to guarantee the inseparability of the Gaza Strip from Israel. In addition to economic integration, Israel maintained tough military control over the Strip.

Israeli occupation during first Palestinian Intifada (1987-1993):

The first Palestinian Intifada (Uprising) started spontaneously in Jabalya refugee camp in the Gaza Strip in December 1987. Within days of it starting, the Intifada had spread throughout the Gaza Strip and subsequently to the West Bank, with a clear political agenda to end the Israeli occupation and achieve national statehood (Butler, 2009).

Although the first Intifada was largely based on nonviolent means and civil disobedience, Israel responded to it brutally by intensifying its measures of collective punishments. These measures included mass arrests, deportations, home demolitions, and the use of live ammunition to suppress peaceful demonstrations and protests. During the first six weeks of the Intifada, 27 Palestinians in Gaza and 15 in the West Bank were killed by the Israel army (Butler, 2009). In total, 1124 Palestinians were killed between December 1987 and September 1993 (Ibid). The collective punishment entailed measures that had economic impacts such as night-time and prolonged daily curfews, and the introduction of magnetic cards. In August 1989, Israel issued an order requiring all Gazan workers to possess a magnetic card to enter Israel (Ibid). The introduction of magnetic cards triggered the current Israeli policy of isolating Gaza, which evolved gradually. During the Gulf War that followed the Iraqi invasion of Kuwait in 1990, Israel enacted the cancellation of the general exit permit from the occupied territories to Israel or through it (Ibid). This move ended the free movement of goods and people on which the "economic integration" of the Gaza Strip had been dependent. Measures regarding movement restrictions contributed to creating extreme financial hardship for many Palestinians in the Gaza Strip. The per Capita Gross National Income dropped by 41% during the first three years of the Intifada, from 1700 to 1000 US Dollars (Roy, 1995, p.295). Moreover, following a spike in

Palestinian violence inside Israel in March 1993, a total closure was imposed by the Israeli Army, whereby the territory was sealed (Butler, 2009). Since then, this closure of the Gaza Strip has never been lifted (Ibid).

Limited Autonomy under the Palestinian Authority [PA] (1994-2000):

The first Intifada contributed to the PLO initiative in 1988 in which it adopted “the two-state solution” (Said, 1989; Cobban, 1990). After the Gulf War, a peace conference was convened in Madrid for two days in the autumn of 1991, which led to a series of unsuccessful negotiations. However, a secret back channel, which was held in Oslo between the PLO and the Israeli government, led to the Declaration of Principles being signed by both parties in Washington DC in September 1993. Subsequently, on 4th May 1994 in Cairo, the PLO and Israel signed the Gaza-Jericho agreement, which established the PA, and Yasser Arafat returned to Gaza, which became his primary residence and headquarters from July 1994 to December 2001, when Israel confined him to the PA headquarters in Ramallah until his death in November 2004 (Butler, 2009). This agreement provided for a five-year transitional period in the Gaza Strip and Jericho, after which final status talks would begin in order to try to permanently settle various issues (Jerusalem, refugees, settlements, and borders). Hamas and the Islamic Jihad carried out military operations, including suicide attacks, in the occupied territories and in Israel (Butler, 2009). The PA was subjected to mounting pressure from Israel to crack down on the Islamists, which led to arrests being carried out by the PA instead of Israel (Ibid). Hence, the Israeli occupation became outsourced through the PA (Gordon, 2008). The outsourcing of the occupation was done not only in the sphere of internal security, but also in the spheres of providing social services and managing the internal economic affairs. The PA became responsible for healthcare delivery, education, social welfare, and local taxes.

Despite the agreements signed between the Palestinians and Israel, the employment of Gazans inside Israel did not improve after the creation of the PA (Farsakh, 2002). However, employment in PA facilities partially compensated for the loss of jobs that resulted from the continuing closures (Farsakh, 2005, p.130).

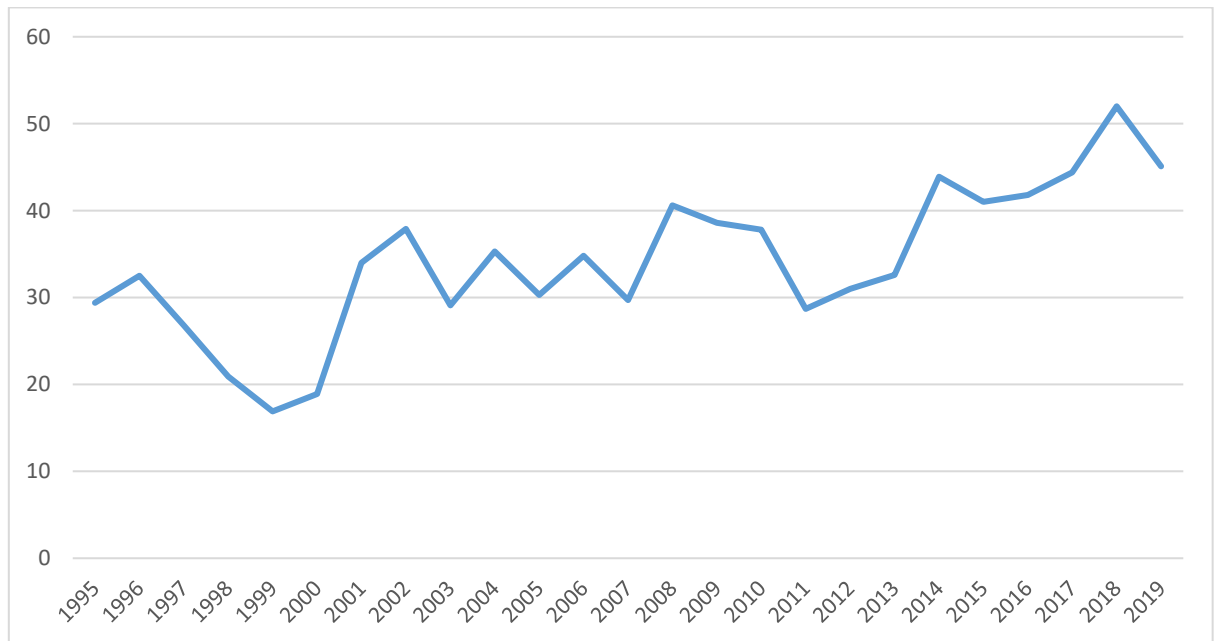
The second (al-Aqsa) Intifada (2000-2005):

The Israel-PLO talks, which were held in Camp David in July 2000, failed to reach an agreement on final issues, including Jerusalem, refugees, settlements, and borders (Butler, 2009). The political failure of the Oslo process paved the way for the start of the second (al-Aqsa) Intifada, which began on 29th September 2000, following Ariel Sharon's visit to Muslim holy places at al-Haram al-Sharif in Jerusalem (Ibid).

The second (al-Aqsa) Intifada entailed intense violence. The Israeli occupation forces responded to the Intifada by using disproportionate military power, and the Palestinian military groups conducted military operations in the occupied territories and inside Israel. The Israeli forces used open fire to disperse demonstrators, employed targeted assassinations, invaded populated areas and targeted the PA security installations, as well as deploying heavy weaponry, including tanks, antitank missiles, attack helicopters and grenades (Butler, 2009). The initial non-violent involvement of the Palestinians in the second (al-Aqsa) Intifada was followed by violent actions by Palestinian para-military groups. These violent actions included firing mortars and locally made rockets on Israeli settlements and military installations inside the Gaza Strip, and carrying out suicide bombings inside Israel (Ibid). This violence was reflected in the increased conflict-related morbidities, disabilities and fatalities. 4,907 Palestinians and 1,063 Israelis were killed between the outset of the second (al-Aqsa) Intifada and the start of the Israeli assault on Gaza in December 2008 (B'tselem, n.d.). Most Palestinians who were killed were from the Gaza Strip, where only 37% of the oPt population lives. 3,001 of the Palestinians who were killed were from the Gaza Strip and the remaining 1,906 were from the West Bank (Ibid).

The effects of the Israeli measures during the second (al-Aqsa) Intifada were not limited to conflict-related fatalities, disabilities and morbidities. The closure of Gaza was amplified by the Israeli Authorities during the second (al-Aqsa) Intifada. Additionally, the Israeli forces divided the strip into 3-4 areas using strategically placed checkpoints (Butler, 2009). This situation resulted in unemployment almost doubling, from 18.9% in 2000 to 34% in 2001; this level of unemployment has not been reversed since then but, rather, has increased further. (See figure 1-2 below)

Figure 1-2: Percentages of Unemployed in the Gaza Strip (1995-2019)⁵.



Current realities:

The president of the PA, Yasser Arafat, who had been the chairman of the PLO since 1969, died in November 2004, four years after the start of the Second (al-Aqsa) Intifada (Butler, 2009). Less than a year before Arafat's death, in December 2003, the Israeli Prime Minister Ariel Sharon declared his intention to physically withdraw Israeli forces and to evacuate Israeli settlements from the Gaza Strip (Ibid). The transition within the PA went smoothly after the death of Arafat, and Mahmoud Abbas, the candidate of the Palestinian National Liberation Movement "Fatah", was elected on 9th January 2005, with the majority of the vote, to be the second president of the PA. Eight months later, on 12th September 2005, Israel completed the implementation of its "Unilateral Disengagement Plan" (Ibid). Although Israel withdrew its forces from the Gaza Strip, it retained control over its airspace and territorial water, as well as its borders and border-crossings (Ibid). This led the UN to legally consider the Strip an imprisoned, sealed off, and occupied territory under the effective control of Israel

⁵ Sources of data are PCBS (2000); PCBS (2016); and PCBS (2020).

(Dugard, 2007). Although the Israeli disengagement from the Gaza Strip was associated with an institution of geographic separation from Israel and the West Bank, the Gaza Strip has become one contiguous geographic area.

A few months after the implementation of the Unilateral Israeli Disengagement Plan, in January 2006, the Islamic Resistance Movement “ Hamas ” won the election for the Palestinian Legislative Council. The Hamas-led government of the PA was sworn in on 29th March 2006 (Butler, 2009). This government was challenged. The USA initiated an international response by suspending its financial support to the PA, on which the latter had been dependent since its establishment in 1994. Israel withheld the transfer of taxes collected by it on behalf of the PA to the latter and instituted a blockade of the Gaza Strip (Ibid). Hamas and its allies in the Gaza Strip captured an Israeli soldier in June 2006 and put him under arrest (Ibid). Subsequently, Israeli air forces shelled the sole electricity power plant in Gaza, carried out military operations inside the Strip, and intensified the closure of Gaza to reach a blockade, which contributed to increasing the Gazans’ financial hardship through pushing unemployment to a high level (Ibid).

The consequences of Hamas electoral victory were not limited to international and Israeli challenges. Factional fighting broke out between the Hamas militia and the official security services of the PA, which was controlled by its rival political faction “ Fatah ”. The inter-factional fighting and security chaos, which took place from 2005 until Hamas’ seizure of power in Gaza in mid-June 2007, claimed the lives of 357 Palestinians, half of whom were civilians who got caught up in incidents of factional fighting (Filiu, 2014 a, p.306). Hamas seized power in Gaza in June 2007 and this prompted new realities. Mahmoud Abbas dissolved the short-lived Unity government, which had been formed in March 2007 and was led by Hamas, declared a state of emergency and appointed an emergency government based in Ramallah in the West Bank; and Hamas in turn formed its de facto government in the Gaza Strip. The international community officially adopted a non-contact policy with Hamas officials and ceased their direct support for Gaza’s public services, including healthcare (International Crisis Group, 2008). Israel declared the Gaza Strip a “ hostile entity ” and tightly restricted the passage of people and goods into and out of it, making it a

hermetic enclave, especially when the Rafah terminal, which connects the Strip with Egypt, was closed; additionally, the Israeli forces launched a succession of different military operations on the tiny territory.

Israel conducted an assault on the Gaza Strip towards the end of 2008. Although Israeli tanks invaded inner Gaza city neighbourhoods, they then retreated to their base where they divided the Strip into two parts. A few days later Israel declared a unilateral ceasefire. On 18th January 2009, the Israeli forces were physically withdrawn from the Gaza Strip. Internally, Hamas emerged stronger after the Israeli onslaught on the Gaza Strip during the winter of 2008-2009 (Baconi, 2018, pp.151-161). The withdrawal of the Israeli forces and the minimal damage and losses experienced by its militia, in comparison with the devastating losses among the civilian population, were considered a triumph by Hamas (Ibid). In addition to the Israel assault in the winter of 2008-2009, Israel launched many assaults on the Gaza Strip, including eight days of airstrikes in 2012, 50 days of airstrikes and military ground operations in the summer of 2014, and the last major assault in May 2021, when Israeli air forces relentlessly bombed the Gaza Strip for 11 days (Filiu, 2014 b; International Crisis Group, 2021). Besides some 1400 Palestinians who were killed in Gaza during the Israeli assault in winter 2008-2009, 3324 have been killed since January 2009 (B'tselem, n.d.).

Even before the assault, Hamas was able to monopolize the local violence inside the Strip, as it was able to overcome the challenges of armed clans and Salafist groups (International Crisis Group, 2008). The movement of goods through tunnels, which found their way underground just before the Israeli assault on Gaza in winter 2008-2009, increased and contributed to providing more employment opportunities and to availing people of supplies, which were scarce in the local market during the first two years following the declaration of Gaza as a hostile entity by Israel in 2007. Additionally, the intensity of the Israeli imposed siege on the Gaza Strip was somewhat relaxed following the Israeli attack on Mavi Marmara in May 2010; and the Egyptian Revolution, which resulted in ousting the Egyptian president Hosni Mubarak in February 2011, contributed to opening up the Rafah terminal. Hence, the tightly imposed Israeli siege was somewhat eased.

The tight Israeli siege of Gaza, coupled with the end of the short-lived (2008-2014) phenomenon of the underground tunnels between Egypt and the Gaza Strip, contributed to unprecedentedly increasing levels of unemployment and poverty in the Gaza Strip. Unemployment among the active labour force increased (see figure 1-2) from 32% in 2013 to 52% in 2018.

1.4.4 Health Status and demographic characteristics

The Palestinian society in the Gaza Strip is predominantly constituted of a refugee community, which is young and rapidly growing. The population size has grown more than four times during the last 37 years from slightly more than half million in 1985 to slightly more than 2.2 million in 2022 (MoH - State of Israel, 1989; PCBS, 2022 a) [**For tracing demographic changes in the Gaza Strip, see table 1-1 below**]. More than two thirds (69%) of Gazans are refugees (Palestinian Health Information Centre (PHIC) - Ministry of Health (MoH), 2021, p.1). Though decreasing, a substantial proportion of the refugees live in eight camps. The percentage of refugees living in refugee camps decreased from 55% in 1987 to 37.3% in 2019 (UNRWA, 1988, p.41; UNRWA, 2020, p.51). More than two fifths (41.2%) of the population are younger than 15 years of age, and only 4.4% of are above the age of sixty (PHIC- MoH, 2021, p.1). This high percentage of young people reflects the high fertility and low child mortality. The total fertility rate, though decreasing, is still high, standing at 3.2 births for an average woman of reproductive age (15-49 years) (Ibid). The infant mortality rate decreased from 22 in 2002 to 10.7 deaths per 1000 live births in 2020 (PHIC-MoH, 2015, p.7; PHIC-MoH, 2021, p.55). This relatively low infant mortality rate is mainly attributed to an almost universal immunization coverage. Reflecting the high birth and low death rates, the population growth rate, though decreasing, is still high; it stood at 2.8% in 2022 (PCBS, 2022 a). The crude birth rate was 32.1 and the crude death rate was 2.8 per 1000 in 2022 (Ibid).

The population in the Gaza Strip has been undergoing an epidemiological transition, whereby non-communicable diseases have overtaken communicable diseases as the main causes of morbidities and mortalities; and the burden of conflict-related morbidities and mortalities is high, especially when Israel carries out military assaults on the Gaza Strip. Cardiovascular disease, cancers, cerebrovascular diseases, lung diseases, and renal failure were the five leading causes of deaths in

2019 (PHIC-MoH, 2020, p.53). Accidents and injuries, including conflict-related ones, were the leading cause of death, contributing to 35.5% of the total mortalities, in 2014, when Israel carried out an extensive military assault on the Gaza Strip (PHIC-MoH, 2015, p.10).

Table 1-1: Demographic changes in the Gaza Strip (1985-2022)

Year	1985 ⁶	1997 ⁷	2009 ⁸	2017 ⁹	2022 ¹⁰
Population size (1000)	527	997	1,444	1,876	2,227
Sex Ratio		101.5	103.1	102.8	102.7
Dependency Ratio		114.5	89.1	80.1	76.9
Median Age		14.8	17	19.1	19.3
Crude Birth Rate / 1000	54.4	45.4	36.9	34.7	32.1
Crude Death Rate /1000		4.7	4.1	3.4	3.4
Growth Rate (%)	3.4	4.1	3.3	3	2.8
Total Fertility Rate		6.9	5.3	4.5	3.9
Life Expectancy (Male)		69.9	69.9	72.3	72.8
Life Expectancy (Female)		71	72.5	74.5	75
Average household size		6.9	6.5	5.6	5.6

1.4.5 Current healthcare system configuration and arrangements

Healthcare is provided to Palestinians in the oPt, including the Gaza Strip, by four main health providers. First, there are government health services provided by the MoH and the Police Medical Services (PMS). In addition to its stipulated role as the governing body of the national health system, the MoH provides Primary Health Care (PHC) in the Gaza Strip in 52 PHC centres, and secondary and tertiary healthcare services in 13 hospitals (PHIC-MoH, 2021). The bed capacities of these hospitals constitute 78.4% of the total bed capacity in the Gaza Strip (Ibid). Fixed co-payments are paid by the users of MoH PHC services and the outpatient clinic hospital services for drugs, lab investigations, and diagnostic tests. For example, token payments of 3

⁶ Source of data Ministry of Health - State of Israel (1989)

⁷ Source of data is PCBS (2009)

⁸ Source of data is PCBS (2009)

⁹ Source of data is PCBS (2017)

¹⁰ Source of data is PCBS (2022 a)

New Israeli Shekels (NIS), equivalent of 0.75 USA dollar, are charged for each item of drugs dispensed at the MoH PHC centers (Modol, 2010). The MoH is mandated by the Public Health Law to provide Maternal and Child health (MCH) care and healthcare for communicable infectious diseases to the entire population (Palestinian Authority (PA), 2005). Moreover, those who are enrolled in the Government Health Insurance (GHI) scheme are entitled to receive the healthcare provided by the MoH (PA, 2004). In addition to services they provide at their own healthcare facilities, the MoH and PMS refer patients to healthcare outside their own facilities, either inside or outside the Gaza Strip. The MoH referred 26,855 patients to receive healthcare outside its healthcare facilities in 2019 (PHIC-MoH, 2020, p.28). The MoH and patients who are referred by it outside its facilities officially contribute variably, based on categories of enrolments in the GHI scheme and based on the patient health-related conditions, to costs incurred as a result of these referrals (PA, 2004). The Minister of Health, or a delegated official, may officially exempt beneficiaries of the MoH services from paying fees or co-payments after conducting social enquiries (Ibid). However, there is no clear official benchmark to exempt beneficiaries of the MoH services from paying fees or co-payments according to predefined socio-economic and poverty status.

Second, PHC services are provided free of charge by UNRWA to Palestinian refugees through a network of 22 PHC centres, where more than 4.2 million medical consultations took place in 2019 (UNRWA, 2020, p.52). The high level of utilization of the UNRWA PHC services could pose a challenge to their quality. Additionally, the UNRWA assists Palestinian refugees with the costs of deliveries, and selected surgical and hospital procedures in NGO contracted hospitals (Ibid). Almost 11 thousand patients benefited from the UNRWA's assistance with hospital services in 2019 (Ibid). The level of UNRWA financial contribution toward assisting hospital services varies depending on the agency's categorization of refugees according to their financial hardship status, and ranges between full financial coverage and 80% contribution (Modol, 2010).

Third, a wide range of health services are provided by private not-for-profit organisations, financed mainly by out-of-pocket payments. The cost of these services is generally lower than those offered by the for-profit private sector, and the sector receives considerable physical and financial resources from donors (Challand, 2009, pp.130-153). However, its services are underutilized. The bed occupancy of the

hospitals that belong to this sector is much lower than the occupancy of the MoH hospitals. The bed occupancy of NGO hospitals was 44.1% compared to 95% at the MoH hospitals in 2019 (PHIC- MoH, 2020, p.12).

Fourth, the private for-profit sector consists mainly of public sector employees who engage in dual practice, i.e. working simultaneously in both private and public healthcare sectors. Additionally, there were 737 private pharmacies in 2020, where the purchase of over-the-counter medicines was described as a common practice (PHIC- MoH, 2021, p.38; Beckerleg et al., 1999). In addition to the four components of the local healthcare delivery system, the MoH refers patients from the Gaza Strip to healthcare services in the West Bank and Jerusalem, Israel, and Jordan and Egypt. More than 25,000 patients were referred in 2019 for treatment outside the MoH facilities (PHIC- MoH, 2020, p.27). Besides patients referred by the MoH for treatment outside the Gaza Strip, patients seek treatment abroad, especially in Egypt, at their own expense.

The healthcare system in the occupied Palestinian territories (oPt), like other Low and Middle-Income Countries (LMIC), is financed from the government budget, household expenditure on healthcare either through payments for enrolments in voluntary or compulsory prepaid health insurance schemes or through direct out-of-pocket payments, and external assistance to the health sector (Mills, 2014; PCBS and MoH, 2020). The Palestinian National Health Accounts, which were produced by the PCBS and the MoH (2020), provide detailed information about the share of health expenditure as a percentage of Gross Domestic Product, and about the contribution of different sources to the total health expenditure in the oPt from 2000 to 2018. The share of health expenditure as a percentage of Gross Domestic Product during that period ranged between 9.1% in 2016 and 11.7% in 2004 (PCBS and MoH, 2020). The Palestinian National Health Accounts identified different sources that contribute to health expenditure, including (i) government schemes and compulsory contributory healthcare financing schemes, (ii) voluntary health insurance schemes, (iii) household out-of-pocket payments, and (iv) external health assistance, expressed in the combination of the budget of non-profit institutions and the world contributions (Ibid). The first source contribution ranged between 31.7% in 2001 and 47.7% in 2010; the second source contributed between 1.9% in 2012 and 3.1% in 2006; the household OOPP ranged between 39.5% in 2008 and 44.8% in 2015; and the external assistance

contributions to total health expenditure in the oPt ranged between 10.1% in 2014 and 26.2% of total health expenditure in the oPt in 2001 (Ibid). The Palestinian National Health Accounts provide merely aggregate data about health expenditure in the oPt. Although the Palestinian National Health Accounts do not provide disaggregate data related to the West Bank and the Gaza Strip separately neither about the contribution of different sources to total health expenditure nor about the share of health expenditure, it is plausible that out-of-pocket payments and payments for private voluntary health insurance scheme contribute to healthcare financing in the Gaza Strip less than in the West Bank. The publications of the PCBS that report the results of the Palestinian Expenditure and Consumption Surveys indicate that out-of-pocket payments paid by households in the Gaza Strip for health-related products and services have been less than those paid by households in the West Bank [**see Table 2-2 in chapter 2, and see for example (PCBS, 1997b; PCBS, 2018)**]. Similarly, the percentage of Gazan households enrolled in private health insurance schemes has been repeatedly lower than among West Bankers (PCBS, 1998a; PCBS, 2005a).

1.5 Thesis Structure

My thesis is arranged in eight chapters, including this introductory and background chapter. The remaining chapters are organised as follows:

Chapter 2 presents the background, and methods and findings of a literature review that I conducted to identify the state of knowledge about the organization and the availability of healthcare, access to healthcare, and out-of-pocket payments for health-related products and services in the Gaza Strip.

Chapter 3 presents the research design and methods used in the three strands of my research, as well as reflexive accounts of my positionality as the researcher.

Chapter 4 provides details of the statistical analysis used to identify the scale and burden of out-of-pocket payments for health-related products and services in the Gaza Strip from 1996 to 2017, as well as the results of this analysis.

Chapter 5 presents the results of the analysis of the qualitative inquiry, which was inspired by the life-history Interviews approach, and provides conclusions.

Chapter 6 presents the evolutionary trajectory of the public-private mix of healthcare and entitlement to healthcare in the Gaza Strip (1948-2020), and shares findings, which demonstrate how the private provision of healthcare was encouraged mainly after 2009.

Chapter 7 provides a discussion of the findings of this research.

Chapter 8 concludes the thesis.

1.6 Potential contributions of the thesis

This thesis contributes to the field of health policy and systems research, in general, and to this field in the Gaza Strip, in particular; as well as to Palestinian and Middle Eastern studies. My thesis could help to shed light on the realities of healthcare services in the Gaza Strip; on the way these services have changed; and how Gazans have interacted with these services. Hence, my thesis could help in reducing the invisibility of Gaza and its populations. I provide a wealth of original data, generated through interviews with 33 householders and 17 health officials in the Gaza Strip, and present the results of a secondary data analysis of the 11 rounds of the Palestinian Expenditure and Consumption Survey (PECS), focusing on the magnitude and burden of out-of-pocket payments for health-related products and services in the Gaza Strip from 1996 to 2017.

In contributing to the health policy and systems research on the Gaza Strip, this thesis could make contributions to research related to settings that share some similarities with the Gaza Strip. The background presented in this chapter has demonstrated that Gaza, through the different periods and political regimes that followed the start of the Palestinian Nakba in 1948, has been a microcosm of a protracted conflict, which has been interrupted by some short intervals of relative tranquility and lengthy periods of low-intensity conflicts that preceded or were followed by the flaring up of the conflict. Additionally, this background has shown that poverty and financial deprivation has been one of the main characteristics of Gazans, who are predominately internally displaced Palestinian refugees, throughout the modern history of this very special place. The protracted political conflict, the continuous financial adversity, and the predominance of the refugee population have all made the Gaza Strip a scene of humanitarian actions and interventions to alleviate an adversity

that seems to be never-ending in the context of the absence of a political settlement. Hence, my thesis can potentially contribute to the discussion on healthcare in settings of protracted conflicts, financial deprivation, and humanitarian interventions.

Besides the possible contribution of this thesis to health policy and systems research related to the Gaza Strip and to similar settings, my research could possibly offer a methodological contribution to efforts for monitoring the progress in achieving financial health protection, and could contribute to discussions on health system strengthening.

There have been noticeable changes and innovations in monitoring the health-related sustainable development goal of improving health; however, the current approaches in monitoring are dependent on tracing quantitative indicators of services coverage and Financial Health Protection. Additionally, the traced healthcare services coverage indicators capture only a combination of 8 indicators related to reproductive and newborn health, child immunisations, infectious diseases, and non-sector determinants (improved water sources and sanitation) (WHO WB, 2015). This set of quantitative statistical indicators appears to be minimalist, ignoring the coverages of other services that are not included by these indicators. My research, which I present in this thesis, offers a qualitative approach, which enquires, through Life-history Interviews, about the access to and coverage for healthcare in the Gaza Strip over more than three decades. Chapter 3 of this thesis shows that only a few research used Life-history Interviews to study access to healthcare. Additionally, the time conventionally required to carry out these interviews is known to be lengthy, requiring at least 2 interview sessions. In this thesis, I present a practical version of conducting these interviews in one session for an average of 1-2 hours. This version of Life-history Interviews could potentially contribute to methodological aspects of tracing changes in access to healthcare.

Besides the potential methodological benefits of the way that I carried out the Life-history Interviews, my thesis could demonstrate the critical contribution of understanding historical changes to health policy analysis. This research presents the findings of 11 rounds of a household survey that were repeated over more than 2 decades. To the best of my knowledge, only a few publications reported the scale of out-of-pocket payments and their catastrophic and impoverishing burden over an

extended period. These findings about the changes in out-of-pocket payments over more than 2 decades are accompanied by findings of the Life-history Interviews, which capture healthcare-seeking experiences over more than 5 decades, and by a synthesis of the healthcare system trajectory over more than 7 decades. Thus, this research can potentially contribute to illuminating the role of history in shaping health systems and policies related to it.

Additionally, this research could contribute to the debates related to universal access to healthcare in mixed health systems. The findings presented in this thesis, which show that the changes in the socioeconomic distributions of out-pocket payments were associated with increasing the social stratification of healthcare, could point to the risks that result in encouraging the growth of private healthcare when publicly-provided services are neglected.

It can be argued that Gaza is a particular and exceptional case. I concur that Gaza has many particularities; however similar situations have been emerging around the world. Ekeland and Roy (2021) eloquently indicated that: *“mini-Gazas are developing around the world. From Gaza to Lesbos, from Lesbos to Afghanistan and beyond, sites of exception are growing where people are barred from legitimate political discourse, unrecognized but kept alive, without claim to community or nationhood—declared unfit, without a past and hidden from history, and consigned to abstraction”* (Ekeland and Roy, 2021).

Chapter 2

Healthcare in the Gaza Strip: A systematic review of empirical studies.

2.1 Introduction

In this chapter, I review the evidence about healthcare in the Gaza Strip from relevant empirical studies. This is because my thesis will explore changes in (i) out-of-pocket payments for health-related products and services, (ii) the experiences of people interacting with the healthcare delivery system, and (iii) the pattern of public-private healthcare provision and entitlement to healthcare, especially after the start of first Palestinian Intifada in 1987.

Knowledge about the Gaza Strip is limited. The Strip has been neglected by Middle East scholars and has been treated as an analytical appendage to the West Bank (Roy, 1995, p3); this is echoed in the state of the knowledge about health policy and systems research. Pavignani and Riccardo studied the Palestinian healthcare arena and noted that the inadequate available information made exploring the Gazan healthcare system challenging (Pavignani and Riccardo, 2013, p.31). They called for the study of its healthcare in more detail than has been done previously without diluting the Gaza-specific features in the national portrayal of healthcare in the oPt (Ibid, p.33).

I have emphasized in the introductory and background chapter the importance and interconnectedness of tackling out-of-pocket payments for health-related products and services, access to healthcare, and the public-private dichotomy of healthcare. I have attempted to portray the state of the evidence regarding the three interrelated aspects of healthcare addressed in my thesis. The sketch I have provided in the previous chapter of the state of the knowledge regarding healthcare in the Gaza Strip has demonstrated that this knowledge is scant for the period to be addressed in the thesis. Although some publications have explored the financial consequences of out-of-pocket payments in the oPt, these have not tackled out-of-pocket payments or FHP in the Gaza Strip. The available evidence on access to healthcare services in the Gaza Strip has demonstrated that Gazans who exercise choice in terms of their healthcare provider rely mainly on publicly-provided healthcare, and supplement this reliance by

using private healthcare or even by purchasing over-the-counter medicines from private pharmacies. Additionally, I have indicated that the private healthcare sector has been inadequately studied.

In this chapter, I develop a more systematic approach to exploring the state of the knowledge related to the three interconnected aspects of healthcare in the Gaza Strip that are explored in this thesis. Following this introduction, I present the methodology used for the systematic search for, and identification of publications related to these three aspects of healthcare in the Gaza Strip. I then present the findings of the publications reviewed and discuss these findings. Finally, the content of the chapter is discussed and conclusions are reached.

2.2 Methodology

As indicated in the introduction to this chapter, the aim of this literature review is to identify and present the available empirical evidence about the three aspects of healthcare investigated in my research in order to assess the effects of the socioeconomic and political changes, especially after the start of the first Intifada, on these interrelated aspects of healthcare in the Gaza Strip. The research questions addressed in this literature review are:

- What is known about the organization and availability of healthcare service delivery in the Gaza Strip?
- What is known about access to health-related products and services in the Gaza Strip?
- What is known about the scale, distribution and impact of out-of-pocket payments for health-related products and services in the Gaza Strip?

Accordingly, I carried out a systematic search for empirical evidence relevant to (i) the organization of healthcare services and their availability, and to the development of public-private healthcare services; (ii) access to health-related products and services; and (iii) out-of-pocket payments for health-related products and services. As the empirical evidence sought by this research included journal articles and other publications, including grey literature, the search for relevant publications was done using academic and non-academic databases. These databases were identified after

consultation with Donna Watson, the Social Policy librarian at the School of Social and Political Sciences, University of Edinburgh, and after consulting the Global Health Policy subject guide for using library resources. The databases used for the search included PubMed, Web of Science, Scopus, ProQuest (International Bibliography for Social Science), and Google Scholar. In addition to these databases, the institutional online repositories of the WHO and the WB were searched for relevant publications. These repositories included the WHO institutional repository for information sharing (iris) and the WB Open Knowledge Repository (OKR). While the online bibliographic databases and the institutional repositories were the primary sources for the search, the reference lists from publications obtained through the primary sources were used to identify potential additional publications. Additionally, the web page of the PCBS was navigated.

I searched these bibliographic databases and repositories using broad search terms to maximise the yield. The search terms used in this review combined “Gaza” with [“Healthcare”, “Health Care”, “Financial Protection”, “out-of-pocket”, and “Expenditure”].

After searching each database and recording the number of titles retrieved, I screened the titles online and excluded all those that I judged to be irrelevant to my research questions. I exported titles that had not been excluded to an Excel spreadsheet, screened the exported titles, read the abstracts, and scanned their full texts to assess their relevance to my review. Finally, I read the retained publications to assess whether they met the inclusion criteria.

Because the focus of this review was on empirical evidence regarding the three aspects of healthcare to be addressed in this research, I included only publications based on empirical research or on a review of the empirical research on (i) the organization and availability of healthcare, and the development of its public-private dichotomy, (ii) access to health-related products and services, and (iii) out-of-pocket payments for health-related products or services, or a combination of more than one of them. Other publications, such as letters, comments, opinion pieces, and abstracts without full text publications were excluded from the publications retrieved. Only publications that tackled these aspects with a focus on the Gaza Strip were included. Publications that reported on the occupied Palestinian territories (oPt) in general

without acknowledging the differences between the Gaza Strip and the West Bank were excluded. Similarly, publications that focused on Palestinian refugees without tackling the particularities of the Gaza Strip were excluded. I updated my search in May 2022. Given the historical nature of my research project, I included any publication indexed before May 2022. The inclusion of publications was also based on my linguistic abilities. Only publications written in Arabic or English were included. I recognize that much empirical research has been presented at conferences, such as the Lancet-Palestinian Health Alliance annual meetings, but only their abstracts have been published. So, I included only publications where the full text was available. The algorithm for including and excluding publications is schematised in figure 2-1.

The process of deciding which publications should be included followed four main steps, as sketched in figure 2-2, whereby the number of publications retained from each data source during each step of this process was tabulated. Additionally, Annex II-I provides details of the number of publications retained during each step according to the five combined searches. The initial search yielded 12,191 titles, including duplicates. After the online screening of the titles and the exclusion of titles that I judged to be irrelevant to the review aim and questions, a total of 11,625 titles were excluded, and 566 titles, including duplicates, were retained and exported into an Excel file. This file contained Excel spreadsheets for each data source searched and for each search term. The titles exported to the Excel file were read again and screened for their relevance and if relevant their full texts were retrieved. If there was doubt about including the publication for full reading, it was scanned and skim-read. The retained publications were put in one sheet and duplicates were eliminated. After excluding the duplicates, 34 publications were read in order to make a final decision about their inclusion or exclusion. After the final inclusion and exclusion decisions had been made, 18 publications were retained through the systematic search. Additionally, four further publications were identified from the publications read. Only one of them was retained for the review. Hence, a total of 19 publications were retained from the systematic search.

There was a limited yield of publications relevant to the review questions and relatively limited information was obtained from most of these. Recognizing that the PCBS publishes reports, many of which provide a descriptive analysis of the surveys conducted by it, I visited the website of the bureau. The website contains 1,879

publications that report different aspects of the PCBS' interest (PCBS, 2022 b). Although I reviewed the titles of all of the publications available in the PCBS, I focused on the publications about "Health" and "Living Standards". The results of some surveys were reported in a variety of publications, such as preliminary, main, final, and area focused reports, and even press conference reports. Acknowledging the different versions of some surveys, I chose the report that focused on the Gaza Strip and the latest version of that report. In total, I reviewed 19 reports from the website of the PCBS in addition to the 19 publications included through the systematic search of the databases and repositories. Hence, a total of 38 publications were finally included in this review.

Table 2-1: Databases and repositories - steps followed to identify publications relevant to the review

Sources of Search	Steps of identifying relevant			
	1 st		3 rd	4 th
PubMed	383	31	11	
Web of Science	296	31	11	
Scopus	504	48	13	
ProQuest	1,954	28	13	
Google Scholar	4,263	422	68	
WHO iris	4,717	149	0	
WB OKR	74	6	0	
Total (including	12,191	715	116	

*Steps for identifying relevant publications:

1st step: Initial hits of publication titles that appeared after searching the database using Gaza and the corresponding words: ["Healthcare", "Health Care", "Financial Protection", "out-of-pocket", and "Expenditure"].

2nd step: Number of publications retained after online screening of the initially retrieved titles.

3rd step: Number of publications retained after further screening of their titles tabulation in excel sheet, reading of their abstracts, and scanning of their full text.

4th step: Number of publications retained after reading their full text.

Figure 2-1: Algorithm for including publications in the review

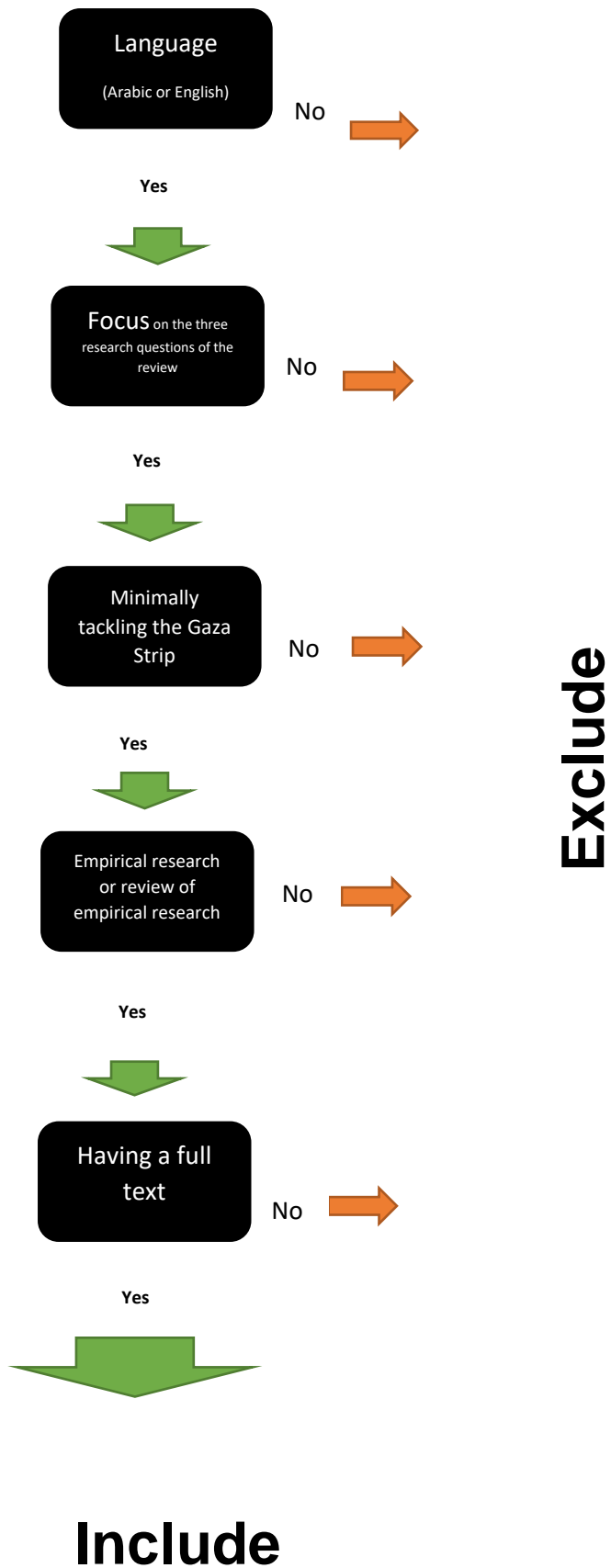
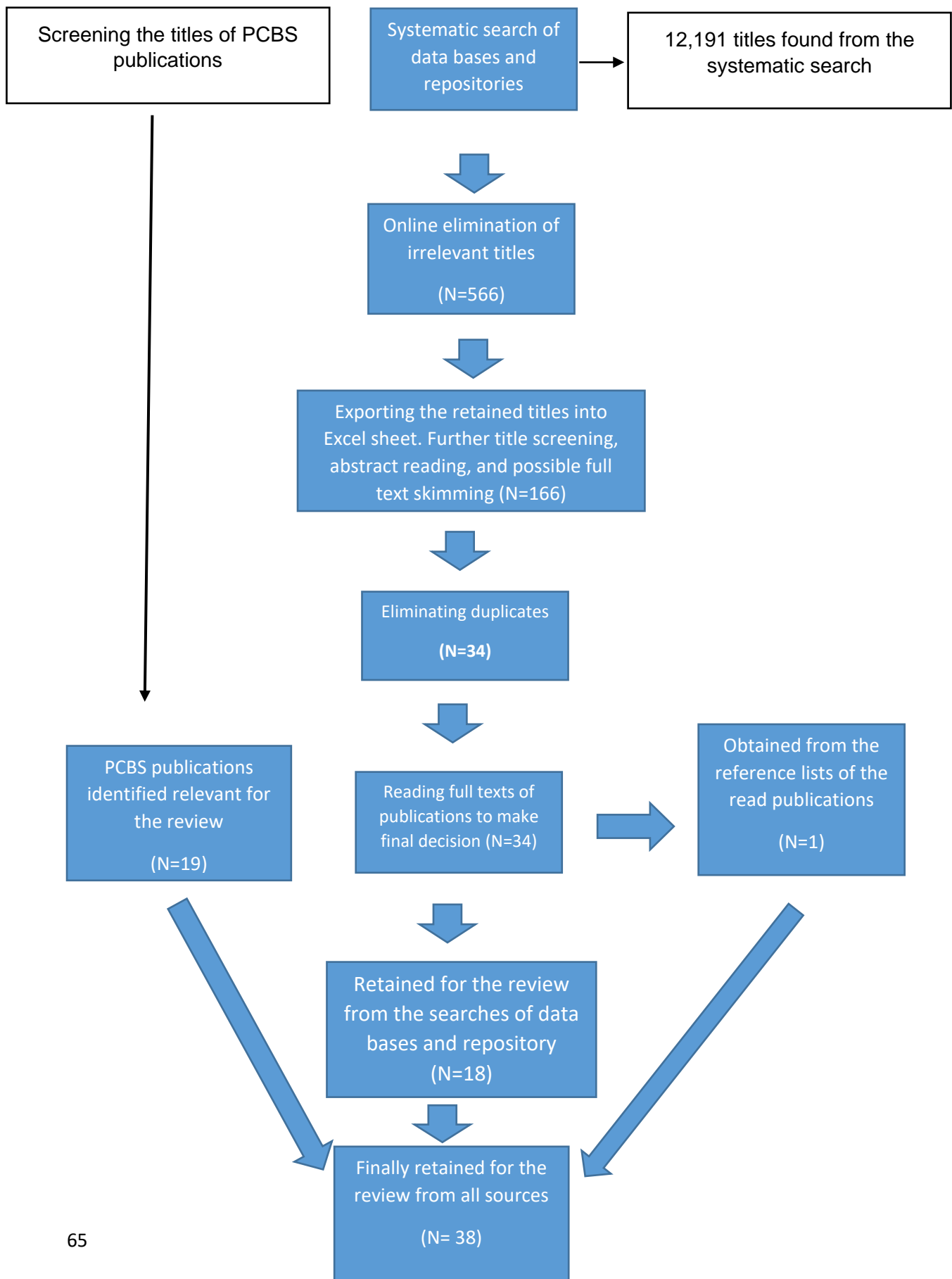


Figure 2-2: Process of identifying publications that address the review questions



2.3 Results

The presentation of the results of the search is pursued through three main subsections that correspond to the three questions in this review, namely (i) organization and availability of healthcare services, and the development of the public-private dichotomy of healthcare, (ii) access to health-related products and services, and (iii) out-of-pocket payments for health-related products and services. These subsections are divided when appropriate according to the emerging themes related to each of them and to the relevant aims of the review.

2.3.1 Organization of healthcare services in the Gaza Strip

I portray the organization of healthcare services by presenting the information obtained from the reviewed publications about (i) the organizational structure of the healthcare delivery system, (ii) the availability of health-related products and services, and (iii) the availability and development of the public-private healthcare services.

Organizational structure of healthcare delivery system

Many of the articles reviewed indicated that the healthcare delivery system in Gaza, similar to that in the West Bank, consists of four components: (i) the government healthcare services, including those of the Ministry of Health (MoH) and the Police Medical Services (PMS); (ii) the UNRWA healthcare services; (iii) not-for profit private healthcare; and (iv) for-profit private healthcare. It was also observed that indigenous healthcare coexists with western allopathic healthcare services, and that Gazans seek treatment and healthcare outside the strip.

Four main healthcare providers provide primary, secondary, and tertiary healthcare in the occupied territories: the Palestinian MoH, Palestinian NGOs, UNRWA, and the private for-profit sector (Mataria et al., 2009). This organizational structure of a mixed healthcare delivery system in the oPt was also mentioned in many of the publications reviewed (Abu-Zaineh et al., 2008; Abu-Zaineh et al., 2009; Abu-Zaineh et al., 2011; Mataria and Khoury, 2008).

Similar to the findings of the publications that addressed healthcare in the oPt in general, publications that focused exclusively on healthcare in the Gaza Strip also reported the same configuration of the local healthcare system in the Strip. For

example, Jebiril (2021), who attempted to study the political economy of health in the Gaza Strip, highlighted the four components of the healthcare delivery system in the Gaza Strip. Besides reporting on the four main components of healthcare delivery in the Strip, some publications indicated that government healthcare services, which have been provided mainly by the MoH since 1994, are also delivered by the PMS (Abu Hashem, 2007; Jebiril, 2021). Additionally, indigenous and western medical practices coexist in delivering healthcare in the Gaza Strip (Jebiril, 2021). In addition to the organizational structure of the locally available healthcare, the publications reviewed reported that Gazans seek treatment and healthcare outside the Strip (Abu Hashem, 2007; Abu-El-Noor, 2011; Jebiril, 2021).

The available evidence indicates the fragmentary nature of the healthcare delivery system, with low levels of coordination between its components (Jebiril, 2021). This low level of coordination among the health providers creates a messy system of overlapping medical visits, prescriptions, and treatment plans (Smith, 2015). Besides the low level of coordination between these components of the healthcare delivery system, there is a split in the government healthcare services between the Gazan administration and the Ramallah administration of the MoH (Jebiril, 2021).

Most of the publications that addressed the organizational structure of the healthcare delivery system did this in their background sections and concentrated on this structure during the time the study was carried out. However, the chronology of the development of the health sector in the Gaza Strip was presented by Jebiril (2021), mainly based on wider literature that focused on the health sector in the oPt in general.

Availability of health-related products and services

While there is generally good geographic availability of healthcare institutions and services, the availability of certain health-related products and services has been reported to be inadequately available inside the Gaza Strip.

Households that participated in a health access survey carried out by the PCBS in 2003 reported good availability of healthcare institutions and practices in the localities where they lived (PCBS, 2004). Almost all of them (more than 94%) indicated that healthcare centres, pharmacies and physician practices were available in the localities where they lived, compared to only 66.2% of them who reported the

availability of a local hospital (Ibid). This geographic availability of healthcare services can be attributed to the tiny size of the Gaza Strip. Additionally, the expansion of healthcare services after the establishment of the PA in 1994 may have contributed to the increased availability of these services. The hospital capacities of the MoH and NGO healthcare services in the Gaza Strip have increased since the establishment of the PA (Hamdan, 2007).

Notwithstanding the reported geographic availability of healthcare institutions, the publications reviewed reported unavailability or inadequate availability of certain healthcare services in the Gaza Strip, or at publicly provided healthcare facilities. Most of the health service users who participated in group interviews carried out to assess views towards Maternal and Child Health (MCH) care in the Gaza Strip reported that there was an inadequate supply and lack of availability of drugs at the government and the UNRWA healthcare facilities (Beckerleg et al., 1999; Lewando-Hundt et al., 1997). Adolescents who participated in qualitative research carried out by Abu Hamad et al. (2021) indicated that the shortage of medicines and unavailability of laboratory tests were among the main challenges facing them when they visited the publicly-provided healthcare services of the MoH and UNRWA.¹¹ Additionally, there is a dearth of age-appropriate and gender-sensitive information and services available to adolescents at the publicly-provided healthcare facilities (Abu Hamad et al., 2021).

The unavailability of certain services leads patients to seek healthcare and treatment outside the Gaza Strip. Although there are three government hospitals that provide cancer care, there is a lack of comprehensive specialised services to manage cancer in the Gaza Strip (Halahleh and Gale, 2018). Most prostate cancer survivors reported the unavailability of several health-related products and services that are necessary for diagnosing and treating their condition, such as drugs, equipment, diagnostic reagents, and radiotherapy (Abu-EI-Noor, 2011). Mataria and Khoury (2008) indicated that the inadequate availability of tertiary healthcare services has led to the demand for these services by providers outside the oPt.

¹¹ Although the ownership of UNRWA belongs to the UN, I considered it throughout this thesis document as a public provider of services based on the free-of-charge nature of these services.

Availability and development of the public-private healthcare services

The evidence related to the availability and development of the public-private healthcare in the Gaza Strip is mainly based on a review of publications that focused on the national portrayal of healthcare in the oPt. These publications, however, also tackled some aspects of public-private healthcare in the Gaza Strip. They focused on the initial period that followed the establishment of the PA in 1994, and indicated the dominance of the government in the provision of hospital services and of the UNRWA in delivering PHC services.

There was an increase in government PHC centres in the oPt after the establishment of the PA in 1994 and the hospital capacities of the MoH and NGO healthcare services in the Gaza Strip also increased (Hamdan, 2007). Private healthcare grew significantly in the oPt after 1994, with the perceived prospect of peace and stability after the Oslo agreements (Ibid). Since its inception in 1994, the PA has attempted to support an open market economy, with active involvement of the private sector in all economic aspects (Mataria and Khoury, 2008). Besides the initial potential for stability in the oPt and the PA's support for an open market economy, donor policies to increase private involvement and a decreasing state role in the provision of social services have contributed to the growth of private healthcare (Hamdan, 2007). Reflecting a public policy trend towards promoting the private provision of healthcare, there has been an increase in the supply of private for-profit healthcare (Ibid). There was a considerable increase in the number of private practices in the oPt between 1998 and 2003, where the most important growth was in the number of private pharmacies and dental practices (Ibid). These doubled in number due to the graduation of many pharmacists and dentists from local universities (Ibid). The general characteristics of the private for-profit health sector in the oPt are that this sector has an important role in providing ambulatory medical care services and it focuses mainly on curative medical care (Ibid). Moreover, private healthcare services are prevalent for economic reasons where the well-off population is concentrated. For example, private healthcare is concentrated more in the urban areas than in the rural areas, and in the West Bank more than in the Gaza Strip (Ibid).

Information about private healthcare in the oPt in general and in the Gaza Strip in particular is limited to that reported by the Healthcare Providers and Beneficiaries

Survey (HPBS) that was carried out by the PCBS in 2005. This information indicates that, apart from private pharmacies, more than (53.3%) of the 263 surveyed private for-profit institutions were medical specialists' private clinics, a quarter (25.2%) dental private clinics, an eighth (12.5%) private medical laboratories, and 3.3% generalist medical clinics (PCBS, 2006 a). Although the information about the private for-profit sector in the Gaza Strip is limited, this sector has remained marginal. This marginal contribution of the private sector to healthcare delivery in the Gaza Strip is reflected in the dominant role of the healthcare services provided by the MoH and UNRWA. Hamdan et al. (2003) indicate that the role of the UNRWA is more prominent in the Gaza Strip in terms of providing PHC services than in the West Bank. The proportion of PHC centres operated by the UNRWA in the Gaza Strip as a share of all PHC in the territory is more than double its contribution in the West Bank [17% vs. 7%] (Ibid). In 1999, the contribution of the government health services to the hospital capacity in the Gaza Strip was higher than its contribution in the West Bank (71.9% vs. 44.4%), and the contribution of the private for-profit sector to the hospital capacity in the Gaza Strip was very marginal compared to its contribution in the West Bank (2.9% vs.7.9%) (Ibid). Additionally, the healthcare services offered by the NGO sector were less prominent in the former than in the latter (Ibid).

This dominant role of publicly provided healthcare (government and UNRWA) and the marginal contribution of the private sector portrayed by Hamdan et al. (2003) has also been echoed by Mataria and Khoury (2008). Healthcare services in the Gaza Strip are mainly provided by the UNRWA and the MoH in the absence of a strong private for-profit sector and the fragmentation of the private not-for-profit sector (Mataria and Khoury, 2008). Secondary and tertiary healthcare services in the Gaza Strip are mainly provided by the Palestinian MoH (Mataria et al., 2009), and the provision of tertiary healthcare has historically been dependent on services outside the Strip (Mataria and Khoury, 2008). While most healthcare services outsourced by the MoH in the West Bank have been outsourced locally, the opposite is the case for the outsourced services in the Gaza Strip, whereby most of them were outsourced to healthcare facilities outside the Strip (Ibid).

2.3.2 Access to, and use of health-related products and services

The presentation of the findings on the second question of the review concerning knowledge about access to health-related products and services in the Gaza Strip is organized around two subthemes. The first subtheme, which encompasses several aspects of access, presents the knowledge obtained from the review on the pattern and determinants of access. The second subtheme presents the findings related to barriers that compromise access to healthcare.

The pattern and determinants of access

In terms of preventive healthcare, access is good and almost universal. There was a predominant reliance on the publicly-provided healthcare services of the MoH and UNRWA in accessing these services between 1996 and 2020. Similar to the good access to preventive healthcare, access to other aspects of healthcare services seemed to be adequate in 1996 and 2003, and the financial difficulties or the unavailability of services did not prevent most of those who were ill from accessing treatment or healthcare. This adequate access to healthcare services can be attributed to the relatively good health coverage, which is manifested in the entitlements of most people in the Gaza Strip to UNRWA free healthcare, to MoH low-cost healthcare, or to both. As a result of the high percentage of refugees entitled to UNRWA PHC services and its subsidies to some secondary healthcare services, and of the good and improving enrolment in the Government Health Insurance (GHI) scheme, there is relatively good coverage by the incomplete and fragmented healthcare services. However, the knowledge about health coverage is limited to two points in time during the decade following the establishment of the PA in 1994. The availability of multiple health providers and coverage within a mixed healthcare system has enabled Gazans to seek treatment and healthcare from multiple healthcare providers, both public and private. The choice of these providers has been influenced by different factors, including health status, entitlement to healthcare services, demographic determinants, and socioeconomic status. However, the socioeconomic inequity in regard to access to healthcare in the Gaza Strip is less pronounced than in the West Bank.

Good access to preventive healthcare

The health surveys conducted by the PCBS between 1996 and 2020 indicate that there is good and improving access to preventive services (such as vaccination and antenatal care services), and that most users of preventive healthcare, which targets maternal health during pregnancy and childbirth or the treatment of common childhood illnesses, such as diarrheal disease and acute respiratory infections, use the government healthcare services and UNRWA PHC services.

Antenatal care

The majority of pregnant women (76.8%) who were pregnant during the fieldwork of the health survey in 1996 reported that they had received antenatal care (PCBS, 1998a). The reported attendance for antenatal care increased four years later, as access to antenatal care was reported to be almost universal. Almost all (98.3%) of the women who were pregnant three years before the health survey in 2000 reported that they had attended antenatal care services when they were pregnant (PCBS, 2001b). More than half (59.9%) of them used the antenatal care provided by the UNRWA, 14.1% used the government PHC centres, 3.5% used government hospitals, more than one fifth (20.7%) used the services of private for-profit healthcare, and only 1.8% used the antenatal care provided by NGOs (PCBS, 2001b).

The pattern of access to antenatal care reported by the Demographic and Health Survey (DHS) carried out by the PCBS in 2004 showed no change, as the universal access to antenatal care was maintained and the UNRWA and government PHC centres preserved their dominance as the main providers of care. More than three quarters of women who were pregnant within three years of the DHS used either the UNRWA (60.7%) or government (16%) PHC services, and the remaining women used government hospital services (7.5%), private physicians' clinics (13.0%), NGO health settings (1.3%), and private hospitals (1.2%); 2.8% did not receive antenatal care (PCBS, 2006b).

The universal access to antenatal care reported in the DHS in 2004 and in preceding surveys has been preserved, as indicated in the findings of the Palestinian Family Health Survey (PFHS) in 2006, the Palestinian Multiple Indicator Cluster Survey (PMICS) in 2014, and the PMICS in 2019-2020 (PCBS, 2007a; PCBS, 2015; PCBS, 2021). Almost all (99.1%) women who were pregnant two years before 2006 received antenatal care.

Deliveries

Professionally trained health attendants assisted almost all women during deliveries and most institutional deliveries occurred in public facilities of the MoH and UNRWA. The vast majority (96.7% and 98.3%) of deliveries that occurred within three years before 1996 and 2000, respectively, took place in healthcare institutions [or were assisted by a professionally trained birth attendant] (PCBS, 1998a; PCBS, 2001b). More than a third (36.4%) of the deliveries that took place before the health survey in 1996 were assisted at government hospitals, more than a third (34.8%) were assisted at private facilities or at private doctor practices, and almost a quarter (24.7%) were assisted at UNRWA and government PHC facilities; the remaining 4.1% were assisted by others or elsewhere (PCBS, 1998a). Almost half (46.6%) of the deliveries that took place three years before the health survey in 2000 were assisted at government hospitals, 15.5% at UNRWA maternity facilities, almost a third (31.1%) either at private doctors' practices or at private maternity facilities, and 6% at NGO health facilities; only 0.8% were assisted at home (PCBS, 2001b). A high proportion of deliveries were assisted by professionally trained birth attendants. 81.1% of women who delivered within three years of the Demographic and Health Survey (DHS) in 2004 were assisted by physicians, 17.2% by a nurse, and 1% by a midwife; only 0.4% were assisted by a Dayya (a trained traditional birth attendant) and 0.1% by a friend (PCBS, 2006 b). The use of healthcare institutions for birth was maintained for three years within the DHS, in 2004. The use of government hospitals for deliveries became more frequent and the use of private healthcare decreased in comparison to deliveries reported before 2000. The increase in the proportion of deliveries that were assisted at government hospitals and the reduction in the proportion of deliveries that were assisted at private healthcare settings can be attributed to the increasing capacity of government hospitals and the reduction in the financial resources of Gazans after the start of the second (al-Aqsa) Intifada in September 2000.

The dominant use of government hospitals for assisting deliveries reported by the DHS in 2004 was preserved in the results reported by the PFHS in 2006, and there was a steep decline in the proportion of deliveries provided by the UNRWA maternity facilities. This decline in the proportion of deliveries assisted at UNRWA facilities can be attributed to the fact that these midwife-led facilities were closed in 2006 (Wick and Hassan, 2012). Almost all (99.5%) of the deliveries that took place before the PFHS

in 2006 were assisted by professionally trained birth-attendants. More than two thirds (69.0%) of the deliveries that were reported by the PFHS in 2006 took place at government hospitals, 4.4% at UNRWA maternity facilities and 2.8% at government health centres; the remaining deliveries were provided by the private sector, including private hospitals (9.7%) and NGO hospitals (3.7%), or at private specialist clinics (9%) (PCBS, 2007a).

Recent data provided by the PMICS in 2014 indicates that more than three quarters (77.0%) of the deliveries that took place up to five years before the survey were in government hospitals and the remainder were assisted at private facilities (PCBS, 2015). The most recent data provided by the PMICS in 2019-2020 indicate that the pattern and distribution of deliveries has not changed. All of the deliveries that took place up to five years before the survey were assisted by professionally trained birth attendants. Most of these deliveries (87.5%) were assisted by physicians, and the remainder (12.5%) were assisted either by a nurse or by a midwife (PCBS, 2021a). The majority took place at government hospitals and the remainder at private healthcare settings (Ibid).

Family planning

Most users of family planning services use UNRWA and government health services. The Palestinian Family Health Survey carried out by the PCBS in 2006 indicates that 60% of family planning users use the family planning services offered by the UNRWA PHC centres, 17.4% government PHC centres, 5% government hospitals, and the remainder private healthcare services, including NGO health facilities (3.2%), private pharmacies (5.8%), private physicians (5.6%), and private health centres and hospitals (2.3%) (PCBS, 2007a).

Childhood common illnesses and immunizations

The majority of children aged under-five who had acute diarrheal illnesses or acute respiratory infections within two weeks before the various health surveys consulted healthcare providers, and most of these consultations took place at the publicly-provided healthcare facilities of the MoH and UNRWA.

More than two thirds (69.5%) of children aged under-five who had diarrheal illnesses and more than half of those who had acute respiratory infections in 1996

consulted a healthcare provider (PCBS, 1998a). More than half (56.3%) of the children who had diarrheal diseases and almost all (99.6%) of the children who had symptoms of acute respiratory infection up to two weeks before the health survey in 2000 sought healthcare or treatment, and most of them used the government healthcare services or UNRWA PHC services (PCBS, 2001b). Almost a quarter (23.7%) of those who reported childhood diarrheal illnesses up to two weeks before the health survey in 2000 indicated that they had sought treatment or advice at UNRWA PHC centres, 39.1% at government PHC centres and 18.3% at government hospitals, 6.2% at NGO health facilities, 5% at private hospitals, 12.7% at private doctors, and 7.6% at private pharmacies (PCBS, 2001b). Almost a fifth (18.9%) of those who had symptoms of acute respiratory infection sought treatment at UNRWA PHC centres, almost a third (32.2%) at government PHC centres, 11.9% at government hospitals, 4.5% at NGO health centres, 3.6% at private hospitals, 13.6% at private doctors, and 7.1% at private pharmacies, while the remainder (17.9%) used other modalities of treatment (PCBS, 2001b). This pattern of seeking care, which can be characterized as having good access to healthcare provided mainly by the MoH and UNRWA, persisted, as indicated by the data presented in the reports of the PFHS in 2006, and the PMICS in 2014 and 2019-2020 (PCBS, 2007a, PCBS, 2015; PCBS, 2021).

In addition to the relatively good access to care for common but mostly self-limited early childhood diseases, there has been high and improving vaccination coverage of vaccine-preventable diseases for infants and children, as confirmed by various health surveys carried out from 1996 to 2020 (PCBS, 1998a; PCBS, 2001b; PCBS, 2005a; PCBS, 2007a; PCBS, 2015; PCBS, 2021).

Good and improving health coverage

There was good and increasing health coverage in the Gaza Strip from 1996 to 2004, but there is no information available about the health coverage before the establishment of the PA in 1994, or after 2004.

More than three quarters (76.8%) of those who were surveyed by the Health Survey in 1996 considered themselves covered by a health plan, whereby 41.8% were enrolled in the Government Health Insurance (GHI) scheme, 30.7% considered themselves covered by the UNRWA healthcare services, and 1.8% by the Ministry of

Social Affairs (MOSA); only 2.5% were enrolled in private health insurance plans (PCBS, 1998a). The Demographic and Health Survey (DHS) conducted by the PCBS in 2004 indicates that only 6.2% of the Palestinians in the Gaza Strip did not have any health coverage. While the DHS reported that 65.5% of those surveyed were refugees who were covered by the UNRWA, it also indicated that 66.5% of Gazans were enrolled in the GHI scheme, 8.7% were enrolled in the PMS health insurance, 3.0% were covered by the MOSA, and 1.1% were insured by private health insurance plans (PCBS, 2005a). The increasing health coverage may reflect both the expansion of the GHI after the establishment of the PA in 1994 and the introduction of free enrolment in the GHI for those households who were negatively affected by the second (al-Aqsa) Intifada in 2000.

Good access to, and reliance on publicly-provided healthcare

The majority (59.7%) of those who had encountered unexpected illnesses or injuries within two weeks before the health survey conducted by the PCBS in 1996 consulted a healthcare provider (PCBS, 1998a). Most (58.1%) of those who did not access a healthcare provider to treat their illnesses made this choice because they perceived their illnesses to be simple or because they were busy, or because they relied either on self-medication (26.6%) or on traditional methods of healing (9.3%) (Ibid). Only a very small proportion did not consult a healthcare provider either because they could not financially afford to seek treatment (3.8%), or because healthcare services were not available (2.1%) (Ibid).

Most of those who consulted a healthcare provider in 1996 used the services offered by public providers [Government health services or UNRWA]; more than a third (36%) used UNRWA PHC centres, 17.9% government health centres, 14.6% government hospitals, 24.1% private hospitals, and 7.4% private pharmacies (Ibid).

Similar to what was reported by the Health Survey in 1996, most of those who received healthcare for health-related conditions, including chronic diseases, antenatal care, routine check-ups, and urgent care in 2003 used government health services and UNRWA healthcare (PCBS, 2004). Almost one third (32.5%) of those who accessed healthcare services for their health-related conditions, in general, used UNRWA PHC services, 29.6% government PHC services, 16.4% government

hospitals, 16.7% the services of private doctors, 3.1% private hospitals or private health centres, 1% NGO health services, and 0.7% other healthcare options (Ibid). This general pattern of use of the different categories of healthcare services differed according to the health-related conditions targeted. For example, the UNRWA seems to have been more prominent in providing healthcare to those with chronic diseases, antenatal care and other preventive services, as well as routine check-ups rather than having a general role in healthcare provision. Similarly, government hospitals and private doctors' practices delivered most care provided to those who encountered urgent illnesses. Most patients with chronic diseases used the services of either UNRWA PHC centres (43.0%), government PHC centres (13.7%), or government hospitals (21.4%); and less used private healthcare services, including private doctors (20.3%), NGO hospitals (1.1%), and private hospitals (0.5%) (PCBS, 2004). Most of those who had routine medical check-ups used UNRWA PHC centres (47.0%), government PHC centres (16.9%), or government hospitals (13.4%); and less used private healthcare provided by private health centres (4.6%) or NGOs (0.1%). Most antenatal care was sought from UNRWA PHC centres (72.8%), and the remainder took place at government PHC centres (11.8%), private physicians' clinics (11.8%), and NGO health institutions. Most urgent healthcare took place either at government hospitals (40.4%) or at private physicians' practices (40.4%) (Ibid).

Reflecting the mixed nature of the healthcare delivery system, the publications reviewed indicate that Gazans have multiple choices when it comes to accessing different healthcare providers. They seek healthcare from any source that can provide it, creating a chaotic system of overlapping medical visits, prescriptions, and treatment plans (Smith, 2015). Lewando-Hundt et al. (1997) reported that women are able to exercise extensive choice in Maternal and Child Health (MCH) clinic use, as they use a number of health services besides the government or UNRWA PHC centres for themselves and for their children. The majority of the women who took part in the study reported that the government or UNRWA PHC centres were their first resort when seeking care, and that they then used private healthcare if their health conditions did not improve (Lewando-Hundt et al., 1997). The women reported that they had been able to compare a range of clinics from both the public (government and UNRWA) and private sectors, and that movement between the government and UNRWA PHC centres had been common (Ibid). Gazans are indeed frequent users of PHC services.

Most of the interviewed users of PHC services, which are mainly provided by the MoH and UNRWA, reported that they had used these services more than three times every six months. (Abu-Mourad et al., 2008). There was an alternation in using professional and non-professional providers (possibly self-medication or even skipping treatment for self-limited illnesses) of healthcare for the treatment of diarrheal illnesses (Abuzerr et al., 2019).

Determinants of the healthcare provider choice

Reflecting the better financial situation in the West Bank and the more prominent role of the private sector, Hamdan et al. (2003) reported that 43% of Palestinians in the West Bank turned to private practices, while only 21% in the Gaza Strip turned to these practices as a first choice. Similarly, enrolment in private health insurance schemes in the Gaza Strip was very marginal [0.3% in the Gaza Strip compared to 17.1% in the West Bank] (Hamdan et al., 2003). However, enrolment in the GHI scheme in the Gaza Strip was higher than in the West Bank [51.1% and 25.3% respectively] (Ibid). Hence, the poverty and low macroeconomic indicators in the Gaza Strip have been important determinants of the reliance on low-cost or free-of-charge healthcare provided by the government health services and by the UNRWA.

The choice of healthcare provider and the levels of use of the PHC services depend on users' demographic, social and economic characteristics; and on their health conditions, the availability of services, and the level of care. The hierarchies of the resorts and the choice of healthcare among users of MCH services varied depending on users' social and economic status and the extent to which they were faced with a lack of availability of drugs and poor communication with providers (Lewando-Hundt et al. 1997). Most women reported relying mainly on the UNRWA and government PHC facilities because they could not afford private healthcare for all of their curative care (Ibid). The free healthcare and drugs at the UNRWA PHC centres appeared to be a major incentive to use the services of these centres (Lewando-Hundt et al., 1997). Women in a better financial position said that they used these PHC centres only for immunization (ibid).

People with low incomes, in households headed by a woman or by householders with a low educational level, those living in rural areas, and those who

were above the age of five years old, tended to choose non-professional providers rather than others to care for diarrheal illnesses (Abuzerr et al., 2019). The use of PHC provided mainly by the UNRWA and MoH health centres was more frequent among ever-married women, people with poor living conditions and the unemployed, older people, and those with a poor health status (Abu-Mourad et al., 2008).

Equity of access to healthcare

The worse off in the oPt have a disproportionately greater need for all levels of healthcare (primary, secondary, and tertiary). However, with the exception of primary healthcare, the utilization of all levels of care appears to significantly favour the rich, i.e. the better-off use all levels of healthcare, except PHC, more than the worse-off (Abu-Zaineh et al., 2011). While the use of PHC is mainly concentrated among the worse-off Palestinians in the oPt, this use of PHC is less concentrated among poor Gazans than the worse-off in the West Bank. The pro-rich nature of the use of the other levels of healthcare (out-patient and in-patient secondary healthcare, and tertiary healthcare) is less concentrated among the better-off in the Gaza Strip than among comparable people in the West Bank (Ibid).

Barriers to accessing health-related products and services

There are various barriers to accessing healthcare. These include the unavailability of health-related products and services, financial and cultural barriers, as well as organizational and communication barriers. Additionally, the political context of the Gaza Strip, which entails frequent Israeli military onslaughts and a protracted blockade, since 2007, contributes to delayed or denied access to healthcare.

Adolescents in Gaza face a range of barriers that prevent them from accessing healthcare, including the dearth of age-appropriate information and services and the insensitivity of medical staff at publicly-provided healthcare services towards adolescent needs (Abu Hamad et al., 2021). This makes adolescents' use of healthcare services very limited except for in the case of acute illnesses (Ibid). Additionally, despite having health insurance, the financial burden of treatment, drug shortages and the unavailability of laboratory tests pose a challenge to adolescents'

access to healthcare (Ibid). There is a perception among some girls that poor families would prefer to spend their money on their sons; however, adolescents generally reported that their families decided on health expenditure based on the severity of the illness, regardless of gender (Ibid).

The majority of prostate cancer survivors reported facing at least one barrier to using healthcare for their health condition at a certain point in their treatment (Abu-El-Noor, 2011). There have been organizational barriers to receiving appropriate care for prostate cancer, such as long waiting times, the unavailability of physicians in their offices at government hospitals, waiting for the results of a diagnosis, and the complicated referral process for treatment outside the Gaza Strip (Ibid). Communication barriers, such as not being respected by health professionals and physicians treating patients in a different way if they were at their private practices, were reported by Abu-El-Noor (2011). The unavailability of drugs at government health facilities led prostate cancer survivors to purchase drugs at their own expense, contributing to the socioeconomic barriers, which include the high costs of drugs, diagnostic tests, private doctor fees, and the cost of transportation (Ibid). Geographic factors within the Gaza Strip were a major barrier to accessing care for patients with prostate cancer before September 2005, and the restriction of movement through border-crossings was also one of the major barriers to accessing care outside the Strip (Ibid).

Smith (2015) indicated that the siege, as a process of political domination that aims to isolate an entire population, poses a unique threat to healthcare provision in the Gaza Strip. He argued that the Siege impinges on effective healthcare provision through two central, intertwined processes: the withholding of materials and resources and the undermining of healthcare at the system level (Smith, 2015). Most patients with cancer in the Gaza Strip are referred for treatment outside the Strip because of the lack of specialist services for cancer; however, these referrals have recently decreased because of the closure of border crossings (Halahleh and Gale, 2018). The blockade of the Gaza Strip has been one of the major barriers to accessing care among patients with prostate cancer (Abu-El-Noor, 2011). The inaccessibility of cancer care outside the Gaza Strip has contributed to the increased chance of death among cancer patients. Patients who were denied or delayed access to chemotherapy or radiotherapy had higher mortality rates than patients who obtained permits to

access these modalities of cancer treatment for the period from 2015 to 2017 (Bouquet et al., 2021).

In addition to the contextual barriers related to the restriction of movement from the Gaza Strip, the recurrent military assaults on the Strip contribute to the inaccessibility of healthcare. Wick and Hassan (2012) indicated that despite the high coverage of institutionalized maternity services in the Gaza Strip, there is no system planned for these services during exacerbations of the conflict. Aiming to make the childbirth experiences of Gazan women in a war-like situation visible, Wick and Hassan (2012) interviewed women who gave birth or assisted with births during the 22 days of Israeli assault on the Gaza Strip in winter of 2008-2009. The women interviewed reported experiencing difficulties accessing maternity services in overcrowded hospitals or at their homes, and that there were no safe places to give birth during the Israeli assault (Wick and Hassan, 2012).

2.3.3 Out-of-pocket payments on health-related products and services

Some information regarding out-of-pocket payments on health-related products and services was gained from the publications reviewed. The cost shouldered by patients who access treatment outside the Gaza Strip is high (Abu Hashem, 2007). Gazans use some adaptive mechanisms to overcome the financial burden of seeking healthcare, including relying on financial assistance, foregoing treatment, and using traditional healing methods (Abu Hamad, 2021). The regressive pro-rich character of out-of-pocket payments on healthcare was confirmed. Out-of-pocket payments tend to increase the overall inequality in the income distribution in the oPt; however, this pro-rich character of out-of-pocket payments is more pronounced in the West Bank than in the Gaza Strip (Abu-Zaineh et al. 2008; Abu-Zaineh et al. 2009). The value of household out-of-pocket payments on health-related products and services and their share of total household expenditure are both higher in the West Bank than in the Gaza Strip. Similarly, the value of out-of-pocket payments and their share of total expenditure among better-off Gazan households are higher than among more disadvantaged households.

Recognizing that many Gazans access tertiary healthcare that is unavailable in the Strip through referrals by the MoH to healthcare facilities outside Gaza, Abu

Hashem (2007) aimed to assess the financial burden of the expenses incurred by patients referred for treatment outside the Strip. He indicated that almost two thirds (60.8%) of patients referred for outside-treatment were exempted from cost-sharing and that almost 20% of those who were referred shared less than 25% of the costs (Abu Hashem, 2007). Besides the high percentage of those exempted from cost sharing, more than two-fifths (42.2%) of the patients who were treated abroad received financial assistance from different sources to cover all or some of the expenses incurred for their travel and lodging (Ibid). The costs incurred by patients treated outside the Strip was high, ranging between 1000 and 65,000 New Israeli Shekels (NIS), with a mean of 4,466 NIS and a median of 6621 NIS (Ibid). Similar to the financial assistance received by those who are treated outside Gaza, some families caring for the health of their adolescent children seek financial assistance to pay for their medication (Abu Hamad, 2021). Other families either just skip treatment, especially for the most costly treatment, or use traditional remedies (Ibid).

Abu-Zaineh and colleagues used the Palestinian Healthcare Utilization and Expenditure Survey, which was conducted by the PCBS in 2004, to assess the equity of the healthcare financing system in the oPt through two different articles. In the first article, they borrowed the decompositions approach, which was designed to deal with the problem of close-income equals in equity analysis, and applied it to the domain of healthcare financing (Abu-Zaineh et al. 2008). In the second article, they used developments in assessing equity of taxation to assess the equity of the healthcare financing system (Abu-Zaineh et al. 2009). These articles ascertain the regressive (inequitable and pro-rich) nature of out-of-pocket payments in the oPt, and report some particularities of the healthcare financing system in the Gaza Strip compared to the West Bank.

Applying the decompositions approach to the domain of healthcare financing, they confirmed the regressive character of out-of-pocket payments on healthcare, which was more pronounced among the worse-off groups of the population in the oPt (Abu-Zaineh et al., 2008). They indicate that out-of-pocket payments tend to increase the overall inequality of the income distribution; however, this effect is more pronounced in the West Bank than in the Gaza Strip (Ibid). Applying advances in measuring the effects of taxation on overall equity to the domain of healthcare financing, they re-confirmed the pro-rich effect of out-of-pocket payments on the

overall income inequality (i.e. post out-of-pocket payments income) in both the West Bank and the Gaza Strip, although this is less pronounced in the latter than in the former (Abu-Zaineh et al. 2009).

Hamdan et al. (2003) reported that the monthly household expenditure on health-related products and services as a share of the total household expenditure is higher in the West Bank than in the Gaza Strip. This was confirmed through reviewing the results of the 11 rounds of the Palestinian Expenditure and Consumption Survey (PECS), which were reported through 11 reports published by the PCBS. The results pertaining to household out-of-pocket payments for health-related products and services are summarized in table 2-2 on the next page. They indicate that the monetary value of out-of-pocket payments on health-related products and services and their share of total expenditure have been consistently low in comparison with the level in the West Bank.

Beside the low levels of out-of-pocket payments in the Gaza Strip compared to the West Bank, the reports of the first four rounds of the PECS, which provide detailed descriptive statistics related to both the Gaza Strip and the West Bank indicate that out-of-pocket payments among the less privileged were lower than among the more privileged Gazan households. The better-off households spent more money and a greater share of their total expenditure on health-related products and services than households with less financial resources (PCBS, 1997b; PCBS, 1998b; PCBS, 1999; PCBS, 2005b). For example, better-off households spent 3% of their total expenditure on health-related products and services in 1996, compared to 1.60% spent by the middle group of households and 1.14% by the worse-off households (PCBS, 1997b). This pattern of out-of-pocket expenditure among the different levels of households persisted in 1997, 1998, and 2004 (PCBS, 1998b; PCBS, 1999; PCBS, 2005b). However, there is no disaggregated data relating to the Gaza Strip for the subsequent PECS rounds.

Table 2-2: The levels of out-of-pocket payments in the Gaza Strip and the West Bank (1996-2017)

PECS round year	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
Reference source	(PCBS, 1997 b)	(PCBS, 1998 b)	(PCBS, 1999)	(PCBS, 2005)	(PCBS, 2006 c)	(PCBS, 2007 b)	(PCBS, 2008)	(PCBS, 2010)	(PCBS, 2011)	(PCBS, 2012)	(PCBS, 2018)
The Gaza Strip											
Average monthly household out-of-pocket payments on health-related products and services in Jordanian Dinars (JDs).	13.86	14.97	14.02	22.00	14.40	18.40	17.20	38.80	21.20	24.10	22.50
Average percent of out-of-pocket payments on health-related products and services as a share of the household total expenditure.	2.55%	2.80%	2.67%	4.10%	1.93%	3.30%	3.80%	4.20%	2.90%	3.20%	3.40%
The West Bank											
Average monthly household out-of-pocket payments on health-related products and services in JDs.	23.19	26.28	24.77	32.40	25.00	33.30	34.40	47.40	42.30	40.60	38.70
Average percent of out-of-pocket payments on health-related products and services as a share of the household total expenditure.	3.43%	3.93%	3.91%	5.10%	4.15%	4.70%	4.30%	6.80%	4.00%	3.70%	4.00%

2.4 Discussion

Although the initial yield of the publications identified through the systemic searches of the databases and institutional repositories was not very voluminous, through integrating this yield with relevant publications of the PCBS, I was able to synthesise the data in order to address the three questions in this review. This synthesises benefited from the inclusion of relevant detail, encountered in the publications reviewed. This enabled me to produce, what I believe to be, the first review that has attempted to systematically identify publications and to synthesise the knowledge that addresses healthcare in the Gaza Strip. While some aspects of some of the review questions were addressed somewhat adequately by the information identified and synthesised, others were only addressed to a very underdeveloped extent. Additionally, almost all aspects of the three questions were addressed by information that lacked a historical perspective, i.e. from the outset of the first Intifada in 1987 to the current times. Hence, this review provides only a glimpse of the healthcare situation, rather than the evolutionary trajectory of healthcare in the Gaza Strip. In the following pages I focus on summarizing the key findings of the review, discuss them, and then present my views about their implications for my thesis.

Many of the articles reviewed addressed the organizational structure of the local healthcare delivery system, indicating its mixed nature, and pointing to the coexistence of indigenous healthcare practices alongside western allopathic healthcare services, and recognizing that treatment is also sought outside the Strip. Despite the generally good availability of healthcare institutions and services in the localities in which the respondents to the Health Access Survey in 2003 lived, certain health-related products and services were inadequately available. The knowledge about the public-private dichotomy of healthcare is mainly based on national portrayals of healthcare in the oPt; however, the evidence suggests that publicly-provided healthcare is more prominent in the Gaza Strip than in the West Bank and that private healthcare in the latter is more developed than in the former.

There was good and almost universal access to preventive, maternal and childhood healthcare interventions, and a predominant reliance on the publicly-provided healthcare services of the MoH and UNRWA in accessing these interventions between 1996 and 2020. Similar to the good access to preventive healthcare, the

access to other aspects of healthcare services seemed to be adequate in 1996 and 2003, and financial difficulties or the unavailability of services prevented only a small proportion of those who encountered acute illnesses from accessing treatment in 1996. This adequate access to healthcare services can be attributed to the relatively good and improving coverage of the incomplete and fragmented healthcare observed at two points of time, in 1996 and 2003. The availability of multiple health providers and coverage within a mixed healthcare system enables Gazans to seek treatment and healthcare from multiple healthcare providers, both public and private. Their choice of provider is influenced by a variety of factors, including their socioeconomic conditions. However, the socioeconomic inequity of access to healthcare in the Gaza Strip is less pronounced than in the West Bank. Despite the reported good access to healthcare, there are several different barriers that impede this access. Some of these barriers are related to Gaza's particular political context, including the frequent Israeli military assaults and the protracted blockade.

The most comprehensive survey data related to access is that which has tackled access to preventive services. This covers the whole period that followed the establishment of the PA in 1994. However, there is no information covering the preceding period. The data indicates that there is good access to preventive interventions and reliance on the public healthcare provided by the MoH and UNRWA. However, the data from these surveys, similar to other demographic and health surveys in low-income and middle-income countries, cannot provide an adequate picture of the categories of healthcare providers that deliver most of the healthcare services in the healthcare system as whole. Indeed, McPake and Hanson (2016) questioned whether the pattern of the public-private mix in healthcare, which is regularly described on the basis of these surveys, can be relied on to describe the pattern of public-private provision in the health sector as a whole. In his framework to assess health services delivery and coverage, Tanahashi (1978) portrays a ladder that spans from the targeted population towards effective coverage, which is achieved when people receive satisfactory services. Besides the lack of a full historical perspective on the access to, and coverage of healthcare services, the materials reviewed barely addressed how the healthcare accessed met Gazans' needs and expectations.

Patients who accessed treatment outside the Gaza Strip were burdened by high levels of out-of-pocket payments. They relied on financial assistance to overcome the high costs of seeking healthcare. Other adaptive mechanisms to overcome the financial burden of seeking healthcare included foregoing treatment, and using traditional healing methods. The pro-rich character of out-of-pocket payments in the Gaza Strip was less pronounced than in the West Bank. This is analogous to the finding that the socioeconomic inequity of access to healthcare in the Gaza Strip was less pronounced than in the West Bank. This lower level of inequity in the Gaza Strip compared with the West Bank may be attributed to the predominance of refugees who are entitled to UNRWA services in the former than in the latter. It was noted that refugees sometimes have better access to health services if there is a strong international relief response, and their health may improve as a consequence of their displacement and therefore their access to healthcare services provided by externally-funded international bodies, including UN agencies (Bornemisza et al., 2010). In addition to the possible effect of the prominent role of UNRWA PHC services in the Gaza Strip in provoking less inequity compared to the West Bank, the tiny size of the Strip can contribute to better access to healthcare for Gazans. The levels of out-of-pocket payments and their share of total household expenditure in the Gaza Strip are low compared to in the West Bank; and out-of-pocket payments and their share of total expenditure among worse-off Gazans are lower than among more advantaged Gazans.

Notwithstanding the availability of some knowledge about out-of-pocket payments on health-related products and services, there is no study that addresses financial catastrophes and impoverishment resulting from household expenditure on health-related products and services.

2.5 Conclusions

The current state of the knowledge on the organization of healthcare, access to health-related products and services, and out-of-pocket payments was identified through a systematic search, and the findings of this search were detailed and discussed in this review chapter. It has enriched the sketch that I portrayed in chapter 1 about knowledge about healthcare in the Gaza Strip. This review confirms that there is a serious gap in the knowledge about the catastrophic and impoverishing out-of-pocket

payments for health-related products and services in the Gaza Strip. It generally supports my suggestion that there is some knowledge on access to healthcare services in the Gaza Strip; it augments the knowledge that I reported in chapter 1; and it confirms the piecemeal nature of this knowledge and its lack of a full historical perspective. Furthermore, the information synthesized in this review about access to healthcare has identified certain gaps in the literature about the effectiveness of healthcare in meeting the needs and expectations of the targeted population. Finally, the review confirms the mixed nature of the healthcare delivery system in the Gaza Strip, presents some knowledge about the availability of health-related products and services, and emphasizes the inadequacy of studies about the public-private mix of healthcare and how this mix has evolved.

Accordingly, in the next chapter, I will provide more detail on the research questions presented in chapter 1, in order to explore (i) the scale, the composition, and the catastrophic and impoverishing burden of out-of-pocket payments on health-related products and services; (ii) the experience of Gazans accessing and paying for healthcare, especially after the start of the first Intifada in 1987; and (iii) the evolutionary trajectory of the development of the public-private dichotomy of healthcare in the Gaza Strip. In the next chapter I will also present the conceptual and methodological aspects of addressing these research questions.

Chapter 3

Research Design

3.1 Introduction

In this chapter, I will present the research design of my thesis and provide a reflexive account of my position as the researcher and my background.

After stating the main objective of the research reported in this thesis and detailing its research questions, I will present the epistemology and ontology of my research, and will discuss Critical Realism as the overarching research paradigm used in this research project. I will then provide accounts of my reflexivity, including a detailed account of my positionality. Subsequently, I will discuss my methodological approach and present the methods used in gathering the information and data to address the three overarching research questions.

I will present the details of the data sources used to address each research question, provide reflexive and replicable accounts of the data collection, give details of the data management, and provide accounts of the relevant data analysis. Before proceeding to a brief conclusion, I will summarize the ethical considerations taken throughout the research project, and I will conclude with some critical reflections on the limitations of the study design.

3.2 Research objective and research questions

The main objective of this research project is to investigate changes in healthcare in the Gaza Strip following changes in the way Gaza and its population were dealt with following the start of the first Palestinian Intifada in 1987. This objective is pursued through an increased understanding of the possible changes in: (i) the ability of the healthcare system to protect the people, and different groups of them, from the financial burden of accessing and using healthcare; (ii) the experiences of individuals and households of interacting with the healthcare system, in terms of their choice of health providers and entitlement to healthcare, the quality of the care they received, and the barriers, including social and financial barriers, which they encountered when seeking care or treatment; and (iii) the development of both private and public

healthcare and their mix and intersections, and the changes in entitlement to healthcare.

The overarching research questions and the subsidiary research questions that correspond to each of these research objectives are:

- (i) What changes were there in the ability of the local healthcare system in the Gaza Strip to protect the population and its different socioeconomic groups from the magnitude and burden of out-of-pocket payments on healthcare during the period from 1996 to 2017?

This research question will be addressed by posing the following subsidiary research questions:

- a- *What changes were there in the monetary value of out-of-pocket payments for healthcare among households?*
 - b- *What changes were there in the proportion of household out-of-pocket payments for healthcare as a share of households' financial resources?*
 - c- *What changes were there in the proportion of expenditure on components (i.e. payments on pharmaceuticals, out-patient care, and in-patient care) as shares of household out-of-pocket payments?*
 - d- *What changes were there in the catastrophic effects of out-of-pocket payments for healthcare among households, analysed by socioeconomic group, during the study period?*
 - e- *What were the effects of out-of-pocket payments for healthcare on poverty in households?*
- (ii) What changes were there in the experience of Palestinians in the Gaza Strip in regard to accessing and paying for healthcare, especially after the start of the first Palestinian Intifada in 1987?

This second main research question will be addressed by posing the following subsidiary research questions:

- a- *What changes were there in the barriers, including financial and social barriers, to accessing healthcare after the start of the first Palestinian Intifada in 1987?*
- b- *What are the adaptive mechanisms that are used by individuals and households to overcome the barriers to accessing healthcare?*

c- *What is the pattern for choosing healthcare providers and what changes were there in this pattern after the start of the first Palestinian Intifada?*

(iii) How did the conflict, policies, actions and inactions, and contextual factors affecting the healthcare system impact on the development of the public-private- mix of healthcare services and their intersection, and on changes in the entitlement to healthcare services?

3.3 Critical Realism

My research project is informed by the philosophical approach of Critical Realism, which evolved from the writings of Bhaskar (1978). Critical Realism is compatible with my values and personal beliefs. In this thesis, I explore complex issues related to health policy and health systems and I was inspired by Mixed Methods Research in designing the empirical research on which the thesis is based. Critical Realism is seen by Gilson (2012, p.35) as the stand point of health policy and health systems research. The emergence of Critical Realism was seen as a positive step for complexity theory (Reed & Harvey, 1992), and is considered to have made a particular contribution to Mixed Methods Research (Tashakkori and Teddlie, 2010, pp.145-169).

Reality, according to Critical Realism, consists not only of events that are experienced but also of events that occur independently of our experience, and of the structures and mechanisms that produce the events (Blaikie, 2009:101). Critical Realism distinguishes between the real, the actual and the empirical worlds (Sayer, 2000, pp.10-11). While the main concern of Critical Realism is the being, i.e. the ontology, it takes a relatively tolerant stance towards epistemology (Ibid, p 32). Epistemology, which is “a way of understanding and explaining how we know what we know” (Crotty, 1998, p.3), is considered by Crotty (Ibid, pp.10-11) to be the starting point for research design. I adopt the epistemology of social constructionism, which is compatible with realism (Crotty, 1998, p.11). Critical Realism accepts ‘weak’ social constructionism, which considers that truth and meaning are socially constructed, but does not accept ‘strong’ social constructionism (Sayer, 2000, p.60). Weak constructionism, according to advocates of Critical Realism, merely emphasizes the

socially constructed nature of knowledge and institutions, but strong constructionism claims that objects or referents of knowledge are nothing more than social constructions (Sayer, 2000, p.90). Accordingly, proponents of Critical Realism suggest that objective realities exist, but cannot be directly known; instead, they suggest that to describe the objective world, people must engage in interpreting this world. Hence, Critical Realism combines the objectivity of a realist ontology with the subjectivity of critical epistemology.

3.4 Reflections on the influence of my position on the research project

Reflexivity is an important concept for health systems research, and health systems researchers need to think carefully about their positionality (MacGregor and Bloom, 2016). Reflexivity in research is an ongoing reflection of the self, the process, and representation, and entails critically examining power relations and politics in the research process, and the researcher's accountability in the data collection and interpretation (Sultana, 2007). A reflexive research process can bring more nuanced understandings of issues, where the boundaries between the process and content are fuzzy (Sultana, 2007). Reflexivity has two aspects: personal and epistemological. Personal reflexivity focuses on the positionality and the specific nature of the researcher, while the epistemological reflexivity emphasizes the ways in which the research questions could define or limit the research outcomes and could also strengthen the validity of the research.

The relative subjectivity and interpretative nature of the constructionist epistemology that I have adopted require detailing aspects of reflexivity, including being explicit about my position as the researcher and detailing the possible influence of my knowledge and approach towards knowledge of the research project as a whole. I will present my positionality to shed light on any possible effects of my personality, nationality, social position, or experience on the research process and interpretation of the findings, as the researcher's personal and cultural background, and attitude and relationships towards the researched group, influence the research process and findings (Agar, 1996, p. 91).

I am a Palestinian man. I was born and raised in Gaza, and I have spent most of my life there. Additionally, I practised as a medical clinician there for 24 years, including 13 years of involvement in public health practice and health services

research. This background is sufficient to qualify me as an 'insider'. Placing me on only on one side of the insider-outsider dichotomy might oversimplify my position and personal background (DeLyser, 2001). Every person who lives in his own community has his own individual experience, background, and viewpoints, and I am no exception.

I was raised in a lower middle class family. Besides my social location and background, my position is also defined by my social and political beliefs and values. Since early adolescence, I have been influenced and inspired by the emancipatory appeal of socialism. A few months after starting my studies in the USSR, I joined the Palestinian Communist Party at the age of 18. The Palestinian Communist Party is a tiny leftist faction that adopted the political views of the Soviet Union about the Palestinian-Israeli conflict. Unlike all of the other Palestinian factions, the Palestinian Communist Party was reluctant to adopt the armed struggle against Israel and more inclined towards a political settlement of the conflict. Being a member of a party that originated from a party initially established by Jewish immigrants to Palestine contributed to shaping my views towards the Israeli-Palestinian conflict, and towards the emancipation of Palestinians, especially the disadvantaged groups among them. My initial ideological background has been influenced and challenged by my experience and this has led me towards continuously revising my beliefs, changing my affiliations, and refusing fixed-ideologies. However, I have retained my attachment to human emancipation and social justice.

Like most Palestinians in Gaza, I and my family have been subject to harsh Israeli measures. I and my family members were interrogated and harassed, and my brother was arrested for five years by the Israeli military authorities for throwing stones and Molotov when he was 16 years old.

Like all Palestinians in Gaza, I have lived under the Israeli occupation and control. I have crossed the crossing point between Gaza and Israel several times and was stripped searched once. I survived three major Israeli assaults on Gaza in the winter of 2008-2009, in November 2012, and in the summer of 2014. From 3-17 January 2009, the Israeli tanks were just a few hundred metres from my flat. I survived with my family despite having little water and food, no electricity or the internet, but with bullets and white phosphorous instead.

My politics concern not only the Israeli-Palestinian conflict and my socialist beliefs, but also internal Palestinian affairs. I participated very actively against the corruption of the Palestinian Authority government but was never physically or emotionally harassed by it. When it comes to Hamas (Gaza's Government), even minor whispers or latent words result in interrogation and threats. Eventually, I sought asylum and was granted refugee status in the UK in 2019.

I have worked in Gaza with all of the providers of healthcare, except private for-profit healthcare. My experience with the healthcare there was not limited to the providers of services, but also as a user of them. I used them as I am diabetic and hypertensive. Also, when my family members were sick, I escorted them, in particular since 1984, when my late brother started haemodialysis. This background as a provider and as a recipient of healthcare in Gaza led me to experience some of the negative aspects of the healthcare system. My experience led me to concur with a statement made by the editor of the Lancet that "the unfortunate reality is that health remains neglected by all those who have a role in shaping the future" of this occupied territory (Horton, 2010).

Besides the above, I bring to my doctoral research my previous experience in researching the use of, and payment for healthcare in the Gaza Strip. My knowledge about the use of, and payment for healthcare in Gaza may have increased my subjectivity as a researcher.

As a Palestinian who was born and lived most of his life in the Gaza Strip – and having spent over 20 years as a medical and public health practitioner - it was impossible to be a "detached observer" (Blaikie, 2009, p51) during the research process, including during the fieldwork in Gaza. Although I am in favour of the emancipation of people in Gaza, I tried to avoid being a "reflective partner", the stance associated with Critical Theory (Ibid, p.52), but not Critical Realism; but I am sure that I was not fully successful. Therefore, I think that I acted somewhere between a "reflective partner" and a "faithful reporter" (Ibid, p.51).

During the research process I was influenced by my own subjectivity, personal background, and professional and research experience, which have shaped my beliefs and political background. These influences shaped the nature of my enquiry, my choice of methods, and, to a lesser extent, my interpretations of the findings. I endeavoured to recognize the interpretative nature of my approach, made efforts to be open-minded and interrogate my views, and attempted to support and challenge

my interpretations by fully presenting the information and data that I gathered in all of its confusing and contradictory detail, while pursuing an analysis that best fits this detail.

It could be argued that this type of critical self-evaluation might result in navel-gazing and being self-indulgent. But such self-awareness can also contribute to the transparency of the research process, knowledge production and interpretation of the knowledge produced, and allows for a reflection on “how one is inserted in grids of power relations and how that influences methods, interpretations, and knowledge production” (Sultana 2007). While my prior knowledge and background helped this research, especially with regard to the data and documentary access, the research itself continually influenced me as a researcher and challenged my knowledge and thoughts.

3.5 Methodology

I use Mixed Methods Research (MMR) in this research project to address the three overarching research questions. The MMR design is considered to be superior to single approach designs due to its potential to simultaneously address a range of confirmatory and exploratory research questions with both qualitative and quantitative approaches (Teddle and Tashakkori, 2009, p.37). MMR can additionally provide stronger inference, and offers the opportunity to incorporate divergent views (Ibid, p.37). The methodology of MMR provides strengths that offset the weaknesses of both quantitative and qualitative research (Creswell and Plano Clark, 2006, p. 9).

The Mixed Methods methodology that I used in this research project combines three strands. These three strands address the three research questions. In the first strand, which addresses the first overarching research question, I used quantitative data from the 11 rounds of the Palestinian Expenditure and Consumption Survey (PECS). These rounds of the PECS were collected and collated by the PCBS annually in 1996-1998; then, in 2004-2007; subsequently, in 2009-2011; and finally in 2017. I address the second research question by using qualitative data that I collected in the Gaza Strip between September 2016 and September 2017. These data were collected by interviewing 33 householders living in 29 households. These interviews were inspired by the Life-history approach and were designed to capture individual and

household experiences with the healthcare delivery system after the start of the first Palestinian Intifada in 1987. I address the third research question by reviewing documents, reports and literature that tackle healthcare in the Gaza Strip even before its emergence as a recognized geopolitical entity in 1948. I complement and corroborate this review with interviews I carried out in Gaza with 17 key-informants who have worked within healthcare and who have been engaged in health policy development and in health policy implementation in the Gaza Strip.

The research questions in this project and its three research strands are related to each other in different ways. The three research questions and the corresponding strands address changes in healthcare at three levels. The first question, and therefore the first strand, addresses changes at the macro (societal) level; the second, at the individual and household (micro) levels; and the third at the level of health systems and policies, i.e. at a meso-level of research inquiry.

Although MMR can employ a multilevel design, the micro and meso levels of inquiry should be nested within the wider macro level of research. The multilevel MMR is only possible in hierarchically structured social organizations, such as hospitals or schools, in which one level of analysis is nested within another, for example when patients are within wards and wards are within a hospital (Teddlie and Tashakkori, 2009, pp.127-128). In my research, the three different levels of design, i.e. the three strands of my research, are not nested within each other. Having more than one type of collected data, i.e. qualitative and quantitative, without, or with little integration of the findings and inferences, suggests that my research could be described as quasi-mixed methods (Teddlie & Tashakkori, 2006). Research is only truly MMR if there is an integration of the approaches across all stages of the study, while Quasi-Mixed Methods Research designs are those in which two types of data are collected, but with little or no integration of the findings and inferences (Teddlie and Tashakkori, 2009, pp. 127-128).

Accordingly, in this thesis, I present all aspects of the information and data generation, the findings and their interpretations, and the discussion and inferences gained from each strand of my research project separately. I then provide in the Discussion of this thesis (Chapter 7) my reflections on the implications of the

inferences and conclusions gained from each strand for the other strands of the research project.

Despite the growing interest in and use of the MMR design, the quasi design is rarely mentioned in the literature and in the textbooks on MMR. There are very limited descriptions of the difference between the quasi-mixed design and the true MMR design (Teddlie and Tashakkori, 2006; Teddlie and Tashakkori, 2009, pp. 127-128). To the best of my limited knowledge, only the textbooks on mixed methods authored by Plano Clark and Ivankova (2016) and edited by Creamer (2018), and the SAGE Handbook of Applied Social Research Methods edited by Bickman and Rog (2013) provide some accounts about this design. However, the quasi design has been widely used. Nearly half (45%) of the mixed methods published research studies in social and behavioural sciences reviewed by Alise and Teddlie (2010) were deemed by them to have used a quasi-mixed design.

I employ throughout the quasi-mixed design of this project an inductive research strategies. Inductive research strategy is well suited for exploratory and descriptive research questions (Blaikie, 2009, pp.83-85). The research questions of project, which are detailed in section 3-1 of this chapter, are mainly exploratory; but there is a desire to understand how each of the results of the three main research questions contribute to each other. Therefore, I suggest that although the overarching research strategy of this research is initially inductive, it has elements of retroductive research strategy, whereby an explanation is achieved by locating the real underlying structure or mechanisms responsible for producing regularity, identifying the context in which this regularity happens, and using creative imagination and analogy from the data to the explanation (Blaikie, 2009, p.9; Blaikie, 2007, pp. 9-10).

3.6 Methods for Addressing Research Questions

As indicated above, I address the three main research questions by using three different methods. The first question in this research project is addressed using a secondary analysis of quantitative data from the PECS. The second question is addressed using qualitative interviews, which I carried out in the Gaza Strip between September 2016 and September 2017. The third research question is addressed by reviewing documents, reports and literature; and I complement and corroborate this

review with the interviews that I conducted with 17 key informants in the Gaza Strip in August and September 2017.

I started tentatively analysing the data from the first 10 rounds of the PECS (1996-2011) in March 2016, when I obtained them from the PCBS. I drafted the first preliminary report on my findings regarding out-of-pocket payments in March 2017.¹² Hence, the methods used to address the three research questions were mainly sequential. In the following section of this chapter I present these methods in the order in which the research questions are presented.

I present the methods separately to achieve some clarity, to respect the fact that there is no integration of the analysis, and to allow possible elaboration on all aspects of these methods, including the data sources, collation and management, and analysis. My intention, through providing as much detail as I can regarding all aspects of the methods, is to achieve transparency and to secure as much as possible repeatability and replicability of the methods used and of the research process.

Spellman (2015) calls for replicable research and considers that omitting details about methods is a source of non-replicability. I agree with Spellman (2015) that there is a need to change the way in which scientists conduct, analyse and share their research. Research should be repeatable in the same context or in other contexts, so it is desirable to have as much detail as possible about research processes and methods. However, it appears to me that it is difficult from the social constructivist perspective to have the same results. It has been acknowledged that a number of supposedly robust findings of clinical trials are not replicable, and that this lack of replicability is much more prevalent in the social sciences (Norman, 2017). In the following subsections, my aim is that the readers will be able to understand what was done in enough detail and that my work will be reasonably replicable.

3.6.1 Change in out-of-pocket-payments (1996-2017)

The first strand of my research involved attempting to assess changes in out-of-pocket payments for health-related products and services through secondary analysis of the Palestinian Expenditure and Consumption Survey (PECS). Secondary data analysis is the analysis of data or information that was either gathered by someone else or for

¹² I commenced the full data analysis of the PECS data only after obtaining the 11 rounds of the survey data at the end of 2018.

some other purpose, and often a combination of both. Below I provide a descriptive account of the data source, based on information provided by the PCBS, and I highlight the possible limitations of the data. I then provide details of the data management and outlines of the data analysis, which will be detailed in chapter 4. When presenting the data management and analysis, I present some choices made in the data management and analysis and I attempt to justify these choices.

3.6.1.1 Data Source

The data source for identifying possible changes in out-of-pocket payments on healthcare was the PECS, which was carried out by the PCBS to provide indicators of the living standards in the occupied Palestinian territories (oPt) [i.e. *the West Bank, including east Jerusalem, and the Gaza Strip*]. It was first carried out between October 1995 and the end of September 1996. The survey was then conducted from January 1997 until the end of that year, and subsequently during the 1998 calendar year. The regularity of the survey was interrupted until January 2004, when it was resumed yearly for a full calendar year until the end of 2007. It was then resumed for three subsequent years in 2009, 2010 and 2011, from January until the end of the year, and was interrupted until the last round, which was conducted from October 2016 to September 2017. Hence, the PECS is a repeated cross-sectional study.

The PECS targeted all Palestinian households residing in the oPt during the fieldwork operations. It used a two-stage, stratified design, whereby a sample of *cells* was selected at the first stage from the PCBS master sample frame; then, a sample of *households* was selected at the second stage. Stratification was applied at four levels: the first level was by district; the second by place of residence (i.e. towns and city which have municipalities, villages, and refugee camps); the third by locality size; and the final by cell identification, in that order.

The response rate ranged between 94.3% in 1996 and 71.4% in 2017 for the whole oPt, and the number of households that participated in the survey in the Gaza Strip ranged between 396 in 2007 and 1335 in 1996. Table 3-1 summarizes the number of participants and available response rates for the 11 rounds of the PECS.

Table 3-1: Sample size and response rates for the 11 rounds of the Palestinian Expenditure and Consumption Survey (PECS) between 1996 and 2017.

Year	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017	Total
Source of Information	(PCBS, 1997)	(PCBS, 1998)	(PCBS, 1999)	(PCBS, 2005)	(PCBS, 2006 c)	(PCBS, 2007 b)	(PCBS, 2008)	(PCBS, 2010)	(PCBS, 2011)	(PCBS, 2012)	(PCBS, 2018)	
Number of Households responded to the Survey and Response Rate												
West Bank	3212 (92.03%)	2279	1965	1934	1401	853	835	2654 (85.5%)	2575 (82.4%)	2909	2897	23514
Gaza Strip	1335 (95.15%)	991	886	1164	751	428	396	1194 (67%)	1182 (81.6%)	1408	842	10577
Total (oPt)	4547 (94.3%)	3270	2851	3098	2152 (77.5%)	1281 (79.3%)	1231 (71.8%)	3848 (79.6%)	3757 (82.1%)	4317 (88%)	3739 (71.4%)	34091

The data from the PECS were consistently weighted in the same way. The weight of the sampling (Statistical) unit was defined as the mathematical inverse of the selection probability. The weight of the enumeration areas was calculated in the first stage based on the probability of sampling each enumeration area selected. The weight of households in each enumeration area was calculated in the second stage, and the initial household weights resulted from the product of the weight of the first stage and the weight of the second stage.

Data Collection:

Each household was provided with a record book (diary) to record their daily expenditure over a period of one month. The different versions of the PECS questionnaire were designed according to **the United Nations / International Labour Organization (UN/ILO)** recommendations for Household Budget Surveys according to the concept of the National Accounts System 1993 (SNA, 93) and other changes based on the **Classification Of Individual Consumption by Purpose (COICOP)** system. This questionnaire inquired about the demographic and socioeconomic characteristics of household members and a list of goods, possessions and belongings available to each household. It also asked detailed questions about the income, consumption and expenditure, including spending on health-related products and services, of all household members. The individual and household characteristics documented through the questionnaire were comparable across all PECS rounds, except for some variables that were introduced in the most recent rounds of the survey. These new variables were the refugee status of the head of the household, the residential place (rural, urban or refugee camp) of the household, possession of a mobile phone, and access to Wi-Fi. Similarly, the consumption and expenditure items and groups were consistent across the different years as they were dependent on the COICOP system and SNA, 93.

Data limitations and weaknesses

The data in the PECS has some weaknesses and limitations. Some of these limitations are related to household surveys and to the cross-sectional study design, which cannot establish a cause and effect relationship (Aschengrau and Seage, 2003, p.153). Other limitations are related to household budget surveys, as these surveys do not include data about the use of healthcare.

Some other limitations of the PECS data are related to the diary approach used to capture household expenditure and consumption on different items. The advantage of the diary approach is that it reduces bias as the household members document their consumption or expenditure at the time when it is occurring, but it also has certain disadvantages. This approach presumes that household members, or at least the person who documents the expenditure and consumption has a relatively high degree of literacy, as it requires the documentation of all daily expenses for a period of one month. This disadvantage should not be exaggerated as there is a high level of literacy in the Gaza Strip. There are also problems in defining the consumption and expenditure items as it is not clear how to report individual expenditure items, e.g. meals outside the household and other individual consumption and expenditure. Additionally, reporting and documenting the financial costs of items, especially those items that are frequently consumed, can lead to “diary exhaustion”.

4.6.1.2 Data Management and Analysis

The management of the PECS data entailed laborious and lengthy work. This can be attributed to the segmentation of the data into 11 datasets, whereby each set of data consists of separate SPSS files. The total number of SPSS files supplied by the PCBS was 67. Additionally, the laborious and lengthy work was attributed to the multiplicity of the variables that needed to be recoded or reclassified.

The first step in the data operationalization entailed merging the relevant SPSS files for each round of the PECS. The merging of the SPSS data files was done on the basis of the household identification number, and every merged data file was given a name and a variable that identified the PECS round year. The two main variables that were needed to identify out-of-pocket payments on health-related products and services and their catastrophic and impoverishing burden were the amount of household expenditure on health-related products and the level of financial resources available to the household, expressed in income, expenditure, or consumption. The amount of the first, i.e. household expenditure on health-related products and services, was identified through the summation of all items spent on these products and services (items 3301-3328). Household consumption was used as a proxy measure to assess and measure the financial resources available to households. Consumption is the preferred indicator to measure poverty in developing countries, as it is assumed to be

less volatile than income and is thus seen as a better measure of living standards (WB Group, 2015, p.6). Practically, consumption is more easily and accurately measured than income particularly in countries with a low level of participation in the formal labour market (Ibid). Accordingly, household consumption was identified through summing all of the consumption groups and items. After creating a numeric variable that captured household consumption, I created a categorical variable that classified each household according to the consumption quintiles, and given that consumption differs across survey years, this was applied to each round separately. The identification of household out-of-pocket payments on health-related products and services (OOPP), household consumption, and the household consumption quintiles enabled me to carry out an analysis of the changes in OOPP and the share of OOPP as a proportion of households' total consumption, and subsequently to adjust these to inflation, as detailed in chapter 4.

To address the change in OOPP, I carried out an analysis of the change in their components over the studied period, from 1996 to 2017. The UN Department of Economic and Social Affairs (DESA) - Statistical Division (SD) - has consistently broadly classified household spending on health-related products and services, in different revisions of COICOP, into three main categories: (i) Medical products, including medicines, appliances and equipment, (ii) outpatient care services, and (iii) inpatient (hospital) care (DESA - SD, 2000; DESA - SD, 2018). Accordingly, I created three numeric variables that captured household spending on three main components of OOPP, through summing the spending items related to these components. Subsequently, I created three numeric variable to capture the proportion of each component as a share of total household OOPP. Similarly, I divided the OOPP on medical products, appliances and equipment into two subcomponents, and the OOPP on outpatient care into four subcomponents, as will be detailed in chapter 4.

Household OOPPs are considered catastrophic when they constitute a large proportion of household resources, expressed either in terms of their income, expenditure, consumption or capacity to pay. A catastrophic OOPP leads households to have their financial conditions and wellbeing disturbed. There are several approaches and thresholds through which to identify and to estimate Catastrophic Health Expenditure (CHE). Several empirical studies have used the proportion of household OOPP as a share of household budget, expressed in income, expenditure,

or consumption as the basis for the identification and estimation of CHE. A known example of these studies is the work of Wagstaff and van Doorslaer (2003) in the Vietnamese context. These studies adopted the Budget Share Approach and used different thresholds. Besides the Budget Share Approach, there are other approaches that can be used to identify and estimate CHE. One approach that is prominent among them is based on the household's capacity to pay (CTP), which accounts for spending on essential items and assumes that household resources, expressed either in income or in consumption expenditure, are available for health expenditure only after spending on essential items. A common method that uses the CTP approach to assess CHE is that adopted by Xu et al. (2003) to account for non-food expenditure. The method used by Xu et al. (2003) has been adopted for a long time by the WHO due to it being more relevant for developing countries, especially Low and Middle Income Countries (LMIC). The denominator used by Xu et al. (2003) is the household expenditure net of a standard amount, which represents subsistence food spending for households that are above the subsistence level, or the household expenditure net of the actual food spending for households that are below the subsistence level. Another CTP approach is the methodology used by the Pan American Health Organization (PAHO) and the WB, whereby the denominator is the total household expenditure net of actual food expenditure (Cylus et al., 2018). Additionally, the WHO office in the European Region has used a CTP approach that accounts for housing and utilities' costs alongside food costs in identifying the household resources available for OOPP (Ibid). Additionally, Wagstaff and Eozenou (2014) proposed a unified methodology in which impoverishing and catastrophic payments are mutually exclusive outcomes.

The WHO and International Bank for Reconstruction and Development / The WB (2017) have chosen the Budget Share Approach as the basis for calculating CHE, and have identified two thresholds to monitor the progress towards UHC. These thresholds have OOPPs of 10% and 25% of household consumption expenditure. The Budget Share Approach tends to be easy in terms of its calculation and communication (WHO and WB, 2017). Therefore, I use the budget share approach, and the lower threshold, i.e. 10% of the household budget, to estimate CHE. I rely on and use the lower threshold based on the expectation that a higher number of households will have incurred catastrophic health expenditure. Having a bigger number was judged to be beneficial for the statistical analysis, especially for fitting models of logistic regression.

Additionally, the use of one threshold will not prevent me from comparing the results of my analysis on the Gaza Strip with other settings and contexts.

Based on the two numeric variables available that capture the total household consumption and OOPPs incurred by the household, I created another numeric variable to capture the proportion of OOPPs as a share of consumption. This was done by dividing the former by the latter. According to the value of the proportion of OOPPs as a share of consumption, I created a dummy variable, which was necessary for the calculation of CHE. If the share of OOPP equals or exceeds 10% of household consumption, number one (1) was assigned to the dummy variable; otherwise, zero (0) was assigned. This dummy variable is very crucial for the calculation of CHE, as I will demonstrate in chapter 4, and is used as the dependent variable for carrying out the logistic regression analysis.

The burden of households' OOPP is felt markedly when households and individuals are pushed into poverty as a result of payments for healthcare. The effect of the OOPP on poverty is estimated through calculating the number of people who fell into poverty with and without the OOPP. Accordingly, I created two dummy variables. The first dummy variable concerned poverty before incurring OOPP. If the household consumption was below the International Poverty Line (IPL), I assigned one (1) to the variable; otherwise, I assigned zero (0). The second dummy variable concerned poverty after incurring OOPP, whereby I assigned one (1) to the variable if the consumption net of OOPP¹³ was below the IPL; otherwise, I assigned zero (0). These two dummy variables were used to calculate the gross and net poverty indices, which are detailed in chapter 4. In addition to these two dummy variables, I created a third dummy variable, which was used as a dependent variable to assess through logistic regression the correlates and the determinants of the impacts of OOPP on poverty. The third dummy variable took the value of one (1) if poverty resulted from OOPP; otherwise, it took the value of zero (0).

I recoded also the independent variables needed to carry out the logistic regression. As far as the main aim of the logistic regression was to confirm the

¹³ The OOPPs do not include in general the premiums for health insurance; however, they entail adding these premiums when they are used to assess their impact on poverty (Mataria et al., 2010).

regularities found in the catastrophic and impoverishing OOPP in terms of a change over the years, I created an independent categorical variable that captured each of the 11 rounds of the PECS. Additionally, I identified other correlates of the occurrences of catastrophic and impoverishing OOPP based on the literature, the particularities of the Gaza Strip, and a literature review by Azzani et al. (2019) on the determinants of catastrophic health expenditure. The operationalization of these correlates entailed recoding the numeric variables into categorical variables, and reclassifying the variable from the file that contained individual characteristics of the household members into a file that captured the households' characteristics. For example, payment for health insurance was recoded into a categorical nominal variable; and the characteristics of household heads were reclassified and then recoded. While no missing variables were encountered when performing different aspects of the analysis, there were some important variables that were introduced by the PCBS only after the third round of the PECS. These variables included the refugee status of the households and their place of residence. They were thought to be important correlates of incurring catastrophic and impoverishing OOPPs. Thus, I performed a separate logistic regression analysis taking them into account, and I present the results of this analysis briefly in chapter 4, which presents the results of analysing the PECS data to assess changes in OOPPs, and provides accounts of the analytical approaches used to achieve these results.

3.6.2 Change in households' experience of the healthcare delivery system

The second strand of this research project addresses the second research question through a qualitative enquiry initially inspired by the Life-history approach, which is a form of oral history that relies on qualitative interviews to document individual accounts of interviewees of their lives over a period of time (Jessee, 2019). Life-history Interviews are valued as a form of autobiographic narrative, due to their ability to amplify the voices of individual actors and provide their insights on historical events; additionally, these interviews are seen as challenging the elite power structure that used to control the production of history in many settings, to reveal the multiple truths of lived experiences, and to "democratize history" (Ibid). These traits of Life-history Interviews have made them popular in studying often veiled experiences and perceptions in many fields and settings. Paul Thompson, a notable oral historian, focused on studying the lives of working-class people (Thompson, 1975; Jessee,

2019). These interviews have also been used in conflict settings, where atrocities are common. For example, Jessee (2019) used them to study the lived experiences of genocide survivors in Rwanda and Bosnia. Life-history Interviews have also been used in health research such as mental health, (in)fertility, and socioeconomic determinants of health; but they have not been widely used in the field of health systems research (Witter et al., 2017).

However, due to their ability to capture unknown experiences during conflicts, Life-history Interviews have recently been used by health policy and systems researchers in conflict and post-conflict settings. The life histories of health workers in four countries that experienced conflict or crisis were studied and indicated that there had been mixed motivations for joining the health professions in these countries (Witter et al., 2018). Besides, studies have also addressed the experience of health workers in post-conflict countries, Life-history Interviews have also been used to investigate healthcare-seeking behaviours during times of conflict and crisis in Cambodia, Uganda, and Zimbabwe (Ros et al., 2015; Ssali et al., 2015; Ssali and Theobald, 2016; Buzuzi et al., 2016; Ros et al., 2018). The Life-history Interviews showed that patients with chronic diseases in Zimbabwe had been negatively affected by the introduction of user fees, which led to their level of healthcare utilization becoming low, the postponement of visits, and the bypassing of healthcare facilities to avoid paying consultation fees (Buzuzi et al., 2016). Research conducted in Cambodia using Life-history Interviews to understand the impacts of health-seeking experiences from 1950 onwards on the economic situation of households provided historical insights into the development of the healthcare system, showing that rudimentary western medical practices began to emerge before the conflict there but were largely inaccessible (Ros et al., 2015). They suggest that traditional medicine in Cambodia has been undergoing a process of commercialization with significant impacts on poor households (Ros et al., 2018). They indicate that impoverishments associated with health were a regular feature of Cambodian respondents' accounts across all periods, and that this impoverishment has become associated with seeking healthcare since 2000, despite the arguably pro-poor features of the healthcare schemes (Ros et al., 2015). Additionally, Life-history Interviews exploring gendered experiences during the conflict in Northern Uganda inquired about health and health-care seeking experiences during and after the conflict (Ssali and Theobald, 2016; Ssali et al., 2015). The interviewees

emphasized the importance of strategies that generate income to enable them to navigate the post-conflict Northern Ugandan healthcare system, which is characterised by poorly functioning public facilities and expensive but well facilitated private healthcare (Ssali et al., 2015). The experiences of Ugandans suggest the importance of mental health issues while re-constructing a holistic, accessible and responsive healthcare system that goes beyond a focus on physical rebuilding of the healthcare infrastructure (Ssali and Theobald, 2016).

As far as I am aware these three sets of Life-history Interviews, which were conducted in Zimbabwe, Cambodia and Northern Uganda, are the only Life-history Interviews that have addressed healthcare-seeking behaviours. The ability of Life-history Interviews to capture changes in healthcare-seeking experiences in conflict affected settings motivated me to use their approach in my qualitative inquiry.

One characteristic of Life-history Interviews is the length of the interviews, which leads to their ability to capture intimate details of individuals' lived experiences. The classic length of the life story is to have 2-3 interviews of an hour to an hour and a half each (Atkinson, 1998, p.24). I planned for my interviews to be conducted in two sessions, each of which would last approximately one and half hours. I carried out my Life-history Interviews with the first interviewee in three sessions over almost five and half hours (324 minutes). This led me to feel optimistic that I could continue in the same way but this was not the case. I met the second interviewee twice in the backyard of his house and interviewed him in two interview sessions that lasted for more than three recorded hours in total (184 minutes). I suggested having a third session. Although the second interviewee politely welcomed my suggestion, he told me that he did not have anything to add in an additional session. I encountered a similar experience with the third interviewee, whom I met once for one hour. This experience led me to recognize the difficulties of recruiting potential interviewees, especially women, who could be interviewed for a lengthy amount of time and for more than one session. All women whom I interviewed in their homes were interviewed jointly with their husbands or their elderly mothers. I subsequently planned for the interviews to take place in one session that would last for between one and two hours; and this is what happened. Although I felt "saturated" by the content of most of the interviews and by the cumulative picture drawn from the 32 interview sessions that I carried out with the interviewees, I recognize that the short length of the interviews affected the

intimacy of the details provided by the interviewees. Additionally, this short length affected how the interviews were carried out. Life-history Interviews are usually led by the interviewees, who narrate their individual stories (Jessee, 2019). I think that the opposite happened in the interviews that I conducted in the Gaza Strip. This prevented the interviews from being open-ended and they were not as in-depth as was ideally required.

In addition to the effects of the short length of the interviews on the intimacy of the details narrated by the interviewees and on the way the interviews were carried out, I think that my positionality as a health professional who has practised in the Gaza Strip had some effects on the interviewees. Although I mentioned in my un-recorded talk with the interviewees that I was aware of the inadequate performance of the healthcare system and of the many negative practices occurring in healthcare facilities, I noticed that some of them were reluctant to provide accounts of their negative experiences. I expressed empathy with the interviewees and encouraged them to narrate their negative lived experiences with healthcare, especially when I enquired about the quality of healthcare. In what follows, I provide descriptive accounts of the data collection processes, including a selection of the interviewees and how the interviews were carried out, as well as the data management and analysis.

3.6. 2.1 Data collection

The Life-history Interviews aimed to capture individual and household experiences with healthcare since the start of the first Palestinian Intifada in 1987. These experiences include healthcare seeking behaviours, provider choice, quality of healthcare, and barriers, including social and financial barriers, to accessing healthcare. A purposeful approach was used to select the interviewees. Purposive sampling is a deliberate selection of specific individuals, events, or settings because of the crucial information that they can provide, which cannot be adequately obtained through other means (Liamputtong, 2019). I targeted household heads who were at least 15 years old in 1987, i.e. at least 44 or 45 years old during the data collection in 2016 and 2017, respectively. Besides the age of the participants, I considered the variation of the interviewees, in terms of their sex, socioeconomic situation, health conditions, refugee status, and place of residence. I selected interviewees through referrals from friends, colleagues, social workers, and managers of women's activity centres. I requested that referees nominate possible interviewees who would be willing

to be interviewed and I informed them about the desired characteristics of the interviewees. The sampling of the interviewees was thus purposive, with maximum variations.

After obtaining agreement from the potential interviewees through those who had referred them, I contacted the potential interviewees by mobile, informed them about the topic and the purpose of the interviews and asked for their initial agreement to be interviewed; I also agreed with them a convenient time and place for the interview. Most of the interviews took place at the homes of the interviewees. Two interviews took place in the workshops where the interviewees worked, and another two in cafés. Additionally, recognizing that it was difficult to interview women in their houses, I contacted four women-activists and asked them to nominate women who frequented the women's activity centres as interviewees. These activists helped me to interview nine women in these centres. All of the participants met the age selection criteria, except four who were under 44 years old; I opted to be flexible and included them in my interviews. Eventually, I found it was sensible to have relatively young interviewees as older interviewees were less likely to have recent experiences of maternal and child healthcare services. I conducted 29 interviews with 33 interviewees. The number of interviews was determined by flexibility, balancing the breadth and depth of the collected data, and by the saturation. Saturation occurs when little or no new data could be generated (Liamputtong, 2019). I decided to halt recruiting new interviewees when I felt that any additional interview would only generate fewer data, if any. Out of the 33 interviewees, there were 15 women and 18 men. Three interviews were carried out with couples; one interview was carried with a single woman and her 80 year old mother; the remaining 25 interviews were carried either with female or male heads of households. 19 of the interviewees were refugees, 10 were non-refugees, and the remaining four were either refugees married to non-refugees, or non-refugees married to refugees. Non-refugees married to refugees have become entitled to UNRWA healthcare services since 2006. Nine of the interviews took place in refugee camps, and the remaining 20 outside refugee camps (12 in urban and eight in rural or semi-rural areas). The recorded time of the interviews ranged between 44 minutes and 324 minutes, with a median duration of 67 minutes and an average of 79 minutes.

Although I tried to have a diverse sample from the perspective of the financial ability of the interviewees and their households, it seems to me that most of the interviewees were either poor or from the middle class. Table 4-2- below presents the interviewees' demographic profiles, an aspect of their financial condition during the time of the interviews, and the recorded time length of the interviews.

Just before and during the recording of the interview, I attempted to establish a rapport with the interviewees through re-introducing myself and having a general discussion with the interviewees. In addition to the previous explanation I had given them on the phone, I explained to the interviewees the subject of the interview again, assured them of their anonymity and the confidentiality of the content of the interviews, and recorded their consent. I carried out the interviews with the help of an open-topic interview guide (Annex III-I). At the beginning of the audio-recorded interviews and after obtaining their consent (Annex III-II a and b), I asked them about their backgrounds. Then, I enquired chronologically about common and serious recallable illnesses that they had encountered individually during their childhood, adolescence, and before getting married. I asked them about their own, or their wives' healthcare experiences with pregnancy and childbirth, and early childhood illnesses for each of their children. I specifically asked about the providers of antenatal care, and care during childbirth, and childcare; how they perceived the quality of care and the financial and social barriers to receiving healthcare. As I progressed in my inquiries I asked them about their assessment of possible change in the pattern of healthcare they sought for these health-related conditions, and possible changes in their livelihoods and financial conditions over their life course. I also discussed with the interviewees the impact of changes in the household financial conditions on their choice of healthcare providers, and the effects of health conditions and of seeking treatment on their financial conditions.

Additionally, I enquired about the possible development of common or serious ailments that they or their household members might have had over their lives, how they sought care and treatment for these ailments, what barriers they had encountered, and how they overcame them. I recognized that the interviewees could

Table 3-2: Characteristics of interviewees and duration of recorded interviews.

SN	Pseudonym	Age	Gender	Refugee Status	Place of Residence	Governorate	Number of household members	Financial Aid from MoSA	Recorded Interview in minutes
1	Fadya	48	Woman	Refugee	RC	Rafah	16	Yes	71
2	Shurbasi	49	Man	Refugee	RC	Middle	7	Yes	82
3	Shaer	51	Man	Refugee	RC	Rafah	7	Yes	59
4	Abou Imad	71	Man	NRMR	Urban	Gaza	12	No	68
5	Khadija	46	Woman	NR	Rural	Khan Younis	10	No	64
6	Sameeha	64	Woman	RMNR	Rural	Khan Younis	12	Yes	65
7	Najeya	55	Woman	Refugee	Urban	Rafah	9	No	70
8	Thaer	51	Man	Refugee	Urban	Gaza	9	No	58
9	Ghatas	45	Man	Refugee	Rural	Khan Younis	9	No	98
10	Abou Taleb	54	Man	Refugee	RC	Middle	9	No	61
11	Hasina	64	Woman	NRMR	RC	Gaza		Yes	68
12	Zaghlool	50	Man	Refugee	RC	North	7	No	102
13	Samara	48	Woman	Refugee					
14	Samer	54	Man	Refugee	RC	Middle	7	No	70
15	Halima	71	Woman	Refugee	Urban	Gaza	11	Yes	49
16	Majdeya	69	Woman	NRMR	Urban	Gaza	6	Yes	59
17	Shameya	57	Woman	Refugee	Urban	Gaza	6	No	47
18	Abou Ghali	70	Man	refugee	Urban	Khan Younis	12	yes	
19	Hisham	54	Man	NR	Urban	Gaza	10	No	184
20	Saida	64	Woman	NR	Urban	Gaza	10	Yes	51
21	Ismail	54	Man	Refugee	Rural	North	9	No	42
22	Salma	36	Woman	Refugee					
23	Salam	34	Man	NR	Rural	Khan Younis	5	Yes	67
24	Harb	60	Man	NR					
25	Rahma		Woman	Refugee	RC	Middle	10	No	74

26	Zaid	52	Man	NR	Rural	North	10	No	60
27	Rantisi	43	Man	Refugee	Urban	Khan Younis	4	yes	110
28	Khalil	51	Man	Refugee	RC	North	11	No	324
29	Sameera	42	Woman	NR	Rural	Khan Younis	5	Yes	72
30	Madiha	60	Woman	NR	Rural	Khan Younis	3	Yes	56
31	Fada	80	Woman	NR					
32	Bader	48	Man	NR	Urban	Gaza	2	No	70
33	Salim	54	Man	Refugee	Urban	North	8	No	44

Table legend :

MoSA : Ministry of Social Affairs

RC: Refugee Camp

NRMR: Non-Refugee Married to a refugee

RMNR: Refugee Married to a Non-Refugee

NR: Non-Refugee

not recall every ailment, especially minor and common illnesses, so I asked them about the possible changes in their pattern of dealing with these ailments in general. If there were individuals with specific chronic ailments, such as non-communicable diseases or disabilities, in the households, I discussed with the interviewees their related healthcare experiences. At the end of the interviews, if applicable, I asked the interviewees about how their married children used healthcare for their households and discussed possible comparisons between the ways they used healthcare for their families and how their children used healthcare. Before concluding the interviews, I requested their insights and reflections on their experiences with healthcare.

3.6.2.2 Management of Life-history Interviews

I transcribed all of the 29 interviews myself. This was time consuming since the transcriptions entailed translating the interviews into English, as all interviews were conducted in Arabic language. While time consuming, the self-transcription and translation was useful. It enabled me to become more familiar with and more attached to the data. While transcribing the interviews, I recorded my thoughts and incorporated these with the notes that I had recorded during the fieldwork in Gaza. This enabled me to produce case summaries for each interview. These case summaries captured the salient patterns and changes in the experience of the interviewees. Beside the benefits of the self-transcription and self-translation in terms of my increased familiarity with the data, these methods prevented any loss of the real meaning of what the interviewees had indicated, which might have occurred had the transcription and translation been outsourced.

Following the transcription of the interviews, I exported the translated transcripts into the Nvivo software for the analysis and coding of the data (Bazeley and Jackson, 2013; Lumivero, 2015). I then read through the transcripts of the interviews on NVivo word by word, and line by line, and proceeded in coding the textual data. Coding entails assigning “labels to segments of data that depict what each segment is about” (Charmaz, 2006, p.4). I coded sentences or groups of sentences that had a clear or a latent meaning alongside the surrounding sentences, in order to understand the context of what had been said. The coding technique that I used considered the possibility of using overlapping (co-occurring) coding, and was an exhaustive (detailed) scheme. The overlapping (co-occurring or simultaneous) coding

entails the possibility of coding the same textual data more than once. Overlapping coding is appropriate when the data's content suggests multiple meanings (e.g., descriptively and inferentially) that require and justify more than one code (Miles et al., 2019:73). The exhaustive nature of the coding scheme entails coding all text in the interviews according to descriptions or meanings. Hence, every word went into, at least, one category and there were no left-overs.

4. 6.2.3 Analysis of Life-history Interviews

The analysis of Life-history Interviews, which was inductive, started at the beginning of data collection and continued throughout the following phases of the research project. I maintained a research diary, where I documented not only what I did, but also my observation and thoughts during the data collection and management. This diary helped me to analyse and interpret these interviews iteratively, i.e. I did not conduct the analysis just once, but I kept repeating it throughout my research. In general I adopted thematic analysis as my overall analytic approach to analysing these. Additionally, I supplemented this thematic analysis by using a time grid approach to capture changes in the use of providers of maternal healthcare. To capture the essence of the pattern of healthcare seeking behaviours and payments for healthcare and their changes, I was guided flexibly in the thematic analysis of the interviews by the six steps of thematic analysis described by Braun and Clarke (2006). These steps include getting familiar with the data, generating the initial codes, searching for themes, reviewing the themes, defining and naming the themes, and writing the report (Ibid).

I was familiar with the data since I had collected and transcribed them myself. Additionally, the strategies for documenting my notes during the interviews, listening to the recorded interviews and recording my thoughts, and making case summaries for each interview, which I used during and after the fieldwork, all enabled me to feel that I was immersed in the data. In addition to the thematic analysis described above, similar to what was done by Ros et al. (2015, p.8), I constructed an Excel spreadsheet that used a coloured time grid to show the providers of antenatal and childbirth care for each child according to the year, from 1963. As illustrated in annexes V-I and V-II, the time-coloured grid consists of columns in the vertical axis and rows in the horizontal axis. Columns represent the time, and rows represent the individual interviewees. When a health-related event (pregnancy or childbirth) was reported at the intersection

of the column and the row, I filled the corresponding cell with specific colour that is assigned to denote specific provider of healthcare. This approach of using time-colour grid enables differentiating the pattern of using different healthcare providers across different periods of time. Hence, reviewing the account of data help understanding the influence of historical factors, different health policy interventions or other factors on each period of time (Ros et al., 2015, p.8). The use of time-colour grid in displaying data is similar to the tabulation of data labelled by Miles et al. (2019, pp.189-202) as temporally ordered table and event listing matrix to help tracking events and changes in them. These approaches of displaying data through tables and matrices contribute to organizing qualitative data and to enhance their trustworthiness (Cloutier and Ravasi, 2021).

3.6.3 Changes in public-private healthcare

3.6.3.1 Data Source

I addressed the third overarching research question of my research using a wide range of documentary sources. I complemented and corroborated these documents by interviewing 17 key-informants in the Gaza Strip. In the following sections, I will outline the two data sources, and describe the management and analysis of these data and how I integrated them. The decision to use a documentary review as an initial source of data to address the third research question to understand how the public-private mix of healthcare has evolved in the Gaza Strip in the shadow of the protracted conflict was based on the ability of documents to capture the historical change. Documents are the only viable source and can help in understanding the historical roots of a specific issue (Bowen, 2009).

Documentary Sources:

My use of documentary sources followed an iterative journey and built on my experience with and exposure to publications related to the Palestinian healthcare system. I was keen to collect documents pertaining to the health status and healthcare system in the occupied Palestinian territory (oPt), even before starting to study for my degree in Public Health in 2003. Some of these documents are still accessible through the internet. Others were published as hard copies. When I started my PhD, I did a quick PubMed search of the published research on the healthcare services and healthcare system in the Gaza Strip. This revealed that there was only limited

evidence in published journal articles. Besides the issue of the limited body of knowledge, even the articles that tackled the healthcare system in the oPt in general concealed the difference between the Gaza Strip and the West Bank, or at best tackled the healthcare system in Gaza as an appendage to the West Bank. Chapter 2 of this thesis shows that there is inadequate evidence about the public-private mix of healthcare and how this mix has evolved.

This search made me aware that these documents, which I assembled and saved to my computer drive over a period that spanned almost two decades, might be an asset in structuring a synthesis of documents related to the historical evolution of the healthcare system in the Gaza Strip and its configuration and performance. Realizing that both documentary research and historical research are tightly connected to each other (Tim, 2001), I started reading and reviewing the documents that I possessed. Additionally, I searched the internet for additional documentary resources related to the Palestinian healthcare system, and purposely visited the websites of certain institutions such as the MoH in Gaza, the MoH in Ramallah, the PCBS, and research institutions. I started my search with fairly broad terms and then I narrowed them. I searched for materials related to: (i) the development of public and private sectors in the mixed health system; (ii) the intersection between these two sectors, such as dual-practices and outsourcing; (iii) the availability of human, material, and financial resources; and (iv) the socioeconomic and political context in the Gaza Strip. In addition to the documents that I used, I analysed the data of the Health Providers and Beneficiaries Survey (HPBS), which I obtained from the PCBS. I made this analysis to explore the possibility of understanding the pattern of provider choice in the Gaza Strip and to ascertain the magnitude of dual practice in the Gaza Strip, as the report of HPBS provides only national estimates without showing the difference between the Gaza Strip and the West Bank. I organized the documents and saved them in specific digital files. Subsequently, I structured an initial synthesis, and reviewed historical developments that have contributed to shaping the performance of the healthcare system and the healthcare arena in the Gaza Strip. After drafting the preliminary analysis of the first 10 rounds of the Palestinian Expenditure and Consumption Survey (PECS) in March 2017 and carrying out a number of Life-history Interviews, in May 2017 I started to do additional searches for documents, updated the available documents by adding newly released ones, and compared the soft

copies with the hard copies that I had in Gaza to check the validity of the soft copies. I read and skimmed all of the documents, and drafted my second review, consulting the new documents and the hard copies that did not have soft versions. When I returned to Edinburgh in October 2017, I updated the documents, searched the WHO archives for additional documents, and sharpened the focus of my inquiry to concentrate on changes in the private-public mix of healthcare and in the entitlement to healthcare services. I continued updating the repository of documents until the end of 2021 and included all of the documents relevant to healthcare in Gaza beginning from just before the emergence of the Gaza Strip as a recognized geopolitical entity in 1949. I ended up with 443 sorted documents. This number of documents might seem surprising. However, it has been observed that *“if you are looking at multiple policies, health issues, or contexts, or reviewing shorter documents (such as newspaper articles), you may look at hundreds, or even thousands of documents”* (Dalglish et al., 2020). While the large number of documents challenged me, it helped to ensure their reliability. The reliability of documents is related to their representativeness (Green and Thorogood, 2004, p.168). The validity of these documents, i.e. their authenticity, is guaranteed by the fact that the vast majority of them are publications of national or international health stakeholders.

Key informants interviews:

When I structured my initial review of the documents in July 2017 while I was in Gaza, I found that these offered limited information about the private health sector, especially the private-for-profit sector, and the relationship between the private and public healthcare. There was also some contradictory information about the development of healthcare, especially before the establishment of the PA in 1994. Additionally, there were some unclear points or inconsistent data in these documentary sources, and only scarce information about some periods. Taking these limitations into account, and to confer more rigour on the documentary review, I decided to interview key informants. Before identifying the potential key informants, I chose the issues that I wanted to discuss with each of them. I purposely identified them according to my judgement of the relevance of their experience and knowledge of the issues that I wanted to discuss and explore with them. I contacted them, informed them about the topic of my research project and my purpose in interviewing them, and asked for their collaboration; if possible, we then decided on a time and place for an interview. I had initially identified 21 potential key-informants and was able to contact 19 of them. One apologized for

personal reasons, and another agreed on being interviewed but told me that this health condition was not optimal and pledged his cooperation when his health improved; sadly he later died. Hence, I interviewed 17 key informants. A list of interviewed participants, alongside the recorded time and topics of the interviews, are tabulated in table 3-3.

Table 3-3: List of key informants, duration of recorded interviews, and the focus of these interviews.

SN	Name and position(s) held	minutes	The focus of the Interview
1	Dr Reyad al-Za'anoon Minister of Health (1994-2002)	78	Getting historical accounts about the development of healthcare before 1967; about policy development directly after the establishment of the PA in 1994, with a focus on the attitude towards private healthcare and entitlements to healthcare.
2	Mr Khalil Shahin Manager of the Socioeconomic Right Unit at the Palestinian Centre for Human Rights.	64	Getting perspectives about the right to healthcare in the Gaza Strip, and about the effects of different actors' policies and practices on this right.
3	Dr Bassam Zaqout Program Manager at the Palestinian Medical Relief Society- Gaza Strip.	38	Getting accounts about the relationship between NGOs and the MoH in Gaza, about the role of donors in supporting healthcare, and about the difference between not for and for profit private health sectors.
4	Dr Ghassan Zaqout Manager of PHC clinics at the Palestinian Medical Relief Society- Gaza Strip.	23	Getting accounts about the work of NGOs in the field of PHC; exploring the new tendencies of using the services of private doctors by NGOs.
5	Dr. Taysir al-Sultan Ex- executive director the Union of Health Works Committees	69	Getting accounts about the work of NGOs in both secondary and Primary Healthcare; exploring the relationships between the NGOs and the MoH in Gaza.
6	Dr Khalil Shaqfa General Director of Health Planning at the MoH in the Gaza Strip.	40	Getting insights about the challenges faced in operating and financing the MoH services in the Gaza Strip; about the policy towards private healthcare and entitlement to healthcare services after 2007.
7	Dr Khamis el-Essie Medical Director of al-Wafa hospital	27	Getting accounts about the work of Al-Wafa hospital, as an example of Islamic health NGOs, in terms of operations,

			the relation with the MoH, and about the role of external assistance in supporting healthcare in the Gaza Strip.
8	Mr Fayez Shalatouni Manager of Health Insurance Unit at the MoH in the Gaza Strip.	33	Exploring Issues related to health insurance, especially the GHI scheme.
9	Dr. Rabah Muhana Founder of the Union of Health Works Committees in the Gaza Strip.	66	Getting general accounts about historical developments in the health sector since early 1970; getting insights about the relationships between the MoH and NGOs; and getting insights about the right to health,
10	(Anonymous) Official at the private Medicine Unit at the MoH in the Gaza Strip.	41	Getting accounts about policies and practices towards private healthcare, about the size of private for profit and not-for-profit healthcare sector, and about licensure of private healthcare facilities.
11	Mr. Hani al-Wehidi Director of Palestinian Health Information Center-MoH in the Gaza Strip.	30	Exploring the validity and reliability of data reported in the MoH reports; getting insights about the relationships the two MoH in Gaza and Ramallah.
12	Dr. Yehia Abed Deputy director of PHC during the Israeli control; General Director of Research and Planning at the MoH (1994-2003), Deputy Chief of MCH USAID Project (2002-2005), consultant to many	40	Exploring unclear aspects of healthcare under Israeli occupation till 1994. Getting accounts about the historical developments in the health sector from 1970 to 2017. Getting accounts about the work of USAID in supporting local NGOs in the Gaza Strip.
13	Dr. Basem Naim the Ex Palestinian Minister of Health (April 2006-March 2007); Minister of Health in the Gaza Government (June 2007-2012); and the holder of the portfolios of Health and Environment at the Higher Government Administrative Committee in the Gaza Strip (March 2017-September 2017)	91	Exploring the policies of MoH in Gaza toward PHC, UHC, and private healthcare. Discussing the operational challenges faced by the MoH, the role of external assistance in supporting the health sector, the effects of the internal Palestinian adversary and the Israeli practices on the healthcare, the relationships between the MoH and different categories of private not for profit sector. Discus the new tendency of outsourcing services by the MoH in Gaza to private sector.
14	Mr Ahmad Lubbad Director of Patient Care Society.	37	Getting accounts about the work of NGOs in both secondary and Primary Healthcare; exploring the relationships between the NGOs and the MoH in

			Gaza; the role of external assistance in supporting
15	Dr. Hussam al-Deeny Manager of Bissan Medical Center of al-Salah Society.	35	Getting accounts about the operational aspects of the work of NGOs in the field of PHC; exploring the relationships between the medical Center and the mother organization; and discussing the role of external assistance in supporting the new tendencies of using the services of private doctors by NGOs.
16	Dr. Tayseer al-Dadah Medical Director of the Union of Health Care Committees in the Gaza	12	Getting accounts about the work of the Union of Health Care Committees in the Gaza Strip.
17	Dr. Alaa Yehya Dentist at the Union of Health Care Committees in the Gaza Strip.	24	Getting accounts about the work of the Union of Health Care Committees in the Gaza Strip, and discuss the difference between private for profit and not-for-profit dental care.

Initially, I obtained agreement from the interviewees to be interviewed through my mobile call and discussion with them. Then I obtained their consent and recorded it with my dictaphone at the beginning of each interview. All key informant interviews were audio-recorded. All of the interviewees except one agreed that their names could be used in the research report. In addition to the individual consent obtained from each participant, I obtained institutional clearance from the Administration of the Ministry of Health [MoH] in Gaza to interview the managers of the MoH in Gaza.

The key informant interviews that I carried out in Arabic language can be considered elite interviews. Elite is a group of individuals who hold or who have held a privileged position in society (Richards, 1996). Interviewing elites has some advantages and disadvantages. Elite interviews can help interpreting documents and reports, can provide unrecorded information, and can help understanding context (Ibid). These interviews are not however without problems. The reliability of participants in these interviews is sometimes questionable, and the power relations between interviewees and interviewers pose certain challenges (Ibid). Gaining access to the elite interviewees, their collaboration during the research and the ethical dimension of the research were problematized from the perspective of the power relations (asymmetry) between me, as the interviewer, and the interviewees (Smith, 2006). It has been argued that the distinction between elite and other types of

interviewees is based on an inadequate conception of power (Ibid). In fact, I gained access to most of the persons that I attempted to interview. The collaboration of the interviewees was adequate in most cases. Even when the collaboration of the interviewees seemed less than adequate, I do not think it was inadequate as a result of the power relationship but possibly due to the sensitivity of the subject of the interviews. I explicitly informed the interviewees about my purpose in interviewing them. The most senior interviewees were more open and cooperative than the middle managers. For example, the interviews with the two ministers of health were the longest of all of the interviews. The interview with the first Palestinian Minister of Health lasted for more than an hour and a quarter, and the interview with the Minister of Health after Hamas' electoral victory in 2006 lasted for more than an hour and a half. Both of these interviews took place in their houses. These two ministers of health gave me more time than all of the other interviewees, as the average length of the interviews was 43.6 minutes and the median interview time was 39 minutes. I think that this relatively generous supply of information and insight reflects their power in the society or in their organization rather than the power relationship between them (the interviewees) and me (the interviewer).

I think that these key informant interviews were influenced by my relationship with most of the interviewees as colleagues and peers. The experience of interviewing one's peers is considered to be very different from other interviews, and poses ethical and social sensitivities (Platt, 1981). Although only one declined my invitation for an interview, some were very short and precise in their responses, while others tried to divert me from the topics that I wanted to enquire about. For example, one academic whom I interviewed due to his previous experience as a middle manager during the Israeli control over the government health services and as an employee of multiple international health projects in the Gaza Strip gave me useful lessons in the history of healthcare and public health in Gaza and in Palestine. However, when we turned to my questions and discussions, he was very brief, diplomatic and cautious in his responses. This possibly prevented me from going deeper in my questions. Another participant, who was a manager of an Islamic health NGO, took me on a tour of his health facility, where our discussion took place. Before starting the interview, he offered me valuable information about his NGO, but this information was not recorded. Additionally, his tour of the facility reduced the time available for the interview, which

lasted for only 39 minutes. Hence, gaining access to the interviewees did not always guarantee their full collaboration.

3.6.3.2 Data Management and analysis

The use of documents and published resources in this review could be considered as a desk research. Although literature reviews are the most common form of desk research, it involves materials from the internet and secondary data analysis (Moore, 2006 a). I sorted the collected data according to the period that prevailed in the Gaza Strip from 1948 to 2020. After organizing them, I approached the publications with a clear purpose of portraying the developments in the public and private sectors in the mixed health system in the Gaza Strip. I tried my best to be organized and systematic, documented every issue that appeared to be salient as I was going through the publications, and made analysis before preceding to make any synthesis of the reviewed materials (Moore, 2006 b). The analysis of data entailed extracting data from the publications according to the time periods of the different political regimes. I extracted quantitative data, such as the number of hospital beds or medical consultations at different points of healthcare service delivery from these documents, put them into an Excel sheet and converted these into graphs to capture trends across certain political regimes. I extracted qualitative information, such as policy statements or objectives, from the documents in a notebook. The data extraction mostly followed the chronology of the political regimes undergone by the Gaza Strip.

The analysis of materials and publications spanned the period during which I read the documents and extracted data from them. However, I started the full analysis only after completing the data extraction from these publications, as one could see the whole picture only after the data extraction was complete (Dalglish et al., 2020). Similar to the data extraction, the data analysis was done in chronological order according to the political regimes undergone by the Gaza Strip, and aimed to trace possible changes in policies, service delivery and entitlement to healthcare. Hence, my analysis of publications was mainly content analysis, which is considered as the process in which a researcher interprets the meaning or the usage of data (Hsieh and Shannon, 2005). I always considered the changes in the context of the political developments and the financial and social situation. I initially drafted the findings of the analysis, and then enriched this draft with texts, insights, and inferences gained

from the key informant interviews. I listened to the interviews several times and made a case summary for each interview. I supported or contrasted some findings from the documentary analysis using text from these case summaries. I then listened to the interviews repeatedly. If an issue arose. I selectively transcribed the text and translated it into English and incorporated it with the draft of the analysis.

I should recognize that: (i) while some interviews were rich in content, others did not add much; (ii) while both the documents and interviews give good accounts about developments during certain periods, information about older periods is limited; and (iii) most of the interviews mainly covered the last ten years. Accordingly, I have presented the results of this strand in two distinct sections of chapter 6. The first section presents the trajectory of healthcare over different political regimes till 2005, and second section concentrates on the period that followed 2005.

3-7 Ethical considerations

I adhered to standards that ensure ethical conduct in the planning, operationalizing, and the presentation of my PhD research. I considered in this chapter the influence of my positionality as a researcher on the research project, and gave a reflexive account about my positionality as a person and as a researcher. As mentioned in the data collection of the Life-history and the key informant interviews, I obtained informed consent from the interviewees. Additionally, I obtained organizational approval from the MoH in the Gaza Strip to interview its officials and employees. I anonymized all names related to the Life-history Interviews. All audio-taped data and transcripts of interviews, which were stored in my personal computer and in 2 online drives (One-drive and Google-drive), were only accessible to me, as indicated in the data management protocols annexed in Annexes III-IV and III-V.

Additionally, my application (ID-205199) for the ethical approval of my PhD research was granted at level 2 by the University of Edinburgh School of Social and Political Science on the 17th of July 2016 (Annex III-VI).

3-8 Methodological limitations

I discussed throughout this chapter the possible methodological limitations of my PhD research. I highlighted the quasi-nature of mixed research methods that I used in my research and indicated that this nature allows little or no integration of the findings and inferences from the three research strands. Additionally, I discussed the weaknesses

of the PECS and highlighted that householder interviews did not follow the conventional ways of conducting Life-history Interviews.

3-9 Conclusion

In this chapter, I have detailed the research questions of my PhD thesis. I discussed critical realism-a research stance- that combines the realist ontology with a social constructionist epistemology and considers realities as objectively existing but unknown directly. Given the relative subjectivity of the constructionist epistemology, I have presented reflexive accounts of my positionality and its possible influence on this research. I discussed then the mixed methods research methodology that I used to combine the three strands of my research and highlighted the limitations of its quasi-character in making integrated inferences. I presented therefore the data sources, management, and analysis of the three research strands separately. Finally, I summarized the ethical aspects considered in this research and presented the salient methodological limitation of my research. In the following chapters, I will present the findings of this research; then, I will discuss them and draw conclusions.

Chapter 4

Changes in household out-of-pocket payments for health-related products and services.

4. 1 Introduction

This chapter analyses how the scale, composition and burden of out-of-pocket payments (OOPP) for health-related products and services changed among the population and among different socioeconomic groups in the Gaza Strip from 1996 to 2017. The analysis relies on a range of quantitative approaches developed to capture the extent, severity and composition of OOPP on healthcare. After this introduction, this chapter is divided into 3 parts. In the first, the approaches to the quantitative analysis are specified. Second, the results from the analysis are presented, interpreted and discussed in relation to the current literature and knowledge in the area. Finally, conclusions are drawn from the results and discussion. The main conclusion of this chapter is the socioeconomic stratifications of out-of-pocket payments and their catastrophic impacts after 2007.

4. 2 Analytical Approaches

The data from 11 rounds of the Palestinian Expenditure and Consumption Survey (PECS) from 1996 to 2017 was analysed using the Statistical Package for Social Sciences (SPSS) Version 24, unless stated otherwise (Field, 2009; IBM Corp, 2016). All of the analyses were weighted using the survey weights provided by the PCBS. The data analysis borrowed from different analytical approaches. The combination of these approaches was used to confer rigour on the findings and to achieve deeper understandings about the change in the OOPP than would have been possible using a single approach. I chose four main different analytical approaches to assess and understand the possible changes in out-of-pocket payments for healthcare (OOPP) and the changes in financial health protection. These four analytical approaches yielded four main outputs: (i) the absolute values of OOPP and their percentage of households' total consumption; (ii) the split in the use of OOPP across different forms of healthcare; (iii) Catastrophic Health Expenditure (CHE), where OOPP reaches high

levels of the household financial resources, i.e.10% or more; and (iv) the impact of OOPP on household poverty.

Following the identification of the third and fourth outputs, multivariate logistic regression models were fitted in order to extend and substantiate some of the results related to the CHE and to the impact of OOPP on household poverty. These models explore different determinants of the occurrence of CHE and poverty resulting from OOPP; and the extent to which the occurrence of CHE and impoverishment changed.

The details of these analytical approaches are presented separately in the following subsections.

4. 2.1 Change in the absolute and relative values of households' OOPP for healthcare

The monetary values of the per capita monthly household OOPP for health-related products and services (thereafter OOPP) and of household consumption were adjusted to inflation. The adjustment to inflation entailed dividing these monetary values by the Consumer Price Index (CPI) of the respective year according to annex IV-I (PCBS, 2022 c; Thompson, 2009). After adjusting these values to inflation, the means of the per capita monthly OOPP and consumption were estimated between 1996 and 2017. The percentages of the means of OOPP as a share of the consumption were then calculated. The analysis was also stratified by the per capita consumption quintiles for each of the PECS 11 rounds. The differences in the means (SE) of OOPP, consumption, and the percentage of the first as a share of the second were informally assessed through a graphic illustration. Then, an Analysis of Variances (ANOVA), with a post hoc Bonferroni Correction, was used to assess whether there was a statistically significant difference between the means of OOPP, between the means of OOPP share of consumption, and between the means of consumption over the period from 1996 to 2017. This analysis was employed to ensure robustness of inference.

4.2.2 Change in the different components of OOPP

In the second analytical approach, I calculated the average means (SE) of the proportion of OOPP on components of household health expenditure as a share of the total OOPP across the years among households that incurred any OOPP, and

among their consumption quintiles as proxies of wealth groups. These components of OOPP and their subsequent subdivisions are:

- (i) Medical products, including medicines, appliances and equipment,
- (ii) Outpatient care, including physician fees, payments for dental healthcare, diagnostic tests, and fees paid to practitioners other than physicians and dentists (nurses, physiotherapists, and traditional healers).
- (iii) In-patient Care, including hospital and ambulance services.

4.2.3 Change in household Catastrophic OOPP

If OOPP reaches certain levels, households may experience financial difficulties that impact on their well-being. In this thesis, I quantify the severity of households' OOPPs using the Catastrophic Health Expenditure (CHE) measure, which indicates that OOPPs constitute a sufficiently large proportion of household resources. CHE is one of two indicators used to monitor the progress towards achieving UHC, which is one target of the goal of improving health, i.e. the third goal in the Sustainable Development Goals (WHO and WB, 2015; WHO and WB, 2017; WHO and WB, 2020; WHO and WB, 2021).

I estimated the incidence (the head counts) of CHE using SPSS version 24, and I used the ADePT software to validate these results and to calculate the Standard Errors (SE) of the estimates. The estimation was based on the following formula, which was used by Chhun et al. (2015, p.4) based, in turn, on the previous work of O'Donnell et al. (2008) and Wagstaff and van Doorslaer (2003):

$$H = \frac{1}{N} \sum_{i=1}^N E \left[\frac{T_i}{X_i} > Z \right] \quad \text{(Equation 4-1)}$$

Where:

- N is the sample size.
- i is the serial rank of the household from 1 to N .
- $E [\dots]$ is an indicator function that equals 1 if $\frac{T_i}{X_i} > Z$ and zero if otherwise.
- T_i is the amount of OOPP.
- X_i is the amount of total household consumption.

- Z is the threshold (i.e. 10 % of total household' consumption).

The choice of the thresholds used to consider OOPP catastrophic is to some extent arbitrary. Although most studies use multiple benchmarks to estimate CHE, only one threshold is used in this chapter. This threshold is 10% of total household consumption as a proxy for the household budget. The choice of this budget share threshold is based, as mentioned in chapter 3, on the WHO and the WB (2017) decision's to use them to monitor the progress towards the UHC within the Sustainable Development Goals.

The incidence of CHE does not capture the degree to which OOPPs exceed the threshold Z , as a proportion of households' resources. To address this limitation, the intensity of CHE was calculated (Wagstaff and van Doorslaer, 2003; O'Donnell et al., 2008; Wagstaff, 2009); and the calculation was done according to the notation used and presented by Chhun et al. (2015: 4), which is:

$$O = \frac{1}{N} \sum_{i=1}^N E \left[\left(\frac{T_i}{X_i} \right) - Z \right] E \left[\frac{T_i}{X_i} > Z \right] \quad (\text{Equation 4-2})$$

The analysis of CHE is presented for the whole sample of each year of the PECS rounds (1996-1998, 2004-2007, 2009-2011 and 2017) and is also stratified by wealth stratum in each round (using household consumption quintiles as a proxy for wealth groups).

4.2.4 Change in the Effects of the OOPP on households' poverty

The burden of household OOPP is felt markedly when households and individuals are pushed into poverty because of payments for healthcare. To evaluate the impact of OOPP on poverty, a useful approach is to estimate the additional number of people in poverty as a result of OOPP. The effect of OOPP on poverty is estimated through calculating the poverty head count with and without OOPP. The poverty head count with OOPP is the "Gross" poverty head count and the poverty head count without OOPP is the "Net" poverty head count. Both are expressed as percentages of the total population. The absolute difference between the "Gross" and the "Net" poverty head counts indicates the effect of OOPP on the poverty headcount, i.e. the incidence of impoverishment.

The calculation of both the “Gross” and the “Net” poverty head counts requires the identification of the poverty line (IPL). In addition to the relative poverty line, which is determined by the median (or the 60 percentile) of the national income or its proxies (Expenditure or Consumption), there are two internationally endorsed absolute poverty lines (Wagstaff et al., 2018). The first International Poverty Line (IPL) measures extreme poverty and currently stands at 1.9 International Dollars.

The measurement of IPLs in International Dollars entails considering the Purchasing Power Parity (PPP) of the International Dollar in 2011. Therefore, the calculation of the IPLs for each survey year from 1996 to 2017 entailed their conversion to the PPP of 2011 in the Local Currency Unit, which is the New Israeli Shekels (NIS), in 2011 prices and the prices prevailing at the time of the relevant Household survey by using the Consumer Price Index (CPI).

The PPP for the actual individual consumption in the occupied Palestinian territories (oPt) was 2.23 in 2011 (ESCWA, 2015). The PCBS (2012) reports that the price of goods, commodities and services varied considerably across different areas of the oPt and that prices in the Gaza Strip were lower than in the rest of the oPt. The PCBS therefore worked jointly with the World Bank to construct spatial price indices that would enable a meaningful comparison of living standards across the oPt. This work resulted in the purchasing power of the NIS for the Gaza Strip being estimated to be 0.92 of the purchasing power of the oPt, specific Purchasing Power for the NIS to have the PPP at 2.052 in 2011. The PPP was then converted to NIS using the prices from 2011 and was adjusted according to the CPI for each year. Annex IV-I details the calculations of the IPL for the Gaza Strip.

To calculate the gross poverty head count (H_{gross}) and the Net poverty head count (H_{net}), the following formulae were used, as notated in Chun et al. (2015, p.6):

$$H_{gross} = \frac{1}{N} \sum_{i=1}^N E[X_i < PL] \quad \text{[Equation 4-3]}$$

$$H_{net} = \frac{1}{N} \sum_{i=1}^N E[(X_i - T_i) < PL] \quad \text{[Equation 4-4]}$$

Where:

N is the sample size.

E is an indicator function that equals 1 if $X_i < PL$ or $(X_i - T_i) < PL$ accordingly and zero if otherwise.

X is the per capita total household consumption in Household $i=1, \dots, N$;

T is the per capita OOPP on healthcare; and

PL is the poverty line.

i is the rank of the household, which ranges from 1 to N.

The poverty head count does not capture how far people are pushed below the poverty line as a result of OOPP or the possibility that OOPP may push already poor households further into poverty (Wagstaff, 2009). Therefore the pre and post OOPP poverty gaps are calculated to estimate the aggregate shortfall from the poverty line before and after incurring healthcare payments. The post healthcare payments poverty gap, the gross poverty Gap, is expressed as:

$$G_{gross} = \frac{1}{N} \sum_{i=1}^N (PL - X_i) E[X_i < PL] \quad \text{[Equation 4-5]}$$

And the Net Poverty Gap (G_{net}), i.e. the pre healthcare payments poverty gap, is expressed as:

$$G_{net} = \frac{1}{N} \sum_{i=1}^N (PL - [X_i - T_i]) E[(X_i - T_i) < PL] \quad \text{[Equation 4-6]}$$

As notated clearly in Chhun et al. (2015, p.6).

It is worth noting that while OOPPs, which are used as a numerator to estimate CHE, do not include the premiums for health insurance, the OOPPs considered for the estimation of the healthcare impoverishing effect entail adding the premiums for health insurance to the sum of all of the healthcare expenditure items covered (Mataria et al., 2010).

4.2.5 Determinants of the occurrence of CHE and Impoverishments

Following the exploration of the change in the indices of catastrophic and impoverishing OOPPs, two multivariate logistic regression models were used to model mainly whether the chance of incurring CHE and Impoverishments changed during the 11 rounds of the PECS from 1996 to 2017. The flexibility of a multivariate model enabled the exploration of the determinants of CHE and impoverishment during the period 1996 to 2017 as the fitted models were based on the pooled sample of all rounds. The multivariate logistics regression models were fitted for the occurrences of catastrophic health expenditure at the threshold of 10% of total consumption. The results of the third analytical approach show (in subsection 5-3-3- of this chapter) that the concentration of the incidence of CHE alternated between worse-off and well-off households with a clear pattern across different rounds during the period from 1996 and 2007, and that CHE became concentrated among better off households between 2009 and 2017. Therefore, these multivariate logistic models were fitted to allow the exploration of whether these differences, which occurred after 2007, held after controlling for potential confounding variables.

A step-by-step multi (blocks) logistic regression model was applied to explore the determinants of the occurrence of CHE. Since the main objective of the logistic regression was to assess the change in the occurrence of CHE, the first block assessed the relation between CHE and time (the survey round). The second model added to the first block variables related to entitlement and access to healthcare services. Those variables were the payment of premiums for health insurance, refugee status and place of residence. The payment of premiums for health insurance implies enrolment in the health insurance scheme. Refugee status indicates entitlement to UNRWA healthcare services, and residence in refugee camps implies better access to UNRWA services. In the third model, independent variables related to household structure were added to the previous block. The independent variables related to the household structure included (i) categories of the numbers of household members, (ii) the availability of a 65-year old or older family member in the household, and (iii) the groupings of the number of 14 year old or younger children in the household. The fourth model controlled for the effects of the individual characteristics of household heads on the occurrences of CHE. The independent variables related to the characteristics of the households' heads were literacy, sex, and age group of the head

of the household. The fifth model added the per capita consumption quintiles to the previous models. Finally, the sixth model added the interaction between the per capita consumption quintiles and the two distinct periods [(1996-2007) and (2009-2017)] to the previous blocks.

Refugee status and living inside refugee camps can be seen as important correlates of access to healthcare in the Gaza Strip. More than two thirds of the population are refugees who are entitled to UNRWA healthcare services. The UNRWA PHC facilities are mostly positioned inside refugee camps (Hamdan et al., 2003). Since the PECS data did not capture refugee status or place of residence before 2004, an additional logistic regression was performed for the data from 2004 to 2017. This logistic regression model was done similarly to what was done for the data from 1996 to 2017, but the two additional independent variables were added to the second block and subsequently to the following blocks.

Besides the logistic regression models for the occurrence of CHE, logistic regression was performed to explore the determinants of the occurrence of impoverishment resulting from OOPP. These models were fitted mainly to assess the change in the occurrence of impoverishment after controlling for potential confounders. Since impoverishment is concentrated mainly in the quintiles that are close to those who are affected by poverty, i.e. the second and the third quintiles, I did not control for the consumption quintiles (see subsection 4-3-4).

4.3 Results

4.3.1 Change in the absolute and relative values of OOPP

Figures 4-1 and Figure 4-2 illustrate the changes in the monthly means of per capita consumption and OOPP, respectively, [in New Israeli Shekels (NIS)] adjusted to inflation. Figure 4-1 shows that the per capita consumption fluctuated somewhat between 1996 and 2017 and was at its lowest values in 2007 and 2017. An ANOVA test with a multiple comparison using Bonferroni correction (Annex IV-II) shows that the per capita consumption was statistically different in 1996, 2004, 2007, 2009 and 2017 from the other rounds. Figure 4-2 illustrates that the OOPPs fluctuated between 1996 and 2017; however, an ANOVA test with multiple comparisons using Bonferroni correction shows that it was only different in 2009 from 1996 (Annex IV-III). Figure 4-3 shows that the mean percentage of OOPP as a share of consumption fluctuated during the period from 1996 to 2011; then it surged in 2017. An ANOVA test with a

multiple comparison using Bonferroni test (Annex IV-IV) confirms the visual assessment that the percentage of OOPP as a share of total consumption was statistically different at the level p value of less than 0.05 only in 2017. *It can be extrapolated therefore that the high percentage of OOPP as a share of total consumption in 2017 resulted from the reduction in consumption rather than from a change in the levels of OOPP.*

Figure 4-1: Change in the monthly means of Per Capita consumption (adjusted to inflation) in New Israeli Shekels (NIS) between 1996 and 2017.

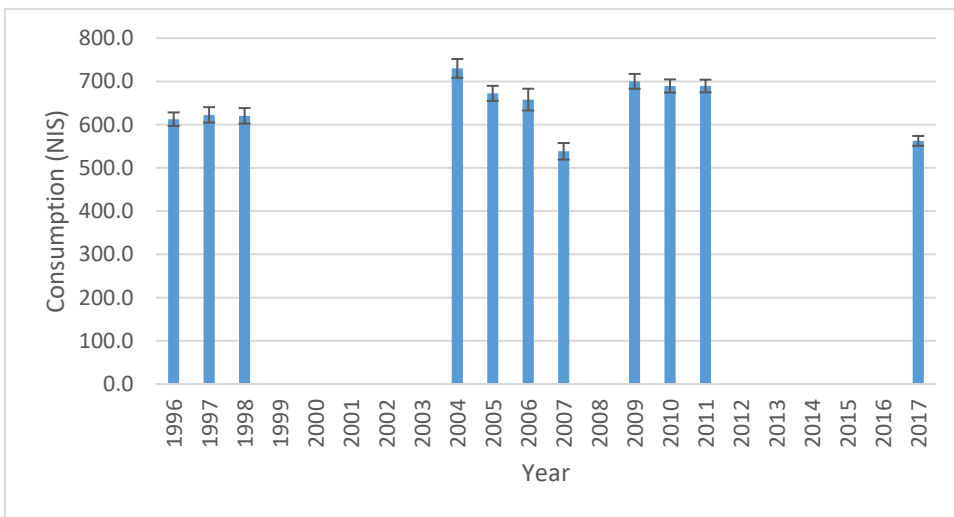


Figure 4-2: Change in the means of monthly Per Capita OOPP (adjusted to inflation) in New Israeli Shekels (NIS) between 1996 and 2017.

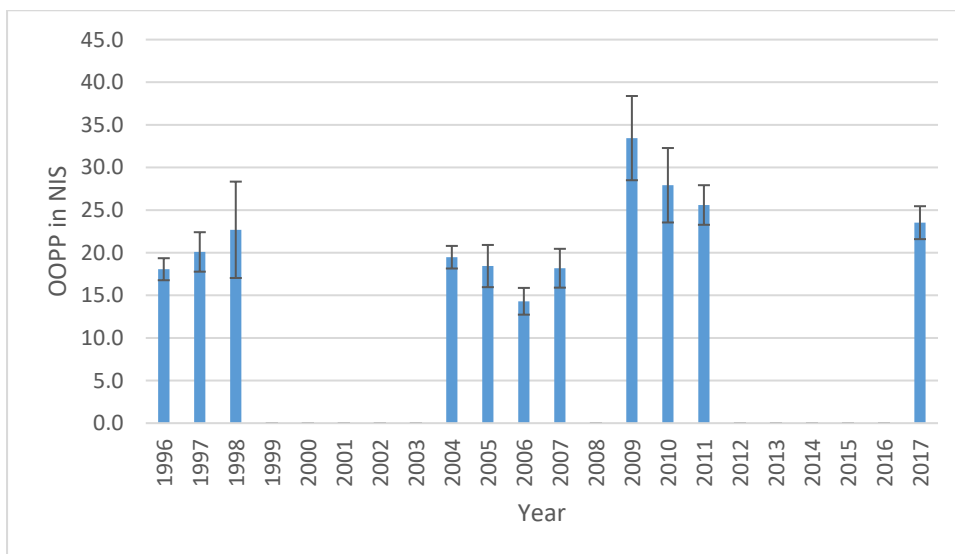
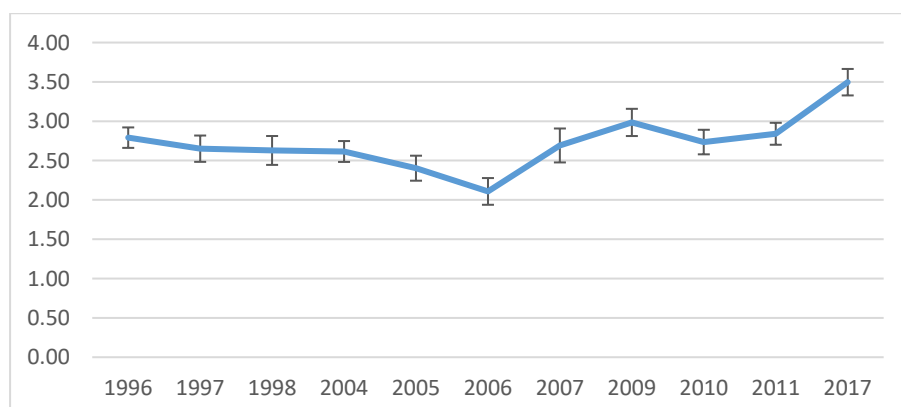
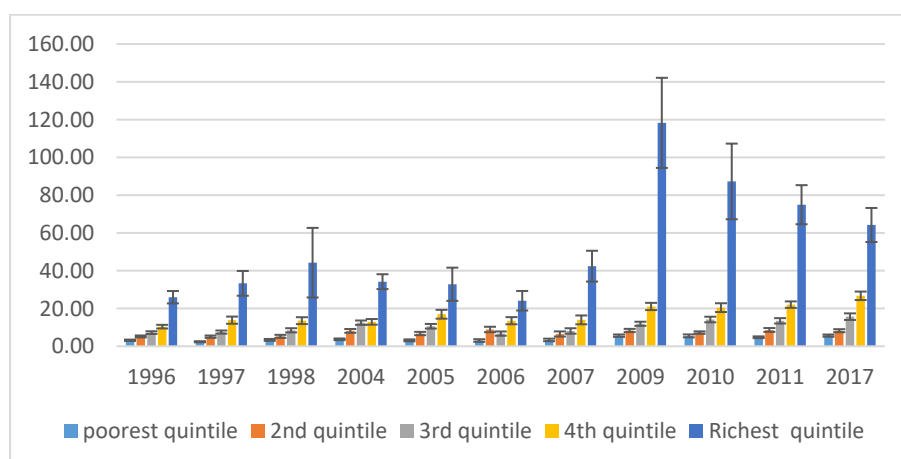


Figure 4-3: Change in the mean percentages of per capita OOPP as a share of Per Capita consumption between 1996 and 2017.



The per capita OOPPs were constantly higher among the higher consumption quintiles than the lower ones. However, the difference between incurring OOPP among the highest quintiles and the lower quintiles consistently increased, especially after 2007(See Figure 4-4 and Annex IV- V).

Figure 4-4: Average OOPP in NIS among different wealth (consumption) quintiles between 1996 and 2017.



This uneven change in the per capita OOPP has been associated with almost comparable changes in the amount of consumption among different quintiles of households (See figure 4-5 and Annex IV-VI). The percentages of OOPP as a share of consumption to become much higher among the highest (richest) quintile to become much higher among the highest quintile than the lower quintiles after 2007, namely from 2009 to 2011 (See Figure 4-6 and Annex IV-VII). Hence, there are increasing

gradients in the proportion of OOPP as a share of households' financial resources between the financially most privileged group of households and the other groups after 2007. Figures 4-4 and 4-5 suggest that this increase in the gradients is attributable to the increased amount of OOPP spent by the financially most privileged group of households.

Figure 4-5: Average consumption in NIS among different wealth (consumption) quintiles between 1996 and 2017.

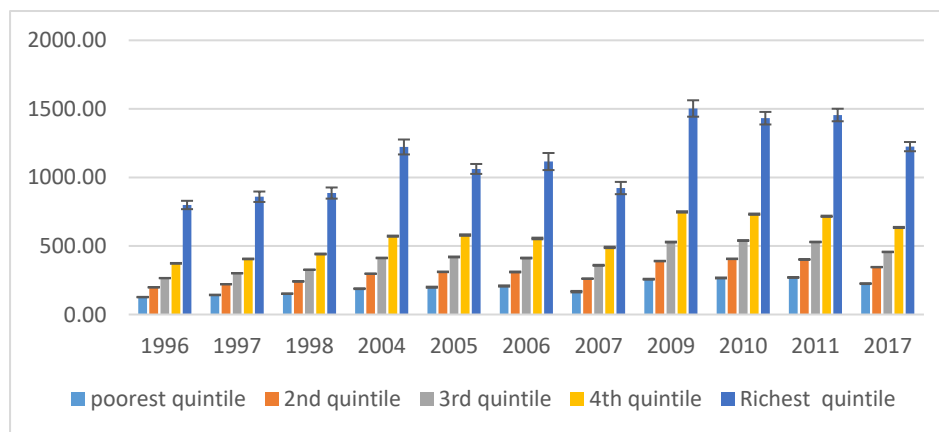
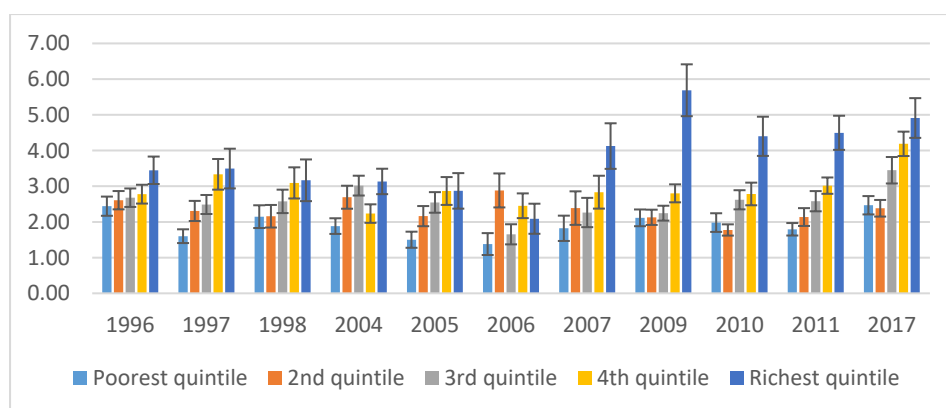


Figure 4-6: Percentage of OOPP as a share consumption among different groups of households according to wealth (consumption) quintiles between 1996 and 2017.

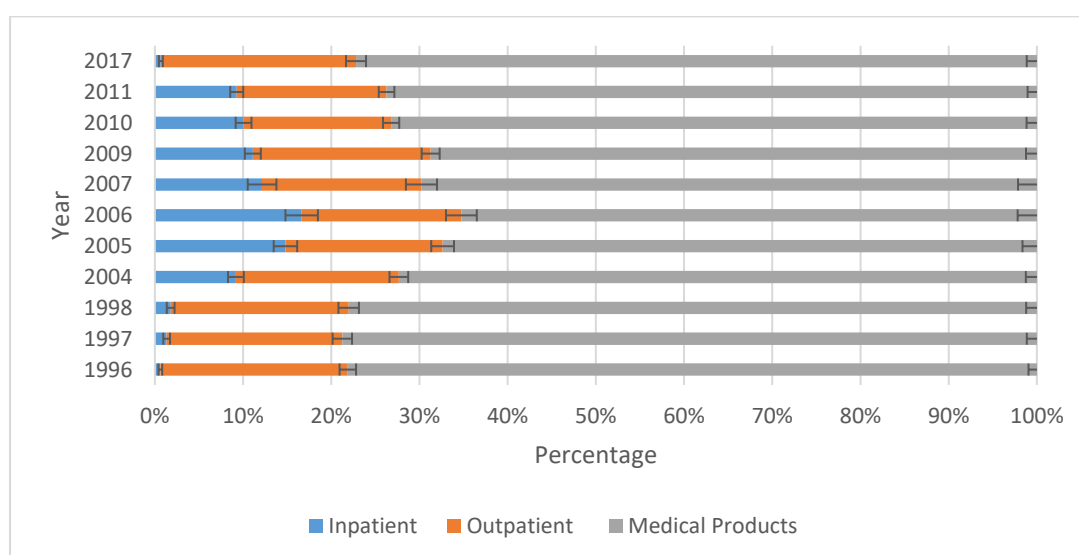


4.3.2 Change in the composition of the OOPPs for healthcare

Figure 4-7 shows that payments on medical products, including medicines, appliances and equipment dominated health expenditure made by households that incurred any OOPP, followed by payments on out-patient and in-patient healthcare services. It shows that the proportion of household spending on medical products, including

medicines, appliances and equipment as a share of OOPPs steadily declined between 1996 and 2006 and subsequently steadily increased during the period from 2007 to 2017. Simultaneously, the proportion of households spending on in-patient healthcare as a share of OOPPs steadily increased during the first period (1996-2006) and then decreased during the second period (2007-2017). Additionally, it shows that the proportion of expenditure on out-patient healthcare as a share of OOPPs somewhat fluctuated but was steady during the entire period from 1996 to 2017.

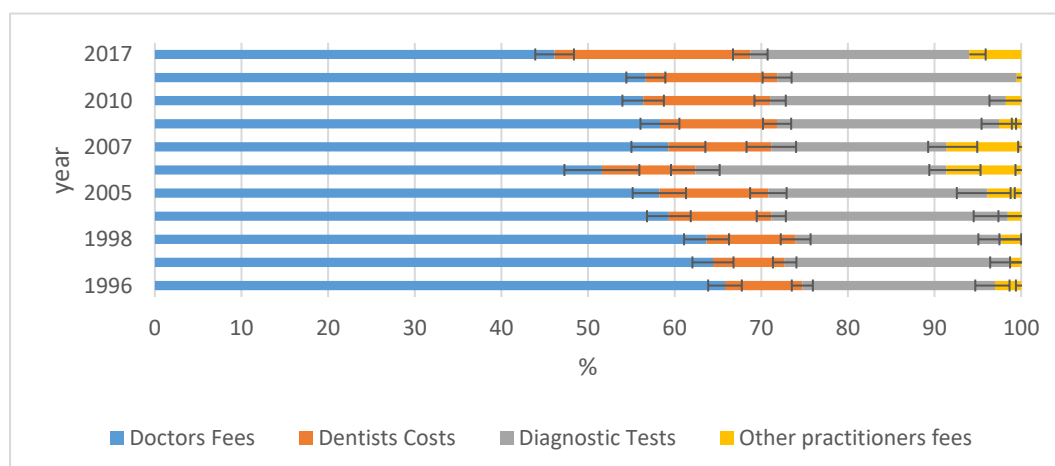
Figure 4-7: Change in the average percentage of OOPPs spent on different components of healthcare as a share of the total OOPPs from 1996 to 2017.



The expenditure on medical products was consistently dominated by spending on medicines, while the spending on the purchase, borrowing and maintenance of equipment and disposables was marginal and generally decreased over the study period. The percentage of spending on medicines as a share of spending on medical products ranged from 89.1% in 1996 to 96.9% in 2017.

Figure 4-8 illustrates that the household expenditure on outpatient services was dominated by fees paid to physicians, followed by payments for diagnostic tests and dental care and fees paid to practitioners other than physicians and dentists (i.e. nurses, physiotherapists and traditional healers). It shows that the percentage of physician fees as a share of household payments for outpatient care was the highest, but that it generally decreased. The percentage of dental costs consistently increased; and the shares of diagnostic test costs and fees paid to practitioners, other than physicians, fluctuated.

Figure 4-8: Change in the percentage of spending on different components of outpatient care as a share of the total OOPPs spent on outpatient care between 1996 and 2017.



The above results, which report that OOPPs were constantly dominated by spending on medicines, can be explained by the frequent unavailability of these medical products at public health facilities. The different publications reviewed, which were presented in chapter 2, demonstrated the unavailability or limited availability of health-related products, including medicines, in these facilities (Beckerleg et al., 1999; Lewando-Hundt et al., 1997; Abu-El-Noor, 2011; Abu Hamad et al., 2021). The predominance of expenditure on pharmaceuticals is similar to in other settings in developing countries, such as in India (Selvaraj et al., 2018). Notwithstanding this similarity, the particularities of the Gaza Strip could have led to this high expenditure on medicines. Gaza's pharmaceutical market has been dependent on the supply of medicines and other health-related products from Israeli pharmaceutical manufacturers, which are priced to supply the more affluent Israeli and global markets (Obeidallah et al., 2000; Almi, 2012). Additionally, the pharmaceutical market in the Gaza Strip, similar to other developing countries, is unregulated, and the purchasing of medicines from private pharmacies without prescriptions is common (Beckerleg et al., 1999; Hammad et al., 2012).

The large share of spending on medicines has consistently contrasted with the share of household OOPP spent on inpatient services, which has ranged between less than 1% and 16%. This is similar to other settings in developing countries, such as Vietnam (Van Minh et al., 2013). The low percentage of OOPP spent on inpatient services implies the initial miniscule nature of private hospital services and the

population's reliance on government hospital services to receive inpatient care. Even though OOPPs on inpatient hospital services have been quite low throughout, they increased rapidly between 1996 and 2006; then they steadily decreased from 2007 to 2017. The change in this percentage is attributable to changes in the supply of private inpatient services, and the change in the demand for and the use of these services that resulted from the worsening of the macroeconomic situation in the Gaza Strip. Before the establishment of the PA in 1994, there was only one private hospital with 80 beds (State of Israel- Ministry of Health, 1994, p.12). During the period that followed the establishment of the PA, the number of private hospitals and their capacity increased exponentially. In 2017, there were 15 such hospitals and their capacity was 606 beds (PHIC - MoH, 2018, p.13). The per capita Gross Domestic Product decreased during the period between 2006 and 2017 by more than 25% from 2,115 USA dollars (USD) to 1,574 (USD) (PCBS, 2022 d). This deterioration in the financial situation explains the gradual decline in the OOPP spent on inpatient services.

Figure 4-9: Percentage of spending on medicines and health-related products as a share of OOPP among different quintiles between 1996 and 2017.

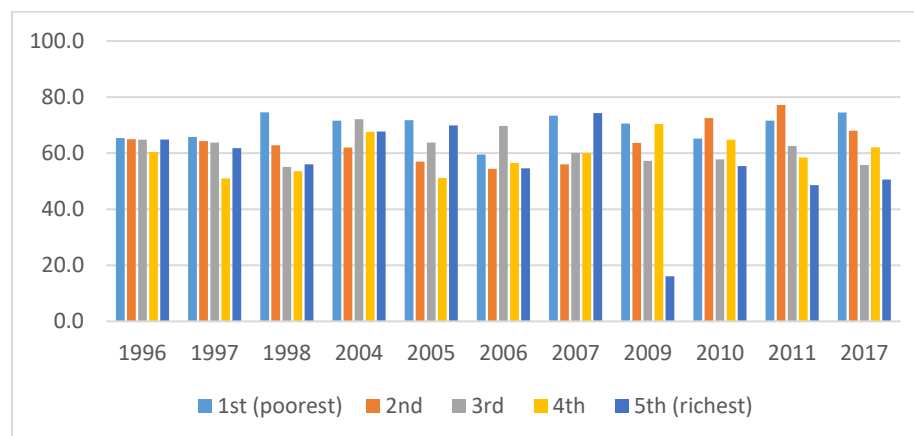


Figure 4-10: Percentage of spending on out-patient care as a share of OOPP among different quintiles between 1996 and 2017.

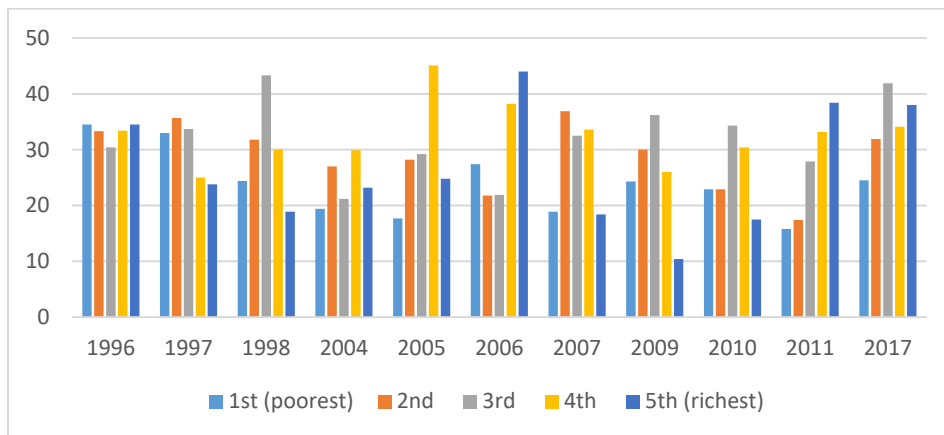
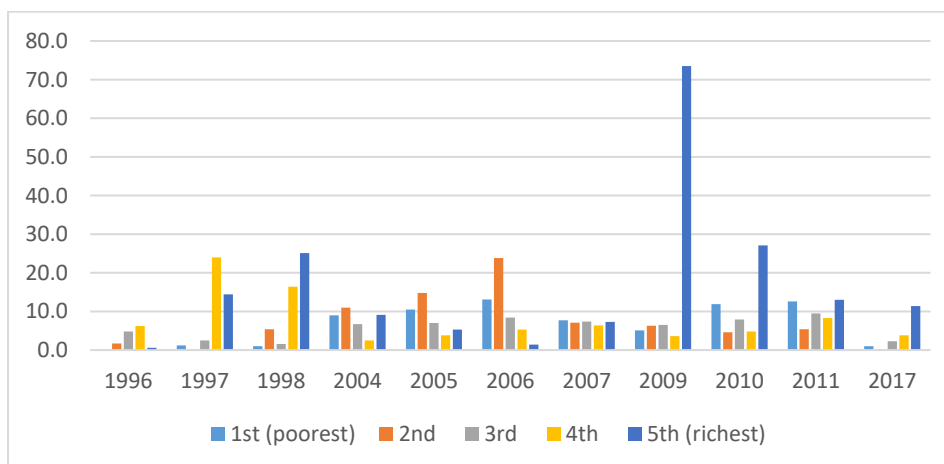


Figure 4-11: Percentage of spending on in-patient hospital care as a share of OOPP among different quintiles between 1996 and 2017.



Analysis of the composition of OOPP, which was stratified by the household consumption quintiles as proxies of wealth groups, are presented visually in Figures 4-9, 4-10, and 4-11. They show that there has not been significant visible change in the share of spending on medicines and health-related products among different wealth groups, there has been some changes in the share of spending on out-patient care since 2011 among wealth groups, whereby the spending has become stratified according the level of financial affluence. Importantly, there has been change in the share of spending on inpatient care since 2009, whereby the wealthiest group started to spend on inpatient care more than any other wealth group.

4.3.3 Change in the catastrophic effect of OOPP in the Gaza Strip between 1996 and 2017

Figure 4-12 shows that the overall incidence of CHE at the threshold of 10% of household consumption (from here CHE) fluctuated between 1996 and 2011, but surged remarkably in 2017. It shows that the quintile-specific CHE was the highest among the lowest consumption quintile in 1996. Thereafter, its distribution became mixed until 2007, after which CHE became consistently higher among the higher consumption quintile than the lower quintiles (See Annex IV-VIII).

Figure 4-13 shows that the overall intensity of CHE ranged between 0.3 and 0.4, except in 2006, when it was as low as 0.2; the highest values of its intensity were 0.66 and 0.69 in 2009 and 2017 respectively. The amounts that exceeded the thresholds of CHE, i.e. the intensity of CHE, were generally low, apart from the visible increases observed in 2009 and 2017. The quintile-specific intensity of CHE to some extent mirrored the pattern of the quintile-specific incidence of CHE (See Annexes IV-VIII and figure 4-13).

Figure 4-12: The overall and quintile-specific incidence of CHE in the Gaza Strip between 1996 and 2017.

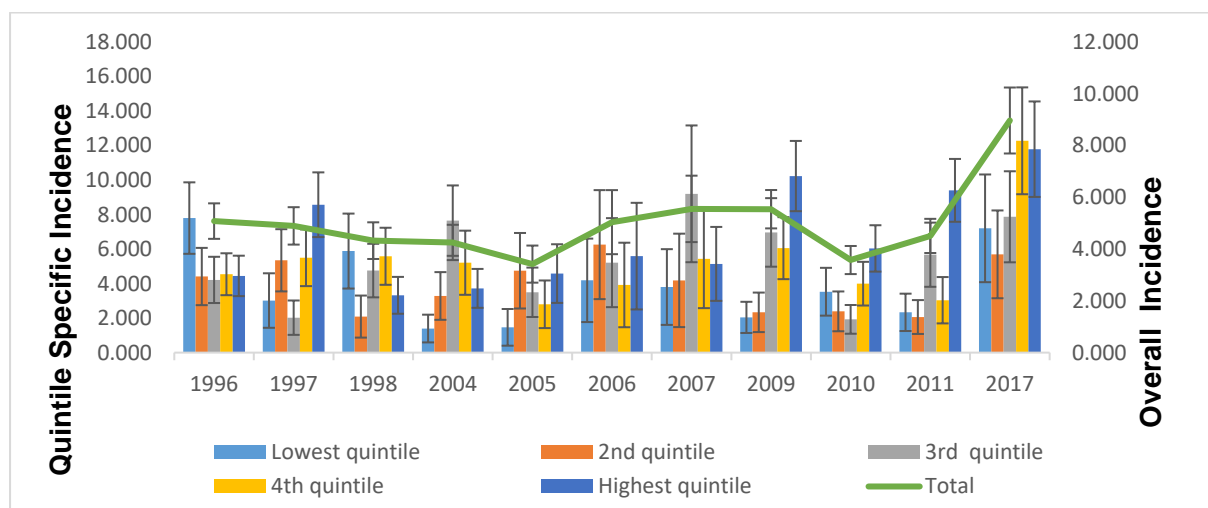
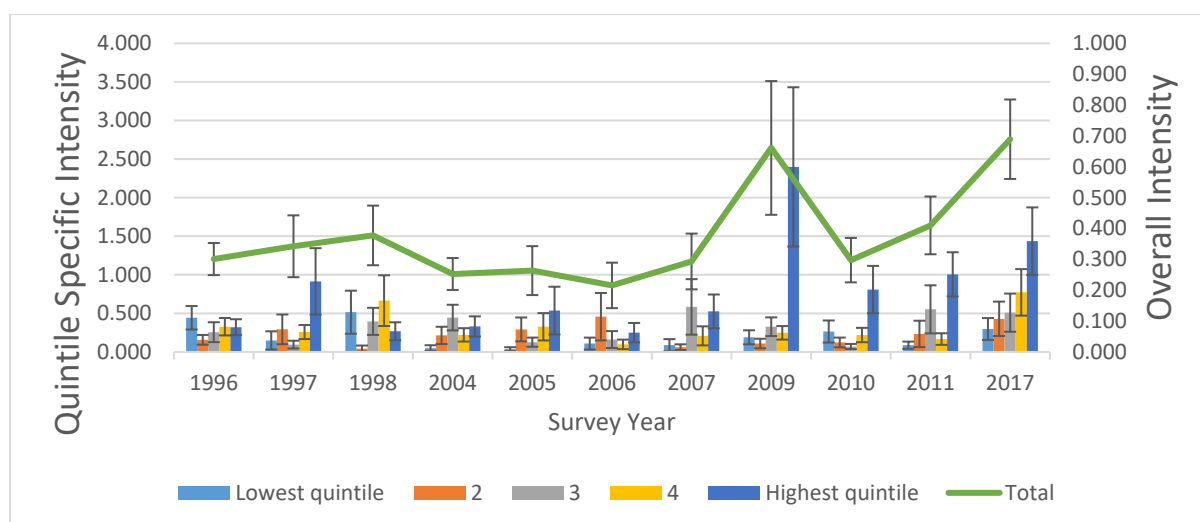


Figure 4-13: The overall and quintile-specific intensity of CHE in the Gaza Strip between 1996 and 2017.



Since the quintile-specific measures do not fully capture whether the financially worse-off or better-off groups were more affected by CHE, the distribution-sensitive measures of CHE are used (Wagstaff and van Doorslaer, 2003). These distribution sensitive measures are the Concentration Indexes and the Rank Weight of the incidence and intensity of CHE. The positive values of the Concentration Index indicate that there is a greater tendency for the better-off to exceed the catastrophic payment threshold, and the negative value indicates that the worse-off have a greater tendency to incur catastrophic payments on healthcare (Ibid). The rank-weighted incidence and intensity are greater than the incidence and intensity of CHE when CHEs are higher among the poor; and the ranked-weighted incidence and intensity are smaller than the incidence and intensity of CHE themselves when catastrophic payments are greater among the better-off (Ibid). I calculated these distribution sensitive measures using the World Bank software ADePT. The distribution sensitive measures are annexed in [Annex IV-XII]. They indicate when they are read in consultation with [Annexes IV-VIII, IV-IX, V-X, and IV-XI] as applicable to the interpretation of the Ranked-weighted measures that the concentrations of the incidence and to a lesser extent the intensity of CHE tended to alternate and to change across the better-off and the worse-off groups between 1996 and 2007. They then tended to be concentrated among the better-off groups from 2009 onwards.

This results subsection has shown that the incidence and intensity of CHE in the Gaza Strip are low. The proportions of the world population that incurred CHE at the 10% threshold were 9.7% in 2000, 11.4% in 2005, and 11.7% in 2010 (WHO and WB, 2017). Recent estimates indicate that 12.7% and 13.2% of the world's population incurred CHE in 2015 and 2017 respectively.¹⁴ Hence, the incidence of CHE is relatively low in comparison with global estimates.

Similar to the trend observed in the percent of OOPPs per cent of total consumption expenditure, the incidence of CHE went through seemingly, insignificant fluctuations during the span of the PECS rounds, apart from in 2017, when a remarkable increase is visible. Additionally, the change in the incidence of CHE among different wealth groups after 2009 imitates the change observed in the percentage of OOPPs as a share of household budget. Hence, it appears that the isolated increase in CHE in 2017 resulted from the reduction in household financial resources, expressed in consumption, rather from the increase in the scale of OOPPs, and that the change in the socioeconomic gradients between the different wealth groups after 2009 is attributable to the increasing amount of OOPP spent by the most financially affluent group of households.

4.3.4 Change in the effects of OOPPs on poverty

The fourth indicators that I have explored in this chapter are related to the effects of OOPP on poverty. These indicators are the poverty head count before (net) and after (gross) incurring OOPP on healthcare, and the poverty gap before (net) and after (gross) OOPP. Table 5-1- summarizes the indicators of the effects of OOPP on poverty. It shows the absolute and relative difference between the net and gross poverty indicators, and the proportion of the absolute poverty gap as a share of the poverty line at 1.9 international dollars per day. While the absolute difference is the result of subtracting the gross from the net difference, the relative difference is the absolute difference divided by the gross indicator (poverty head count or poverty gap as applicable). The proportion of the absolute difference in the poverty gap as a share of the poverty line is the absolute poverty gap difference in the local currency divided

¹⁴

<https://apps.who.int/gho/data/view.main.FINANCIALPROTECTIONWBINCOMEGROUP01v?lang=en>

by the poverty line in the same currency. To demonstrate which groups of households are most affected by the impacts of OOPP on the incidence of poverty, table 4-2 summarizes the absolute difference between the net and gross head counts among the different consumption quintiles of the households from 1996 to 2017.

Table 4-1 shows that the absolute poverty head count difference, i.e. the incidence of poverty resulting from incurring OOPP, ranged between a maximum of 4.22% in 1998 and a minimum of 2.34% in 1996. It appears from the results that the effects of OOPP on poverty did not have an overarching trend over time, especially during the period from 2004 to 2017. Although the absolute poverty gap difference almost doubled from 0.11 NIS in 1996 to 0.21 NIS in 2017, this increase disappears if the absolute difference in the poverty gap is normalized or adjusted to the value of the poverty line. Table 4-1 shows that the absolute poverty gap difference as a proportion of the poverty line was low and almost stable, ranging between 0.012 and 0.015. The low amounts of OOPPs, which were able to push people into poverty, are reflected in the predominance of the near-poor being pushed into poverty by their payments on health-related products and services. Table 4-2 shows that people from the quintiles adjacent to the poverty line, i.e. from the second (poor) and the third (middle) consumption quintiles, were those who were mainly impoverished by OOPP.

Table 4-1: Healthcare Impoverishments in the Gaza strip using the IPL of 1.9 International Dollar.

year	Poverty Head count		Difference		Poverty Gap (NIS)		Poverty Gap Difference			IPL at 1.9 dollars (in NIS)
	Gross (after OOPP) (%)	Net (before OOPP) (%)	Absolute (%)	Relative (%)	Gross (with OOPP)	Net (without OOPP)	Absolute (NIS)	Relative (%)	% of absolute difference as a share of IPL	
1996	50.62	52.96	2.34	4.62	1.260	1.370	0.110	8.730	1.36	8.069
1997	46.61	49.92	3.31	7.10	1.230	1.350	0.120	9.756	1.38	8.722
1998	46.27	50.49	4.22	9.12	1.280	1.420	0.140	10.938	1.52	9.235
2004	38.98	41.77	2.80	7.18	1.160	1.320	0.160	13.793	1.51	10.562
2005	35.80	38.94	3.14	8.78	1.050	1.190	0.140	13.333	1.29	10.821
2006	39.06	42.30	3.24	8.30	1.220	1.370	0.150	12.295	1.32	11.323
2007	54.93	58.01	3.08	5.61	2.140	2.300	0.160	7.4766	1.39	11.499
2009	39.68	42.44	2.76	6.95	1.430	1.610	0.180	12.587	1.32	13.686
2010	38.82	41.52	2.70	6.95	1.440	1.610	0.170	11.806	1.22	13.921
2011	38.23	41.74	3.51	9.19	1.330	1.520	0.190	14.286	1.36	14.001
2017	53.92	57.26	3.34	6.19	2.470	2.680	0.210	8.502	1.45	14.506

Table 4-2: Incidence of poverty resulted from OOPPs among different consumption quintiles of the households from 1996 to 2017

Year	Quintile				
	1 st	2 nd	3 rd	4 th	5 th
1996	0.000	0.077	11.002	0.250	0.000
1997	0.000	2.596	12.645	0.013	0.000
1998	0.000	9.454	9.299	0.548	0.000
2004	0.000	11.370	0.670	0.000	0.000
2005	0.000	13.009	0.897	0.000	0.000
2006	0.000	14.314	0.000	0.000	0.000
2007	0.000	0.000	14.216	0.000	0.000
2009	0.000	10.864	1.186	0.000	0.000
2010	0.000	10.841	1.186	0.000	0.000
2011	0.000	13.404	2.520	0.000	0.000
2017	0.000	0.000	15.577	0.000	0.000

The incidence of impoverishment in the Gaza Strip has been consistently far above the global average; it has been similar to the world's regions with the highest impacts of OOPPs on poverty, and similar to settings where poverty is highly prevalent. The WHO and the WB (2017) global monitoring report to track UHC provides data about the incidence of impoverishing health spending at the 2011 purchasing power parity of the 1.9 international dollars a day poverty line. The data indicate that the incidence of impoverishing health spending decreased globally from 2.1% in 2000 to 1.8% in 2005; then it decreased to 1.4% in 2010 (WHO and WB, 2017). Hence, the incidence of impoverishing OOPP has been consistently higher than the global average. Additionally, this incidence of impoverishing OOPP in the Gaza Strip has been above the incidence of impoverishment in most of the WHO and WB regions, including those to which the occupied Palestinian territories belong. The high incidence of impoverishment in the Gaza Strip is only similar to the WHO South East Asia region, where it was the highest among the six WHO regions, standing at 3.9% in 2000, 3.3% in 2005, and 3.1% in 2010 (WHO and WB, 2017). It is also similar to the incidence of impoverishment in the South Asia region, which has the highest incidence among the seven regions of the WB (Ibid). The incidence of impoverishment in the South Asia Region was 4.5% in 2000, 3.7% in 2005, and 3.5% in 2010. Only a few countries have recently reported a higher incidence of impoverishment due to OOPP than the highest recent estimates of impoverishment in the Gaza Strip in 2011, when it stood at 3.51%. These countries are Sierra Leone [13.42% in 2011], Bangladesh [6.98% in 2016], Afghanistan [4.52% in 2013] and India [4.16% in 2011] (WHO and WB, 2020: 34-37).

Similar to the comparatively high incidence of impoverishment, the poverty gap increase due to incurring OOPP is also high in the Gaza Strip. The global monitoring report on financial protection in health in 2019 produced by the WHO and the WB (2020) provides information about the poverty gap increase due to out-of-pocket health spending expressed as a percentage of different poverty lines, including the international poverty line of 1.9 international dollars per day. Comparing the poverty gap increase due to OOPP in the Gaza Strip at the International Poverty Line of 1.9 dollars with the information reveals that the increase in the Gaza Strip is higher than the most recent aggregate estimates for the oPt, i.e. the West Bank and the Gaza Strip

(WHO and the WB, 2020). Additionally, the increase in the poverty gap due to OOPP is higher than the estimates for most countries except countries and territories with a prevalence of poverty. Some of these higher estimates were reported from Sierra Leone [8.19% in 2011], Benin [3.06% in 2011], Bangladesh [2.69% in 2016], Afghanistan [1.94% in 2013], Uganda [1.51% in 2016], and Yemen [1.5% in 2014] (WHO and WB, 2020, pp.34-37). Since these countries and territories, similar to the Gaza Strip, are among the poorest areas of the world, it appears that the increase in the poverty gap and the incidence of impoverishment due to OOPP are related to the high prevalence of poverty.

4.3.5 Determinants of Catastrophic Health Expenditures (CHE) and Impoverishment and their change

The fifth set of findings presented in this chapter are related to the determinants of occurrences of Catastrophic Health Expenditure (CHE) and impoverishment resulting from household payments on healthcare. First, I present the findings of logistic regression models between the occurrence of CHE and different sets of multiple independent variables. These logistic regression models were fitted mainly to confer rigor on the findings that the incidence of CHE at the threshold of 10% was higher in 2017 than in the other years, and that the quintile-specific incidence became higher among the most privileged groups of households after 2009. Then I present the results of a logistic regression between occurrences of impoverishment that were influenced by OOPP, and the independent variables that presumably affected their occurrences. The main purpose of fitting this logistic regression model is to confirm that the incidence of impoverishment was stable from 1996 to 2017 when controlling for other independent variables. Additionally, these two models can shed light on variables that could have significantly influenced the financial hardship and impoverishment that resulted from OOPP from 1996 to 2017.

4. 3.5.1 Catastrophic Health Expenditures (CHE)

Table 4-3-a and table 4-3-b show the Odds Ratios (OR) from the multivariate stepwise models for the occurrence of CHE at the threshold of 10% (CHE10% thereafter). The ORs of all rounds of the PECS are lower than the most recent round in 2017, with a statistically significant P-value ($P < 0.0001$) after controlling for the other independent variables introduced in models 2-6. This confirms the statistical robustness of the finding that the incidence of CHE10% in 2017 was higher than in other years.

When the second model was introduced the OR of incurring CHE10% among those who paid premiums for health insurance was lower than for those who did not, with a statistically significant P value [**OR= 0.816 (0.685-0.971); P<0.05**], but the OR was attenuated after controlling for the independent variables introduced with the third model and the association was no longer statistically significant [**OR=0.915, (0.765-1.093); P>0.1**].

All of the independent variables introduced in the third (Household Structure) model are statistically significant at $P<0.05$ after controlling for the other independent variables. Households with no children or with fewer than five children have lower odds ratios and therefore less chance of incurring CHE10% than households with five or more children ($P<0.05$). Households without any person over the age of 65 have lower odds ratios and therefore less chance of incurring CHE10% than those with at least one household member aged at least 65 years old or older; this result is statistically significant at the level of $p<0.05$ [**OR=0.705 (0.511-0.972); P=0.033**]. Grouped categories of households with less than 10 persons have higher odds ratios of incurring CHE, and therefore chances, of incurring CHE10% than households with at least 10 household members (**P=0.003**).

That households with less than five children aged 14 or less have lower odds ratios and therefore less chance of incurring CHE10% than households with five or more children is plausible. Having more children can lead to increased demand for healthcare services and possibly to increased payments for healthcare. The finding that households with no-one aged 65 years or above have a lower chance of facing financial catastrophes as a result of healthcare payments than households with at least one member in this age group is plausible. People aged above 65 years old are expected to be more likely to have morbid health conditions, and households where they live are therefore expected to pay more for healthcare. This finding is consistent with research in Turkey (Yardim et al., 2010), Thailand (Somkotra and Lagrada, 2009), China (Li et al., 2012), Vietnam (Minh et al., 2013), and many other countries. The finding that the occurrence of CHE is inversely associated with family size is similar to results in other international settings. Research done by Van Minh et al. (2013) in Vietnam, Li et al. (2012) in China, Kronenberg and Barros (2014) in Portugal, and Brown et al. (2014) in Turkey showed similar findings. However, other studies have found the opposite: that the size of households is a risk factor for financial

catastrophes (for example the studies by Li et al. (2013) in China, Su et al. (2006) in Burkina Faso, and Narıcı et al.(2015) in Turkey). The evidence that households with large families in the Gaza Strip are less susceptible to the burden of OOPP could be attributed to the hypothesis that people who live in larger families can provide care to other family members when they are sick, meaning they use health services less and therefore have a decreased requirement for OOPP, as suggested by Halliday and Park (2009). Additionally, larger households could also find more support and resources from the broader social network when one of their members encounters an illness, as suggested by Van Minh et al. (2013).

Except for the variable that depicts the literacy of household heads, none of the other independent variables that were introduced in the fourth model (household heads' characteristics' correlates) have statistically significant ORs. Households headed by illiterate family members have a statistically significantly higher OR of incurring CHE10% than those headed by a person who can read and write [OR =1.515 (1.130-2.032); 0.001< P<0.01]. This evidence that households headed by an illiterate person have more chance of catastrophic health expenditure than households headed by a person who can read and write could be explained by the demand for healthcare. Households with less education may be less efficient in maintaining their health and may make less effective use of healthcare and preventive services (Grossman, 1972). Hence, households headed by an illiterate individual may be less efficient in maintaining the health of their members and therefore their use of and payment for healthcare may be higher than their literate counterparts.

The odds ratios of incurring CHE10% among households in the lower consumption quintiles during the period between 1996 and 2017 are less than one (i.e. the odds ratio related to the fifth (richest) quintile), and have a P value of less than 0.0001. The first (poorest) consumption quintile has an odds ratio of 0.49 [**95% Confidence Interval (CI) between 0.33 and 0.72; P<0.0001**]. Similarly, the second (poor) and third (middle) quintiles have lower odds ratios than one with a statistically significant p value of less than 0.05 [**OR=0.33, 95% CI (0.22-0.50); P<0.0001 for second quintile; and OR=0.63, 95% CI (0.45-0.88); P<0.01 for third quintile**]. Although the odds ratio for incurring CHE10% for the fourth (rich) quintile is lower than unity, it is not statistically significant [**OR= 0.83 (0.62-1.12); p>0.05**]. This evidence, that households with lower per capita consumption quintiles have less chance of

incurring catastrophic health expenditure than those from the highest quintiles, is consistent with findings in other settings, for example in Thailand (Somkotra and Lagrada, 2009), Vietnam and Turkey (Brown et al., 2014; Narıcı et al., 2015) as well as in Kenyan slum communities (Buigut et al., 2015).

The sixth model of the logistic regression analysis shows that the interaction between the two identified periods [(1996-2007) & (2009-2017)] and the consumption expenditure quintiles is statistically different at $0.001 < p < 0.05$. The statistically significant results of this interaction, alongside improvements in the model fitness through increasing the Nagelkerke R square, confer statistical robustness on the previous findings (in subsection 4.3.3) that the incidence of CHE10% during the first period from 1996 to 2007 was concentrated differently from the second period from 2009 to 2017. This confirms that the socioeconomic gradients in the occurrence of catastrophic health expenditure after 2009 changed direction over the time period, such that during the first period [1996-2007] the lower quintiles were at a greater risk of incurring catastrophic health expenditure, while the opposite was the case in the second period [2009-2017]. The logistic regression results show that households from the first (poorest) quintile during the period from 1996 to 2007 had 1.6 times the odds of incurring CHE10% compared to those of the same quintile during the period between 2009 and 2017. However, these results related to the first quintile have marginal statistical significance, i.e. a p value of more than 0.05, but less than 0.1 [**OR=1.63, 95%CI (0.97-2.73); p=0.064**]. Households from the second (poor) quintile during the first period between 1996 and 2007 had almost three times the odds of incurring CHE10% compared to those from the same quintile during the second period [2009-2017]; this is statistically significant, the p value being less than 0.0001 [**OR= 2.94, 95% CI (1.74-4.98); P<0.0001**]. Households from the third (middle) quintile during the first period [1996-2007] had 1.5 times the odds of incurring CHE10% compared to those from the same quintile (middle) during the second period [2009-2017]; but with marginal statistical significance; i.e. a p value of more than 0.05 but less than 0.1 [**OR= 1.5, 95% CI (0.94-2.40); P=0.087**].

When the independent variables related to refugee status and household place of residence (in the refugee camps versus outside them) were included in the logistics regression analysis during the period between 2004 and 2017, this did not change the

overall results. Additionally, neither of the odds ratios for incurring CHE10% of the variables introduced was statistically significant (See Annex IV-XIII).

Table 4-3-a: Multivariate odds ratios of incurring CHE by the time, healthcare access and household structure correlates during the period from 1996 to 2017 [the first 3 blocks].

Model	1st	2nd	3rd
2Likelihood	5083.216	5078.48	4953.94
Nagelkerke R Square	0.009	0.01	0.042
Hosmer&	1	0.854	0.118
Years (2017 reference)	****	***	**
1996	0.577 (0.428-0.777) ***	0.555(0.411-0.749)***	0.595 (0.438-0.808)**
1997	0.608 (0.441-0.836)**	0.606 (0.440-0.834)**	0.635 (0.458-0.880) **
1998	0.560 (0.398-0.788)**	0.555 (0.394-0.780)**	0.582(0.411-0.825) **
2004	0.567 (0.411-0.781)**	0.599(0.433-0.830)**	0.600 (0.432-0.834) **
2005	0.426(0.285-0.638)***	0.454 (0.302-0.682)***	0.478(0.317-0.720) ***
2006	0.470 (0.290-0.760)**	0.477(0.295-0.772)**	0.510 (0.314-0.828) **
2007	0.644(0.418-0.994)*	0.623 (0.403-0.962) *	0.648 (0.418-1.005) +
2009	0.695(0.524-0.922)*	0.733 (0.550-0.976)*	0.713 (0.534-0.951) *
2010	0.487(0.356-0.667) ***	0.519 (0.378-0.713)***	0.501(0.364-0.691) ***
2011	0.551(0.413-0.736)***	0.590 (0.439-0.793)***	0.581 (0.431-0.782)***
Payment for health insurance (Did not pay -reference)			
Paid for health Insurance		0.816(0.685-0.971)*	0.919 (0.771-1.096)
Number of children (5 or more - reference)			*
No children			0.864 (0.645-1.157)
1-2 children			0.630 (0.458-0.868) **
3-4 children			0.773 (0.600-0.995) *
Availability of 65 years old or older households members (Yes- reference)			
No			0.624 (0.514-0.759) ***
Number of households' members (10 or more - reference)			***
1-4 members			2.885 (2.056-4.049)***
5-7 members			1.669 (1.253-2.224) ***
8-9 members			1.353 (1.006-1.819)*
Constant	0.105 ***	0.117***	0.108***

Table 4-3-b: Multivariate odds ratios of incurring CHE including household head's correlates, proxies of income, and the interaction between proxies of income and two identified periods ([1996-2007] and (2009-2017)) [the last 3 blocks].

Model	4th	5 th	6 th
2Likelihood	4953.94	4927.009	4907.448
Nagelkerke R Square	0.042	0.047	0.051
Hosmer&	0.118	0.272	0.796
Years (2017 reference)	***	***	***
1996	0.555 (0.406-0.758)***	0.527 (0.385-0.720)***	0.382 (0.256-0.571)***
1997	0.598(0.430-0.832)**	0.567 (0.407-0.790) **	0.412 (0.272-0.625)***
1998	0.546 (0.384-0.777) **	0.515 (0.361-0.734) ***	0.375 (0,243-0.578)***
2004	0.571 (0.410-0.796)**	0.548(0.393-0.765) ***	0.399 (0.264-0.604)***
2005	0.458 (0.303-0.692)***	0.442 (0.292-0.668) ***	0.320 (0.197-0.519) ***
2006	0.490 (0.301-0.796)**	0.467 (0.287-0.760)**	0.341 (0.197-0.588)***
2007	0.630 (0.406-0.977)*	0.610 (0.393-0.947)*	0.443(0.267-0.734)**
2009	0.696(0.521-0.930)*	0.688(0.515-0.920) *	0.686 (0.513-0.919)*
2010	0.489 (0.355-0.674)***	0.479(0.347-0.661)***	0.474 (0.343-0.656)***
2011	0.576 (0.428-0.776) ***	0.563 (0.418-0.758) ***	0.557 (0.413-0.752)***
Payment for health insurance (Did not pay -reference)			
Paid for health Insurance	0.922 (0.772-1.101)	0.913 (0.765-1.091)	0.915 (0.765-1.093)
Number of children (5 or more- reference) *		*	*
No children	0.942 (0.688-1.291)	0.833 (0.604-1.149)	0.855 (0.619-1.183)
1-2 children	0.649 (0.469-0.897)**	0.614 (0.443-0.850)**	0.636 (0.459-0.883)**
3-4 children	0.774 (0.600-0.997)*	0.741 (0.574-0.957)*	0.763 (0.590-0.986) *
Availability of 65 years old or older households members (Yes- reference)			
No	0.707 (0.513-0.974)*	0.701 (0.508-0.967)*	0.705 (0.511-0.972)*
(10 or more - R)	***	**	**
1-4 members	2.534(1.741-3.689) ***	2.078(1.409-3.065) ***	2.101(1.421-3.106)***
5-7 members	1.563 (1.158-2.109) **	1.425(1.051-1.933)*	1.480(1.089-2.012) *
8-9 members	1.311 (0.973-1.767)+	1.264 (0.936-1.706)	1.327 (0.981-1.793)*
Sex of the head of the household (Female -reference)			
Male	1.183 (0.880-1.591)	1.190 (0.884-1.603)	1.198 (0.889-1.614)
Literacy status of the head of the households (Literate - reference)			
Illiterate	1.373 (1.027-1.835) *	1.496 (1.115-2.007) **	1.515 (1.130-2.032)**
Age of the head of the households (65 years and above - reference)			
15-34 years	1.032 (0.683-1.559)	1.089 (0.720-1.647)	1.087 (0.718-1.646)
35-54 years	0.916 (0.611-1.375)	0.938 (0.624-1.410)	0.946 (0.629-1.423)
55-64 years	0.805 (0.517-1.253)	0.806 (0.517-1.256)	0.796 (0.511-1.241)
Quintiles		**	***
1st Lowest		0.610 (0.454-0.820)**	0.486(0.329-0.718)***
2nd Second lowest		0.582 (0.440-0.769)***	0.328 (0.217-0.496) ***
3rd Middle		0.765 (0.597-0.981)*	0.632 (0.454-0.880)**
4th Second highest		0.871 (0.694-1.092)	0.834 (0.623-1.116)
Interaction (Highest during the second period (2009-2017) – reference			**
1st Lowest (1996-2007)			1.628 (0.972-2.726)+
2nd (1996-2007)			2.944 (1.739-4.984)***
3rd (1996-2007)			1.502 (0.942-2.395)+
4th (1996-2007)			1.086 (0.696-1.695)
Constant	0.092***	0.140 ***	0.152 ***

4.3.5.2 Determinants of OOPPs effects on poverty

Table 4-4 shows the odds ratios (OR) from the multivariate stepwise logistic regression models for the occurrence of impoverishment at the International Poverty Line (IPL) of 1.9 dollars per day, which resulted from incurring OOPP for health-related products and services.

The previous results subsection (4.3.4) demonstrated that the incidence of impoverishment resulting from OOPP did not follow a consistent pattern or trend. These results were confirmed using logistic regression. The odds ratios of incurring impoverishment at the IPL of 1.9 dollars during the first ten rounds of the PECS, from 1996 to 2011, were not statistically significant at $P < 0.05$, from the occurrences of impoverishment during the 11th round in 2017. However, the robustness of the last model for assessing the influence on impoverishment is not strong, as the Nagelkerke R square did not reach 0.05, though it improved gradually after introducing new sets of explanatory independent variables.

When the second block was introduced, the model showed that households that paid premiums for enrolment in a health insurance scheme had a higher odds ratio of impoverishment than those that did not pay such premiums [**OR = 2.283, 95% CI (1.68 – 3.10), $P < 0.0001$**]. The odds ratios of the independent variables introduced with the third and the fourth models, i.e household structure and household head characteristics respectively, were not statistically different at a p-value of < 0.05 . Similar to what was found with CHE10%, the introduction of the refugee status of the households and their place of residence into the second model did not change the overall results of the models that attempted to explain the occurrence of impoverishment during the period from 2004 to 2017. Although there were some small improvements in the robustness of the logistic regression expressed in the Nagelkerke R square, the odds ratios of both of the variables introduced i.e. refugee status and place of residence, were not statistically different from their referenced dichotomy (Annex IV-XIV).

The finding that payments for health insurance, as a proxy for enrolment in it, refugee status, which entails entitlement to UNRWA healthcare services, and place of residence being in a refugee camp as a proxy for better access to UNRWA services, did not protect people from financial catastrophes and impoverishment resulting from

incurring OOPP could be seen as counterintuitive. Additionally, the increased chance of impoverishment associated with payments for insurance could also be seen as counterintuitive. However, these findings are similar to findings found in other settings. Wagstaff and Lindelow (2008) explained the findings of their empirical studies in China, which showed that health insurance was more likely to increase OOPP, CHE and large health expenditure, suggesting that health insurance makes people more likely to use healthcare providers and to move up the provider 'ladder'. The explanation of Wagstaff and Lindelow (2008) could be relevant to the case of the Gaza Strip. People who have better access to healthcare can move more frequently from using the publicly provided healthcare to using private healthcare or to purchasing medicines than those who do not have good access to healthcare. Additionally, the payment of health insurance premiums and enrolment in health insurance schemes can be a manifestation of adverse selection. Adverse selection is one characteristic of the Government Health Insurance in the occupied Palestinian territories (oPt) (Schoenbaum et al., 2005). One example of adverse selection is when a person or a household enrolls in health insurance only after knowing that they are sick and in need of healthcare. Accordingly, one can postulate that households who paid for and who were enrolled in health insurance schemes were more likely to have more morbid conditions and therefore incurred more OOPPs for healthcare.

Table 4-4: Multivariate odds ratios of incurring healthcare impoverishment at the IPL 1.9 International Dollars by time, healthcare access, household structure, and household-head correlates during the period from 1996 to 2017.

Model	1st	2nd	3rd	4th
2Likelihood	2875.231	2840.036	2818.176	28.13.731
Nagelkerke R square	0.001	0.015	0.024	0.026
Hosmer&	1	0.881	0.35	0.339

	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
PECS Rounds ' Years (2017 reference)				
1996	0.850 (0.525-1.376)	0.996 (0.613-1.619)	0.902 (0.550-1.478)	0.844 (0.513-1.391)
1997	1.181 (0.734-1.902)	1.196 (0.742-1.929)	1.094 (0.673-1.779)	1.028 (0.629-1.678)
1998	1.175 (0.718-1.922)	1.217 (0.743-1.994)	1.092 (0.661-1.807)	1.029 (0.620-1.709)
2004	1.054 (0.649-1.711)	0.869 (0.534-1.416)	0.821 (0.502-1.343)	0.786 (0.479-1.288)
2005	0.960 (0.551-1.671)	0.775 (0.444-1.355)	0.727 (0.415-1.273)	0.698 (0.398-1.225)
2006	1.053 (0.533-2.004)	0.994 (0.521-1.895)	0.930 (0.486-1.779)	0.899 (0.469-1.722)
2007	0.887(0.443-1.775)	1.019 (0.508-2.046)	0.963 (0.479-1.939)	0.936 (0.465-1.886)
2009	0.910 (0.567-1.459)	0.758 (0.471-1.220)	0.755 (0.468-1.216)	0.734 (0.455-1.184)
2010	0.925 (0.577-1.485)	0.748 (0.464-1.205)	0.736 (0.456-1.187)	0.723 (0.448-1.167)
2011	1.082 (0.697-1.681)	0.861 (0.552-1.345)	0.829 (0.530-1.295)	0.820 (0.524-1.283)
Payment for health insurance (Did not pay -reference)				
Paid for health Insurance		2.358 (1.745-3.185) ***	2.259 (1.67-3.06) ***	2.283 (1.684-3.096) ***
Size of the households (10 household members or more - reference)				
1-4 household members			0.880 (0.544-1.426)	0.773 (0.451-1.325)
5-7 household members			0.907 (0.648-1.269)	0.853 (0.594-1.225)
8-9 household members			1.225 (0.888-1.690)	1.211 (0.874-1.678)
Availability of 65 years old or older households members (Yes- reference)				
No			0.975 (0.703-1.351)	0.927 (0.599-1.435)
Number of children under the age of 14 years (5 or more children - reference)				
No children			0.610 (0.403-0.922)	0.638(0.405-1.006)
1-2 children			0.777 (0.519-1.162)	0.791 (0.525-1.193)
3-4 children			0.966 (0.718-1.299)	0.963 (0.714-1.298)
Sex of the head of the household (Female - reference)				
Male				0.998 (0.589-1.693)
Literacy status of the head of the households (Literate reference)				
Illiterate				1.422 (0.894-2.262)
Age of the head of the households (65 years and above - reference)				
15-34 years				1.461 (0.747-2.859)
35-54 years				1.172 (0.610-2.251)
55-64 years				1.265 (0.629-2.544)
Constant	0.029 ***	0.017 ***	0.022 ***	0.019***

4.4 Discussion and conclusions

This chapter has shown that the percentage of OOPP as a share of overall consumption was stable during the period from 1996 to 2011. In 2017, it became higher and statistically significantly, in contrast to the previous years between 1996 and 2011. This higher percentage of OOPP as a share of consumption resulted from a drop in overall consumption rather than from increasing levels of OOPP. It was also shown that the percentage of OOPP as a share of overall consumption became much higher among the higher consumption quintiles than the lower quintiles after 2009. This increase in the percentage of OOPP as a share of household consumption in 2017 was reflected in the increasing level of catastrophic OOPP at the threshold of 10% of overall consumption during the same year. Similarly, the change in the pattern of the distribution of the percentages of OOPP as a share of consumption among the different quintiles after 2009 was reflected in the distribution of catastrophic OOPP after 2009. CHE10% became concentrated among the highest consumption quintile after 2009, while their distribution among the quintiles did not have any overarching consistent pattern during the period from 1996 to 2007. This change in the pattern of distribution of CHE10% among the different consumption quintiles was confirmed by the distribution-sensitive measures, i.e. the Concentration Indexes and Rank Weight of CHE, and by the logistic regression. Furthermore, the logistic regression confirmed that CHE10% between 1996 and 2011 was lower than in 2017.

This chapter has shown that the levels of OOPP and CHE in the Gaza Strip were low in comparison with other global and regional settings. It also showed that OOPP was consistently dominated by spending on pharmaceuticals and medical consumables. However, expenditure on this component of healthcare payments decreased steadily from 1996 to 2006; it then increased to return to its original levels. While expenditure on outpatient care was steady, expenditure on inpatient care increased steadily from 1996 to 2006, and then decreased.

The effects of OOPP on poverty were high in comparison with other global and regional settings. These effects are comparable with countries where poverty is widespread and highly prevalent. This pattern suggests that these effects are related to the widespread poverty in the Gaza Strip, rather than to OOPP. The incidence of impoverishment and the poverty gap due to OOPP were stable from 1996 to 2017.

The stable incidence of impoverishment was confirmed using logistic regression models.

Chapter 5

Continuing healthcare for dispossessed people

“I received inhalers in prison the same way as I receive them when I was in Gaza, from the Swedish (clinic) [UNRWA’s largest PHC centre in Gaza City]. They handed me inhalers, the same way, and I was living on them. My use of inhalers even decreased when I was in the Negev [detention camp] as a result of the weather there”.

(Rantisi, 42 years old man with lung cancer)

5.1 Introduction

In this chapter, I present the main findings of the interviews that I carried out in 29 households with 33 interviewees in the Gaza Strip between September 2016 and September 2017. The main objective of these interviews was to capture the experience of the interviewees when they and their family members accessed healthcare services and when they paid for them across different times, especially after the start of the first Palestinian intifada in 1987. This overarching objective was pursued through assessing changes in the financial and social barriers to accessing healthcare; the adaptive mechanisms that had been used to overcome these barriers; and the pattern of and changes in the interviewees’ choice of healthcare providers. After this brief introduction, I will present some preliminary reflections on my observation about the content and context of the fieldwork and interviews. Following these reflections, I will present the results of analysing these interviews. I will then present a discussion of the findings and will conclude the chapter by presenting my conclusions.

5.2 Preliminary reflections

At the outset, the purpose of the interviews with household members in Gaza was to understand their experiences with healthcare, and how these had changed over the last three decades. However, the interviewees tended to focus on the impact on the conflict on their living conditions and the general financial burden. Additionally, the

responses of some participants went beyond the targeted time period. Some childbirth experiences were dated even to the 1960s, and some personal experiences with healthcare services related to the mid-1950s. I felt that I had an ethical obligation to report the responses of the interviewees in regard to their experience of the conflict and their financial difficulties. The initial quote in this chapter serves as a metaphor that captures the interconnectedness between the treatment-seeking experiences and the living conditions of a population that lives in an imprisoned area. The previous UN special rapporteur on the situation of Human Rights in the oPt, John Dugard, described the Gaza Strip as an occupied and imprisoned territory, and the current rapporteur, Francesca Albanese, described the territory to be an open air prison with a multi-layered architecture of confinement (Dugard, 2007; Albanese, 2023).

The housing conditions of the residential units where the interviews were carried out were not always satisfactory. For example, a couple whom I interviewed in their mid-30s had lived with their three daughters in a large polythene tent since 2010. I interviewed them near the tent. Another couple (a 48 year old woman and her 50 year old husband) lived in a small house in a refugee camp near the sea shore with their 7 children, including a disabled daughter; their house had been built similarly to the camp houses in the 1970s. They described their living conditions:

“Living in the camp is suffering and living in this part of the camp is concentrated suffering.” .. “we are living near the sea. Living near the sea is difficult, especially during the winter time.”

Most of the interviewees who resided in urban and semi-urban areas lived in buildings with a few (2-4) storeys, which were packed with large joint families, including their parents, the families of their siblings, or their married sons. The external walls of these buildings showed bare cement bricks as they were neither painted nor covered with grey cement stucco. Some of the alleys that I walked through to reach the interviewees living in the refugee camps were as narrow as one metre or even less. Since Israel bombed the local electricity station in 2006, the Gaza Strip has been experiencing a shortage of electricity. The interviews were sometimes conducted in

rooms or workshops lit by candles, portable electric lights or even by the torches on mobile phones. The recording of my interview with Majdeya (a 69 year old woman) took place in a women's activity centre and was disrupted by the loud sound of an electricity generator in the background. Similarly, the audiotaped interview sessions with Khalil, a 51 year old, which took place in his cycle workshop, recorded a small but noisy electricity generator being switched on and off, and he (Khalil) lit the space with a battery-run torch when the electricity was off.

The interviewees recounted their living experiences and recalled their life events by connecting them to critical historical milestones and to salient dates in modern history. For example, Halima (a 71 year old woman) connected the dates of the birth of her sons to the Israeli occupation of the Gaza Strip in 1967, and recalled that the birth of her fourth child coincided with the death of the late Egyptian president in 1970.

“When the Israelis entered Gaza (in 1967) I had a son in my hands and another son who was 3 years old...” “I gave birth to him [fourth child] on that day, when Abdul Nasser died. I was with women in Jabaliya. My husband's family lived in Jabaliya camp. Women started screaming: “Oh my God, it is harsh for us.” They started slapping their own faces and doing these things. I went to the graveyard with them. I went back home and at the end of the day they took me to the clinic. I delivered him at Jabaliya clinic”.

5.3 Results

The results of the analysis are presented below in five main themes. The first theme relates to the impacts of the conflict on the living conditions of the interviewees. The second theme, which emphasizes the continuing dependence on publicly provided healthcare, captures the pattern of healthcare-seeking behaviours and access to healthcare and presents the options available in terms of accessing healthcare. The third theme captures the interviewees' perceptions about the quality and performance of the healthcare they had accessed. The fourth theme focuses on the financial burden of accessing healthcare and the adaptive mechanisms used to cope with this burden.

The fifth theme captures the stability and changes reported by the interviewees. The themes vary in terms of their density and structure.

5.3.1 Socioeconomic impact of conflict on households

Most of the interviewees indicated that they had had traumatic experiences as a result of the conflict. The interviews suggested that there had been a gradual worsening of the interviewees' financial conditions and that many of them had become dependent on financial aid.

Living in a conflict area

Most of the interviewees reported experiencing severe effects of the conflict on their lives, including displacement and deportation, the death of first-degree relatives, imprisonment, and injuries. Two of the interviewees who were born before 1948 reported that they were displaced with their parents when they were very young, from neighbouring villages into the Gaza Strip. Three interviewees had experienced deportation following the 1967 war.

Five of the interviewees reported the deaths of family members at various stages of the conflict. These ranged from accounts of losing one's father or brother to Israeli soldiers in the 1950s, 1960s, and 1990s to losing their sons to shelling in 2004 or to an assault as recently as 2014. Besides the deaths of family members, the interviewees also reported their own imprisonment or injuries, and injuries inflicted on family members. Six of the male interviewees reported that they had been imprisoned by the Israeli army. Seven of the interviewees reported that they or their family members had been injured by the Israeli army. One reported that two of her sons had been injured during the internal Palestinian factional confrontations in 2006-2007.

The effects of conflict on the financial conditions

Some of the interviewees gave accounts of earlier years, when they, their spouses, or their parents had started working in Israel. They indicated that economic opportunities in the Gaza Strip had become limited, which led them to look for work opportunities in Israel. More than half (16 out of 29) of the interviewees indicated that the breadwinners in their households worked in Israel, which benefited their financial situation.

The start of the first Intifada in December 1987 marked the beginning of worsening financial conditions but this change was neither sharp nor abrupt. Only a few young people, who used to work inside Israel before the Intifada, stopped working there after it started. Although not all of those who worked in Israel stopped working there, economic activities began to decline after the first Intifada.

An analysis of the time when most of those who worked in Israel stopped doing so indicates that most of them stopped working there after 2000, and all of them had stopped by 2006.

The conflict itself had direct or indirect effects on the financial conditions of most of the participants, but some interviewees reported more traumatic experiences that had led to substantial financial losses. Abou Taleb (a 51 year old man) shared an account of the impact of an Israeli incursion on his business. He reported that his sewing business, in which he employed dozens of workers, was destroyed in 2006 during an Israeli incursion into the refugee camp where his business had been erected. He indicated that the destruction of his factory had transformed him from a semi-millionaire into a poor man seeking financial assistance.

Dependence on financial aid

More than half of the interviewees indicated that they received financial assistance from one or more sources. Almost one third of the interviewees indicated that their households received regular financial assistance from the Ministry of Social Affairs (MoSA) of the PA, while some received additional financial support or food supplies from other sources, including from the UNRWA. Additionally, seven of the interviewees reported receiving financial support from other sources, including individuals and charitable bodies. Martyr salaries helped Shaer (a 51 year old man) and Majdyea (a 69 year old woman) to get by.

The worst is now

While the interviewees shared the hardships they had faced across the time period captured by the interviews, many of them repeatedly indicated that the time when the interviews were being carried out was the harshest yet.

For example, Fadya (46 year old woman) indicated that her husband, who used to work in Israel before he was slightly injured in 1990, managed their lives through a small import and export business between Gaza and Egypt and through selling at temporary roaming markets. She indicated that the taxes and tariffs imposed by Hamas on their small business had made it unprofitable. She added that her siblings assisted her family, but that the financial conditions of her brothers, who were employed by the PA and paid through the Ramallah payroll, meant that they could not assist her now as the PA had reduced the salaries of its employees in Gaza:

“.. nowadays I have tight times ... most of times, that we encounter very tight situations that only our God knows about. I could not go to my brothers as I understand that their income is becoming less and less. I cannot throw myself at them”.

Sameera (42 year old woman) who lived with her three children and her husband in severe poverty indicated that the assistance that she used to receive from Islamic charities had decreased during the last few years, before the interview.

5.3.2 Organization of healthcare and the persistence of the public sector role

“We had never gone to the doctors-for-money (private doctors), but we were referred to al-Shifa (government) hospital by the UNRWA doctors. Now we have (government) health insurance. If we need, we can use health insurance and we can go to al Shifa (government) hospital, but I do not need to go to the hospital now I go to UNRWA. UNRWA treatment is good and it saves our money”.

Halima (71 year old woman)

This theme, which captures the interviewees' healthcare-seeking experiences, reveals the plurality of healthcare options available to the interviewees and their households. These options include public and private providers of healthcare. The interviewees repeatedly indicated that publicly provided healthcare was their most frequently accessed option. While some of the interviewees indicated that they barely used private healthcare, others reported combining and supplementing their dominant use of publicly provided healthcare with private healthcare. Besides using the public and private healthcare options available in the Gaza Strip, the interviewees reported receiving healthcare services outside the Gaza Strip. In addition to allopathic

healthcare, the interviewees indicated that they also accessed the services of traditional and spiritual healers. The access to these healers has decreased gradually, but it has not ceased. The interviewees rarely suggested that there had been changes in their individual or household experience in terms of their use of healthcare. However, comparing early and late accounts gave some insights into changes in the use of public and private healthcare. Additionally, some earlier accounts that spanned extended periods of time provided insights about changes that occurred in individual and household experiences. Earlier accounts from the oldest interviewees indicated that the publicly provided healthcare services had been almost the only option used by them for their own health conditions during their childhood, adolescence, and early adulthood before their marriage. Additionally, these accounts indicated that these publicly-provided healthcare services were most often used for antenatal checks and childbirth assistance by the interviewees or for their spouses, and they used these publicly-provided services mostly for treating their children. Later accounts of younger interviewees indicated that the use of publicly-provided healthcare had been supplemented by the occasional use of private healthcare. The apparently dominant use of publicly-provided services can be attributed to the fact that these services are either low cost or free of charge. Hence, changes in terms of using healthcare could have resulted from a change in individuals' or households' financial conditions. Beside changes in financial conditions, changes in the use of healthcare may have resulted from changes in the health conditions of household members and from changes in the healthcare system.

The parenthood of publicly-provided healthcare

Most of the interviewees repeatedly indicated their use of the government hospitals and UNRWA PHC. Some, who are not entitled to the UNRWA healthcare, reported more frequent use of the government PHC services. Fewer interviewees reported incidental use of the Police Medical Services. Most of the interviewees reported that the emergency and reception rooms of government hospitals and PHC centres of the UNRWA had been their first resort when accessing healthcare.

UNRWA: our mother and address

“As a camp?? Just UNRWA clinic”.
“We all depend on UNRWA”.

Harb (60 year old man)

“To UNRWA, to UNRWA. The address is known”.

“The (UNRWA) clinic is the mother of all”.

(Shaer, 54 year old man)

Most of the refugee interviewees, especially those who were living in refugee camps, emphasized the UNRWA's role in their lives. Most of the interviewees who were refugees or married to refugees (23 out of the 29 interviewees) used the UNRWA PHC services for a range of health conditions, and justified their choice in terms of the ease of access and cost, as these services are free of charge. These conditions included pregnancies, childbirths, child illnesses, acute and chronic health conditions and dental problems.

While many of the interviewees reported that there were usually generous supplies of drugs at the UNRWA PHC centres, some indicated that the supply of drugs had become more restricted. Additionally, some of the interviewees indicated that certain medicines were prescribed preferentially based on personal connections.

Most of the interviewees noted that the performance of the UNRWA healthcare was challenged by the overcrowding at its PHC centres. Fadya, a 48 year old woman who had 14 children, had rich and diverse health-related experiences with all of the public and private healthcare options. She indicated throughout interview that although she had been dependent on the UNRWA and other public options for healthcare as a result of her financial conditions, there was overcrowding at the UNRWA PHC centres:

“ Honestly, I do not like UNRWA clinic. I am obliged to go to UNRWA clinic because it is frankly free of charge. I do not like UNRWA clinic because I do not like overcrowding and I do not like the chaos and the loud voice and all of that are present at UNRWA clinic.”

Government PHC services¹⁵

Although the clinics of the government PHC services were reportedly used infrequently by refugees, who are eligible to use the UNRWA PHC services, which are free of charge, the majority of the interviewees (25 out of 29) reported using the government PHC clinics for different healthcare services, especially curative services. The interviewees pointed out that the network of government clinics had expanded, and they linked the use of these clinics to the enrolment in the Government Health Insurance (GHI) scheme and to referrals to government hospitals. Similar to the UNRWA PHC centres, the government clinics provide a range of PHC services. However, interviewees who were eligible to use both services pointed out that the UNRWA PHC centres are larger than the government PHC clinics and provide a wider breadth of services. The interviewees also reported that there were limited supplies of medicines at government PHC clinics, and some (six) of the interviewees reported that co-payments for dispensing drugs deterred them from using the services of these clinics. The narrower scope of the services provided through the government PHC clinics, and the interrupted availability of medicines, as well as the requirement for co-payments for the use of their services meant that these services were used less than the UNRWA PHC centres. This lower level of use of these services made the government PHC clinics less crowded and therefore the waiting times to receive care were lower. For example Sameeha, a 63 year old woman who was eligible for both UNRWA and government services reported that:

“ UNRWA clinic is overcrowded. I wait there for a long time. Not like at our MoH clinic, where who comes can be treated immediately. Maximum, I stay waiting for 10 minutes at MoH clinic”.

Government hospitals

“al-Shifa (government) hospital is the father of all”.

Metaphorically, the above quote regarding the largest government hospital in Gaza by Abou Imad (71 year old man) aptly captures the important role of the government

¹⁵ Here I use the term government PHC and government hospital to name the MoH PHC and MoH hospitals and their predecessors as there was the MOH before 1994.

hospitals there. The government hospitals were reportedly used by all of the interviewees throughout all of the time periods. The accounts regarding childbirth suggest continuous and increasing utilisation of hospital services for deliveries. All of the deaths reported by the interviewees also occurred there. Additionally, complicated procedures and interventions were done at these hospitals, which were reported to have a greater breadth of services than the private hospitals.

Old accounts from some of the older interviewees who had lived during the Egyptian control of the Gaza Strip noted that the use of the services of the governmental hospitals had been free of charge. More recent accounts indicated that the use of the services of these hospitals now requires enrolment in the government health insurance scheme. The most recent accounts indicated that enrolment in the GHI scheme and the requirement for referrals from PHC services to access the emergency and reception rooms of these hospitals was seen as hindering access. Occasional references were made about recent payments of fees for some services provided by government hospitals.

The interviews indicated that the number of these hospitals increased after the establishment of the PA and so access to their services also improved. However, many of the interviewees raised serious concerns about the intersection between these hospitals and private healthcare practices. They shared accounts of specific incidents of preferential treatment by some doctors in government hospitals when they were consulted at their own private practices.

Besides indicating the use of the government health services and those of the UNRWA, some of the interviewees pointed to their use of the Police Medical Services facilities or to their connections to providers employed by it. Some interviewees reported that they had used the services of these facilities because they were eligible to receive these after being added to the health insurance of their sons. Others had used these services free of charge or for nominal fees because they were near their homes. The few ambulatory settings of the Police Medical Services were reported to have attributes similar to government primary healthcare clinics, and the hospitals of the Police were reported to be similar to governmental hospitals.

Private healthcare and the metaphor of private tutor

“.. I know that UNRWA schools are better than the private schools. But if you get a private tutor, who works at UNRWA or at government schools, for your son, who then matriculates at an UNRWA school, your son will excel because he has had a private tutor. It is the same when you go to a private doctor”.

The above quote from Ghatas, a 46-year old man who became entirely dependent on publicly provided healthcare after losing his job and savings, captures the supplementary nature of private healthcare in the Gaza Strip.

The use of private healthcare was reported by all of the interviewees, but most of them indicated that their use of it was irregular. Some of the interviewees reported that their use of private healthcare had been limited to a few isolated incidents, such as dental healthcare. The interviewees linked the use of private healthcare to their financial ability and to the availability of private healthcare options. The earlier accounts indicated that the use of private healthcare by older interviewees was very limited, but the more recent accounts indicated that the interviewees had started combining their dominant use of publicly-provided healthcare with the use of private healthcare. The most recent accounts indicate that the interviewees, especially those with less income, had started to forgo the use of private healthcare.

The interviews suggested that the use of private healthcare was more prevalent for those services that are not offered by publicly-provided healthcare, such as the treatment of infertility and cosmetic procedures, or services that are incompletely offered by publicly-provided healthcare, such as dental healthcare.

Private options to accessing healthcare services include dual-practitioner-run practices, and the services of not-for-profit private institutions. Additionally, the interviewees indicated that they had purchased medicines from private pharmacies, and that they had spent money on healthcare services that they had used outside the Gaza Strip. Some of the interviewees reported that they had purchased medicines for self-medication for minor ailments, for example to relieve toothache when they could not afford treatment by dentists. Others indicated that they had purchased drugs prescribed by private doctors, and even by doctors at public settings when these drugs

were not available at the MoH or UNRWA facilities. More than a third of the interviewees (11 out of 29) reported the use of healthcare services outside the Gaza Strip. Some reported that they had used healthcare services outside the Gaza Strip based on referrals issued by the PA. Others reported that they had paid for these services on their expenses. In addition, the use of the services of traditional healers was reported by most (17 out of 29) of the interviewees.

Dual-practitioner-run private practices

All of the interviewees had used private services run by physicians or dentists, at one point or another, for themselves or for their family members. Only one interviewee reported that he and his wife, who were both working for international organizations, were mainly dependent on private healthcare for treating their health conditions and for trying to conceive a child.

The interviewees usually linked physicians whom they had consulted at their own practices to their workplaces at the publicly-provided healthcare services, especially at the governmental hospitals, and they usually indicated that they had consulted them during the late afternoon. Almost all of the interviewees reported or implied that they had frequented dual-practitioner-run practices to improve on the care they had received at governmental hospitals. Even though the practitioner might have been the same, many of the interviewees reported that they were examined more carefully and were given more detailed information about their conditions when they consulted the physician at their private practice than when they used the services of publicly-provided healthcare.

The interviewees repeatedly reported that these private doctors used their position at publicly-provided healthcare services to encourage the utilization of their private clinics. Some of the interviewees reported that dual-practising physicians used to receive commissions and financial benefits from private diagnostic facilities and from the private pharmacies to which they referred their patients for diagnostic tests and to buy medicines. One woman reported that doctors frightened patients about dangerous sequels to their diseases in order to convince them to have certain surgical procedures done swiftly in private facilities. One interviewee reported that his son had been referred by a dual-practising physician from his own run private practice to have

an orthopaedic surgical operation performed at a government hospital on the condition that he would be paid privately, but a lower price than if the surgical operation took place at a private setting. Another interviewee reported that he paid a substantial sum of money to a senior cardiologist, who brought him from his private practice during evening time to the coronary care unit of a governmental hospital, where he worked, to take care of his father who was admitted to the coronary care unit. These experiences and perceptions that were shared by the interviewees applied to all periods and all political regimes.

The financially indigent interviewees reported that they were exempted by physicians from paying consultation fees for using their own practices or were told that they should not necessarily use private practices and would be served well at the government hospitals. Additionally, the financially least privileged interviewees reported that some specialist doctors whom they had consulted used to charge relatively low consultation fees. Other interviewees reported that some doctors, embedded in popular neighbourhoods and refugee camps, practised at their own houses and charged only nominal consultation fees or did not require fees from indigent users.

Although all of the interviewees reported using the dual-practitioner run private practices with different densities and frequencies, the vast majority of them indicated that they had used these practices as a last resort to treat non-life-threatening health conditions. For example Saida (64 year old woman) described how her son treated their children:

“... my sons take their children to Almustawsaf (literary the dispensary indicating the MoH PHC centre). But if they do not get benefit, they take them to Naser hospital (MoH paediatric hospital in Gaza city). If there is no benefit from both, they take them to a private doctor”.

NGOs

Most of the interviewees reported using healthcare services provided by local Palestinian NGOs. Many of them indicated that these services provided a cheaper option in comparison with dual-practitioner-run practices. Some of the interviewees

linked the healthcare facilities of some of these NGOs to certain political factions or known political figures.

Although it was indicated by the interviewees that the scope of the services in NGO hospitals was neither superior nor wider than in the government hospitals, interviewees who could afford the payments used the NGO services to avoid the undesirable attributes of government hospitals, such as long waiting times, overcrowding, and amenity aspects of the quality of inpatient services. Some of the interviewees reported that they had benefited from UNRWA referrals for childbirth and surgical operations from these NGO hospitals based on cost-sharing.

5.3.3 The perceived performance of healthcare

Many of the interviewees raised criticisms and concerns about the performance of healthcare services and reported delayed or limited access to certain services at healthcare facilities of the MoH and UNRWA. Some indicated unsafe healthcare that they or their family members had received across different periods of time. An elderly woman, who had been dependent on publicly-provided healthcare, reported that she was forced to have a minor surgical procedure done in the private sector because of the inadequate infection control at the government hospitals. Four interviewees reported that their children had disabilities, and attributed these to birth asphyxia or malpractice during childbirth. Additionally, one interviewee reported the maternal death of his daughter after her child was delivered at a government hospital, and attributed her death to a medical error:

“I lost my daughter. (Her name is) Mariam. While she was giving birth to her daughter, they gave her an injection by mistake and she died. She was married and had many children. She had two sons and one daughter; and the last daughter survived while her mother died”

Dissatisfaction with the performance of healthcare services was not limited only to complaints about the safety aspects of healthcare; it was also related to overcrowding in the reception areas and emergency rooms of the government hospitals and UNRWA PHC facilities, lengthy waiting times for invasive and surgical

procedures at the government hospitals, the attitudes of health workers at the government hospitals and UNRWA healthcare centres and their communication with healthcare users, and the amenity aspects of the quality of inpatient services.

Older interviewees expressed their satisfaction with the UNRWA PHC services more than the younger interviewees, who were more critical of these services. There were repeated accounts of the inadequacy of the UNRWA dental care services. Some of the interviewees reported that the results of laboratory tests performed at UNRWA PHC had been inaccurate. One woman reported that she had been left alone without support when she was in labour at a UNRWA maternity facility. Interviewees repeatedly reported that UNRWA physicians prescribed medicines without examining them. For example Shurbasi, a 49 year-old refugee man, described the situation of UNRWA doctors prescribing treatment for patients without even listening to the beneficiary's complaint:

“He (UNRWA doctor) is doing a routine work. It is possible that before you tell him your complaint, he writes the prescription for you. It is possible that before you tell him that you have so and so, he sends you to the dispensary”.

Many of the interviewees reported or implied that they were able to smooth their access to the services of publicly-provided healthcare services¹⁶ and to overcome the negative quality attributes of the services through the efforts of dual-practising practitioners and through personal and social connections. The use of social connections was reportedly common among all of the interviewees, and improving the accessibility and quality of the healthcare at government hospitals was more common among those who could afford to pay for dual-practising physicians. Many of the interviewees reported that they were able to bypass the lengthy waiting lists for surgical or invasive procedures through their social connections. Others reported that attending the private clinics of dual-practising physicians had enabled them to have their surgical operations or cardiac catheterizations done swiftly and had made them comfortable at the government hospitals. Women who described how they had been left without adequate support when they had given birth in government hospitals

¹⁶ Most of the interviewees reported or implied that using the help of dual-practising physicians to smooth their access had occurred at the government hospitals, but one interviewee pointed out that he had experienced these practices at UNRWA PHC facilities.

reported that based on their previous experiences, during the last months of their later pregnancies, they had frequented the private clinics of the doctors who would take care of them at government hospitals when they gave birth to their children. The quote below from Ghatas, a 45 year-old man, encapsulates the alleged reluctance of health workers to do their jobs, the prevalence of the influence of social connections, and the intersection between private practices and government hospitals:

“If you need the (intravenous) solution to be put for the patient, you should search for the nurses to do this. You should bring the nurse to do her job. She will never do her job by herself. If you do not chase them, they will never do their job. The patient could die. It is normal (to have patients dying). If you do not run and chase them, the patient could die. This has Wasta (social connection) and that has Wasta. This one is recommended by that one, and this is supported based on his relations. The private doctor at the end knows his job. When you are discharged or released from the hospital, the doctor will refer you to (his) private clinic, to make follow up at his own private practice”.

Women who delivered at private not-for profit healthcare hospitals described their experience as being comfortable. Although the interviewees praised the services that they had received from dual-practising physicians, in particular for their bedside manner and communication at their private practices, the procedures performed by these physicians at their practices were not always safe. Samara (a 47 year old woman) described her delivery at a private maternity facility, which according to her had resulted in the first of her twins having a disability:

“I followed my pregnancy of the twins at the UNRWA health centre, and I went irregularly during my pregnancy to (Dr IAH) private clinic. He (Dr IAH) supervised my delivery. Between us, what happened to my daughter resulted from a medical mistake by him. He (Dr IAH) performed delivery using a vacuum (extractor) at his private clinic. The clinic was here in the camp. The head of the male child was inflamed (possibly with a caput). He (Dr IAH) told me that the female child would live but with mental disability. I did not understand what he meant at that time. The girl became blue and continued screaming. She was always crying and screaming. She had a hernia as a result of screaming. We had the hernia repaired for her in Gaza. It was a medical error at a private clinic”.

5.3.4 Financial burden of using healthcare

Interviewees' perceptions of their experience of paying for healthcare depended on the financial resources available to them. The financial amount and burden of consulting private practitioners for a single consultation or even for few visits, such as for antenatal check-ups or incidental illnesses, was considered to be low by many of the interviewees. However, interviewees with chronic conditions who needed frequent consultations and those who needed surgical operations complained about the high costs and high financial burdens of using private healthcare. Additionally, interviewees perceived the costs of buying medicines, dental procedures, or treatment in Egyptian healthcare facilities to be high. Some interviewees reported that they had used healthcare services outside the Gaza Strip based on referrals issued by the PA. Others reported that they had paid for these services on their expenses. Interviewees who had used healthcare services outside the Gaza Strip at their own expense had done so mostly in Egypt; however, two of them had used healthcare services as far away as Russia and the UK for very high costs, which they could afford. Even those who were referred by the PA **had** paid from their own pockets. Interviewees referred by the PA to Egyptian healthcare facilities reported that they had paid for transportation, lodging, and sometimes even informal payments to healthcare providers. Most of the interviewees referred by the PA during recent years for treatment outside the Gaza Strip reported that they were referred to Egyptian healthcare facilities, reflecting the restriction of movement of people from the Gaza Strip into and through Israel. Rantisi, a 42 year-old man with lung cancer, reported that he had been referred for treatment to an Israeli hospital and had been treated there once. He was then required to meet with the Israeli special security services to extend his permission to exit the Gaza Strip to continue his treatment in the Israeli hospital, but permission had not been extended. He continued his treatment in Egypt where he needed to pay for transportation and lodging, and to "spread tips".

"The second time, they told me that I had to meet with Mukhabarat [the Israeli intelligence]. I met them, and they asked me about my relationship with this and that, and about those who fire missiles. I asked them if they thought that those who fired missiles would tell me that they were launching missiles, and I told them I didn't know.

After that, I was refused permission to travel for treatment to Israel. I had to continue my treatment in Egypt”.

Even though the burden of incidental and infrequent use of private healthcare was generally perceived to be low by many of the interviewees, some of them were concerned about minimal payments, such as paying co-payments for drugs and diagnostic tests collected at PHC and hospital services of the MoH. Some of them indicated that they could not afford these co-payments or the premiums for enrolment in the GHI scheme.

Adaptive mechanisms

Interviewees reported using a range of adaptive mechanisms to cope with the financial burden of paying for healthcare. These mechanisms included borrowing money and selling assets, such as jewellery and furniture. However most of the interviewees who had borrowed money or sold assets reported that they had done so to pay for food, education for their children, and daily living expenses rather than healthcare. Additionally, the financially least privileged interviewees reported that they rarely borrowed money because of concerns that they would not be able to repay the loans. One interviewee, who was dependent on financial assistance to treat his health conditions, reported that he had repaid the cost of a dental procedure done by a private dentist through giving him a container of olive oil every year for more than two consecutive years.¹⁷ A few of the interviewees, who appeared to be financially privileged, indicated that they had used some of their savings to pay for surgical operations at private healthcare settings or for treatment in Egyptian healthcare facilities. Interviewees indicated that they placed great value on their health; none of them reported forgoing healthcare or treatment, either for chronic or acute health conditions. However, many reported extracting their own or their dependents' teeth at UNRWA healthcare facilities or using analgesics instead of performing other dental interventions.

Some interviewees reported self-medicating using leftover drugs dispensed from PHC facilities. Some reported using prescriptions prescribed for other people or prescriptions prescribed previously for themselves to purchase drugs. Additionally,

¹⁷ The container contains usually 17 litres of olive oil.

some very poor interviewees reported that they relied on financial assistance from local sources or from abroad to receive privately provided healthcare, to dispense medicines from private pharmacies, or even to be treated in Egypt.

Reliance on publicly-provided healthcare services was implied by most of the interviewees who reported very limited use of private healthcare. Interviewees indicated that the choice of publicly-provided healthcare services had always been their first resort even when using private healthcare. The structure of the mixed healthcare system enabled the interviewees and their dependants to use the services of multiple different providers and to exploit the system to decrease the financial burden of using healthcare. Shayma (a 63 year old woman) reported that the availability and use of multiple providers had enabled her son's family to save money of medicines prescribed for her grandchild:

"the son of Mahmoud (her son) was vomiting breastfed milk. They took him to UNRWA (PHC centre) but the child did not improve. They took him to the paediatric [government] hospital. They gave him an Intravenous Solution but he did not improve. Then, they went to a private doctor and he prescribed the treatment for them. When he went to the pharmacy, they told him that it would cost 100 New Israeli Shekels. My son decided to go the UNRWA clinic to see if the treatment was available there. Next day, he went to UNRWA clinic and took the child and prescription. He told them what happened with them. He found that the same drug prescribed by the private doctor was available at UNRWA. They got the drug from UNRWA (PHC centre). They saved 100 NIS. Do you see? The 100 NIS are worthy!! The doctor at UNRWA told him that this prescribed drug is the same that I would have given to you. It is only the bottle that is different. The effect and the drug are the same!!"

5.3.5 Everything has changed, but nothing has changed

The narratives and happenings conveyed through the 29 interviews, which captured the interviewees' life and healthcare experiences between the mid-1950s and the time of the interviews in 2017, appear to be cross-sectional with only very few changes. Interviewees repeatedly indicated their dependence on healthcare provided by government hospitals and the UNRWA. Many interviewees indicated that they had

decreased their use of private healthcare when their financial conditions had become worse, but it was clear from the interviews that the use of private healthcare was continually incidental and complementary to the use of government healthcare services and healthcare provided by the UNRWA. Interviewees generally tended to emphasize the financial burden of living expenses, especially during the last two decades, rather than the financial burden of seeking healthcare. There were some incidents that were narrated by the interviewees that could lead one to think that time does not move, or that it repeats itself as it moves. One interviewee, for example, had received surgical treatment in Israeli hospitals twice in the 1990s, and reported that his mother had been referred for treatment in Egypt in 1955. This indicates that healthcare outside the Gaza Strip has been used throughout different political regimes. Similarly, the UNRWA role of strengthening modern healthcare in the Gaza Strip has been repetitive. Even those who were very critical of the UNRWA praised its introduction of computerized information systems into its PHC centres. Halima, one of the oldest interviewees, reported how a UNRWA doctor had treated her mother in the mid-1950s for bronchial asthma by bringing treatment from Lebanon:¹⁸

“I was 10 years old (i.e. in 1956). The UNRWA doctor told her that he would give her the proper treatment and he prescribed injections that were brought from Lebanon. He wanted to experiment how the treatment would be effective. He mixed the ampoules together and there was an inhaler. It was like removing a nail (improved dramatically) ”.....” He asked her: (how did you feel?). She answered that this was similar to removing a heavy load from her chest. She improved dramatically and she lived till the age of 90 as she died just 5 years ago. She had never forgotten improvement she encountered when this new doctor gave her the inhaled medicine. She is originally from your town. She took also drugs which was called ephedrine. She continued on the inhaled treatment until she died”.

Notwithstanding the stability observed in the pattern of healthcare-seeking experiences, access, and financial burdens, there have been some important changes. The plurality of healthcare options available to Palestinians in the Gaza Strip

¹⁸ The headquarters of the UNRWA Department of Health was stationed in Beirut before the start of the civil war in Lebanon in 1976.

has increased. Private healthcare has become disseminated in all localities of the Gaza Strip, and the geographic access to healthcare has improved. Additionally, women's experiences with maternal healthcare suggests that private healthcare has grown since mid-1980, when pregnant women who used to depend mainly on government or UNRWA antenatal care started combining this with private healthcare. These experiences also suggest that private healthcare has been strengthened since 2006, as since then most pregnant women have combined publicly-provided antenatal care with private healthcare. Moreover, the gradual reduction in traditional birth attendants' assistance during childbirth and then the cessation of this assistance since mid-1990 suggests a decrease in the use of traditional healing. The NGO hospitals have become an umbrella under which private doctors perform surgical operations and assisting births.

Increasing multiplicity of healthcare options

The interviews suggest that multiple options were available to the interviewees and to their households in terms of accessing healthcare services, and that these options have been increasing. This is corroborated by the time-colour matrix of childbearing and childbirth experiences reported by the interviewees.

The time-colour matrix analyses of the use of antenatal care and delivery services among the interviewees who had had pregnant women or births in their households are annexed in Annexes V-I and V-II. The time-colour matrix analysis of antenatal care, which is summarized in Box 5-1, indicates that the use of publicly-provided antenatal care services started to be combined with the use of private healthcare since 1986. Since 2006, most pregnant women have combined publicly-provided antenatal care with private antenatal check-ups. This reflects the increasing availability of private healthcare options since the mid-1980s and the increasing use of these options.

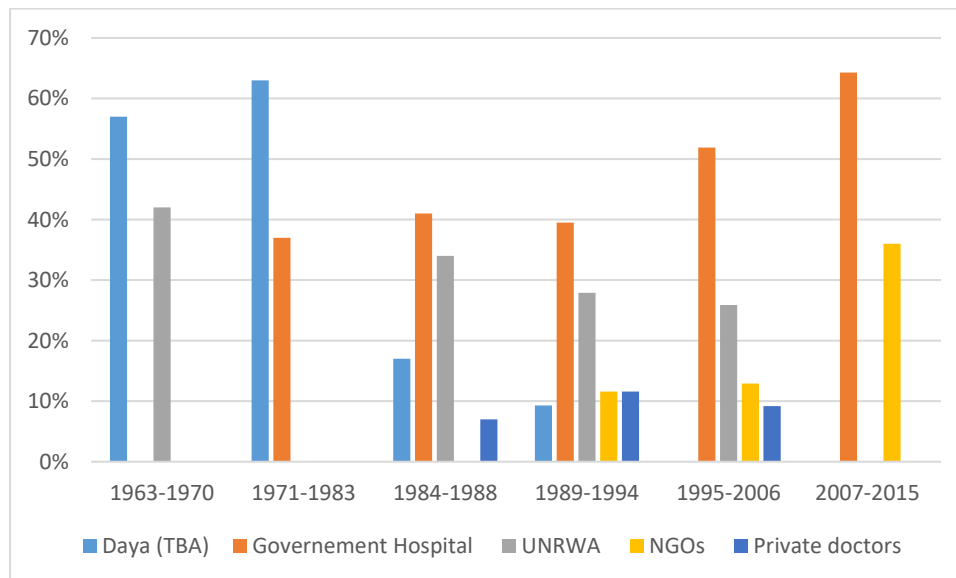
Box 5-1: The use of antenatal healthcare services among pregnant women living in the 29 households.

- The only two women who had been pregnant before 1970 had used the antenatal care of the UNRWA.
- A total of ten pregnant women were reported between 1971 and 1985. Four of these had sought antenatal checks from UNRWA services, four from government PHC services, one from both and one from a private clinic.
- Since 1986, women have started supplementing the use of antenatal healthcare from the UNRWA and Government health services with the use of antenatal healthcare provided by the private sector.
- (1986-2005): Slightly more than a third of antenatal check-ups (33 out of 95) that took place at UNRWA PHC services were combined with private antenatal healthcare. More than half of the antenatal checks (15 out of 27) that took place at governmental health services were combined with private antenatal healthcare.
- Beginning in 2006, all pregnant women who used antenatal care at government health services combined this with private healthcare. Similarly, almost two thirds of pregnant women who used UNRWA PHC centres for their antenatal care combined this care with using private antenatal check-ups.

The reported births, which are captured by the time-colour matrix of births in Annex VI-II, suggest that from 1984 to 1988 a shift began from a reliance on traditional birth attendants (Dayyas) towards more use of UNRWA maternity facilities, government hospitals, and private doctors. They indicate that the use of Dayyas diminished remarkably but did not cease during the first intifada (1989-1994), when NGOs started assisting births. The reported births suggest that the assistance of Dayyas stopped following the establishment of the PA (1995-2006), when the use of government and NGO hospitals increased. Finally, government and NGO hospitals have shared the role of birth assistance since 2006, when the UNRWA closed its maternity facilities and private doctors started assisting births at NGO hospitals. Nine

(64%) out of fourteen deliveries that took place between 2007 and 2015 were assisted at government hospitals, and the remaining 36% took place at non-governmental hospitals. Figure 5-1(below) depicts the change in the childbirth assistance.

Figure 5-1: Change in the use of child birth providers among households (1963-2015)



The reported changes were not limited to the use of healthcare during pregnancy and for birth assistance. Earlier accounts refer to the availability of fewer options, mainly the UNRWA or the Church Mission Society (CMS) hospital for accessing healthcare. Interviewees indicated that while the availability and diversity of these providers had increased and the geographic access to their services had gradually improved, especially after the establishment of PA in 1994, they were dependent on publicly provided healthcare. Interviewees who had experienced the earlier years of the Gaza Strip mentioned repeatedly that they had only a few or even only one option to access healthcare services when they were young. Halima, a 71 year old refugee woman who was displaced in 1948 to the Gaza Strip (and was raised there) indicated that there were no choices other than the UNRWA when she was 10 years old. In her words:

"at that time there was nothing except UNRWA".

Even Harb (a 60 year old man), who was younger than Halima by more ten years, repeated the same meaning conveyed by Halima:

“There is nothing except it (UNRWA). We do not know al-Shifa (government hospital). There was no Al-Aqsa (government hospital) at that time. There were only al-Shifa and Maamadni (Church Mission Society [CMS] hospital). Maamadani (CMS hospital) was only for big (rich) people who had money”.

When I asked Harb about private doctors he replied that he had not needed to go to private doctors as a young person. Similar accounts were repeated by many of the younger interviewees. For example Fadya (a 49 year woman) indicated that people had been dependent on UNRWA healthcare services and that there were no private practices. She stated that:

“ I did not get sick frequently when I was young (Before mid-1980s). But when we became sick, we went to the UNRWA clinic. The UNRWA clinic had a significant role. At that time, there were no private clinics. We were dependant on the UNRWA clinic in our childbirths and in our treatment”.

The relatively limited options for accessible healthcare indicated by the interviewees during the early years of their lives contrasted with their use of many providers when they became older, or their children’s similar pattern of use. Abou imad (a 71 year old man) reported that he had had a gastroscopy done three times with three different healthcare providers:

“ (The second gastroscopy) had the same results. I did it once at al-Shifa (governmental) hospital. I had it done another time at Patients Friends Society (NGO Hospital), and the third time at Police Medical Services hospital. I have a Police Medical Services health insurance as I am added to my sons, who work at the police. Three times at three hospitals and I had the same results”.

Similar accounts indicating the use of many providers of healthcare even for the same episode of illness were repeated by many interviewees. For example Majdeya (a 69 year old woman) described how she treated different health conditions of her eyes:

“ Although I went to Naser ophthalmic (government) hospital for eye allergy, I am using the St John ophthalmic clinic (NGO health clinic) for treating my increased intraocular pressure. I do not pay a lot there. I just pay the consultation fees, and I receive the eye drops from UNRWA”.

The increase in the multiplicity of healthcare options has contributed to improvements in geographic access. The interviews indicated that the number of government hospitals has increased, as has access to their services since the establishment of the PA. While some older accounts indicated that, previously, geographic access to healthcare services was not easy, more recent accounts indicated that healthcare facilities have become more accessible. Abou Imad, a 71 year old man who lived on the southern outskirts of Gaza city, described his experience of accessing healthcare during the 1970s and 1980s.

“... our sufferings were related to the pregnancies of my wife, the childbirth and care of our children. When we wanted to treat our children, I carried them from the eastern part of Gaza City to Saladin Street and sometimes to al-Shifa hospital. We, me and my wife, walked for 5 kilometres. It was a severe suffering. Very severe. We suffered. Sometimes we walked at midnights, and early morning at dawn. This was most daunting and exhausting. The remoteness...”

“We walked 3-5 kilometres during the night times. There were no cars. During the daytimes, we walked for 3 kilometres, then we reach Saladin street we took a car and go to the hospitals. This how our life was.. There were no cars during the seventies and eighties...”

Changing private healthcare

Some interviewees who used the ambulatory healthcare services of NGOs during the 1970s and 1980s reported that they were exempted from paying fees or that the fees were nominal. Other interviewees who had used the services of these NGOs more recently complained that the charges and tariffs collected for using these services had become unaffordable and contended that the NGOs providing these services were charitable only by name. While a few interviewees reported that they had benefited

from exemptions to paying fees to these organizations, some indicated that these organizations avail only those who are linked to them of this benefit because they are linked to the managers of these organizations or to the political factions steering the organizations.

The number of NGOs providing healthcare services has increased since the early 1990s. When interviewees referred to the situation up until three decades ago, they pointed to one old hospital (The Church Mission Society Hospital) and to one or two outpatient clinics belonging to these NGOs. When they referred to recent times, the interviewees mentioned repeated multiple names of the NGO. They also reported that while dual-practising doctors previously performed surgical operations only at their own private practices, these dual-practising doctors had started doing these surgical operations at NGO hospitals. Additionally, three interviewees reported that they had consulted an obstetrician-gynaecologist for antenatal check-ups at outpatient clinics of the NGOs. Hence, it seems that these NGOs have provided an umbrella under which to host the services of private doctors and to institutionalize surgical operations and invasive procedures that used to be performed at their private practices.

It can be inferred from the interviews that private healthcare has undergone changes. Older interviewees reported that when they were young there were very few private doctors and that private healthcare institutions were limited to the Church Mission Society hospital. Recent accounts indicate that the number of private practices run by practitioners has increased. They have become disseminated all over the Gaza Strip, whereas previously they were concentrated in the two main urban areas of the Gaza Strip, i.e. Gaza city and Khan Yunis city (the second largest city in the Gaza Strip). Many interviewees indicated that these private practices have become available throughout the Gaza Strip. Some interviewees reported that for certain procedures there has been a shift from using the services of barbers to using the services of physicians and dentists. One woman reported how her father took her to the barber to extract her teeth when she was young. Another man reported that barbers used to perform circumcisions; then some nurses started to perform them; and finally, now, circumcisions are usually performed by physicians.

As indicated in the colour-time matrix of experiences of childbirth, the number of births assisted by traditional birth attendants has gradually decreased since the

establishment of the PA in 1994. This decrease can also be applied to other forms of traditional healing; however, the use of traditional healers has not ceased. A few interviewees reported that they continued using the services of these healers to alleviate spiritual (or mental) ailments. The recent use of these services and the care of these traditional healers reflects religious and traditional beliefs, and targets mainly self-limiting ailments and emotional disturbances.

5.4 Discussion and conclusions

In this chapter I presented the findings of the analysis of the 29 interviews that I carried out in the Gaza Strip between September 2016 and September 2017. These interviews were inspired by the Life-history approach, and aimed at exploring changes that were experienced by Palestinians in the Gaza Strip when accessing and paying for healthcare, especially after 1987.

The findings indicate that most of the interviewees had been impacted by traumatic events resulting from the conflict, and that their financial situation had deteriorated, leading many of them to become dependent on financial assistance. The interviewees reported that there were multiple options available to them in terms of accessing healthcare, including public and private healthcare options. Most of the interviewees reported that they continually relied on publicly-provided healthcare. This reliance on publicly-provided healthcare was supplemented by occasional use of private healthcare, which was sought according to the financial ability of the user.

There were serious concerns about the safety and quality of the healthcare used by the interviewees, and there were institutional and administrative barriers to accessing effective healthcare. Interviewees reported coping with these barriers through social connections. Additionally, those who could afford the payments for private healthcare consulted dual-practising physicians at their own private practices to cope with these barriers to effective access at publicly-provided healthcare facilities. Although some interviewees reported that even nominal fees for healthcare affected them, most reported that incidental consultations with private practitioners constituted only a minimal financial burden. However, the costs of drugs and the fees for certain procedures, such as dental and surgical operations, were considered to be high. Additionally, the cost of treatment outside the Gaza Strip was reported to be extremely

high. Interviewees had used a range of strategies to cope with the costs and the burdens of healthcare. These strategies included selling assets or borrowing, if they were able to repay the loan. However, most of the interviewees who had used these coping strategies indicated that they had used these strategies to cope with their daily living expenses rather than to cope with healthcare costs. Some interviewees reported receiving financial assistance in order to use private healthcare or to purchase drugs. Some others reported self-medicating using leftover drugs dispensed from publicly-provided PHC facilities. Additionally, the structure of the mixed healthcare system with multiple publicly-provided options enabled interviewees to use these options to decrease the financial burden of healthcare that requires payment.

Generally there was relative stability in the pattern of healthcare-seeking experiences reported by the interviewees. However, there had been some important changes. There is an increasing multiplicity of healthcare options, private healthcare has become disseminated in all localities, and the geographic access to healthcare has improved. Additionally, it was suggested that private healthcare grew from mid-1980, and 20 years later became stronger. There has been a decrease in the use of traditional healing, but traditional health practices have not ceased. Similar to private healthcare in general, the NGO healthcare services have grown, and the hospitals that belong to this sector have become an umbrella under which private doctors perform surgical operations and assist with births.

The findings suggest that despite changes in the financial conditions of most Gazans and in some aspects of the healthcare system, most people in the Gaza Strip continually rely on the use of low cost and free of charge healthcare, which is occasionally supplemented by private healthcare for those who can afford the payments. In the following chapter(s), I will explore how have the public-private mix of healthcare services has been influenced by the protracted conflict.

Chapter 6

The evolutionary trajectory of the public-private mix and entitlement to healthcare in the Gaza Strip (1948-2020).

“The health care system is extraordinarily complex and fragmented. It has various layers – like an old city that has been rebuilt era after era, sometimes incorporating and sometimes obliterating earlier structures”

(Roberts 2005, quoted in Ministry of Health, 2008).

6.1 Introduction

In this chapter I aim to portray and to trace changes in the public-private dichotomy of healthcare services and in the entitlement to healthcare in the Gaza Strip since its emergence as a recognized geopolitical entity in 1948. I pursue this aim by using and reviewing documentary sources, which are complemented and corroborated by interviews with key informants in the Gaza Strip. While tracing the changes in the trajectory of healthcare, I attempt to present the influence of different actors and factors, such as policies and contextual factors, and their interplay on these changes. Additionally, I try to present consistent data that embody secular trends and variations over time.

I present the evolutionary trajectory of public-private healthcare and entitlement to healthcare in chronological order, according to the political regimes that have prevailed in the Gaza Strip since 1948. I first present, in one results section of this chapter, the three periods that followed the emergence of the Gaza Strip as an internationally recognized geopolitical entity in 1948, in three subsections. The first subsection will address the period from 1948 until 1967, during which the Gaza Strip was under Egyptian military control. The second subsection will address the period from 1967 to 1994, when the Gaza Strip was under direct Israeli military occupation. The third subsection will deal with the period from 1994, when the PA was established, until 2005, when Israel implemented its Unilateral Disengagement Plan. In the first

subsection (6.2.1), I emphasize the influence of the humanitarian crisis and financial adversity, the attention of the Egyptian administration after 1957 to Gazan needs, the social policy of the Egyptian regime during the 1960s, and the scarcity of human resources for health on defining the features of the prototype of the healthcare delivery system, which emerged in the Gaza Strip during the first two decades that followed the Palestinian Nakba in 1948. I concentrate in the second subsection (6.2.2) on the evolution of a public-private mix of healthcare services and the entitlement to healthcare during the first two decades that followed the start of the Israeli military occupation in 1967. I will focus then on the developments that occurred after the start of the first Palestinian Intifada in 1987. I will demonstrate in the second subsection that the services of the government hospitals and UNRWA PHC were stagnant, while the government PHC services increased, and that entitlement to free-of-charge Government Health Services ceased to be a reality. I will also describe how the role of private healthcare increased during the first two decades that followed the start of the Israeli military occupation in 1967. The subsequent years that followed the first Palestinian Intifada witnessed a revitalization of the role of the UNRWA in healthcare provision, and the start of the multiplicity and visibility of the private not-for-profit health sector. I demonstrate in the third subsection that both the public and private provision of healthcare were encouraged and the government and UNRWA PHC services were expanded during the first six years that followed the establishment of the PA, and that the exacerbation of the conflict after the start of the second (al-Aqsa) Intifada in 2000 contributed to: (i) the halting of the implementation of the WB and western donors' recommendation to increase the role of the private sector and the introduction of private services in government hospitals; (ii) the expansion of the network of government hospitals; (iii) the introduction of free enrolment in the Government Health Insurance scheme; (iv) an increase in the use of the UNRWA PHC due to the worsening economic situation; and (v) growth in private not-for-profit healthcare, including the Islamic private sector.

In the second results section of this chapter, i.e. 6.3, I focus on the period that followed the implementation of the Israeli Unilateral Disengagement Plan from the Gaza Strip in September 2005. I first detail the influence of different actors on shaping the provision of public and private healthcare. I then focus on the development of the public and private sides of the healthcare delivery system. The results show that there

were indiscriminate effects of the Israeli practices on both the public and private sides of the healthcare system. The multiplicity of donors and the fragmentation of their community made the distinction of their overall influence on public and private healthcare uncertain. On the one hand, the PA contributed to weakening the government healthcare services in Gaza through decreasing the provision of material and financial resources to the MoH facilities, while on the other hand it started to increase the outsourcing of services to Gazan private hospitals, contributing to strengthening private healthcare in the Gaza Strip. The attitudes of the administration of the MoH in Gaza towards the public-private sides of healthcare services and entitlement to healthcare were determined by its (i) inability or unwillingness to finance the Government Health Services; (ii) tight links to Hamas Private Health Sector institutions; and (iii) lack of social vision and the influence of the dominant global (neoliberal) health agenda. This led to: (i) encouraging the private provision of healthcare and discouraging populations who had been dependent for decades on publicly-provided healthcare services from using them; (ii) increasing the financial contributions of users of the Government Health Services; (iii) keeping the publicly provided hospital healthcare functional to serve the poor; and (iv) a willingness to adapt to, or the adoption of, some aspects of the WB recommendation regarding public management of healthcare, such as introducing private healthcare provision at public facilities.

Subsequently, publicly-provided healthcare has not been expanded similar to the population growth, and an environment which favoured nurturing private healthcare, which has grown, especially the number of private not-for-profit hospitals. However, private healthcare did not become a fully independent sector due to its dependence on dual practice, and the hospitals of the MoH and the UNRWA PHC services are still the most dominantly provided and commonly used healthcare options.

6.2 Public-private mix and entitlement to health care (1948-2005)

In this section I present my findings from the documentary review and from key informant interviews about the trajectory of the evolution of the public-private dichotomy of healthcare, and about the changes in entitlement to healthcare services in the Gaza Strip. I tackle the trajectory of the evolution of the public-private dichotomy of the healthcare delivery system and entitlement to healthcare through

pursuing changes during the different periods, from the emergence of the Gaza Strip as a recognized geopolitical entity in 1948, up until 2005. These periods are divided according to the political regimes that have prevailed in the Gaza Strip's modern political history: (i) Egyptian military control [1948-1967]; (ii) Israeli military occupation [1967-1994]; (iii) PA with Israeli military presence in the Gaza Strip [1994-2005] before the implementation of the Israeli Disengagement Plan in September 2005.

6.2.1 Shaping the backbone of healthcare after the Nakba (1948-1967)

Nakba contributed to the worsening of the social and economic situation in the Gaza Strip. Similar to the social and economic aspects, but paradoxically in the opposite direction, the Nakba constituted a turning point that contributed to defining and changing the nature of healthcare and to determining its further development in the Gaza Strip. While the policies towards populations in Palestine during the period of the British Mandate limited publicly provided healthcare to necessary interventions, the humanitarian assistance that followed the Nakba and the Egyptian policies towards the Gaza Strip brought more attention to the public health needs of the population and introduced more free healthcare options to them.

The policy of the government Department of Health under the British Mandate of Palestine concentrated on public health and prevention. The Department of Health provided hospital accommodation for dangerous and infectious diseases and limited it for general diseases to those who were officially affiliated with the British Mandate's administration; hence, this policy left general and surgical care to private practitioners or to private or charitable medical institutions (Institute of Palestine Studies, 1991). These private medical professionals and health institutions were concentrated in the large urban centres, leaving the poor Palestinian peasants who resided in rural areas without medical care (Giacaman, 1994; Giacaman et al., 2003).

Even before the official establishment of the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in December 1949 and the commencement of its operations in May 1950, the Egyptian military authorities and the Egyptian charitable institutions, together with the international community, had strengthened the provision of healthcare in the Gaza Strip (Cottrell, 1949; Cheal, 1988). The UNRWA, which initially offered medical assistance in the Gaza Strip to

refugees and non-refugees alike, provided 385,578 medical consultations during the period from 1 July 1953 to 30 June 1954 to the 300,000 people who lived in the area (WHO. EMRO, 1954). Hence, annually, every person received an average of slightly more than one medical consultation. This was a threefold increase from the level of attendance at government out-patient services among Arab Palestinians during the British Mandate of Palestine, which, in 1946, was on average one annual visit for every three Palestinian Arabs (Institute of Palestine Studies, 1991). Hence, the few years that followed the start of the Palestinian Nakba contributed to increasing the supply and use of outpatient healthcare, which was offered free of charge.

The ten years that followed the short-lived Israeli occupation from late October 1956 to early March 1957 brought greater Egyptian attention to the population's needs (Roy, 1995, p.71). After its return to Gaza in March 1957, the Egyptian administration rehabilitated and expanded the government hospitals that were available in the Strip and built two additional hospitals (Za'anoun, 2002). While Egyptian doctors, who were seconded to serve inside Gaza, were paid allowances for not being able to open private practices in the Strip during their temporary services, Palestinian doctors were allowed to open private practices after the end of their formal work at the Government Health Services (GHS). However, private healthcare was limited to a few practitioners and pharmaceutical outlets that existed in Gaza, in addition to the Church Mission Society Hospital.¹⁹

Mass displacement and the subsequent humanitarian disruption contributed to the availability of UN public healthcare and medical assistance. The increased attention paid by the Egyptian administration to Gaza's needs contributed to expanding the hospital care provided by the local health authorities. Additionally, the dire financial and living conditions of the majority of the population, and the nature of the Egyptian regime and its social policy contributed to the predominance of publicly provided healthcare over private healthcare. Beside these factors, the scarcity of Human Resources for Health (HRH) might have influenced the miniscule nature of private healthcare. Dr Reyad el-Za'anoun indicated that there had been just few medical practitioners in the Gaza Strip in 1950s and 1960s²⁰. The Egyptian

¹⁹ Interview with Dr Reyad el-Za'anoun, the first minister of the Palestinian MoH (1994-2022), on 23rd August 2017.

²⁰ Interview on the 23rd of August 2017.

administration prohibited institutions that could sustain independent political movement in the Gaza Strip (Roy, 1995, p.25). Most Gazans were refugees, who were from rural areas, uneducated, poor and dependent. This led Sara Roy (1995, p.25) to conclude that Gaza developed a “culture that that saw violence, not debate, as its primary form of mediation and political action”. The prohibition of independent institutional development and the local political culture might have hindered Gazans from developing their own indigenous voluntary charitable sector under the Egyptian administration. In fact, the Church Mission Society (CMS) Hospital, which was established in 1908, was the only voluntary private healthcare institution in the Gaza Strip for the entire period of the Egyptian military control and during the early years of the Israeli military occupation.

The Egyptian regime, which was attracted by the appeal of socialism, adopted many features of the Eastern Bloc’s social and political system, which was interpreted into the concept of the welfare state (Fouda and Paolucci, 2017). This influenced the attitude of the Egyptian administration towards the healthcare services inside the Gaza Strip, as it had inside Egypt itself. Government healthcare services were provided to Gazans under Egyptian control free of charge.²¹ However, the medicines prescribed at public facilities were usually purchased by patients, including the poor, from private pharmacies.²²

6.2.2 Healthcare under Israeli military Occupation (1967-1994)

The public-private mix of healthcare delivery has undergone certain changes since the start of the Israeli occupation of the Gaza Strip and the free of charge nature of the Government Health Services (GHS) has ceased to continue to be a reality.

During the period from 1967 to 1987, the Human Resources for Health (HRH) evolved from severe scarcity to a relative surplus. The increased availability of HRH, the implicit encouragement of the Israeli authorities of private practices, and improvements in the population’s income encouraged the growth of private healthcare

²¹ Interviews with Dr Reyad el-Za’anoun, Dr Rabah Muhana, and Dr Yehya Abed (The only three key-informants who lived as adults or practised medicine during the period of the Egyptian Military Control).

²² Interview with Dr Yehya Abed on the 5th of September 2017.

practices, especially among physicians employed by publicly-provided healthcare services.

Following the end of the six day war in June 1967, the entire Egyptian administration and health staff, including doctors and nurses, were taken as prisoners by the Israeli forces (Za'anoun, 2002). Additionally, some Palestinian medical staff, who feared prosecution, immigrated abroad (Ibid). Subsequently, the number of doctors who were employed by the GHS in the Gaza Strip shrank from 97 just before June 1967 to 36 in September 1967, and the number of nurses decreased from 241 to 217 during the same period; it took until 1974 for the number of physicians employed at GHS to be boosted to a level that was comparatively similar to pre-June 1967 (Israeli Ministry of Health, 1977). While the average ratios of HRH to the population at the GHS increased further during the period from 1974 to 1980, these ratios decreased during the period from 1980 to 1988 (Ministry of Health - State of Israel, 1989, p.33).

[See Annex VI-I]

Similar to the experience of the GHS following the 1967 war, there was a shortage of medical and nursing staff at the UNRWA PHC services but this situation was eased by the recruitment of some staff from abroad (UNRWA, 1971). Notwithstanding the UNRWA's ability to overcome the initial shortage of HRH, its health staff remained at the same level reported when the UN started its medical assistance in 1948 to the approximately 200,000 refugees in the Gaza Strip through a team of 14 doctors and four dozen nurses (Cottrell, 1949; Cheal, 1988). 28 doctors and 123 nurses provided PHC services to some 450,000 Palestinian refugees in 1987 (UNRWA, 1988). Hence, the ratio of HRH employed by the UNRWA to the population served remained unchanged over nearly four decades.

Eventually, the inability or unwillingness of the GHS, which was under the control of the Israeli authorities, and the UNRWA to employ additional staff transformed the scarcity of HRH into unemployment among physicians. The Palestinian Red Crescent Society [PRCS] (1986) reported that there were 150 jobless physicians in 1985, and that the salaries of health professionals employed by the Israeli administration at the GHS were low. Doctors compensated for their low salaries or the absence of income by relying on their own private practice. The Israeli administration encouraged dual practice among physicians employed by the GHS, and

the relatively improved economic situation of the population led to financial incentives for doctors to operate their own private practices.²³

According to Ziv et al. (2002) the Israeli administration of healthcare took minimal responsibility in regard to the health of the population. It instituted a premium-based Government Health Insurance (GHI) scheme and introduced a collection of charges for prescribed drugs and diagnostic tests in 1976 (Israeli Ministry of Health, 1981). Many of the interviews with the key informants indicated that people who were not enrolled in the GHI scheme were still able to use the GHS through using other people's insurance cards.²⁴ The automatic enrolment of employees of the civil service and Palestinian workers in Israel, as well as those who opted to enrol voluntarily in the GHI led enrolment in the GHI scheme to reach 80% of Gazan households in 1982 (Ministry of Health - State of Israel, 1986). The PRCS (1986) reported that premiums and co-payments collected by the Israeli administration exceeded their expenditure on the GHS.

Following the end of the four-year war that followed the 1967 start of the occupation between the Palestinian Fedayeen and Israeli forces, the Israeli administration of the GHS made some renovations and extensions inside the governmental hospitals (Israeli Ministry of Health, 1977). The Israeli administration did not build hospitals during the period from 1967 to 1994, which meant that the number of hospital beds remained the same despite the population doubling (Elqura, 1996). Hence, the ratio of hospital beds to population halved during the period from 1967 to 1994. Although hospital services were not accorded proper attention during this period, there was an emphasis on strengthening the capacity of primary care services to address communicable diseases and Maternal and Child Healthcare. This emphasis on primary healthcare was manifested in the fourfold increase in the number of GHS' PHC centres. The number of these centres increased from eight in 1967 to 28 in 1992 (Habasch, 1999). UNRWA healthcare services were not excluded from the effects of this period on the delivery of free of charge healthcare. The Israeli authorities did not allow the UNRWA to construct any additional buildings, and this led the agency

²³ Interview with Dr Rabah Muhana, the founder of the Union of Health Works Committee, on the 31st of August 2017.

²⁴ Interviews with Dr Reyad el-Za'anoon, Dr Yehya Abed, Dr Rabah Muhana, Dr Khalil Shaqfa, and Mr Fayez el-Shalaton.

to rely on the nine premises that had existed before June 1967 (WHA, 1992). In order to overcome the shortages of facilities, the UNRWA introduced afternoon shifts in five of its premises (Ibid).

Consistent with the Israeli policies of pacifying the population of the Gaza Strip following the end of four years of intense confrontations between the Israeli army and the fedayeen (Palestinian resistance fighters), the Israeli authorities licensed a few institutions that had been providing public health activities and ambulatory healthcare.²⁵ Additionally, between 1973 and 1981, the Israeli authorities licensed four Islamic institutions, which later became the backbone of Hamas 'civil society institutions (Roy, 2011, p.74). Some of these Islamic institutions had medical and dental clinics (Ibid, p.119). Notwithstanding the licensure of charitable and Islamic institutions, the activities of the Medical Relief Committees, which were founded in the West Bank at the end of the 1970s, based on national aspirations under the umbrella of the Palestinian Communist Party, were initially outlawed and persecuted in Gaza in the mid-1980s; however they were finally allowed, thanks to international solidarity (Andersson and Jerdén, 1986; Aqel et al., 1987; Habasch, 1999). Although the Israeli authorities licensed some charities and voluntary private institutions, they did not permit the Palestinian plans to build non-governmental voluntary hospitals in the Gaza Strip (Mandell, 1986).

As indicated above, the first 20 years after the start of the Israeli military occupation in 1967 entailed changes in the public and private dimensions of healthcare delivery. The public provision of healthcare saw the introduction of fees for the use of GHS and made enrolment in the GHI scheme a formal prerequisite for entitlement to these services. Additionally, the development of hospital services and of the UNRWA provision of the PHC was stagnant, while the PHC component of the GHS was strengthened. The private health sector went through changes and the number of private healthcare options increased. The monopoly of the Church Mission Society (CMS) Hospital was broken by newly emerging charitable and Non-Governmental Organizations (NGOs). Furthermore, the number of private practices increased thanks to the increased availability of HRH, encouragement from the Israeli military administration and an improvement in the financial situation of the population.

²⁵ Interview with Dr Rabah Muhana.

The picture of the developments during the period under the Israeli occupation would be incomplete without tracing the developments during the time of the first Palestinian Intifada (1987-1994), when there were further reductions in the responsibilities of the Israeli administration, and increased visibility of charitable and Non-governmental Organizations (NGOs); a small private entrepreneurial hospital was opened, and the role of the UNRWA and the use of its healthcare services increased.

The Israeli administration decreased its responsibilities in regard to the provision of GHS during the Intifada. This led Ziv et al (2002) to conclude that if the period from 1967 to 1987 was marked by minimal responsibility for the health of the population in the occupied territories, the period that followed the first Palestinian Intifada in December 1987 was characterized by a reduction in this minimal responsibility.

Popular medical and health committees, which had emerged in Gaza during the few years before the start of intifada, gained more prominence and visibility and increased in number (Habasch, 1999). However, this increase in number should be interpreted cautiously, as it could be attributed to splits among them, as indicated by Challand (2009, p.62), rather than to a remarkable increase in their role in service delivery. The role of entrepreneurial private healthcare increased. A private hospital was opened in 1994 providing orthopaedic surgical operations with some 10 beds and surgical facilities (State of Israel- MoH, 1994).

The UNRWA responded to the Intifada by strengthening its role in service delivery. It almost doubled the number of its employed physicians and increased its HRH, offered emergency services that temporarily employed dozens of HRH, inaugurated physiotherapeutic units in some of its PHC centres, planned for the construction of additional PHC centres and managed the construction of a European union donated hospital (UNRWA, 1989; UNRWA, 1990; WHA, 1992). The increased supply of UNRWA resources during the Intifada was accompanied by a gradual worsening of living and financial conditions, due to the institution of closure and the restrictions on the passage into Israel and the West Bank. The increased supply of UNRWA healthcare services and the worsening of the economic outlook in the Gaza

Strip contributed to an increased utilization of UNRWA free-of-charge healthcare. **[See Annex VI-II to see the increased supply of UNRWA healthcare resources]**

The number of medical consultations at UNRWA PHC services increased from 586,000 medical consultations and 40,000 dental consultations in 1987 (when the number of the eligible refugees was 450 thousand), to 1,392,000 medical consultations and 83,000 dental treatments in 1994, when their number was 660,000 refugees (UNRWA, 1988; UNRWA, 1995). Hence, the numbers and ratios of medical and dental consultations that took place at UNRWA PHC centres increased remarkably during the Intifada.

6. 2.3 Healthcare under the Palestinian Authority (PA) [1994-2005]

Even before establishing the PA in May 1994, the Palestinians were preparing to assume responsibility for the health sector in the oPt. The National Health Plan (NHP), which was developed by the Planning and Research Center (1994, p.6), put “*Health for All, based on universal coverage and equal access regardless the ability to pay*” to the Palestinian society as a highly desirable goal. A few months after the establishment of the PA, in November 1994, an Interim Action Plan (IAP) was initiated by the Palestinian Council of Health and the Ministry of Health (MoH) (1994) for a period of two years, with an overall goal of meeting the immediate health needs of the Palestinians within the framework of the NHP; establishing a National Health Authority capable of managing the health sector effectively and efficiently; ensuring the continuity of healthcare provision; upgrading the level of healthcare services; and formulating a detailed five-year implementation plan based on the NHP. The clearly stated vision of UHC was muddled and challenged by the operations on the ground. The limited resources available to the PA were seen as obstacle to the implementation of policies vis-a-vis UHC.²⁶

With financial and technical support pledged by the international community following the Oslo Accords between the Palestine Liberation Organization (PLO) and the State of Israel, the MoH rehabilitated the GHS, which transferred from the Israeli Administration. Additionally, the MoH expanded the network of its PHC services from

²⁶ Interview with Dr Reyad el-Za’anoon, the first Minister of the Palestinian MoH (1994-2002), on 23rd August 2017.

31 PHC centres in 1994 to 43 centres in 2000, put in place incentives for certain groups to participate in the GHI scheme enabling 63.5% of households in Gaza in 1999 to join it despite growing unemployment, and expanded the services package to the enrollees in the GHI scheme (MOH- Health Management Information System [HMIS], 2000; MOH- HMIS, 2001). In addition to setting out a ministerial management structure and initiating a national health information system, the MoH was able to absorb the available professionals, who were unemployed during the Israeli control over healthcare, into the GHS (Giacaman et al., 2003; Mataria et al., 2009). The PA police and security forces started their Police Medical Services (PMS) through a few clinical facilities and one small hospital. The UNRWA also increased the number of its healthcare facilities and supervised the construction of a 250-bed hospital, donated by the European Commission, which it then handed to the MoH (UNRWA, 1995; MOH- HMIS, 2001).

Private healthcare was not unaffected by the post-Oslo developments. The donor community promotion of the role of the private sector and the discouragement of public sector engagement in service delivery, coupled with relative political stability, led to considerable growth of the private *for profit* healthcare sector in the oPt (Hamdan et al., 2003). While it is true that this happened in the Gaza Strip after the establishment of the PA, it is difficult to generalize the “considerable growth” mentioned by Hamdan et al. (2003) in the Gaza Strip, especially as the relative political stability during the few years that followed the implementation of the Oslo Accords was not necessarily associated with improvements in the economic background in the Gaza Strip. Dr Reyad el-Za’anoon indicated that while the MoH encouraged the entrepreneurial private for-profit sector in the West Bank, it favoured the growth of private not-for-profit institutions in the Gaza Strip. The large expansion of the GHS – according to him – left only limited space for entrepreneurial private investors to invest in healthcare, leading them to invest in what were clearly profit-generating enterprises that were not offered either by the GHS or by the not-for-profit health sector. He indicated that In Vitro Fertilization (IVF) centres and diagnostic imaging are examples of these enterprises²⁷.

²⁷ Interview with Dr Reyad el-Za’anoon.

Consistent with what was indicated by the first Minister of Health – Dr Reyad el-Za’anoon - that the PA encouraged the growth of the not-for-profit sector rather than entrepreneurial private healthcare, the health services of NGOs were expanded. The number of NGO ambulatory healthcare centres in the Gaza Strip increased from 36 in 1996 to 40 in 2000 (MOH-HMIS, 2001). Additionally, several NGO hospitals were established during the first few years after the establishment of the PA in 1994 and their number increased from one solitary hospital before 1994 to 7 in 1999 (MOH-HMIS, 2000). Many NGOs remained active in the fields of community mental health, rehabilitation and health education.

In 1998 the World Bank (WB) published its medium-term development strategy for the health sector in the West Bank and Gaza Strip. The strategy called for a greater role of private health insurance in expanding healthcare coverage, greater managerial autonomy and alternative financial incentives, which were thought to promote hospital efficiency, and the purchasing of health services from the private sector (WB, 1998). It further called for the harmonization of the MoH and UNRWA payment schemes through the gradual introduction of co-payments for UNRWA services, similar to those of the GHS, in order to define the latter benefits packages, increase UNRWA revenue collection ability and improve the complementarity between public and private healthcare (Ibid). Notwithstanding the WB (1998) call for the UNRWA to introduce co-payments for its services, similar to those collected for government PHC services, it continued to provide free-of-charge PHC to eligible refugees, and the number of UNRWA PHC centres increased (MoH-HMIS, 2001). The WB (1998) recommendations for Public Sector Management were echoed in international donors’ attempts to introduce and pilot private services in one of the buildings of al-Shifa hospital, the biggest government hospital, but this proposal was cancelled after the explosion of violence in the third quarter of 2000, when the al-Aqsa Intifada started.²⁸

Despite some increase in the supply of private healthcare, concurrent with the improved supply of publicly-provided healthcare by the MoH and UNRWA, publicly-provided healthcare was consistently the most utilized option during the six years that followed the establishment of the PA. The results reported by Lennock and Shubita (1998) and the PCBS (1997a) indicated that the sizable majority of services used by

²⁸ Interview with Dr Rabah Muhana.

respondents during the first two years after the establishment of the PA took place either at UNRWA or government healthcare services, and the PCBS (2001a) confirmed that the dominant use of publicly provided healthcare continued to prevail in 2000.

Dr Reyad el-Za'anoon indicated that international donors encouraged the MOH to concentrate its efforts on revitalizing PHC and managing the available hospital services that were taken over in 1994²⁹. However the MoH responded to the internal access difficulties created by the Israeli forces following the start of the al-Aqsa Intifada in September 2000 by upgrading three newly-built big governmental PHC centres into three small general hospitals and opened the Gaza European Hospital at the end of 2000 (MOH-HMIS, 2001). The number of MoH hospital beds subsequently increased from 896 in 1999 to 1499 in 2005 (PHIC - MoH, 2006).

The network of government PHC services also expanded during the second (al-Aqsa) Intifada. The number of government PHC centres increased from 43 in 2000 to 56 in 2004; however, the medical consultations that took place at the MoH PHC services declined after 2001 (MoH-HMIS, 2001; MoH-HMIS, 2002; PHIC-MoH, 2006). This decline was concurrent with the increasing use of UNRWA free of charge PHC (UNRWA, 2001; UNRWA, 2005). The increase in the use of UNRWA health services after the onset of the al-Aqsa Intifada was similar to the trend of increased use of UNRWA PHC that started following the 1987 Intifada, when the population's financial situation worsened. This implies that any deterioration in people's financial conditions can lead them to avoid healthcare that requires payments. Even the nominal co-payments that are collected at the MoH PHC services have diverted users from these services towards the UNRWA free-of-charge PHC.

International health NGOs strengthened their presence and operations during the period of the al-Aqsa Intifada (Abu-Sada, 2011). In addition, the services of indigenous NGOs grew rapidly and the visibility and prominence of Islamic Civil Society Organizations active in the health sector also increased during the second intifada. Challand (2008) argues that there was a reawakening of charitable institutions during the second (al-Aqsa) Intifada and points to the vast network of these institutions

²⁹ Interview with Dr Reyad el-Za'anoon.

that were operated by Hamas. The number of NGO hospitals increased and their bed capacities also increased; furthermore the number of NGO ambulatory medical centres increased from 40 in 2000 to 55 in 2005 (MoH-HMIS, 2001; PHIC-MoH, 2006).

Although there are no reliable data about the growth in the private-for-profit sector since 1994, the nature of private practices has not changed. The data presented by Hamdan et al. (2003) show that the availability of private practice in the Gaza Strip was much lower than in the West Bank. The data from the Healthcare Providers and Beneficiaries Survey (HPBS) conducted by the PCBS in 2005 indicate that 93.3% of the workforce of the private-for-profit sector in the Gaza Strip were employed by other sectors and that 96.1% of those employed by other sectors were employed either by the MoH or by the UNRWA.³⁰

The late President of the PA, Yasser Arafat, issued a decree in 2001 to enroll without charge for all those who were negatively affected by the Israeli measures in the GHI scheme (Mataria et al., 2009). Notwithstanding the free expansion of the enrolment in the GHI scheme, this move was not associated with the legislative framework to support the goal of achieving Universal access to healthcare, which was initially declared as a target by the National Health Plan even before the establishment of the PA. Rather, the basic law of the PA, which was ratified by the Palestinian Legislative Council in 2002, explicitly stated that “the economic system in Palestine shall be based on the principles of a free market economy”, and did not mention the right to health or universal health access as objectives of the proto-Palestinian state.³¹ Additionally, the public health law, which was enacted in late 2004, concentrated on Maternal and Child Health and communicable diseases and did not tackle the right to healthcare among other groups of the population needing healthcare for other health problems (PA, 2005). The absence of a legislative framework to expand free enrolment in the GHI can be attributed to the unstable political situation and to the limited resources available to the PA, as indicated by Dr Reyad el- Za’anoon. The absence of a legislative framework was consistent with the neoliberal policies adopted by the PA after the appointment of Dr Salam Fayyad as Minister of Finance in 2002,

³⁰ Based on my descriptive analysis of the HPBS data obtained from the PCBS.

³¹ [2003 Amended Basic Law | The Palestinian Basic Law](#)

when international donors pushed for his tenure to fight alleged corruption (Haddad, 2016, pp.208-237).

Nevertheless, in effect, access to healthcare services in the Gaza Strip became more or less universal after the second (al-Aqsa) Intifada and most users of health services continued to rely on publicly provided healthcare through using either the UNRWA or the GHS. Almost all (96.8%) patients who were recruited in healthcare facilities in the Gaza Strip by the HPBS indicated that they had at least one type of health coverage (PCBS, 2006 b). A household survey of the most recently utilized healthcare services in the Gaza Strip in 2005 showed that 46% of respondents used the healthcare services of the UNRWA, 42.2% used the services of the GHS, 8.1% used the services of NGOs and only 3.3% used the services of private-for-profit providers (WB and Bisan, 2006).

6.3 Healthcare after the Israeli disengagement, and the promotion of Hamas

The three previous subsections, which concentrated on the evolution of the public-private mix of healthcare services and entitlement to healthcare from the emergence of the Gaza Strip until the end of the second (al-Aqsa) Intifada and the implementation of the Israeli Unilateral Disengagement Plan in September 2005, demonstrated the trajectory of healthcare. In this part of the synthesis, I will proceed to demonstrate the developments in healthcare after the implementation of the Disengagement Plan, which led to enabling Hamas to internally control the Gaza Strip. In the following subsections, I will concentrate on the period that followed Hamas' consolidated control that followed in the Gaza Strip. I will first present the attitudes, behaviours, policies and practices of different actors that could have influenced the developments in public-private healthcare and I will then attempt to portray the actual developments in healthcare.

6.3.1 Influences of external actors on public-private healthcare

In the following three subsections, I will demonstrate the effects and influences of actors that have operated from outside the Gaza Strip on the performance and

development of both public and private healthcare. These actors are Israel, the community of donors, and the PA, which, since 2007, has been based in Ramallah; thereafter I will refer to this as the Ramallah Government.

6.3.1.1 Israel

There have been indiscriminate effects of the Israeli practices towards the Gaza Strip on different aspects and sides of healthcare, including its public and private components, in the territory. The Israeli-imposed blockade, which obstructed the movement of materials and resources, undermined healthcare at a system level (Smith, 2015). The intense Israeli military operations, especially the assaults during the winter of 2008-2009 and the summer of 2014, left some private and public healthcare facilities damaged or destroyed (The Health Cluster, 2009; Health Cluster, 2014). Even reconstruction mechanisms agreed between Israel, the international community and the PA could not adequately compensate the destroyed and damaged facilities; instead, these mechanisms created an additional bureaucratic barrier to build destroyed facilities or reconstruct damaged ones (Barakat et al., 2018). Hence, the Israeli policies of preventing the entry of goods and materials required for reconstructing and building healthcare facilities have played role in preventing the expansion of government hospitals that usually require more advanced equipment than those necessary for PHC facilities or small-sized private hospitals.

Additionally, creating through a blockade a context in which the Gazan economy became unviable made the development of private healthcare difficult. The per capita Gross Domestic Product, adjusted to the constant prices of 2015, shrank from 2508 US Dollars (USD) in 2005 to 1212 USD in 2020 (PCBS, 2021b). This reduction in the financial resources available in the Gaza Strip harmed the ability of Gazans to pay for the use of healthcare services that required fees, and therefore created a very difficult environment for the growth of private healthcare.

The Israeli and International Community's financial sanctions against Hamas, as a movement, and Gaza's Government, which is controlled by Hamas, have indirectly contributed to strengthening the private hospitals, which, paradoxically, are affiliated with the Islamic movement. Since Hamas's seizure of power, Gaza's

Government has been keen to levy taxes on imported and locally produced goods³². While Israel collects taxes on imported goods on behalf of the Ramallah Government, the Gazan Government levies taxes again on these goods locally (Hovdenak, 2010). However, banks and large companies, such as telecommunication companies, refuse to deal formally with the Gazan Government or to pay fees and taxes directly to it, fearing foreign and Israeli sanctions and citing a decree of the President of PA, which exempts business in Gaza from paying fees and taxes.³³ It has been agreed between Gaza Government and these large companies that the latter will pay these taxes indirectly to private institutions that are contracted by Gaza's Government to provide services to it. The quota of the MoH in Gaza from these taxes are paid by these large companies to private hospitals which are contracted by the MoH to outsource some services such as maternity care and provision of some hospital procedures³⁴. It was ascertained through many of the interviews that the bids for providing these outsourced hospital services by the MoH in Gaza have gone to not-for-profit Islamic hospitals, which are believed to be close to Hamas.³⁵ Hence, the Israeli and international community measures, which aimed to deprive Hamas and Gazan Government of financial resources, have in fact directed financial resources to Hamas private sector, including its not-for-profit hospitals.

6.3.1.2 Donor community

While most donors froze their operations in the Gaza Strip following Hamas' seizure of power in June 2007 and adopted a non-contact policy with Hamas and its Gaza Government, some of them maintained a role in supporting the health sector (International Crisis Group, 2007). Following the end of the Israeli assault on Gaza in January 2009, International NGOs, which were outraged by the intensity of the assault, strengthened their presence in the Gaza Strip, which was described by Caroline Abu-

³² [Gazans squeezed by triple taxes as Hamas replaces lost income - BBC News](#)

³³ [Hamas urges Gaza banks to pay overdue taxes Middle East--China Economic Net \(ce.cn\)](#)

³⁴ Interview with Dr Basem Naim [the Palestinian Minister of Health (April 2006- March 2007); Minister of Health in the Gaza Government (June 2007- 2012); and the holder of the portfolios of Health and Environment at the Higher Government Administrative Committee (March 2017- September 2017) on 6th September 2017.

³⁵ Interviews with Dr Tayseer al-Sultan, the Executive Director of the Union of Health Work Committees in the Gaza Strip; and with Mr Ahmad Lubbad, the director of the patients Care Society.

Sada of Medecins Sans Frontieres (MSF) as an area of a “Symbolic Conflict” that has been “attracting a huge amount of media attention” and has been “generating intense transnational political mobilization” (Abu-Sada, 2011). Additionally, the non-contact policy was not always adhered to by western countries. International agencies and international governments contacted Gazan Government officials informally or indirectly through international or national NGOs, despite the officially adopted non-contact policy (Qarmout, 2017, p.76).

There is a perception that international donors, especially those from the West, reduced their aid to Gaza Strip especially after the international financial crisis in 2008, the adaptation of the “West Bank First Strategy”³⁶ by influential western donors, and the increased attention to the multiple conflicts that erupted in the Middle East and North Africa after 2011. One of the interviewees voiced this idea.³⁷ However, the diverse sources of funding, continued conflict and historical link between the aid industry and the oPt may have reduced the effects of global, regional, and national changes in the flow of aid to the health sector in the Gaza Strip. Additionally, the spectrum of donors expanded and became much more diverse after Hamas took over in 2007, and especially after the end of the Israeli assault on the Strip in January 2009. The aid has not been limited either to official development and humanitarian support, or to western aid.³⁸ Enthusiastic solidarity groups and Islamic and Arab funding, alongside western assistance, poured support into the healthcare services following the 2008-2009 Israeli assault on Gaza (MoH- Palestinian Health Information Unit(PHIU), 2011). The change in the aid architecture and sources and their diversity have certainly contributed to mitigating the effects of external crises on the flow of support to the health sector in the Gaza Strip. The Minister of Health in the Gazan

³⁶ West Bank First Strategy, which entails focusing on “the West Bank and leaving Gaza behind for now” is a strategy that was adopted by Israel and the USA following Hamas’ seizure of power in Gaza. It entailed creating two drastically different realities in the two Palestinian territories, whereby the West Bank prospers and Gaza despairs in order to either isolate Hamas, weaken it, force it to moderate, or defeat it altogether (Samhuri, 2007).

³⁷ Interview with Dr Bassam Zaqout, the programme manager at the Palestinian Medical Relief Society in the Gaza Strip, on the 26th of August 2017.

³⁸ Interview with Mr Ahmad Lubbad, the Manager of Patient’s Care Society, on the 7th of September 2017.

Government indicated that without donors, the Government Health Services GHS managed by the Gaza Health Authorities could not have survived.³⁹

International aid to the health sector is a political tool that is usually used to promote or exclude certain stakeholders (Challand, 2009). Some international donors have encouraged the role of private sector. For example, the USAID, which stopped the implementation of its health projects in Gaza after Hamas seized power, started a 50 million project in early 2016. The project bypassed the services provided by the MoH in Gaza using the pretext that they were controlled and managed by Hamas, but it supported private sector institutions, including those that are seen to be close to the Islamic social sector.⁴⁰ The conditionality of the funding only going to the private sector has not been limited to some western donors that adopted the non-contact policy with the Gazan Government. Some external Islamic and Arab donors have streamed their funding towards private voluntary organizations. Some Islamic international charities have funnelled funding towards their local Islamic charity partners and restricted their financial support, requiring that it be directed towards certain local charities.⁴¹ Turkey has funded the building of a teaching hospital for the Islamic University in Gaza.⁴² Qatar, which donated 400 million USD \$ to the Gazan Government during the visit of its ex-emir in October 2012, chose to build a hospital for rehabilitation and prosthetic limbs without consulting the MoH administration in Gaza, and decided to keep the hospital under its administration, seemingly for political reasons (The Economist, 2012).

While certain donors require that their support be directed to certain private health institutions, others support the services of the MoH in Gaza by donating equipment and drugs and through building new facilities or reconstructing healthcare facilities that have been destroyed.⁴³ Additionally, UN organizations active in the health sector, such as the WHO, UNICEF and UNFPA, have continued their support

³⁹ Interview with Dr Basem Naim.

⁴⁰ Interview with Dr Yehya Abed, then a manager of a local contractor with the USAID project, on the 5th of September 2017.

⁴¹ Interview with Dr Basem Naim.

⁴² [Turkey supports construction of new university hospital in Gaza – Middle East Monitor](#)

⁴³ [GRM](#)

to the services of the MoH in Gaza and serve as mediators by channelling some funds from western donors.

To sum up, the influence of the donor community on public and private healthcare has not been unidirectional. While some donors have disengaged from supporting public services provided by the MoH or even the UNRWA, as was the case of the USA during the Trump administration, other donors have continued supplying them with material resources and provided technical assistance to public providers of healthcare. Other donors have been interested in the promotion of the private sector. Additionally, sanctions against Hamas and its Gazan Government have contributed to an environment that encourages private healthcare, and sanctions have made the support to the MoH services more difficult.

6.3.1.3 Attitude and practices of the Palestinian Authority (PA)

The practices of the PA Ramallah Government have negatively affected the healthcare services of the MoH in the Gaza Strip. Additionally, there are some recent indicators, which suggest that the Ramallah Government has started encouraging private healthcare in the Gaza Strip.

The numbers of MoH staff, which have been enlisted by the Ramallah Government, declined by almost a third from 8,731 in 2009 to 5,695 in 2020 (PHIC, 2010; PHIC, 2021). This resulted in the Ramallah Government being responsible for paying the salaries of slightly less than half of the MoH staff in Gaza, while the rest were on the payroll of the Gazan Government.⁴⁴ This increased the financial burden on the Gazan Government, as the PA had been responsible for paying the salaries of all of these staff before Hamas' military takeover in June 2007. This is consistent with the trend of the Ramallah government reducing its expenditure on the Gaza Strip. The government expenditure in the Gaza Strip declined from 868.9 million USD in 2011 to 740 million USD in 2020 (PCBS, 2021b).

Additionally, the Ramallah government reduced its supplies of drugs to the MoH facilities in the Gaza Strip. Only 53.9% of the drugs needed in 2011 for running the MoH services were drawn on; the Ramallah Government supplied only 36.2% of the drugs availed, while donations contributed 59%, and the Gazan Government

⁴⁴ Interview with Dr Khalil Shaqfa, the General Director of Health Planning at the MoH in Gaza, on the 28th of August 2017.

contributed to the remaining 4.8% of the drugs supplied (PHIC-MoH, 2012). This pattern of drug supplies and availability has continued in the same way during the subsequent years and this limited availability of drugs has led to a situation whereby sizable proportions of medicinal items at the Central Drug Store of the MoH in the Gaza Strip have reached a level that is insufficient to supply the healthcare facilities for one month (PHIC- MoH, 2021).

The percentage and costs of the services outsourced by the Ramallah Government to private health institutions in Gaza has been marginal, but it has increased recently. The number of patients referred from the MoH facilities in the Gaza Strip by the Ramallah Government to Gazan private health institutions increased from 4,649 patients, which accounted for 2.5% of the cost of outsourced cases, in 2011, to 6961 cases, which represented 5.6% of the cost of outsourced cases, in 2018 (PHIC, 2012; PHIC, 2019).

An official at private medicine unit at the MoH in Gaza reported that two private entrepreneurial medical centres had applied for their facilities to be licensed as private hospitals and that they were planning to have referrals through the Ramallah Government to their hospitals to administer treatment for oncological cases in Gaza.⁴⁵ According to reports published by the MoH in Gaza in the following years, two private entrepreneurial hospitals found their places in the Gazan health sector in 2019 and 2020 after a long absence (PHIC-MoH, 2020; PHIC- MoH, 2021). Additionally, one of the private not for-profit hospitals belonging to Palestinian Red Crescent Society, which is tightly linked to the Ramallah Government, started performing cardiac surgical operations (PHIC-MoH, 2020; PHIC-MoH, 2021).

6.3.2 Internal factors and Hamas management of healthcare

Several external and internal factors and actors have contributed to the development of the public-private provision and entitlement to healthcare in the Gaza Strip. The worsening economic situation of the population hindered the development of an independent and self-reliant private healthcare sector, and the observed surplus of human resources for health contributed to the development of both public and private

⁴⁵ Interview on the 3rd of September 2017.

healthcare. In the following, I argue, based on the interviews that I conducted, that the Hamas-led MoH in Gaza has been influenced by three main motives in shaping its specific doctrine in managing both public and private healthcare. These motivations are (i) its inability or unwillingness to finance the government health services, (ii) its link to Hamas social institutions, especially the private not-for-profit Islamic sector, and (iii) its social vision and being informed by the hegemonic approaches in the dominant global health agenda.

6.3.2.1 Inability or unwillingness to fund the Government Health Services

The Gazan Government has been able - especially during the short-lived period when the supply and merchandise of goods through underground tunnels between Gaza and Egypt flourished between 2008 and 2014 - to generate financial resources through locally collected taxes and fees (Pelham, 2014; Tannira, 2021 a). However, these financial resources have been very limited.

In addition to other factors, the inability of the Gazan Government to obtain enough funds to provide sufficient social services, including healthcare services, and the oversaturation of the MoH hospitals could have led the administration of the MoH in Gaza to seek additional funds from the users of the MOH services, to adopt some aspects related to or behind “Public Financial Management” in the health sector, and to justify the promotion of the growth of private healthcare.

Public Financial Management (PFM) refers to the laws, institutions, systems, and processes by which public resources are planned and executed (Oxford Policy Management, 2023). PFM functions consist of budgeting, financing, expenditure management, accountability, financial reporting and auditing (Nyamita et al., 2015). The suggested mechanism for aligning PFM with healthcare financing are protecting or increasing revenues, redistributed formula based budget allocation for health, output provider payments, and autonomy of health provider (Cashin et al., 2017). Although PFM looks like a technical financial management application to the public sector, it is related to the concepts of New Public Management (NPM). PFM is the most important part in dealing with the internal components’ functions of NPM (Nyamita et al., 2015). The NPM can be traced to the rise of neoliberalism in the USA and UK in 1980s (Simonet, 2011). NPM implementation was variable in the health

sector in different countries and was not necessarily implemented as initially suggested in 1980s, and did not always involve full privatization (Shaw, 2004; Simonet, 2011). However, it bears the initial conceptual underpinnings. NPM implementation in European health systems included policies that promote market mechanism, such as competition in services delivery, considering privatization of various depth, decentralization of decisions within public services delivery, and changes in services delivery scheme (Simonet, 2011).

The Strategic Health Plan produced by the MoH in Gaza emphasized the development of effective, efficient and responsive functional management systems, and the enhancement of financial self-reliance and self-sustainability in the healthcare system; it considered reforming the health insurance scheme (MoH, 2014). The plan stressed financial self-reliance through considering the introduction of co-payments at the level of the secondary health services, increasing beneficiaries' contributions, and minimizing exemptions (ibid). It called for providing financial autonomy to facilities and delegating some financial responsibilities to them to achieve a sustainable financial system (ibid). In practice, the administration of the MoH in Gaza has started collecting co-payments and fees for procedures performed at MoH hospitals.⁴⁶ Additionally, it has enforced the collection of the premiums for enrolment in the GHI scheme.⁴⁷ The MoH has piloted performing elective procedures at the largest hospitals in the Gaza Strip on the basis of fees for these services.⁴⁸

It was repeatedly mentioned by officials of the MoH in Gaza that their inability to provide all services appropriately and the oversaturated hospitals have led them to encourage private healthcare provision. The Minister of Health in the Gazan Government indicated in an interview on 6th September 2017 that : *“having functional private healthcare can divert people who can afford payments for healthcare especially hospital services, from using the MoH hospital, making the burden on these hospitals less and sparing more space for others who cannot afford payments”*. This is in line with what was indicated by the director of the Private Medicine Licensure Unit at the

⁴⁶ Interview with Dr. Khalil Shaqfa, the General Director of the Health Planning at the MoH in Gaza on the 28th of August 2017. .

⁴⁷ Interview with Mr. Fayez el-Shalatoni, the manager of the health insurance unit at the MoH in Gaza, on the 29th of August 2017.

⁴⁸ Interview with Dr Khalil Shaqfa.

MoH in Gaza, i.e. that the provision of healthcare by private institutions decreases the burden of providing healthcare in the MoH facilities: *“We are for privatization. We are for anyone, who tells us that we provide services and services are with good quality. This reduces that burden on us as a ministry (of health). We are under pressure at the Ministry. The burden on the Ministry is very heavy”*.

6.3.2.2 The link between Islamic healthcare sector and the MoH in Gaza

The attitude of the administration of the MoH in Gaza towards encouraging the growth of private healthcare could have been influenced by the tight links between the administration of the MoH in Gaza and healthcare charities and NGOs, which are known to be affiliated with Hamas or which are known to be within the orbit of the Islamic movement. . Hamas NGOs and charities have preserved their links with the political movement. While the Palestinian NGO sector has generally shifted from being connected to and reliant on the Palestinian political factions to becoming fully dependent on donors’ funding and agendas, Hamas NGOs continue to function under the direction of the Islamic movement through funding that Hamas secures from its external political allies (Tannira, 2021b, p.129). Additionally, many of the interviewees from secular health NGOs indicated that the Hamas healthcare charities and NGOs have been treated preferentially by the administration of the MoH in Gaza.⁴⁹ Although officials of the MoH denied this preferential treatment of the healthcare charities and NGOs that are seen to be linked to Hamas, they did not deny the shared vision and interest.⁵⁰ It was reported that even an Islamic clinic, which is seen to be linked to Islamic Jihad, did not receive certain benefits from the MoH that were received by other Islamic clinics, such as supplies of free drugs (Roy, 2011, p.128).

The promotion of the Hamas-private healthcare sector can be seen in the context of what has been going in the Gaza Strip during the past years since Hamas took control of it. It was observed that Hamas has done its best to dominate all aspects of economic and social life; commercial life and trading have also fallen under the umbrella of Hamas and it has become the main actor in the private sector in the Gaza Strip (Tannira, 2021 a). It is therefore unsurprising that the MoH has encouraged the growth of the private healthcare sector associated with Hamas to make the Islamic

⁴⁹ Interviews with: Dr Rabah Muhana, Dr Tayseer al-Sultan, and Mr Khalil Shahin.

⁵⁰ Interview with Dr Basem Naim

movement dominant within the private healthcare sector, which generates income through user contributions locally and through receiving external funds.

6.3.2.3 Hamas' social vision and the influence of dominant global discourses

Hamas has been characterized by the absence of a unifying agenda for socioeconomic changes and by the lack of an overarching organizing social vision (Roy, 2011, pp.183-184). This absence of a clear social vision could have led the Hamas elite, as stated by Tannira (2021 b, p.127) to be “informed by global agendas and which operates according to development frameworks set out by international organisations”, and to be highly influenced by the dominant global discourses regarding access to health care and the role of private sector in the provision of healthcare and by its pragmatic interest. The influence of the dominant discourses of the global health agenda is manifested in the health plan produced by the MoH in Gaza in 2012 (MoH, 2014). Some of these manifestations include facilities autonomy, the split between services' delivery and financing, using market mechanism and adopting some aspects of NPM, and encouraging private healthcare. In addition to the influence of the dominant global discourses regarding access to healthcare, the background of Hamas as a services provider, which sees the provision of healthcare as a charitable action rather than as part of human rights and entitlements, could have influenced the vision of the Islamic movement towards the right to healthcare.

Some Hamas-led MoH officials in Gaza blamed the beneficiaries of the MoH services for their voluminous use of healthcare, especially at the hospital walk-in receptions and emergency rooms. They claimed that user dissatisfaction with the healthcare provided by the MoH healthcare was unjustified, and blamed the users for low quality of the service, which results from the voluminous use of these services. The notion that healthcare is not a guaranteed entitlement for the population was expressed clearly by Dr Khalil Shaqfa, the General Director of Health Planning in the MoH in Gaza. In an interview on 22nd August 2017, he said that:

“The citizen praises the services of NGOs, but when it comes to the services of [the Ministry of] Health, the citizen behaves as if these services are entitled rights. He is ready to pay money for the NGOs, but he considers that it is an obtained right when it comes to the Ministry [health services]”.

6.3.3 The Gaza MoH approach of managing public-private healthcare

One can postulate, based on the interviews that I carried out in the Gaza Strip, that (i) the lack of a clear social framework among Hamas and its administration of the MoH in Gaza and the influence of hegemonic discourses that prevail in the global health agenda; and (ii) the pragmatic reasons and challenges in managing and funding the provision of healthcare and their interest in the growth of the Hamas' private healthcare sector, have influenced the emergence of a doctrine specific to Hamas and the administration of the MoH in Gaza towards managing the public-private mix of healthcare. I argue below that the components of this doctrine aim to: (i) encourage the private provision of healthcare; (ii) discourage the population that have been dependent for decades on publicly provided healthcare services from continuing to be dependent on these services; (iii) outsource hospital services to the private sector; (iv) increase the contributions of users of the MoH services and expand these contributions to hospital services; (v) keep the publicly provided healthcare of the MoH functional to serve the poor; and (vi) adapt some aspects of the public management of healthcare.

Officials at the MoH in Gaza repeatedly indicated that they encourage the private provision of healthcare. The discourse of purchaser-provider split and outsourcing services to the private sector on the basis of user financial contributions to outsourced healthcare services was repeated by the MoH in Gaza officials whom I interviewed. However, they emphasized that they intended to keep the services provided by the MoH functional and to reserve them for those who cannot afford payment or cost-sharing for private healthcare. An official at Private Medicine Unit at the MoH in Gaza emphasized the importance of privatization and the expansion of private healthcare:

“We are for the expansion of the private sector. This expansion is not limited only to us. There is a tendency in all states of the world to privatise the governmental institutions in all fields. Even in water. When did countries succeed in the field of telecommunications? They succeeded when they gave the telecommunications to the private sector. Before that the phone calls were dependent on manual dialling. Look at Egypt now! You can go everywhere and your Wifi I with you. They are much better

than us, who are connected with Israel. So privatization is always good. Additionally, privatization relieves the burden on us as a government”.

The Minister of Health in the Gazan Government indicated that he was planning to “wean” Gazans off of their dependence on the GHS in the longer term, to outsource services to the private sector, and to require people to contribute financially for the services they receive:

*“ The situations of the government, donors and the citizens are not normal. I should think how we could make a “weaning⁵¹” for the citizen from this attachment to the government services in the long term. This means that it is normal to let the citizen go to another service provider and to pay 100 NIS within his abilities. Where is the problem!!?? Previously, this was a crime. It was that the government should pay everything. This **[approach of discontinuing dependence on Government Health Services]** requires a transitional period. It requires that the donor helps you for three or for five years in order to have the citizens used and accustomed to going to the private sector. It is the same as the UNRWA, which gives the people an opportunity to have their surgical operations done at Ahli Arab Hospital (**The Church Mission Society [CMS] Hospital**). UNRWA pays 10 \$ USD and the patient pays 90 \$ USD, **[I interrupted him that the opposite happens as the UNRWA pays 90 USD and the patient pays 10 USD]** or the opposite - he pays 10 USD and the UNRWA 90 USD. Why should the citizen not contribute in return for receiving a bit better services; in order to receive them faster and better and to have more benefits...”.*

Leaving the Government Health Services open for the poor was indicated repeatedly by many of the interviewees from the Gaza Health Authorities. The Minister of Health stated that:

*“I will keep the gates of al-Shifa hospital (**largest hospital in the Gaza Strip**) open. I will not close them. The citizen, about whom you are speaking and who could not [pay], will not find the doors closed in his face. I will keep the government service for him”*

⁵¹ He said the word “weaning” in English, while his talk was in Arabic in general.

The encouragement of the growth of private healthcare services, “weaning” people off their longstanding dependence on publicly provided healthcare, and leaving publicly provided healthcare for poor people could justify the perception that the establishment of a two tier healthcare system has been encouraged. This perception was echoed by Mr Khalil Shahin, the manager of the socioeconomic rights unit at the Palestinian Centre for Human Rights, who stated that:

“We are facing the emergence of two health systems in the Gaza Strip; the first is the health system of essential health services with bad quality available at the government hospitals and institutions and at UNRWA institutions. These services are accessible to the majority of people and 85% of people use them due to the worsening of their financial situation. On the other side, there is a parallel health system which unfortunately emerges and dominates strongly. This parallel health system belongs to the private sector and some of the civic institutions, but as a result of the costs of treatment at this parallel health system, it is affordable only to 15% of the (Gaza) Strip population. This should alarm us as this points to a total collapse of health services and the health system in the Gaza Strip”.

Besides expanding co-payments for secondary health services, the provision of private or semi-private services at MoH hospitals has begun, as indicated by Dr Khalil Shaqfa, the General Director of the health planning at the MoH in Gaza, who reported that the private provision of surgical operations had been piloted at al-Shifa hospital to reduce the waiting times for these surgical operations on the basis of users’ financial contribution to the costs of these procedures:

*“ ... when we had certain funding, we did something for procedures that had long waiting lists, until 2018 or 2019. We asked the doctors who work at the MoH hospital to perform these procedures during the evening shifts when the operation theatres are not occupied. The patients paid fees which were less than the fees charged at the NGOs for example at Asdeqa’a al-Mareedh (**Patient Friends Society**) or at al-Maamadani (**Church Mission Society [CMS] Hospital**) and we were able to reduce the length of the waiting lists”.*

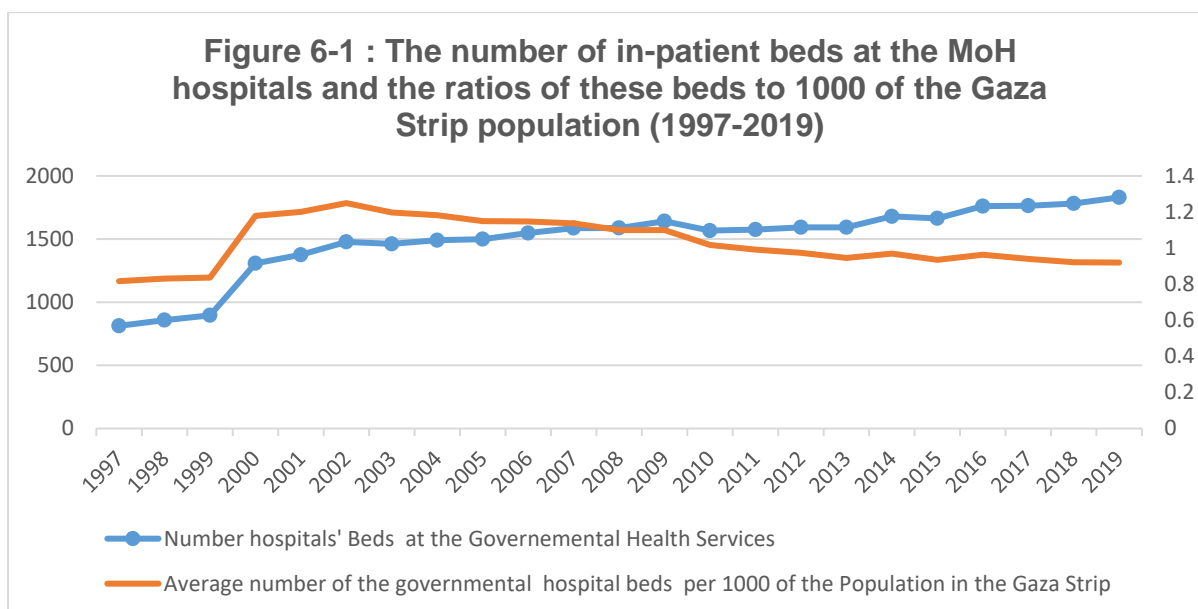
This private provision of healthcare at public facilities of the MoH hospitals can be seen as a manifestation of the “New Public Management” discourse of the 1980s

and 1990s, which encouraged the government to create a split between providers and purchasers of healthcare and to have contracts with their own employees or with their own hospitals to allocate funds in order create the so-called” efficiency of public facilities” through bringing market mechanisms to them (Lewis et al., 1996).

As seen from this subsection, the growth of private healthcare has been encouraged, private healthcare has been introduced to the MoH hospitals, and the MoH has been planning to outsource surgical operations to the private sector on the basis of users’ financial contributions. Additionally, users’ financial contributions are planned to be extended to hospital services, as indicated by the MoH planning document (MoH, 2014). Practically, users’ financial contributions have been collected at MoH hospitals, and the collection of fees and GHI scheme premiums has been enforced, as was repeatedly reported by the interviewees.

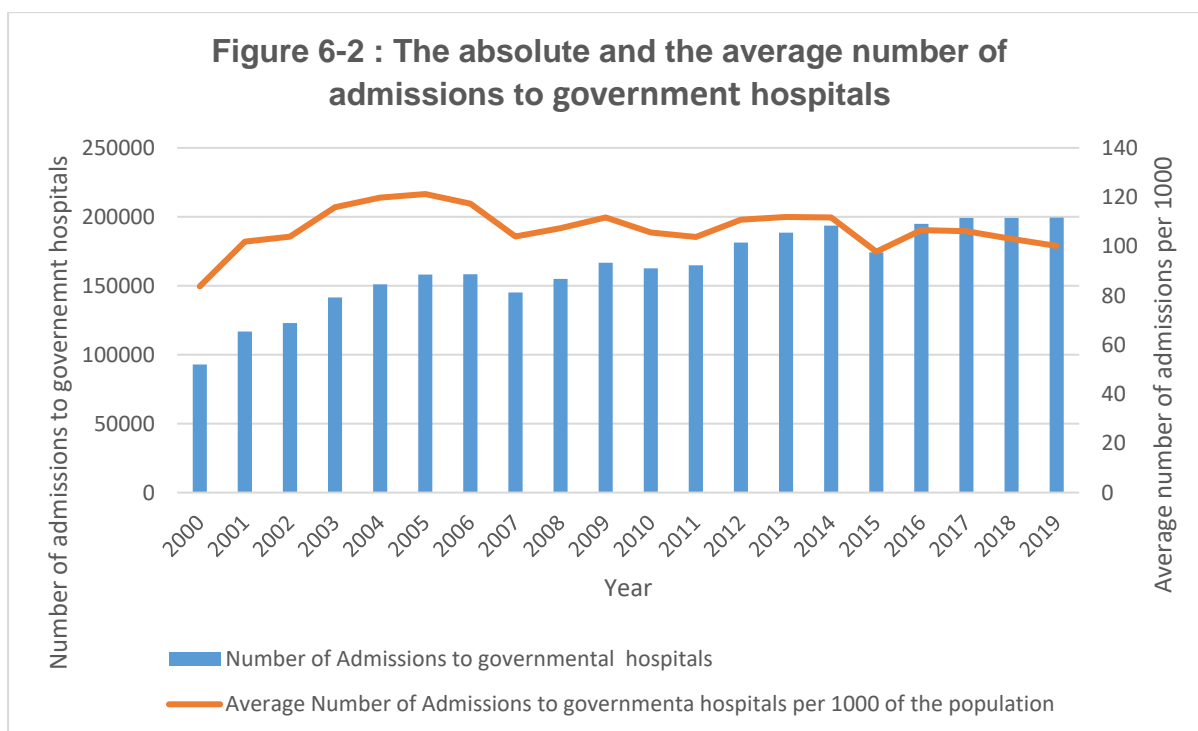
6.3.4 Developments in publicly-provided healthcare

While the number of MoH hospitals in the Gaza Strip increased from 10 in 2005 to 13 in 2009, the number of these hospitals then remained at the same level until 2020 (PHIC-MoH, 2006; MoH-Palestinian Health Information Unit (PHIU), 2011; PHIC-MoH,2021). The bed capacities of these hospitals have increased and there has been investments in day-care beds. However, the increase in their capacities has not been in line with population growth. The number of MoH hospitals’ inpatient beds increased by 24.5% between 2005 and 2020, from 1499 to 1867; however, during this period, the population grew by 56.98%, from 1.304 million to 2.047 million (MoH- PHIU, 2011; PHIC-MoH, 2021; PCBS, 2021). Hence, there was a decline in the ratio of inpatient beds in the MoH hospitals to the population (See figure 6-1). Accordingly, the ratio of inpatient beds reached 0.91 beds per 1000 persons in 2019, which is only slightly higher than the ratio of these beds to the population just before the boost in hospital services after the start of the second (al-Aqsa) Intifada in 2000. Hospital beds’ ratios in the Gaza Strip are much lower than the average ratio of beds in the Organization of Economic Co-operation and Development (OECD), which stood at 4.4 beds per 1000, less than one third of the ratio of beds in Israel, and lower than the lowest ratio reported among OECD countries (OECD, 2021, p. 31). Overall, the ratios of hospital beds to 1000 of the population have been consistently low and have been decreasing during the last years.



This reduction in the ratio of inpatient beds has led the MoH hospitals to become oversaturated with admitted patients. The occupancy rates at these hospitals increased from 82% in 2010 to 95% in 2019 (PHIC - MoH, 2011; PHIC – MoH, 2020). The oversaturation of the hospitals has probably contributed to the relatively short length of patients’ stays and to the reduced admissions. The average length of stay (ALOS) has been consistently low - around three days (PHIC - MoH, 2011; PHIC – MoH, 2020). It is suggested that short ALOS is an indicator of early and premature discharge from hospitals, which leads to bad patient outcomes (Southern and Arnsten, 2015). Besides the relatively low ALOS, which could imply the premature discharge of patients, the ratio of admissions to these hospitals per 1000 of the population has been declining since 2006. Figure 6-2 below shows that admissions to MoH hospitals increased until 2014, and then they almost reached a plateau. Given the high occupancy rates at the MoH hospitals, the stable level of the absolute number of admissions to these hospitals could imply a lack of space to accommodate more admissions, indicating that the MoH hospitals are overstretched, and only allow very serious cases to be admitted to their inpatient wards. Most (60%) admissions to the inpatient wards of the MoH hospitals are admitted through the emergency rooms.⁵²

⁵² Interview with Dr Khalil Shaqfa, the General Director of Health Planning at the MoH in Gaza, on 28th August 2017.



Although the number of MoH hospitals has been stable since 2009 and the ratios of inpatient beds to the population has been decreasing, these hospitals have maintained developments as well as their role as the main provider of secondary and tertiary healthcare services in the Gaza Strip. The number of day care beds increased by 36.2% from 370 in 2010 to 513 in 2019, slightly exceeding the 33.4% increase in the population, from 1.5 to 2 million during the same period (PHIC - MoH, 2011; PHIC – MoH, 2020; PCBS,2021). Three out of every four hospital admissions and discharges and more than 90% of hospitalization days, almost all hospital deaths (98% in 2010), the majority of surgical and endoscopic procedures, 70% of childbirths, the vast majority of visits to reception and emergency rooms (95%-89%), and the majority of outpatient hospital consultations (60%) have been occurring at the MoH hospitals during the past decade (PHIC - MoH, 2011; PHIC – MoH , 2020). The MoH hospitals are the backbone of the hospital services, not only according to their quantitative contribution, but also according to the nature of their role. They have continued to be the exclusive provider of many services, such as cardiac surgery, haemodialysis and the treatment of malignancies, which, until recently, have never been provided by the private hospitals (PHIC - MoH, 2017). Additionally, the breadth of their services is clearly manifested, especially at the largest ones. The vast majority (235 [90.3%]) of

the 260 ICU beds available in the Gaza Strip are located in the MoH hospitals; only 20 of these beds (7.8%) can be found in private not-for-profit hospitals and the remaining 5 beds (1.9%) are in the PMS hospitals (PHIC – MoH , 2020). The comprehensive services provided by the MoH hospitals led the manager of the Patient Care Society, which manages one NGO hospital and a few ambulatory medical centres, to indicate that they do not admit hospital patients with medical risks and that if any complication happens to any of their patients, they refer them to the largest MoH hospital in Gaza city.⁵³

The average per capita ratio of surgical operations that took place at MoH hospitals and their share of the total surgical operations performed in the Gaza Strip declined during the last decade. While the number of operations performed at MoH hospitals increased from 58,510 in 2010 to 64,342 in 2019, their share of all surgical operations in the Gaza Strip hospitals decreased from 81.3% in 2010 to 64.1 % in 2019 (PHIC - MoH, 2011; PHIC– MoH, 2020). This reduction was paralleled by an increase in the number of operations performed at private voluntary hospitals (PHIC - MoH, 2011; PHIC– MoH, 2020). The reduction in the share of surgeries performed at the MoH hospitals was probably due to changes in policies or the environment, which encouraged the growth of private healthcare, rather than being due to the overstretched capacities of the MoH hospitals. The number of surgical theatres increased comparably in MoH and in non-MoH hospitals and it is expected that the number of surgeries also increased evenly. The number of surgical theatres at the MoH hospitals increased from 38 in 2011 to 48 in 2019, while the total number of these theatres increased from 76 to 95 during the same period (PHIC - MoH, 2012; PHIC– MoH, 2020).

While the network of MoH hospitals have been able to maintain their role as the main providers of secondary and tertiary healthcare services in the Gaza Strip, the network of MoH PHC centres has lagged behind during the past decade. The number of MoH PHC centres has decreased, partially due to the destruction of some them during the Israeli assault on the Gaza Strip in the summer of 2014. The number of these centres declined from 56 in 2005 to 54 in 2009 even before the 2014 assault on Gaza; then, after the destruction of five PHC centres in 2014, their number dropped to

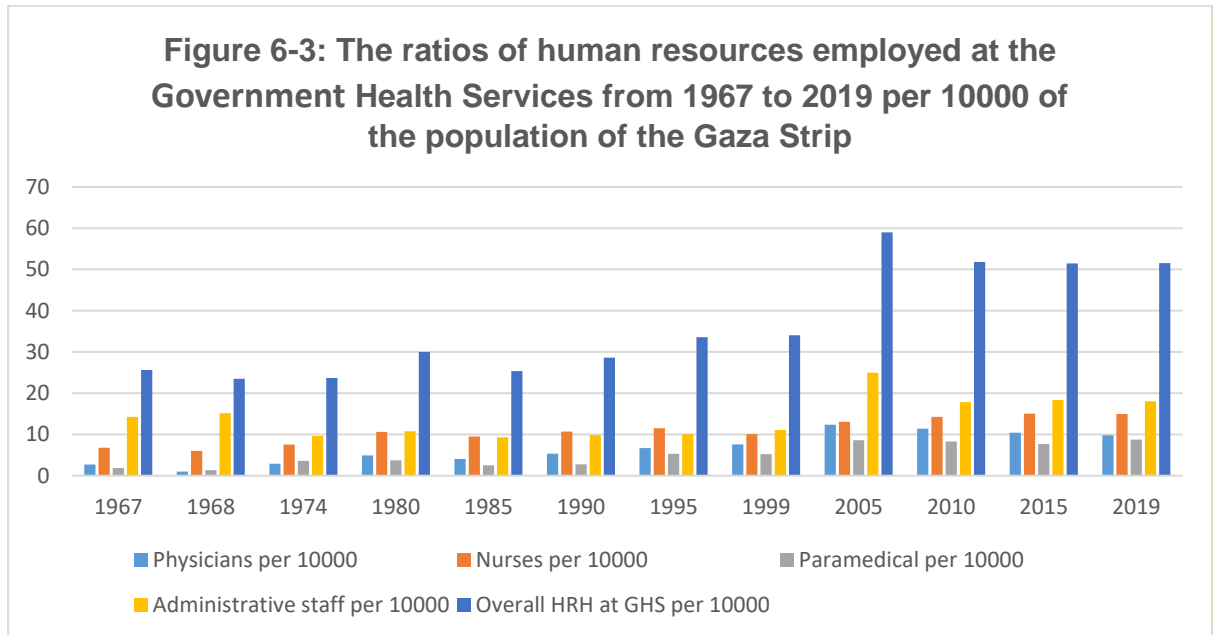
⁵³ Interview with Abou Hamza, the manager of the Patient Care Society, on the 7th September 2017.

49 (PHIC-MoH, 2006, p.13; Health Cluster, 2014, p.9). Only after the reconstruction of some of the centres that were destroyed did their number increase to 52 in 2020 (PHIC-MoH, 2021, p.6). Hence, the number of MoH PHC centres decreased in comparison to their number before Hamas took control.

The reduction in the number of PHC centres might suggest that the MoH in Gaza has had less interest in the provision of PHC services, especially as the UNRWA provides the bulk of PHC in the Gaza Strip. Despite this emphasis on the importance of PHC, the utilization of the MoH PHC services has declined and the human resources at these services have fallen. The number of medical consultations at the MoH PHC centres decreased from 3.3 million in 2004 to 3.1 million in 2009, and then gradually dropped to 2.1 million in 2019 (MoH, 2005, p.15 ; MoH- PHIU, 2011, p.11; PHIC-MoH, 2020, p.6). Annex VI.III shows that the reduction in the utilization of PHC services offered by the MoH during the past decade is part of the decline in the use of these services since the start of the Second (al-Aqsa) Intifada, when the economic situation worsened further. This reduction in the use of these services has probably been due to users avoiding paying fees for drugs and diagnostic tests, and has been coincident with a further increase in the use of UNRWA free of charge PHC services. Besides the reduction in medical consultations at the MoH PHC services, the number of prescriptions at these PHC centres has been steadily decreasing (**See Annex VI.IV**). This reduction in the number of prescriptions can be interpreted as resulting from either the worsening financial conditions of the population, who cannot afford co-payments for drugs, or the limited availability of drugs at these PHC centres, or both.

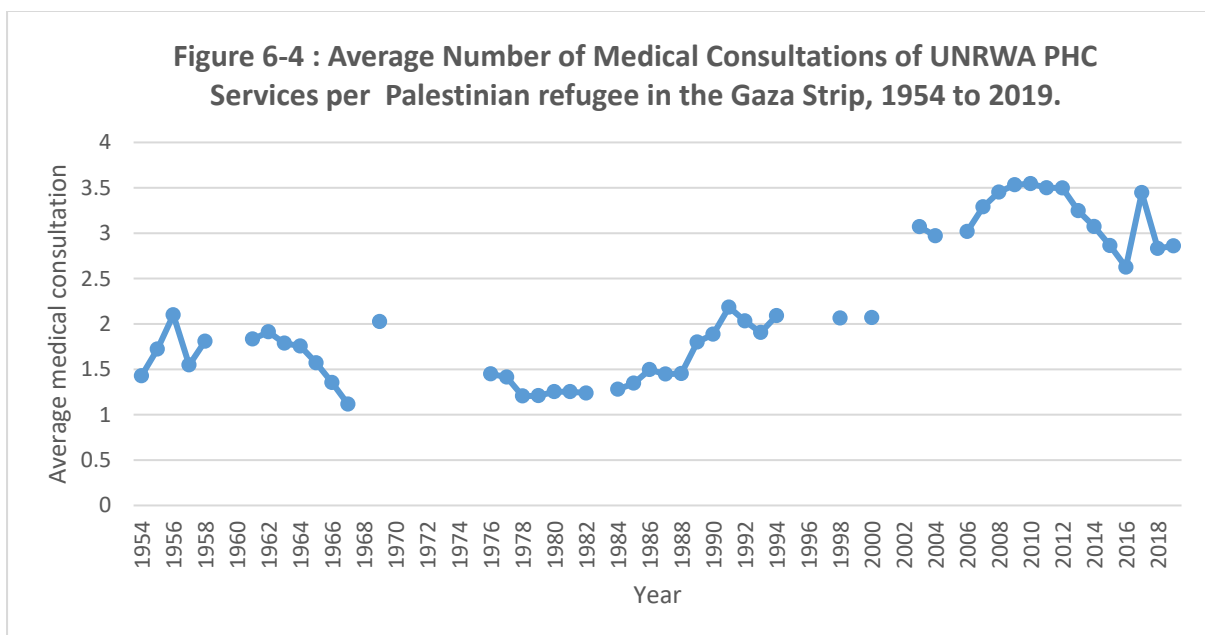
Besides the decline in the number of MoH PHC centres and the reduction in the use of their medical consultations, the number of staff employed at these centres has also decreased. The MoH PHC services workforce declined by 10% between 2005 and 2020, from 2003 employees to 1802 employees (PHIC - MoH, 2006, p. 42; PHIC-MoH, 2021, p. 27; PCBS, 2021). This reduction occurred when the workforce of the MoH was being maintained in line with population growth after the consolidation of Hamas' control in 2009, and when this workforce was not very far from its situation before Hamas' control of healthcare in Gaza in 2007. The MoH workforce increased by 43.39% between 2005 and 2020, from 7693 employees to 11031 employees (PHIC - MoH, 2006, p.42; PHIC-MoH, 2021, p.27). Thus, the workforce of the Ministry hospitals increased by 60.4%, from 4491 to 7194 employees, during a period when

the Gaza Strip's population increased by more than 56.98% (PHIC-MoH, 2006, p.42 ;PHIC-MoH, 2021:27; PCBS, 2021). Hence, the MoH in Gaza concentrated its efforts on replenishing hospitals by human resources at the expenses of PHC services [See Annexes VI.V and VI.VI].



While the government PHC services have been lagging behind, the UNRWA has maintained its historical role as the main provider of PHC services for refugees, who constitute more than two thirds of the Gaza Strip's population. The UNRWA, which has been dependent on voluntary financial contributions from UN member states since its inception in December 1949, has been challenged by a financial crisis since 2015 (Roy, 2015). Additionally, the Trump Administration's decision to stop the USA funding to the UNRWA in 2018 contributed to the exacerbation of its financial crisis (Seita et al., 2018; Ager et al., 2018). However, the UNRWA has continued to operate its healthcare services with very limited human and financial resources. Although the UNRWA's health programme was able to increase the number of its primary healthcare centres from 18 in 2006 to 22 in 2019, and to reconstruct many old premises of its PHC centres, this increase in UNRWA healthcare centres was not associated with an increase in the services offered (UNRWA, 2007; UNRWA, 2020). The increase in the number of these healthcare centres occurred thanks to the abolition of the afternoon shift, introduced after 1984 in five health centres, and the allocation of the services and resources of these shifts to new premises (Modol, 2010).

The number of UNRWA regular staff in Gaza was almost constant during the period from 2006 to 2020, when the refugee population grew from one million to 1.4 million (UNRWA, 2007; UNRWA, 2020). Thus, there was a gradual and steady decline in the ratio of regular HRH employed by the UNRWA [See Annex VI-VII]. Despite the stable number of staff employed by the UNRWA, the agency health programme managed to maintain the supply of its services in response to the needs of the impoverished refugees thanks to temporary recruitment using emergency and project funding, on which the agency has become more dependent. The UNRWAs budget is classified as either “regular general”, “project”, or “emergency” budgetary items, and the UNRWA recruits temporary staff under the project and emergency budget to assist its regular staff, who are paid through the regular general budget (Tannira, 2021b, p.153). Subsequently, the Agency health program in Gaza was able to maintain the number of medical consultations between 2009 and 2019 (4.1 and 4.2 million medical consultations) (UNRWA, 2010; UNRWA, 2020). The average ratio of medical consultations at UNRWA PHC centres to refugees [as shown in in Figure 6-4 below] increased steadily from 2006 to 2009, and then plateaued until 2012, when the UNRWA started reforming the provision of its healthcare services. These reforms entailed the introduction of a family-centred approach to healthcare service provision and e-health to the health information system (Santoro et al., 2016).



To sum up, I can state that despite the stable supply of publicly-provided healthcare services relative to the population growth, these services, while

overstretched to the maximum, have reserved their dominance, though with some nuances. The MoH hospitals have maintained their position as the main providers of hospital services, and the UNRWA has provided the bulk of PHC services in the Gaza Strip.

6.3.5 The growth of private healthcare

The cumulative influence of many actors and many factors has encouraged the growth of private healthcare. From 2009 to 2019, the number of private not-for-profit hospitals more than doubled, from 8 to 17, and their bed capacities increased by 55%, from 334 to 517 beds (MoH- PHIU, 2011; PHIC- MoH, 2020). The number of surgical operations at NGO hospitals almost tripled, from 12,643 to 32,279, during the period from 2010 to 2019 (PHIC - MoH, 2011; PHIC -MoH, 2020). Similarly, the number of non-for-profit medical centres has been growing; the number of these health centres increased from 66 in 2010 to 80 in 2018 (PHIC - MoH, 2019a; PHIC - MoH, 2019b).

Despite an environment that has encouraged the growth of private healthcare and its actual growth, the private health sector has been dependent on dual practising health professionals, and the services offered by private hospitals have been underutilized and dependent in most cases on the provision of diagnostic and surgical procedures and assistance during childbirth. More than two fifths (41.2%) of the 1938 staff employed at private not-for-profit hospitals and 54.4% of the staff employed at NGO medical centres at the end of 2020 were dual practising staff (PHIC-MoH, 2021b). When it comes to physicians, the percentage of them who are dual practising is much higher: 78.4% of the physicians employed by the private not-for-profit hospitals are dual practising (PHIC-MoH, 2021b). A similar pattern was reported in regard to the percentage of dual practising physicians employed by the not-for-profit medical centres at the end of 2017: 73.9% of them were dual practising (PHIC-MoH, 2018).

It is worth noting that the bed capacity of private not-for-profit hospitals has been gradually decreasing since 2014 despite the increasing number of these hospitals. The bed capacity of these hospitals reached 710 in 2013, but since 2014 it has started to decline; in 2014 their bed capacity was 619 beds and since then it has

declined further (PHIC - MoH, 2017). This decline has been coincident with the end of merchandize moving through tunnels that connected the Gaza Strip with Sinai, as the end of this short-lived tunnel phenomenon (2008-2014) contributed to the exacerbation of financial difficulties among the people of Gaza. It was repeatedly reported by the officials of the MoH in Gaza and by interviewees who managed not-for-profit health institutions, which are believed to be linked to Hamas or to be within its orbit, that having multiple private not-for-profit healthcare institutions enabled the attraction of diverse external funds from non-western sources.⁵⁴ Additionally, an official at the Private Medicine Unit at the MoH in Gaza informed me that many not-for-profit medical centres have applied to have their facilities licensed as hospitals, as donors tend to fund hospitals much more generously than ambulatory medical centres⁵⁵. Thus, one can postulate that increasing the number of not-for-profit hospitals without necessarily increasing their bed capacities had mainly had the purpose of competing for external funding. The seeking for external funding may be the cause of the proliferation of these small size not-for-profit hospitals. It was repeated through interviews with managers of both Islamic and secular private not-for-profit institutions that they exempt the indigent people especially from fees for hospitals services. Yet, the situation of private not-for-profit medical centres is very opaque. For example the manager of PHC clinics at the Palestinian Medical Relief Society informed that the actual number of these medical centres is higher than figure reported by the MoH publications⁵⁶. This goes with information gained from an official from the Private Medicine Unit at the MoH in Gaza that it sometimes happens that some unlicensed medical centres provide the healthcare services because they belong to licensed not-for-profit institutions and charities⁵⁷.

Additionally, the bed occupancy rates and hospitalization days at these private hospitals have been consistently low. Although the supply of private hospital care has generally been growing, this has not necessarily led to increased use of it. The contribution of private not-for-profit hospitals to the overall bed capacity of all of the hospitals in the Gaza Strip increased from 9% in 1993 to 17% in 2019 (State of Israel-Ministry of Health, 1994; PHIC - MoH, 2020). However, the contribution of these

⁵⁴ Interviews with Dr Basem Naim, Dr Khamis el-Essi, and Mr Ahmad Lubbad.

⁵⁵ Interview on the 3rd of September 2017.

⁵⁶ Interview with Dr Ghassan Zaqout on the 26th of August 2017.

⁵⁷ Interview on the 3rd of September 2017.

hospitals was limited to 10% of the overall hospitalization days in the Gaza Strip in 2019 (PHIC - MoH, 2020). Hence, the increased supply of private hospital beds has not been converted into increased use of the private hospital beds.

Moreover, the inpatient services at these hospitals have focused on the performance of invasive procedures and on assistance during childbirth. This focus can be attributed to the preference of dual practising physicians to perform their invasive and maternity procedures at private not-for profit hospitals rather than at their own self-operated practices. The executive director of the Union of Health Works Committees indicated that physicians have given up performing these procedures at their own practices as performing them at private hospitals costs them less and saves them from the medical risks. The ALOS at private hospitals has been consistently low - around one day (PHIC - MoH, 2011; PHIC – MoH, 2020). This low ALOS hints at the possibility that the interventions performed at these hospitals are usually neither complex nor complicated and therefore do not require a long hospital stay.⁵⁸

Little information is available about private for profit practices. However, entrepreneurial private practice is vibrant, also thanks to dual practice. An official from private medicine unit at the MoH in Gaza sketched the enumerated private enterprises in the health market. He reported that among the 2240 private outlets enumerated by the Gaza Health Authorities in 2017, there were some 500 private medical clinics of physicians, 770 private pharmacies, 350 private dental practices, 120-130 private laboratories, and 270 allied medical practices. Additionally, there has been an increase in investment in In-Vitro Fertilization (IVF) centres, as the number of these centres has increased from three to nine, and there are two private ophthalmic centre that provide ophthalmic surgery⁵⁹.

These practices and private outlets outnumbered the private for profit practices in the Gaza Strip in 1999, as reported by Hamdan et al. (2003) and then those surveyed through Health Providers and Beneficiaries Survey, which was carried out in 2005 by PCBS (2006). Private pharmacies can also serve as a useful proxy to trace the change in the volume of private entrepreneurial private practices during Hamas'

⁵⁸ Interview with Mr Ahmad Lubbad , the manager of the Patient Care Society, on the 7th of September 2017.

⁵⁹ This is a summary rather than an exact translation of the text of the interview with the official of private medicine unit at the MoH in Gaza .

consolidated control of the Gaza Strip. The number of private pharmacies increased by 45% between 2011 and 2020, from 507 to 737 (PHIC-MoH, 2012; PHIC-MoH, 2021 c). This growth in the number of private pharmacies was much higher than the population growth in the Gaza Strip during the same period. During that time the population of the Gaza Strip increased by 29%, from 1,588,070 to 2,047,969 (PCBS, 2021c). Thus, one can extrapolate that if the private entrepreneurial sector had grown the same way the number of private pharmacies had increased, the volume of private for-profit sector had grown significantly.

6.4 Conclusions

In this chapter I have traced the developments in the healthcare system in the Gaza Strip over more than seventy years to explore how the trajectory of the protracted conflict has affected the public-private- mix of healthcare services and their intersection, and how the entitlement to healthcare services has changed. I have shown that the twenty years that followed the Palestinian Nakba in 1948 defined the structure of the healthcare system in the Gaza Strip and shaped its characteristics of being mainly based on free-of-charge healthcare. I then demonstrated that the first twenty years under the Israeli military occupation were characterized by challenging the free-of-charge nature of the government health services, a stable number of inpatient beds at government hospitals and a stable number of UNRWA PHC facilities, although the population doubled during this time, increasing the role of government health services in providing PHC, as well as the role of the private sector in providing healthcare. I also demonstrated that the UNRWA strengthened its role in the provision of healthcare, and the visibility and multiplicity of private not-for-profit health institutions increased during the first Intifada. I then showed that the period that followed the establishment of the PA witnessed a growth in both public and private healthcare, and that the second (al-Aqsa) Intifada contributed to the expansion of government hospital services and the extension of the free healthcare coverage to those who had been negatively affected by it.

I explored in detail the developments in public and private healthcare after the implementation of the Israeli Disengagement plan in 2005, especially after the consolidation of Hamas' control. I demonstrated that this environment encouraged the growth of private healthcare and discouraged the expansion of the publicly-provided

services of the MoH and of UNRWA. Although the publicly-provided healthcare services of the MoH and UNRWA did not grow in parallel with the population growth during the consolidation of Hamas' control of the Gaza Strip, they maintained their roles as the main providers of healthcare. However, some publicly provided services, such as surgical procedures, have declined during the past decade and the MoH PHC services have been lagging behind the population fast growth. Simultaneously, while the growth of private healthcare is clear, this growth has been challenged by the financial difficulties of the Gazans and the lack of an independent private healthcare sector.

In the next chapter, I will discuss the findings of this chapter alongside the findings of the other two results chapters, and I will draw the conclusion of my thesis.

Chapter 7

Discussion

7.1 Introduction

Chapter 1 of this thesis suggested that there has been a shift in how the Gaza Strip has been dealt with since the first Palestinian intifada, from an area integrated within the Israeli economy into an area separated from it. This shift has resulted in a spiralling deterioration of the economic situation since the onset of the first Palestinian Intifada, and in an intensification of the conflict since the second Intifada in 2000. In that introductory and background chapter, I justified addressing the change in healthcare using piecemeal and limited knowledge about the historical trajectory of healthcare in the Gaza Strip. Additionally, I provided the rationales for using a three-pronged approach to address the possible change in healthcare. Given that I have discussed the findings of my empirical research in some detail in Chapters 4-6, in this chapter I will explore what I consider to be the key findings of the thesis in relation to each of the three overarching research questions. I will reflect on the overall change in healthcare in the Gaza Strip by discussing the possible implications of the findings that resulted from addressing the research questions regarding the possible changes in healthcare in the Gaza Strip in general, taking into account the literature and the context of the Gaza Strip. Subsequently, I will reflect on the overall strengths and limitations of this thesis, and identify potential directions for future research.

7.2 Addressing Research Questions

Chapter 2 of this thesis presented a systematic review of publications related to healthcare in the Gaza Strip. To the best of my knowledge, this is the first review of healthcare in this territory. This review confirmed that there is a lacuna in the knowledge about out-of-pocket payments on health-related products and services, especially about catastrophic health expenditure and the impacts of households' out-of-pocket payments on their poverty. Additionally, the publications reviewed support my initial suggestions, presented in chapter 1, that there is some knowledge on access to healthcare, especially preventive healthcare; and they confirm the piecemeal nature

of this knowledge and the lack of full historical perspectives. Furthermore, the information synthesized in the review about access to healthcare revealed that there is a certain gap in the literature about the effectiveness of healthcare in meeting the population's needs and expectations. The review confirmed the mixed nature of the healthcare delivery system in the Gaza Strip, presents some knowledge about the availability of health-related products and services, and emphasizes the inadequacy of studies about the public and private healthcare and how their mix and intersection have evolved.

The results chapters were organized to address the following overarching research questions in order to achieve the main research aim of exploring the change in healthcare in Gaza Strip when the financial conditions of the population deteriorated and the conflict started to become more intense after the onset of the first Palestinian intifada in 1987:

7.2.1 First Research Question

What changes were there in the ability of the local healthcare system in the Gaza Strip to protect the population and its different socioeconomic groups from the magnitude and burden of out-of-pocket payments for health-related products and services during the period between 1996 and 2017?

The levels of out-of-pocket payments on health-related products and services were almost stable from 1996 to 2017. The composition of these out-of-pocket outlays was dominated by expenditure on medicines.

Despite the relatively stable levels of out-of-pocket payments on health-related products and services, their share of households' financial resources (expressed in household consumption) increased significantly in 2017. This contrasted with the period from 1996 to 2011, when the proportion of out-of-pocket payments as a share of households' financial resources was stable. Given the low level of out-of-pocket payments in 2017 in comparison with previous years and the statistically significant low level of households' financial resources in 2017 relative to previous years, the surge in the proportion of out-of-pocket payments as a share of households' financial resources in 2017 was attributed to the worsening financial conditions of households rather being a result of any increase in the level of out-of-pocket payments.

Additionally, the proportion of out-of-pocket payments relative to households' financial resources has become distinctively higher among the most financially affluent group of households than among other groups since 2009. This observed increase in the proportion of out-of-pocket payments as a share of households' consumption among the most affluent group of households is attributable to the increasing level of out-of-pocket payments among this group since 2009, when the levels of out-of-pocket payments among other groups was stable.

Catastrophic out-of-pocket payments in the Gaza Strip are low in comparison with the global averages; and the pattern of the changes in out-of-pocket payments relative to households' financial resources is reflected in the change in catastrophic out-of-pocket payments. There was a statistically significant increase in catastrophic health expenditure in 2017 in comparison with other years. Additionally, catastrophic health expenditure has become more concentrated among the most financially affluent households than other groups of households since 2009.

Small amounts of out-of-pocket payments have consistently been able to push the near-poor into extreme poverty. The impacts of out-of-pocket payments on poverty have been high in comparison with the global average, and have been similar to other settings with a high prevalence of poverty. These effects were stable from 1996 to 2017.

7.2.2 Second Research Question

What changes were there been in the experience of Palestinians in the Gaza Strip in terms of accessing and paying for healthcare, especially after the start of the first Palestinian Intifada in 1987?

Interviewees who recalled their living conditions and the traumatic experience of the conflict (loss of lives, injuries, imprisonment etc.) had noticed the deterioration in their living and financial conditions after the first intifada in 1987. They showed that their conditions had gradually worsened and most of them had become dependent on financial aid and food assistance provided by institutions or by individuals. The interviewees indicated that their financial conditions had worsened further just before the period of the fieldwork, from 2016 to 2017.

There were multiple options available to the interviewees and their family members and they were continually dependent on the government healthcare services and on UNRWA PHC services for accessing healthcare. These options had been

almost the only options available to them in their early lives, and with time these options had started to be complemented, i.e. by the intermittent use of private healthcare among those who could afford to pay for it. Most of the interviewees reported that private healthcare was their last resort for seeking treatment and healthcare. They reported a mixed picture of exploitation and benevolence in regard to dual-practising physicians, who are usually employed at government hospitals during the official working hours and then practise in their own practices after the end of their official work. While some of them reported that these dual-practising physicians put their financial interests above the care they offered, some others, especially the financially least privileged, indicated that they had experienced the benevolence of dual-practising physicians. Private not-for profit healthcare was repeatedly reported to provide a lower-cost alternative to for-profit private healthcare. However, the picture conveyed by the interviewees implied that the boundaries between not-for profit and for-profit private healthcare had sometimes become fuzzy.

The healthcare experienced by the interviewees was reported to be unsafe. Among those who could afford to pay, access to publicly-provided healthcare had been smoothed and the quality attributes of this care had been improved by frequenting private practices and exploiting social connections.

The financial costs and burden of incidentally consulting private doctors was seen to be low, but having surgical operations done at private healthcare settings, purchasing medicine, and having dental procedures done by private doctors were all reported to have a high cost; and receiving medical treatment outside the Gaza Strip was seen to be very expensive. However, the interviewees' perceptions about the cost of receiving healthcare that requires out-of-pocket payments were dependent on their financial ability. Some of them reported that even nominal co-payments at government healthcare facilities constituted a financial burden. Interviewees reported that they used a range of adaptive mechanisms to cope with the financial costs and burden of using healthcare that requires out-of-pocket payments. However, they indicated that some adaptive mechanisms, such as borrowing and selling assets, which are widely used in other settings, were used mostly in Gaza to cope with the financial burdens of daily living expenses, such as paying for food and other subsistence needs, rather than to pay for healthcare costs. Most of the interviewees implied that they exploited the healthcare system's characteristics, including the multiple free-of-charge or low-cost healthcare options, to cope with the costs of seeking treatment and healthcare.

The use of leftover drugs dispensed at publicly- provided healthcare facilities for self-medication or to treat minor ailments was also reported.

Interviewees suggested that people in Gaza, especially during the three decades that preceded the interviews, were continually dependent on seeking healthcare that was low cost or free-of-charge, which was supplemented by the incidental use of private healthcare; and that access to and the quality of healthcare, and the financial burden of this care have been stable.

Notwithstanding the observed stability in the pattern of healthcare-seeking experiences, the performance of and access to healthcare, and the financial burden of accessing healthcare, there have been some important changes. The plurality of the healthcare options available to Palestinians in the Gaza Strip has increased. The number of government hospitals increased after the establishment of the PA. Private healthcare has become disseminated in all localities of the Gaza Strip, and geographic access to healthcare has improved. Additionally, women's experiences with maternal healthcare suggest that private healthcare services and their use have grown since the mid-1980s, when for example pregnant women who used to depend mainly on government or UNRWA antenatal care started combining this with private healthcare. These experiences also suggest that private healthcare has been strengthened since 2006, as most pregnant women have been combining publicly-provided antenatal care with private healthcare. Moreover, the gradual reduction in traditional birth attendants' assistance during childbirth and thereafter the cessation of this assistance since the mid-1990s suggest a decrease in the use of traditional healing. The NGO hospitals have recently become an umbrella under which private doctors perform surgical operations and assist with births.

7.2.3 Third Research Question

How have the conflict, policies, actions and inactions, and contextual factors affecting the healthcare system impacted on the development of a private-public mix of healthcare services and their intersection, and what changes have there been in terms of entitlement to healthcare services?

The synthesis of the interviews and documents reviewed shows that healthcare in the Gaza Strip has been developed in the shadow of political events and under their direct or indirect influence. The Nakba was a turning point in terms of the levels of healthcare

that were delivered and used, and in shaping the prototype of the healthcare services provided to the population. The humanitarian situation, which entails severe financial adversity for the vast majority of Gazans, has attracted both international and local assistance. Additionally, the nature of the Egyptian regime contributed to the predominance of free-of-charge healthcare services, which were delivered by the UNRWA and the Government Health Services.

Although it contributed to strengthening the PHC component of the Government Health Services, the Israeli control of healthcare contributed, through institution of the Government Health Insurance (GHI) scheme and the introduction of user fees, to ending the official entitlement of Gazans to free-of-charge Government Health Services (GHS), and to stalling the development of publicly-provided healthcare, namely government hospital services and UNRWA PHC. The dual-practice of health professionals was implicitly encouraged during the same period. While some voluntary endeavours that were initiated by local notables, health professionals, and Islamic institutions to provide medical care in the Gaza Strip were permitted during the Israeli occupation, the health committees initiated by the leftists in the West Bank in the late 1970s were outlawed and prosecuted in the Gaza Strip. The first Intifada, which started in December 1987, contributed to revitalizing the UNRWA provision of PHC, which had been stagnant since the mid-1960s, to reducing the already minimal responsibility of the Israeli authority for providing GHS, and to inducing the multiplicity and visibility of health committees and other health NGOs.

The environment of so-called “peace-building” and “state-building” after the Oslo accords in 1993 modestly encouraged private healthcare and financial and technical support was offered to improve the PHC offered by the UNRWA and the GHS. However, the initial commitment to implement UHC was muddled and challenged by operational issues. The implementation of the World Bank’s prescription for an increased role for private sector in healthcare provision was halted by the failure of the so-called “peace process” and the start of the second (al-Aqsa) Intifada in 2000, when free enrolment in the GHI scheme was offered to those who were negatively affected by the Israeli measures, leading to almost semi-universal healthcare but without a legislative framework. Additionally, the MoH hospital and PHC network was expanded, UNRWA PHC services were used more due to the further worsening of the

population's financial adversity, the services of NGOs expanded and Hamas' private health sector became more visible during the period of the second (al-Aqsa) Intifada.

Although the prototype of the healthcare system that emerged after the Nakba, which entailed the predominance of free-of-charge healthcare, was destabilized during the four decades that preceded Hamas' consolidation of their control of the Gaza Strip, the end of the Israeli onslaught on Gaza in the winter of 2008-2009 marked a turning point in reshaping the environment that could have contributed to the public-private healthcare services. This environment was influenced by the policies and practices of Israel, some donors, the Ramallah Government, and Hamas-led MoH in Gaza.

The Israeli imposed blockade negatively affected the provision of healthcare through obstructing the movement of materials and resources and undermining healthcare at a system level. The policy of financially boycotting the Gaza Government deprived the GHS of resources and indirectly benefited Hamas' private healthcare sector. The most influential Israeli practice affecting public-private healthcare may have been the imposed siege, which contributed to the population's financial adversity and subsequently to the inability of most people to use healthcare that required payment.

The effect of donors has not been even on the public-private dichotomy of healthcare. Some donors favour financing private healthcare, while others have contributed to publicly provided care.

The Ramallah Government has been indifferent in providing supplies to GHS in Gaza, contributing to the weakening of these services. At the same time, there has been a recent trend whereby the Ramallah Government started increasing the outsourcing of services to Gazan private hospitals linked to its faction or its ruling elite. The attitude of MoH in Gaza towards the public-private dichotomy of healthcare services and entitlement to healthcare is determined by its (i) inability or unwillingness to finance the GHS; (ii) tight links to Hamas' private health Sector institutions; and (iii) Hamas' lack of social vision and the influence of the dominant global (neoliberal) health agenda (see subsections 6.3.2). This has led the MoH in Gaza to have its own doctrine towards the public-private dichotomy of healthcare services, which includes: (i) encouraging the private provision of healthcare and discouraging populations who have been dependent for decades on publicly-provided healthcare services from using them; (ii) increasing the financial contributions of users of the GHS; (iii) keeping the

publicly provided hospital healthcare functional to serve the poor; and (iv) adopting some aspects of the new public management of healthcare, such as introducing the private provision of healthcare at public facilities (see subsections 6.3.3).

Subsequently, publicly-provided healthcare has not been expanded in line with population growth, and there is now an environment that favours nurturing private healthcare, which has grown, especially the number of private not-for-profit hospitals. However, private healthcare has not become a fully independent sector due to its dependence on dual practice, and the hospitals of the MoH and the UNRWA PHC services are still the most dominantly provided and used healthcare options.

7.3 Integrative discussion of the empirical findings

The design used to address the three overarching research questions under investigation in my research project was quasi-mixed methods research. I indicated in Chapter 3 that quasi-mixed methods, unlike true Mixed Methods Research, does not allow either full integration or triangulation of the results reached from one method or strand with those results of another method or strand. Hence, meta-inference cannot be reached from the three different stands that make up my research. However, I think that the results gained from one strand or method of inquiry can inform the discussion of the results achieved through another strand or method of inquiry and can therefore contribute to widening the understanding of the change in healthcare, in general, and the reasons for this change. For example, the levels of change in out-of-pocket payments for health-related products and services can be discussed and therefore can be better understood- though not be fully explained- in the light of the findings regarding the change in healthcare-seeking behaviours, which were generated through the qualitative inquiry that adopted the Life-history interview approach. Similarly, the insights regarding the evolution of public-private healthcare gained through the documentary review, corroborated by the elite-interviews, can contribute to discussions regarding the levels of the changes in out-of-pocket payments.

7.3.1 Consistent low levels of out-of-pocket payments and persistent reliance on public sector

The relatively low levels of out-of-pocket payments, and therefore catastrophic health expenditure, for health-related products and services found through the statistical analysis of the 11 rounds of the Palestinian Expenditure and Consumption Survey

(PECS) can be understood in the light of the pattern of healthcare-seeking revealed by the qualitative enquiry that was inspired by the Life-history Interviews approach. Additionally, the sparse publications, which were found through the literature review about the most chosen options of healthcare that had been used by the Palestinians in the Gaza Strip, postulate the low levels of out-of-pocket payment.

The qualitative enquiry revealed that Palestinian households have been continually dependent on seeking free-of-charge treatment and healthcare options and options that require only nominal co-payments for drugs and diagnostic tests, and that people who can afford to pay supplement these options with the incidental use of private healthcare. Additionally, the results of the surveys conducted by the PCBS show that most of those who consulted a healthcare provider in 1996 and in 2003 used the services offered by the UNRWA and the MoH (PCBS, 1998a; PCBS, 2004). These findings of interviews with householders about continuing reliance on publicly provided healthcare and the literature that indicated the predominant use of public sector make it very plausible to have consistently low levels of out-of-pocket payments.

The reliance on publicly-provided healthcare options cannot be isolated from the historical trajectory of the healthcare system and its structure, which has been evolving throughout this trajectory, and from the socioeconomic conditions of the Palestinians in the Gaza Strip. The structure and the nature of the local healthcare delivery system were defined during the first 20 years that followed the emergence of the Gaza Strip as an artificial geopolitical entity following the Nakba in 1948. The prototype of the healthcare system that emerged was defined by the socioeconomic background of the Gazan population, who were mostly poor and dispossessed people who relied on humanitarian aid, by the humanitarian interventions that were manifested through the provision of free-of-charge medical assistance, mostly through the UNRWA to Gazans, and by the nature of the Egyptian regime, which controlled the territory and offered free-of-charge healthcare to its population. The prototype of this local healthcare system was characterized by the dominant free-of-charge provision of UNRWA PHC and GHS, which existed alongside a single not-for-profit missionary hospital and a few private medical practitioners and pharmacies.

The free-of-charge nature of the government healthcare services was challenged by the introduction of the government health insurance scheme and user

fees for drugs and diagnostic tests. The UNRWA PHC and Government hospital services stagnated and private healthcare was encouraged during the two decades that followed the start of the Israeli military occupation in 1967. However, the prototype of the local healthcare system did not change remarkably. Yet, in the 1980s, people started plausibly complementing their dominant dependence on publicly-provided healthcare with the incidental use of private healthcare. The results of the time-matrix analysis of women's experiences with maternal healthcare services, presented in chapter 5 (subsection 5.3.5, Box 5-1, and Figure 5-1) demonstrated that pregnant women started combining their solitary use of antenatal healthcare provided by the UNRWA and government PHC services with the use of antenatal check-ups at private healthcare settings in 1986, and that the use of private healthcare for childbirths started at around the same time, in 1984.

Although people started to supplement their reliance on the UNRWA PHC and government hospitals with the incidental use of private healthcare in the 1980s, this does not necessarily indicate a remarkable change in the configuration of the local healthcare system. Two distinct factors could have led to supplementing the dominant use of publicly-provided healthcare with the incidental use of private healthcare. Those factors were the increased supply of human resources for health, and therefore the supply of private healthcare, and improvements in the financial conditions among Palestinians in the Gaza Strip. I showed in chapter 6 (section 6.2.2) that there has been a surplus in doctors since the mid-1980s (PRCS, 1986), and that private healthcare has been encouraged. The integration of the local Gazan economy into the more affluent Israeli economy and the ability of the Palestinian workers to work in Israel before the first Intifada contributed to increasing the levels of income among Gazans (Roy, 1995).

I argue that the shape and prototype of the healthcare delivery system that emerged with the emergence of the Gaza Strip as a geopolitical entity was stable, though it was challenged during the 27 years of the Israeli control over healthcare services in Gaza. Although there is comparative data about healthcare use among Gazans before the establishment of the PA in 1994, the available evidence suggests that the UNRWA PHC and the government healthcare services were the most commonly used healthcare options just after the establishment of the PA. The results of the health survey conducted by the PCBS in 1996 support this, as more than two

thirds (68.5%) of those who used healthcare within two weeks before the survey had used either UNRWA or MoH healthcare services (PCBS, 1998a). A similar picture was reported by Lennox and Shubita (1998), who indicated that 64% of those surveyed by them just after the establishment of the PA had used publicly-provided services for acute illnesses that they had encountered within one month before the survey and that the rest had used private healthcare. Interestingly, these two surveys were conducted at around the same time, when the PCBS started collecting data for the PECS in 1996, through which I demonstrated the consistently low levels of out-of-pocket payments. These consistently low levels of out-of-pocket payments correspond with the cross-sectional healthcare-seeking experiences over time that were indicated by most of the interviewees that I reported on in chapter 5.

The stable low levels of out-of-pocket payments demonstrated by the results of the statistical analysis, and the continuous dependence on publicly-provided healthcare services, which has been supplemented by the incidental use of private healthcare, shown in the experiences reported by the interviewees in the qualitative enquiry that was inspired by the Life-history approach, can be understood by their low ability, or even inability, to pay for healthcare that requires out-of-pocket payments, and by the typology of the healthcare delivery system, including the typology of the private sector in Gaza.

It is clear that the financial situation of most Palestinians in the Gaza Strip is poor. The local economy during the 20 years after the emergence of the Gaza Strip following the Nakba had remained woefully fragile and underdeveloped making it incapable of attaining self-reliance (Roy, 1995). This underdeveloped economy resulted from the destruction of the pre-capitalist social relation of production, the dramatic changes in the social structure following the displacement of refugees into the territory in 1948, and the Egyptian policies, which imposed constraints on development (Ibid, 92). The integration of Gaza's local economy into the Israeli economy after the start of the Israeli occupation in 1967 contributed to relative individual prosperity among people in Gaza and to improved financial conditions there, but hindered the development of the indigenous local economy (Roy, 1995). A sizeable proportion (43%) of the Gazan workforce were employed in Israel just before the outset of the first Palestinian Intifada in 1987 (Mandell, 1985). Employment inside Israel started to decline after the start of the first intifada, and declined further during

the subsequent period, until it ceased in 2006 (Farsakh, 2002; Farsakh, 2016). This led the unemployment level in the Gaza strip to climb into high digits (See figure 1-2 in chapter 1). This increased unemployment among Gazans contributed to the worsening of the financial conditions among most of them. The per capita Gross Domestic Product in the Gaza Strip decreased by 38.8% during the period from 2000 to 2020, declining from 1,971.9 USD to 1,207.5 USD (PCBS, 2021b). The poverty in the Gaza Strip climbed to unprecedented percentages of the population, qualifying Gazans and Gaza as among the poorest peoples and territories of the world. The percentage of people below the poverty line in the Gaza Strip increased from 38.8% in 2011 to 53.0% in 2017 (PCBS, 2012; PCBS, 2018).

The portrayal of the economic conditions in Gaza that I have sketched above testifies that the economic situation and financial conditions of most Gazans have been very low. I argue that although the financial conditions improved a little during the Israeli occupation before the start of the first Intifada, this improvement did not contribute to an accumulation of wealth among most Palestinians in Gaza; it just enabled them to get by and to manage their daily living expenses. Hence, Gazans have been living under very dire financial conditions, and their ability to pay for healthcare requiring out-of-pocket payments has been generally low.

People usually cope with their limited financial resources and therefore limited ability to pay for healthcare requiring out-of-pocket payments by using different adaptive mechanisms, which include attempting to receive healthcare without spending money (Russell, 1996). The free provision of healthcare services has enabled poor households in Sri Lanka to access treatment and has protected them from the high costs of healthcare without adopting risky coping strategies (Russell, 2001).

Most people in the Gaza Strip have limited financial resources and therefore limited ability to pay for healthcare. I argue that these limited financial resources and ability, together with the minuscule nature of private healthcare when Gaza was under the Egyptian military control, led most people in Gaza to develop a culture of dependence on the free provision of healthcare. Even when their financial abilities improved during the 1980s, they kept this culture of relying on free-of-charge and low cost healthcare options, and started supplementing these options with the incidental

use of private healthcare, if they could afford to pay for it. This is manifested in the stable proportion of out-of-pocket payments as a share of households' financial resources between 1996 and 2011, and simultaneously the stable incidence of catastrophic health expenditure during the same period. When the proportion of out-of-pocket payments as a share of households' financial resources, and therefore the incidence of catastrophic health expenditure, surged in 2017, this was due to a statistically significant drop in households' financial resources while out-of-pocket payments remained at the same level as during the preceding years.

In addition to the population's limited financial ability, the configuration of the healthcare delivery system and model of private healthcare, within the mixed healthcare system, have contributed to the stable levels of out-of-pocket payments and to the pattern of healthcare-seeking experiences. Private healthcare in the Gaza Strip consists mainly of dual-practitioners who subsidize their low income earned from working at the government hospitals with their own-run private practices, private pharmacies, private not-for-profit hospitals and medical centres, and a few entrepreneurial medical and diagnostic centres. The private not-for-profit sector grew substantially after the establishment of the PA in 1994, and entrepreneurial private practices and enterprises have grown; however, there is no comparative data about this growth, apart from data regarding private pharmacies. The number of private not-for-profit medical centres increased from 36 to 80 after the establishment of PA in 1994; and the number of private not-for-profit hospitals increased eight-fold during the period from 1994 to 2010, from one solitary hospital before the establishment of the PA, and then more than doubled to 17 hospitals during the subsequent decade. Despite the definite continuous growth of the not-for-profit private sector, this sector, similar to the private entrepreneurial sector, has been dependent on dual practice. Having a private sector dependent on dual practice enables this sector to charge users less. Additionally, the growing activities and numbers of not-for-profit private healthcare institutions, which are usually financially supported by external donors, offer the opportunity to provide cheaper services than those offered by dual-practising specialists and a few entrepreneurial enterprises. Hence, the private sector in the Gaza Strip offers healthcare at a relatively low cost for those who can afford to pay out-of-pocket. It was ascertained through the analysis of the PECS data that payments on medicines have consistently far exceeded payments to practitioners for outpatient

care combined with inpatient hospital charges. Shortages of medicines at facilities that provide free-of-charge or low cost services are common. Therefore, these medicines, which are purchased from the private sector, could have been prescribed by providers practising at these facilities. Hence, the high percentage of out-of-pocket payments for medicines as a share of total household health spending, as demonstrated in the findings of the PECS analysis, does not indicate necessarily the use of private healthcare providers.

7.3.2 Social stratifications of out-of-pocket payments and healthcare

After demonstrating the nature of the private healthcare sector in the Gaza Strip, and its dependence on dual-practice and its growth after the establishment of the PA in 1994, I think it is worth situating this sector in the global context of the private sectors within mixed healthcare systems. The private sectors in low and middle income countries have been categorized into five categories according to specific metrics (Mackintosh et al., 2016): (i) a dominant private sector, as is the case of India and Nigeria; (ii) a highly commercialized public sector, as is the case of China; (iii), a high-cost private sector at the top of stratified public sector, as in Argentina and South Africa; (iv) a private sector complementing a universalist non-commercialized public sector, as in Thailand and Sri Lanka; and (v) a stratified private sector shaped by low income and by the characteristics of the public sector, for example Tanzania, Ghana, Malawi and Nepal (Ibid).

I showed in chapter 6 that despite the recent growth in the private sector, this sector has never been dominant. This leads me to exclude the first category of a dominant private healthcare sector as in India and Nigeria. Similarly the typology of a healthcare system characterized by public-identity and private behaviours, as in China, does not fit the characteristics of the current or the previous publicly-provided healthcare in Gaza (Mackintosh et al., 2016). Although user charges have been applied to diagnostic tests and medical prescriptions in the government PHC since the mid-1970s, these are nominal. Additionally, the charges recently applied to some procedures at the government hospitals were motivated by the inability of the MoH in Gaza to finance the provision of healthcare, and they do not fully entail inducing private behaviours of government hospitals, as these charges are not comparable with the fees paid for the same procedures in the private sector and some of these procedures

are performed exclusively at government hospitals. Mixed healthcare systems with high-cost private sectors on the top of a stratified system with a low reliance of the public sector on charges, as is the case of Argentina and South Africa, are characterized by a relatively high share of private and social insurance in health spending and sizeable activity of private healthcare at the secondary and primary levels of care (Mackintosh et al., 2016). I demonstrated before in chapter 6 that the activity of the private sector, despite increasing recently in certain areas such as surgical operations and invasive procedures, has generally been insubstantial. Additionally, the percentage of those who are covered by private health insurance is marginal and decreasing; for example 2.5% of Gazan households were enrolled in various private health insurances plans in 1996 while the figure was 1.1% in 2004 (PCBS, 1998a PCBS, 2005a). The typology of the private sector exemplified by the cases of Argentina and South Africa is apparently far from the reality of the mixed healthcare system in the Gaza Strip.

The other two categories of private sectors within mixed healthcare systems seem to be relevant for discussing the private sector in the Gaza Strip and situating it within the global context. The category of a private sector complementing a universalist non-commercialized public sector, as in Thailand and Sri Lanka, is characterized by a low-to-moderate out-of-pocket payment share on total health expenditure, a low private sector share of in-patient hospitals, and very low or no public sector fees (Mackintosh et al., 2016). Additionally, the contribution of the private sector to preventive health services is low and there are good health outcomes, and most physicians practising in the private sector work in the public sector simultaneously in Sri Lanka (Ibid). I argue that the characteristics of the mixed healthcare system and the position of the private and public sectors within this system in the Gaza Strip makes it fit this category. The historical roots of the current healthcare system and the multiplicity of public healthcare options available to the population have made access to healthcare in the Gaza Strip almost semi-universal. Although the automatic entitlement to and the free-of-charge nature of government healthcare was challenged by the introduction of the GHI scheme and nominal co-payments for medicines and diagnostic test in the mid-1970s, the enrolment in the GHI has never prevented people from using government healthcare services in the Gaza Strip, as indicated in chapter 6. Additionally, the plurality of healthcare options in Gaza means that only 6.2% of the

population are without any health coverage (PCBS, 2005a). In addition to the almost universalist nature of access to healthcare in Gaza, similar to Sri Lanka, there have been good health outcomes and most preventive health services are provided by the public sector, and most physicians practising in the private sector simultaneously work in the public sector. Moreover, out-of-pocket payments, as revealed by the analysis of the PECS data, have been low and stable, similar to the pattern in Sri Lanka, as indicated by Mackintosh et al. (2016).

However, the healthcare system in the Gaza Strip underwent some important changes during the decade that followed the implementation of the Israeli Disengagement plan in 2005, especially after the consolidation of Hamas' internal control after the end of the Israeli assault on the Strip in the winter of 2008-2009. These changes can be considered a shift, or an incipient transformation, from a healthcare system with a private sector complementing a universalist non-commercialized public sector to a mixed healthcare system with a private sector that is stratified and shaped by the population's low income and by the characteristics of the public sector. This category of mixed healthcare systems, found in some countries in Africa and Asia, including Tanzania, Ghana, Malawi and Nepal, is characterized by the stratification of the private sector, with private hospitals and clinics for the financially better-off groups, while the financially disadvantaged groups of the population use mostly low-quality private healthcare offered at a low cost in dispensaries and shops (Mackintosh et al., 2016). The public sector in countries with a private sector that is stratified between the poor and the rich relies variably on fees and charges, and these charges affect the demand for private healthcare as charging poor people at public facilities leads them to use low cost and low-quality private healthcare (Ibid).

I argue here that the healthcare system has started, since the beginning of Hamas' consolidated control in the Gaza Strip, to transform towards acquiring some elements of a healthcare system with a stratified private sector. The financially affluent groups of population have started using private health settings, including hospital and outpatient care, more than before, while the financially disadvantaged groups continue to rely on the public sector and complement this reliance with the incidental use of low-cost private healthcare. This incipient transformation has resulted in increasing the difference between the financially most affluent group and other groups on the scale, the share, and the catastrophic impact of out-of-pocket payments since 2009. I

showed in chapter 4 that the scale of out-of-pocket payments, their share of households' financial resources, and their catastrophic burden have become distinctively higher among the most financially affluent group of households than among other groups since 2009. Additionally, I demonstrated in the same chapter that, since then, the share of spending on inpatient hospital care has become higher among the financially most affluent group of households, while this share among other wealth groups has been stable or has decreased. These findings regarding the change in the socioeconomic distribution of the scale, share, burden, and composition of out-of-pocket payments are in line with the findings presented in chapter 6 about the growth of private hospital services, especially their activities in performing uncomplicated surgical and invasive procedures. Additionally, chapter 6 indicated that although the government hospitals have maintained their role in providing inpatient care, they have been overstretched beyond their maximum capacities.

The increasing out-of-pocket payments among the financially most affluent group of the population and the increasing activities of the private inpatient hospital sector suggest that the most affluent people have started to use this growing sector more since the consolidation of Hamas' control in the Gaza Strip. Yet, the stratification of the private sector is not certain, and the picture of this sector is complex in terms of fitting it into the global portrayal of the stratified private sector, which is determined by low income and public sector characteristics. The services of the not-for-profit private sector are used, though variably, by different socioeconomic groups. The MoH in Gaza started outsourcing hospital services to the private not-for-profit sector based on user cost sharing. Additionally, this sector exempts those who are indigent completely or partially from fees, especially expensive fees for surgical and invasive procedures. As indicated in chapter 5 based on the Life-history Interviews, affluent users of healthcare may use the private not-for-profit sector to overcome the lengthy waiting times for surgical and invasive procedures in the underfunded government hospital services, and to avoid the overcrowding and quality aspects of amenity in these overstretched hospitals.

The MoH in Gaza applies charges for certain procedures and has piloted private provision in its hospitals, but as far as this provision of private healthcare in government hospitals goes, its piloting only began just before or during my fieldwork in Gaza, and therefore it is not known whether these charges have led people to seek

low-cost and low-quality care in the private sector, as has happened in countries that are categorized as having health systems with a stratified private sector. Additionally, there is no evidence that the collection of user fees at government hospitals has diverted people from government hospitals to the private sector, especially when there is no real alternative to the government hospitals in the Gaza Strip. The over-the-counter purchase of drugs has been described as common in Gaza (Beckerleg et al., 1999; Hammad et al., 2012). However, the private pharmacies from which these over-the-counter drugs are purchased in Gaza are not similar to the drugs shops and dispensaries available in countries with a stratified private sector. These pharmaceutical outlets provide, in the context of stratified private sector, a low cost but also low quality alternative to public facilities that provide healthcare on the basis of users' contribution, as described by Mackintosh et al. (2016). There is no evidence suggesting that the over-counter purchase of drugs in Gaza constitutes an alternative to the use of free or low-cost healthcare in public facilities. Although the knowledge about the disseminated private not-for-profit medical centres and about the widespread dual-practitioner run private practices is opaque, it is not plausible that some of these medical centres and private dual practices serve as an alternative to free or low-cost publicly provided healthcare in Gaza. Hence, it is not possible to conclude that the health system in Gaz have already transformed from one to another category of health systems.

I argue, based on data that I gathered about the public and private health sectors in Gaza, that the old system, which emerged after 1948 when the Gaza Strip emerged, has not died, but has been through changes. A new configuration of a socioeconomically stratified mixed health system has been emerging, but has not been born yet. This incipient new configuration is consistent with the discourse conveyed by the key-informant interviews with the MOH officials in Gaza and with the findings of the PECS analysis, which revealed that there have been increased differences in incurring out-of-pocket payments, especially on inpatient healthcare, between the financially most well off group and other groups since 2009.

7.3.3 Quality and safety of healthcare, and the “Doctor’s dilemma”

The thematic analysis of the qualitative enquiry, which was inspired by the Life-history interview approach, indicated that although the interviewees, consistent with the general findings of the statistical analysis of PECS, reported a relatively low burden in terms of paying for healthcare, they also reported encountering negative experiences when they accessed healthcare. These experiences ranged from encountering overcrowding at UNRWA PHC centres and government hospitals and other negative quality attributes of the healthcare they accessed to encountering unsafe healthcare and the consequences of this unsafe healthcare. Additionally, interviewees reported that doctors who usually practise simultaneously at their own practices and at the publicly-provided healthcare facilities exploit them financially.

Possibly reflecting concerns about the quality of healthcare provided to the population in the Gaza Strip, the patient-safety culture and the technical quality of healthcare from the perspective of human resources for health received the attention of publications. Elsous et al. (2016), who attempted to provide benchmark data for the safety culture in the Gaza Strip, indicated that the percentage of respondents who held a positive attitude toward patient-safety culture was low. The score reported by nurses and physicians working in neonatal intensive care units in six government hospitals fell below what is considered to be the threshold for a positive score (Abu-El-Noor et al., 2017). The participation of health professionals in patient safety training in the Gaza Strip has been inadequate (Abu-El-Noor et al., 2019; Alfaqawi et al., 2020). Most doctors acknowledged that even the most experienced and competent nurses and doctors make errors and that these are not completely avoidable and doctors have no responsibility to disclose errors to patients (Alfaqawi et al., 2020).

Besides articles that have tackled the patient-safety culture, some articles have addressed the technical guidelines for managing certain conditions and assessed the adherence to these guidelines and to standard practices. Research has shown that the quality of the clinical practice guidelines for Diabetes Mellitus is disappointingly low, and have recommended using a gold standard to improve the quality of these guidelines (Radwan et al., 2017 a). Additionally, the overall adherence to these diabetic guidelines is considered suboptimal among both the Ministry of Health (MoH) and UNRWA PHC practitioners; however, adherence is higher among UNRWA

practitioners than among their counterparts at the MoH PHC services (Radwan et al., 2017 b). There are a variety of barriers that prevent adherence to the diabetes guidelines within the MoH and UNRWA PHC services. Some of these barriers are related to the environment, while others are related to the guidelines themselves; however, the organizational culture has a marginal influence on the adherence to these diabetic guidelines (Radwan et al., 2018; Radwan et al., 2017 c). Besides the low adherence to the diabetic guidelines, there are low levels of compliance with infection prevention and control among practitioners working in government hospitals. In one study, it was found that only 2.3% of these practitioners had a copy of the infection prevention and control protocols and the majority (65.8%) of them were not even aware of the protocols; furthermore, the healthcare facilities lacked essential equipment and materials for infection prevention and control (Eljedi and Dalo, 2014).

The experience of the interviewees in this study was not limited to the safety and quality attributes of the healthcare they received, but was also related to their experience with dual practising physicians, who were perceived by some of the interviewees to be exploiting patients for the financial gain. These perceptions remind me of the play of Bernard Shaw, "Doctor's dilemma", whereby doctors with limited resources choose to take care of those who they believe are the most worthy of being saved, but the situation is more complicated as there is more demand from patients than can be satisfied (Shaw, 1922). This doctors' dilemma and the perception of exploitation among patients could have resulted from the widespread dual practice and concurrent holding of multiple jobs among practitioners who work at publicly-provided healthcare facilities. Like in many low and middle income countries, dual practice, though understudied, is common in the occupied Palestinian territories (oPt) and this has generated debates (Russo et al., 2014; Alaref et al., 2017). More than a quarter (26%) of doctors employed at publicly-provided healthcare services in the oPt - with a small difference between the West Bank and the Gaza Strip - declared having a second job; however, this proportion of dual practitioners is likely to be an underestimate (Palestinian National Institute of Public Health (PNIPH) et al., 2019). Indeed, the private healthcare sector in the Gaza Strip, as demonstrated in chapter 5 and in chapter 6, is largely dependent on dual practice.

While dual practice can have some advantages, it certainly has disadvantages. It augments the low earnings of practitioners employed at publicly-provided healthcare

facilities and therefore contributes to increasing the supply of providers who are ready to work in the public sector and to increasing the quantity of and improving access to publicly-provided healthcare services (Berman and Cuizon, 2004). Additionally, dual practice has been seen as a possible positive contributor to the quality of care in the public sector. Practitioners employed at government healthcare services who have private practices can have more financial incentive to perform well at their place of employment in order to gain a better reputation and attract patients to their private practices; hence this can contribute to improving the quality of care in public services (Ibid). However, this phenomena of holding concurrent jobs in public and private healthcare settings has its disadvantages. Dual practising practitioners face incentives for rent-seeking from patients through providing poor services in public settings and referring them to their own private practices, and therefore negatively affect the quality of care in the public sector and expose patients to a financial burden (Ibid). Additionally, dual practising, in the context of a limited ability of governments to monitor practitioners' work and behaviour, contributes to undermining the ethos of public services by emphasizing fees-for-services financial incentives that lead to provider-induced demand, lack of cost consciousness, and higher cost (Ibid).

7.3.4 The effects of conflict and its manifestations on healthcare

Throughout this thesis, especially in the results chapters, I have shown the salience of the political and socioeconomic context of the Gaza Strip in defining the initial shape of the mixed healthcare system and in contributing to its further development, as well as in determining the pattern of, and the changes in healthcare-seeking behaviours, and contributing to the extent of out-of-pocket payments and to the socioeconomic distribution and changes in it. This context is manifested clearly in the perpetuated conflict and in its implications for the dispossession of Gazans and their socioeconomic adversity, which has been addressed mainly by humanitarian interventions without any political settlement of this protracted conflict. The continuing conflict has motivated Israel to use economic means in addition to military and political measures to control the territory and its populations. This was done either through integrating the underdeveloped local economy into the affluent Israeli economy before the first intifada or through imposing economic sanctions after its onset in 1987, and especially after the blockade of Gaza reached the level of siege following Hamas'

seizure of power in 2007. In addition to the economic and military manifestations of conflict, the Palestinian responses to their plight have contributed to the overall context of conflict. Manifestations of these responses to the conflict include the factional Palestinian politics and the internal Palestinian adversary. In the following part, I present the implications of the conflict and its manifestations in the healthcare system, as presented in the results of my research, and discuss them.

The first years that followed the start of conflict itself played a role in shaping the prototype of the healthcare system in the Gaza Strip. The conflict also brought the attention of the international community to the plight of the Palestinians, and it contributed by providing humanitarian and medical assistance, and public health interventions to the population. Paradoxically, the humanitarian crisis and displacement that followed the Nakba contributed to international responses that led to the establishment of UNRWA and therefore to improving accessibility to healthcare among Palestinians in the Gaza Strip. I showed in chapter 6 that the use of healthcare among them increased three-fold a few years after the start of the Nakba, and the displacement that followed it. This paradoxical phenomena was similar to other conflict-affected settings, which later encountered displacements, and where there were strong international relief responses following these displacements (Von Roenne et al., 2010; Orach Brouwere, 2004; Van Damme et al., 1998).

It is cynical but true that there were responses either by the international community or by political regimes that controlled Gaza after each cycle of high intensity conflict. Examples of these positive responses that contributed to strengthening healthcare in Gaza include the increased attention of the Egyptian administration to the population's needs after the short-lived Israeli occupation during the Suez crisis in 1956-1957, which led to boosting the government hospital services. The UNRWA strengthened its stagnant role in providing PHC and in contributing to healthcare after the start of the first intifada, and this was concurrent with increasing the number and visibility of NGO health services. The second (al-Aqsa) Intifada motivated the MoH to expand the government hospitals and introduce free enrolment in the GHI scheme, and contributed to an increased role of Hamas' Civil Society contribution to the provision of healthcare. Additionally, the conflict itself, as in the case of the second (al-Aqsa) Intifada, prevented or postponed the implementation of donor prescriptions for the health sector to boost private healthcare, introduce private

services in government hospitals, and harmonize the UNRWA services with the government PHC services.

The economic adversity in the Gaza Strip, which has almost always been associated with the conflict, has contributed to all aspects of the healthcare system. I discussed in the previous section how the broadly low and stable levels of out-of-pocket payments for health-related products and services can be attributed to the financial conditions and the population's low ability or inability to pay for health services. Additionally, the surge in the level of catastrophic health expenditure observed in the last round of the PECS in 2017 was due to the significant reduction in household wealth rather than any increase in out-of-pocket payments. Although the impact of out-of-pocket payments on poverty was stable from 1996 to 2017, this impact was high according to international standards. The high impact of out-of-pocket payments on poverty indicates that even low out-of-pocket payments are able to push high percentages of the near poor into extreme poverty.

Most of the population in the Gaza Strip are refugees, whose parents or grandparents were peasants who were dependent on agrarian means of production before their displacement into the Gaza strip following the start of the Palestinian Nakba in 1948. Dispossessed from their land and original means of production, these refugees, like most of the other non-refugees in the Gaza Strip, have been dependent on financial assistance, manual labour, and employment in the service sectors. This pattern of financial dependency, sources of earning, and job-holding has impacted the adaptive mechanisms they use to cope with the financial burden of using and paying for health services. The adaptive mechanisms used in other settings in developing countries, where agriculture constitutes an important source of economic production, such as selling or exchanging livestock and valuable agriculture tools, were not reported by the householders interviewed except in one case, in which the interviewee reported exchanging olive oil for the cost of his dental treatment.

Additionally, most of the householders interviewed reported that they used selling assets, such as jewellery, and borrowed money to cope with the financial burden of daily living expenses rather than to cope with the financial burden of using and paying for health services. This reflects both the high financial burden of daily living expenses and the relatively low burden of using health services. The most

frequent adaptive mechanisms used to cope with the financial burden of using private healthcare and of purchasing medicines and other health-related products were reliance on financial assistance and exploiting the characteristics of the mixed healthcare system in the Gaza Strip.

Besides the effects of dispossession and the low macroeconomic situation on out-of-pocket payments and on the nature of adaptive mechanisms used to cope with health service costs, each cycle of deterioration of the microeconomic situation - together with the increasing unemployment after the outset of the first Intifada in 1987- contributes to a shift in seeking healthcare from those that require out-of-pocket payments towards more reliance on healthcare services that are offered free of charge or at lower costs. These shifts were clear and manifested after the start of the first intifada in 1987, when there was a significant increase in medical and dental consultations offered by UNRWA PHC services, and they occurred again after the start of the second (al-Aqsa) Intifada in 2000, when there was an increase in the use of UNRWA free-of-charge PHC services that occurred concurrently with a decline in medical consultations at the MoH PHC services, which require co-payments for drugs and diagnostic tests.

The effects of the Israeli imposed economic sanctions have not been limited to the macroeconomic environment in which the mixed health system operates, but have also extended directly to the health system itself. These sanctions have contributed to the decreased ability to reconstruct the damaged and destroyed healthcare facilities, and to expand government hospitals. Simultaneously, the Hamas-led Gaza Government has been able to bypass and exploit sanctions against it by levying taxes from corporate entrepreneurial private companies. Some of the taxes collected have been poured into financing the activities of private not-for-profit hospitals, which, ironically, are associated with Hamas itself. Besides the effects of the sanctions on the stagnant growth of government hospitals, the factional Palestinian politics and the internal Palestinian adversary have contributed to the weakening of the government healthcare services, which have not expanded in parallel with the population growth. At the same time, the rival Palestinian governments in Gaza and Ramallah have benefited from the growth in the size and activity of the private healthcare sector, especially private not-for profit hospitals, which are believed to be associated with political factions that stand behind the Gaza and Ramallah governments.

The situation in the mixed health system that has been emerging during the last decade, as a result of the influence of sanctions and the factional Palestinian politics, is reminiscent of the healthcare system that emerged during and after the Lebanese civil war (1975-1991) and in the wake of the Israeli military occupation of the country that started in 1982. The public health sector shrank to a minimum in terms of quantity and quality during the civil war, and Lebanese civilians who were caught in the crossfire turned to medical assistance provided by armed groups, sectarian groups and local parties that controlled their localities, and entrepreneurial private healthcare (Sen and Mehio-Sibai, 2004). This contributed to remarkable growth in private healthcare and out-of-pocket payments among Lebanese households, which contributed almost three quarters of the total health expenditure in the country seven years after the end of the civil war (Ibid). In Gaza, the growth of the private sector and the stagnation of the government health sector, especially at the level of hospital services, have not proceeded as far as in Lebanon. However, they might be advancing in that direction, as was repeatedly suggested in this discussion chapter and in chapter 6 of this thesis.

7.4 Strengths and Limitations

In addition to the shortcomings and methodological limitations of the research discussed in chapter 3 of this thesis, there are a number of strengths and limitations of the work that are presented throughout this document. In terms of strengths, the most important strength of this research is its contribution to the evidence about healthcare in the Gaza Strip. This research project addressed a major gap in the evidence regarding the extent, the composition, the burden, and the socioeconomic distribution of out-of-pocket payments for health-related products and services in the Gaza Strip. Through a qualitative enquiry new data about people's experience with healthcare, it confirmed that people in the Gaza Strip rely mainly on healthcare provided by the government hospitals and by the UNRWA PHC services. The qualitative enquiry showed that people who could financially afford started since mid-1980s to complement their dominant use of free-of-charge and low cost services by intermittently using private healthcare. It also highlighted that although the interviewees perceived the financial burden of seeking healthcare to be low relative to the burden of daily living, they complained about the safety and the quality of the healthcare they accessed. Moreover, this thesis presented new evidence about the

development of the mixed healthcare system during an extended period of time that spanned from the emergence of the Gaza Strip as an artificial geopolitical entity to the current times. This evidence is mainly based on Gaza-specific data, including reports published mainly in Arabic by the MoH in Gaza on the development of healthcare during the last decade. These reports, which are barely known in international circles, alongside key informant interviews conducted in Gaza, produced new and unknown evidence about the new environment in which the healthcare system functions and about the actual developments in both the public and private sectors during the last decade.

Methodologically, a strength of this research is that it has produced a robust statistical analysis that confirms that there has been an increasing difference in catastrophic out-of-pocket payments between the financially most and least affluent wealth groups of the population in the Gaza Strip since 2009. In terms of interpreting this finding, this research benefited from having multiple strands and linked them together. The socioeconomic stratification in catastrophic health expenditure started when an environment that nurtured the growth of private healthcare emerged after the strengthening of Hamas' control in the Gaza Strip, and when there was growth in the number and activities of private hospital services, which occurred in the context of stagnant growth of government hospital services, which were underfunded and overstretched beyond their maximum capacity. Hence, the new socioeconomic stratification of out-of-pocket payments can be understood in the new context of an emergent stratification of the healthcare system.

Substantively, another strength of this research is that it has produced a picture about the historical development of the mixed healthcare system. This picture includes detailed accounts about out-of-pocket payments, healthcare seeking experiences, and the trajectory of the public and private health sectors.

A number of limitations are evident within this research. This research is exploratory and encompasses different but interrelated aspects of healthcare over a period of time. Its exploratory nature is associated with rich data gathered through the three strands of this research, and this could have led to a somewhat shallow or implicit interpretation of the results. Recognizing the invisibility of Gaza's healthcare, I was interested in providing new data that addressed the research questions. Indeed, I felt

when presenting the findings and when writing this document that I was putting an ocean into an aquarium. Hence, the exploratory nature of this research, the inability to succinctly present important details, and possibly my personal traits have negatively influenced the presentation of my research.

As for what could have been done differently in this empirical research, the data gathering and recruitment of the interviewees could have been done differently. For example, in recruiting participants for the interviews with householders I could have targeted more affluent participants than I did to capture different and more heterogeneous experiences in seeking healthcare. Additionally, I found it sensitive to ask interviewees detailed questions about their levels of income or wealth. This led me to perceive most of the interviewed householders, with only a few exceptions, to be near-poor or even poor. Furthermore, I could have targeted more women when recruiting householders for the interviews as women can be seen as more attached to seeking healthcare for themselves and for their children.

I encountered a dearth of documented data about private for-profit healthcare and about dual practitioners. Unfortunately, this dearth of documents was not counterbalanced by interviewing representatives from the private for-profit sector or by interviewing dual practising practitioners. Most of the key informant interviews were carried out with officials at the MoH in Gaza or with managers in the not-for-profit private healthcare sector. This limited evidence about for-profit private healthcare could have been addressed by interviewing relevant interviewees, but due to the sensitivity of dual practice and their informal nature I was not able to carry out these interviews. However, this limitation offers a direction for future research.

7.5 Directions for future research

The findings of this research and its limitations have opened up new avenues for further research related to healthcare in the Gaza Strip. The most salient findings of this research are related to the relatively recent increased socioeconomic differences in the extent and the catastrophic impacts of out-of-pocket payments between the financially most affluent group and other groups of people in the Gaza Strip. This increase in socioeconomic differences between the financially most disadvantaged and least disadvantaged is paralleled with the suggested social stratification of the mixed healthcare system. This phenomenon requires further investigation. I suggest following and monitoring the possible change in the configuration of the healthcare

system, and investigating the use of private and public healthcare alternatives among a representative sample of individuals and households in the Gaza Strip to capture the disparities in accessing healthcare in general and in choosing public versus private healthcare services. This investigation into the use of health services and the choice of healthcare providers could be done concurrently with investigating how these healthcare services and medicines are paid for.

Although there are some publications that have addressed the patient-safety culture among health professionals and the adherence to technical standards of care among professionals, the literature reviewed in chapter 2 of this thesis indicated that there are barely any publications that have addressed how the healthcare accessed by Gazans meets their needs and expectations. Additionally, the qualitative interviews with the households presented in chapter 5 showed that there were serious concerns among the interviewees about the safety and quality of the healthcare they accessed. Therefore, there is a need to investigate the performance and quality of healthcare provided to Palestinians in the Gaza Strip.

Similar to the concerns conveyed by the householders who participated in the qualitative interviews about the quality of healthcare, they reported rent-seeking behaviours among physicians and other practitioners who hold different jobs in the public and private sectors concurrently. This dual practice is common, as indicated in chapters 5 and 6 of this thesis and in the literature (PNIPH et al., 2019; Alaref et al., 2017). However, there is no study that has addressed this phenomena in the Gaza Strip. Therefore, I suggest that more research could be done on this aspect.

While there is some information about the not-for-profit private sector, especially in hospital settings, information about the for-profit private healthcare sector is very limited - to only a number of private pharmacies and licenced practices. Similar to the opacity of the picture about the private for-profit healthcare sector, there is little knowledge about curative healthcare services provided by outpatient medical centres. Therefore, there is a need to study the private for-profit sector in the Gaza Strip and explore its nature beyond the official numbers, as well as to explore the disseminated private not-for-profit medical centres that are reportedly underreported by the official publications of the MoH in Gaza.

This research showed that there has been growth in the number of private not-for-profit healthcare institutions that are believed to be affiliated with Hamas' social sector. While the Islamic social sector and Hamas civic institutions were studied by Roy (2011) and the reawakening of health charities associated with the Islamic movement during the second (al-Aqsa) Intifada was noticed by Challand (2008), there is no study focusing on the Islamic private not-for-profit health sector in the Gaza Strip. My research explored this sector and presented some of the findings, albeit from the wider perspective of the development of the mixed healthcare system during the last decade. I propose exploring this diverse sector in more depth.

One of the findings revealed from the sole policy document produced by the MoH in Gaza and the interviews with key informants indicates the existence of a doctrine in the Hamas-led MoH in Gaza towards a public-private mix of healthcare. This doctrine entails promoting the involvement of the private sector in providing social and healthcare services, opening the door to a more socially stratified mixed healthcare system, adopting the provision of private healthcare in government hospitals, and expending co-payments to government hospitals. While the ascendance of Islamists in governing the state and the healthcare system in Egypt was limited to less than one year and their participation in Tunisian governance stopped recently, Hamas has been in power and either controlling or co-controlling Gaza since June 2007. This relatively lengthy experience of Hamas managing the healthcare system offers a unique opportunity to examine how Islamists govern healthcare and to explore their perspectives when they are in power, towards the right to health and the public and private sides of the mixed healthcare systems. I argue that Hamas' perspectives and experiences in managing health and social services should be researched in more depth than I have done and should be presented in more detail than they were in this thesis.

Chapter 8

Conclusions

This final and brief chapter will conclude the research study by summarizing the key findings in relation to the research aim and questions, highlight the value and contribution of my research, and discuss the implications of these findings and contributions.

My research aimed to study changes in interrelated aspects of healthcare during a period of time which witnessed an intensification of conflict and a deterioration of macroeconomic indicators in the Gaza Strip. These changes in healthcare were analysed by studying the changes in the extent and the burdens of out-of-pocket payments for health-related products and services, in people experiences accessing and paying for health services, and in the trajectory of the mixed health system in the Gaza Strip.

The results of my research showed that the extent, composition and impoverishing impacts of out-of-pocket payments were broadly stable during the period under study between 1996 and 2017. Similarly, catastrophic health expenditure was stable but it surged at one point of time in 2017, reflecting the significant worsening of macroeconomic situations in the Gaza Strip. While the catastrophic health expenditure was low according to international comparisons, reflecting the low levels of out-of-pocket payments, the impoverishments due to health-related payments were among the highest in the world. This reflected the dire financial situation of most people as even the low levels of out-of-pocket payments were able to push the near poor among them into extreme poverty. The low levels of out-of-pocket payments and their catastrophic impacts should not be oversimplified or seen as a manifestation of the so-called “health system resilience” (Ashour, 2016; van de Pas et al., 2017). Indeed, Gazan Householders, who have been continually dependent on publicly provided free-of-charge and low-cost healthcare services complemented by incidental use of private healthcare, expressed serious concerns about the safety and the quality of healthcare. Additionally, they reported examples of dual-practitioner rent-seeking behaviours, which are believed to be rampant.

Moreover, the research results showed that the prototype of the current local mixed health system, which is characterized by the central role of publicly-provided healthcare, had been materialised solidly during the first two decades that followed the emergence of the Gaza Strip as a recognized geopolitical entity after the start of the Palestinian Nakba in 1948. This prototype, which was initially characterized by free-of-charge healthcare and by a very limited private sector, has seen continuous changes during the four decades of Israeli occupation of Gaza starting June 1967. The free-of-charge nature of the government health services was challenged by the Israeli administration of healthcare, the introduction of user fees, and by conditioning the entitlement to these services to the enrolment in the government health insurance scheme. Additionally, the government hospitals and UNRWA PHC had been stagnant during the first two decades of the Israeli occupation. Simultaneously, private healthcare had been promoted. The private sector thrived when pregnant women began to use its services in the mid-1980s to complement their antenatal check-ups at government and UNRWA PHC. This way of seeking antenatal care concurrently occurred when women started giving birth at private facilities. The role of UNRWA in the health sector was revived during the first intifada, and the quantity and the visibility of health NGOs increased; while the responsibilities of the Israeli occupation authorities towards the government health services had become more limited. There was simultaneous growth in the services provided by both public and private healthcare sectors during the initial period that followed the establishment of the PA; however, pledges to make access to healthcare universal had not materialized. The failure of the so-called “peace process” after the start of the second (al-Aqsa) Intifada contributed to halting the implementation of the World Bank recommendations for an increased role for the private sector in healthcare. Additionally, it pushed the PA to bypass the advice of international donors to concentrate on expanding PHC services and leave the government hospitals in the same capacities taken over from the Israeli administration. Subsequently, the government hospital services were expanded significantly during the second (al-Aqsa) Intifada. Additionally, free enrolment in the government health insurance scheme was offered to victims of Israeli violence and economic sanctions during the same period, leading to almost semi-universal healthcare but without a legislative framework.

Meanwhile, the macroeconomic situation deteriorated further, the supply side of the healthcare system experienced changes, and an environment fostering the

growth of the private provision of health emerged after Israel's disengagement plan and the rise of Hamas's influence in the Gaza Strip. While the underfunded government hospitals, whose growth was static, were overstretched to maintain their crucial central role in providing hospital services, the number of not-for-profit private hospitals was doubled and their underutilized capacities increased. The private provision at government hospitals was piloted, user contributions at hospital levels were introduced, and the growth of the private sector was encouraged by Hamas-led MoH in Gaza. The increased supply of private healthcare, especially at the hospital level, encouraged those who can afford to seek this care. Consequently, the out-of-pocket payments and their catastrophic impacts became clearly stratified after 2007 between the financially most affluent group and other Gazans. The financially most affluent people started after 2007 to pay more on healthcare, to allocate a higher proportion of their out-of-pocket payments to in-patient care, and to incur catastrophic health expenditures more than other dissimilar groups of Gazans. This suggests the appearance of a socioeconomically stratified mixed healthcare system after Hamas ascendance to power in 2007.

As shown above, my research has been able to draw a picture of the trajectory of healthcare in the Gaza Strip over a period of time spanning the start of Palestinian Nakba in 1948 and the emergence of the territory as an internationally recognized geopolitical entity till current days when people and actors trapped in Gaza were left to seek their own survival. Apart from occasionally making news headlines during flare-ups in the seemingly never-ending conflict, and appearing in reports by the humanitarian aid agencies or publications produced from security perspectives, the Gaza Strip, its people, and social services have been largely invisible. I think that this invisibility of Gazans constitutes a form of violence against them, and this research is mainly a modest contribution to reducing this invisibility.

This research has generated new evidence on the change in the out-of-pocket payments in the Gaza Strip after the establishment of the PA. As far as I know, this is the first project to produce data about catastrophic health expenditure and on how the payments incurred by Gazan households impact their poverty. Through these metrics and indicators, this evidence does not only help to retrospectively understand the changes in the ability of the local healthcare system to protect Gazans from the financial sequences of using health services. It also shows the effects of household financial situations and their significant deterioration on the rise in catastrophic

sequences of paying for health-related products and services out-of-pocket. The research also demonstrates that modest household financial abilities enabled even small amounts of out-of-pocket payment to push a relatively high percentage of the near poor to extreme poverty. Additionally, this new evidence solidly revealed the stratification of out-of-pocket payments and their catastrophic financial impacts between the most and least disadvantaged groups, and that this stratification was to a large extent due to increased spending on hospital services among the most affluent people in the Gaza Strip after 2007. Moreover, by producing this evidence about catastrophic and impoverishing out-of-pocket payments on health-related products and services in the Gaza Strip, this research contributes to a few publications related to out-of-pocket payments and FHP in conflict-affected settings.

This research generated new data about the experiences of Palestinian householders in the Gaza Strip when seeking treatment and paying for health services during an extended period of time that captured experiences dating back to the 1950s. This new data ascertained the pattern of seeking care among the householders and revealed some changes in this pattern in terms of some shifts in choosing public and private providers. Additionally, it contrasted the perceived low financial burden of seeking treatment with insights about the safety and the quality of healthcare provided, and about the rent-seeking attitudes and behaviours of some government hospital practitioners who run their own private practices after their duty at hospitals. The data also demonstrated the effects of the protracted conflict on the socioeconomic and living conditions of householders and their families, and showed the influence of these effects on the choice of private versus public providers of health services and on the specific adaptive mechanisms used by Gazans to cope with the financial burden of healthcare. In addition to the contribution of the qualitative enquiry of interviewing householders to enhancing the state of knowledge related to healthcare in Gaza, the data can potentially offer a methodological contribution to practically trace experiences in choosing healthcare providers and seeking treatment over the life course by overcoming some disadvantages of classical Life-history Interviews. These disadvantages include the lengthy interviewing time, which can constitute a real burden on both the researched and the researchers.

The third contribution of my research is the synthesis I made about the evolutionary trajectory of the local mixed health system in the Gaza Strip. This trajectory showed the effects of conflict and socioeconomic conditions on the

development of a prototype of healthcare and on the changes in its public-private mix over more than seven decades. This synthesis is mainly focused on information related to the Gaza Strip without diluting Gaza-specific features in the portrayals of the health system in the occupied Palestinian territories, which have mainly been based on data and insights about the West Bank. This synthesis extravagated evidence through different documentary sources and interviews. Additionally, it brought new data to the potential attention of the international audience about the period that followed Hamas's ascendance into power. Almost all publications by the MoH in Gaza since then were produced in the Arabic language, making them barely noticed by international circles interested in healthcare in the Gaza Strip. Additionally, this synthesis relied largely on interviews with key-informants which focused on the last decade before the interview dates. Hence, the synthesis offers new evidence about the development of the mixed health system in Gaza after Hamas control. It reveals that the Hamas-led MoH in Gaza developed a doctrine that replicates and imitates neoliberal approaches toward the public-private mix of healthcare. This doctrine alongside the influence of other actors and factors supported the growth of the private sector that occurred concurrently with the very indolent growth in the public sector. This created an environment that encouraged the incipience of a socioeconomically stratified mixed health system that is emerging in parallel with the financial stratification of out-of-pocket payments. This should alarm those who are concerned about people in Gaza that the current tendency of ignoring the healthcare provided by the public sector and concentrating on supporting private healthcare will harm most people in the Gaza Strip, and may lead if this tendency continues to the possible development of a two-tier mixed health system (Ashour, 2018).

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Annexes

Annex II-I Bibliographic data bases search yield

Data base	Terms of Search																			
	"Gaza" and "Healthcare"				"Gaza" and "Health care"				"Gaza" and "out of pocket"				"Gaza" and "Financial Protection"				"Gaza" and "Expenditure" for all data bases or "Health Expenditure" for google Scholar			
	Steps of identifying relevant publications																			
	1 st	2 nd	3 rd	4 th	1 st	2 nd	3 rd	4 th	1 st	2 nd	3 rd	4 th	1 st	2 nd	3 rd	4 th	1 st	2 nd	3 rd	4 th
Pub Med	152	12	4		220	18	6		4	0	0		0	0	0		7	1	0	
Web of Science	134	12	4		150	18	5		0	0	0		0	0	0		12	1	0	
Scopus	109	12	5		367	33	9		4	0	0		0	0	0		24	3	0	
ProQuest (International Bibliography for Social Science)	429	5	4		967	16	6		29	1	1		5	0	0		524	4	2	
Google Scholar *	21. 4K	77	9		33. 2K	145	22		1.0 7 K	172	29		291	2	0		972	26	2	
WHO institutional repository for information sharing (iris)	698	78	2		268 4	110	3		431	50	0	0	102	15	0	0	802	79	0	0
WB Open Knowledge Repository (OKR)	1	1			13	2			1	1			1	1			58	1		

- Google Scholar provides access to the first 1000 titles of found publications and their full texts.

Steps of identifying relevant publications:

1st step is the initial hits of publications' titles appeared after searching the data base using Gaza and the corresponding word(s).

2nd step entails number of publications retained after online screening of initially retrieved titles

3rd step entails number of publications retained after further screening titles tabulated in excel sheet, reading their abstracts, and scanning their full text

4th step entails number of publications retained after reading the full text of the publications

Annex III-I: An open topic guide for Life-history Interviews

Introduction to the research:

- Informing the participants about the reasons behind asking them to be interviewed. Introducing myself to the participant.
- Assurance the participants about the confidentiality and anonymity of their names and information.
- Asking the participants whether it is appropriate to start interviewing them, and getting their informed consent.

Background information on the participant, his/her family, and building rapport and confidence

- Getting general information about the age, marital status, education, major events in life, employment and livelihood, and health conditions of the interviewees.
- Getting information about the household composition and residential place.
- Getting information about the family (households) members, their age and other demographic characteristics, employment and education, if relevant, and health-related conditions.
- Getting background about major milestones in personal and household trajectory.

Early life illnesses and treatment-seeking behaviours:

- Enquiring about recallable illnesses encountered by the interviewee before getting married, and about the treatment-seeking behaviours to address these illnesses. Discussion about the satisfaction of the care received, if relevant.
- Getting information about life course major events before getting married (education and employment).

Treatment-seeking behaviours before having the first child:

- Enquiring about any preconception care received or any use of healthcare to conceive a child. If relevant, enquiring about the cost of this care, how the financial conditions influenced the choice of healthcare provider and the effects of using healthcare on the household financial conditions.
- In the case of pregnancy, enquiring about the main provider of antenatal care, the frequency of antenatal check-ups, whether the services of the main provider of antenatal were supplemented by the use of another provider of antenatal care, the satisfaction with the received antenatal healthcare, and the financial burden of using antenatal care and its effect on the provider choice. In addition to asking about the effects of financial conditions on the provider choice, ask about other reasons for provider choice.

Treatment-seeking behaviours after the first pregnancy:

- Where did the delivery of the first child (and subsequently the 2nd, 3rd, 4th, etc.) take place? Enquiring about factors, especially financial, that contributed to choosing the place of delivery.
- Enquiring about satisfaction with childbirth care, and the financial burden of childbirth.

- Enquiring about the provider(s) of childcare for common childhood illnesses.
- Enquiring whether this particular child (and subsequent children subsequently, and other household members, including the interviewee and his/her spouse) encountered serious illnesses, injuries, or required surgical, dental or invasive procedures.
- Who was the provider (s) of care? Why this provider was chosen? What was the level of satisfaction with the received care? What were the financial sequences of using healthcare? Was there any coping mechanism for the healthcare cost?
- In the case of chronic diseases, ask about the main provider of care, whether the services of the main provider were supplemented by the use of another provider and the regularity of using each provider; the satisfaction with the received care; the reasons, especially financial, behind using specific provider; and the financial burden of using care and the possible coping mechanism to override the financial burden.

Changes in experience:

- As progressing in enquiries and in the time periods, ask about any possible change in the financial conditions of the households, the health conditions of household members, the pattern of healthcare use and provider choice, the quality of and satisfaction with the received healthcare, the change in the healthcare cost, etc.
- If applicable, ask about a comparison between how the interviewee sought healthcare and how his/her children did when they have their own households.

Closing the interview:

- Ask the interviewee whether s/he wishes to add any additional information, and thank him/her.

Annex III- II a: Original Informed Consent form template for Life-history Interviews in Arabic

السيدة/العزيزة

بعد التحية؛

أحيطكم علماً بأنني أقوم بإجراء مشروع بحثي للتحضير لرسالة الدكتوراه في جامعة إدنبرة، و يسعى مشروع البحثي إلى دراسة التغييرات في الأعباء المالية الواقعة على الأسر الفلسطينية جراء أحوالهم الصحية و بشكل خاص نتيجة لاستخدام الخدمات الصحية في قطاع غزة خلال العقود الثلاث الأخيرة التي شهدت تدهوراً في الأحوال الاقتصادية و المعيشية لأغلب سكان قطاع غزة. بالتالي فأنتي أئوي القيام بسلسلة من المقابلات مع أرباب الأسر الفلسطينية في قطاع غزة لدراسة تجربتهم في استخدام الرعاية الصحية والإنفاق عليها خلال العقود الأخيرة.

إنني أتوجه إليكم آملاً أن تسمحوا لي بمقابلتكم للإستفسار عن تجربتكم مع النظام الصحي في قطاع غزة و عن تأثير أوضاعكم الاقتصادية والمعيشية ، و عن تأثير إستخدامكم للرعاية الصحية على أوضاعكم الاقتصادية و المعيشية. إنني على أي حال أقدر عالياً قراركم سواءاً بالموافقة أو عدمها. وفي حال موافقتكم بالمشاركة في هذا المقابلات، فإنه سيتم تسجيل هذه المقابلة و سيتم نسخ محتوى هذه المقابلة، و سيتم تحليل هذا المحتوى لاستعمالها في رسالتي للتقدم لدرجة الدكتوراه، و قد تستعمل نتائج هذا التحليل في أعمال منشورة، مثل المقالات الأكاديمية، و بالتالي فقد أستخدم مقتبسات من محتوى المقابلات، بدون الإشارة إلى إسمكم أو إلى أية تفاصيل أخرى عنكم. في حال موافقتكم على مقابلتكم، فإن لكم الخيار في عدم الإجابة على أسئلة محددة، كما أن لكم كامل الحق في الإنسحاب من المشاركة في المقابلة في أي مرحلة منها أو بعد إنتهاؤها. كما أود التأكيد أنه سيتم حفظ تسجيلات هذه المقابلات و محاضرها في مكان آمن و لن تتم الإشارة إلى إسمكم و أية تفاصيل قد تفضي إلى ذلك.

إن كنتم مستعدون بالمشاركة في بحثي و بالسماح لي بمقابلتكم وتسجيل المقابلة و باستخدام محتواها كما ذكرت سابقاً، فالرجاء توثيق هذه الموافقة بالتوقيع على نموذج الموافقة أدناه.

الباحث

د.مجدى محمد عاشور

0599636273

S532529@ed.ac.uk

أقر أنتي أوافق على المشاركة عبر إجراء المقابلة معي و تسجيلها و على إستخدام محتوى المقابلة كما ذكر سابقاً.

الإسم : _____

التوقيع: _____

التاريخ: _____

Annex III-IIb: The original informed consent form template for Life-history Interviews translated into English

Dear.....

Greetings

I am currently undertaking a research project for my PhD thesis at the University of Edinburgh. My research project seeks to study the changes in the health-related financial burdens shouldered on Palestinian households, especially those resulting from the use of healthcare services in the Gaza Strip during the last three decades, which have witnessed a deterioration in the financial and living conditions of most of the population of the Gaza Strip. I intend to conduct a series of interviews with Palestinian heads of households in the Gaza Strip to examine their experience in using and spending on healthcare over the recent decades.

I approach you with the hope that you will allow me to interview you about your experience with the health system in the Gaza Strip, about the impact of your financial and living conditions on your use of healthcare, and about the impact of your use and expenditure on health care on your financial and living conditions. In any case, I highly appreciate your decision, whether to approve or not. If you agree to participate in this interview, this interview will be audio recorded and the content of this interview will be transcribed, this content will be analysed for use in my doctoral thesis, and the results of this analysis may be used in published works, such as academic articles, and therefore I may use excerpts from the content of the interviews, without indicating your name or any other details about you. If you agree to be interviewed, you have the option not to answer specific questions, and you have the full right to withdraw from participating in this research at any stage or after its completion. I would also like to emphasize that the recordings and transcripts of these interviews will be kept in a safe place and your name and other details that may lead to your identity will be anonymised.

If you are willing to participate in my research by allowing me to interview you, audio record the interview, and use its content as mentioned above, please document this consent by signing the consent form below.

Respectfully,

Majdi Ashour

S1532529@ed.ac.uk

0599636273

I confirm that I have agreed to be interviewed for this research project and that the recorded interview, or excerpt from it, may be used as described above.

Name: -----

Signature: -----

Date: -----

Annex III-IIIa: The original Informed Consent form template in Arabic for Key Informant Interviews

السيدة/ة العزيزة/ة

بعد التحية؛

أحيطكم علماً بأنني أقوم بإجراء مشروع بحثي للتحضير لرسالة الدكتوراه في جامعة إدنبرة، ويسعى مشروعني البحثي إلى دراسة التغييرات في الأعباء المالية الواقعة على الأسر الفلسطينية نتيجة لاستخدام الخدمات الصحية في قطاع غزة خلال العقود الأخيرة التي شهدت تدهوراً في الأحوال الإقتصادية والمعيشية لأغلب سكان قطاع غزة. لقد قمت بتحليل مسوحات إنفاق وإستهلاك الأسر الفلسطينية العشر بين 1996 و 2011 لمعرفة التغييرات في إنفاق الأسر الفلسطينية على الصحة في قطاع غزة. كما أنني قمت بمراجعة للمنشورات ذات الصلة، لتفهم العوامل التي ساهمت في تغيير الأعباء المالية لإستخدام خدمات الرعاية الصحية. ولقد أدركت أن مراجعتي للمنشورات بحاجة إلى إغناء عبر إجراء مقابلات مع المسؤولين والممارسين الصحيين ذوي المعرفة والخبرة. لذا فإنني أتوجه إليكم آملاً أن تسمحوا لي بمقابلتكم للإستشارة بمعارفكم، وأراءكم، و تجاربكم.

إنني أقدر عالياً قراركم سواءاً بالموافقة أو عدمها. وفي حال موافقتكم بالمشاركة في هذا المقابلات، فإنه سيتم تسجيل هذه المقابلة و سيتم نسخ محتوى هذه المقابلة، سيتم تحليل هذا المحتوى لاستعمالها في رسالتي للتقدم لدرجة الدكتوراه، وقد تستعمل نتائج هذا التحليل في أعمال منشورة، مثل المقالات الأكاديمية، وبالتالي فقد أستخدم مقتبسات من محتوى المقابلات. في حال موافقتكم على جراء المقابلة معكم، فإن لكم الخيار في عدم الإجابة على أسئلة محددة، كما أن لكم كامل الحق في الإنسحاب من المشاركة في المقابلة في أي مرحلة منها أو بعد إنتهائها. كما أود التأكيد أنه سيتم حفظ تسجيلات هذه المقابلات و محاضرها في مكان آمن و لن تتم الإشارة إلى إسمكم و إلى إية تفاصيل قد تفضي إلى ذلك، إلا في حال عدم ممناعتكم من إستخدام إسمكم و وصفكم.

إن كنتم مستعدون بالمشاركة في بحثي و بالسماح لي بمقابلتكم وتسجيل المقابلة و باستخدام محتواها كما ذكرت سابقاً، فالرجاء توثيق هذه الموافقة بالتوقيع على نموذج الموافقة أدناه.

تقبلوا فائق الإحترام،

الباحث

د.مجدي محمد عاشور

0599636273

S532529@sms.ed.ac.uk

أقر أنني أوافق على إجراء المقابلة معي و تسجيلها و على إستخدام محتوى المقابلة.

الإسم:

التوقيع:

التاريخ:

الموافقة على إستخدام الإسم: نعم لا

الموافقة على إستخدام الصفة: نعم لا

Annex III-IIIb: The original informed consent form template for Key Informant Interviews translated into English

Dear.....

Greetings

I am currently undertaking a research project for my PhD thesis at the University of Edinburgh. My research project seeks to study the changes in the financial burdens shouldered on Palestinian households resulting from the use of healthcare services in the Gaza Strip during the recent decades, which have witnessed a deterioration in the financial and living conditions of most of the population of the Gaza Strip. I have already analysed ten rounds of the Palestinian Expenditure and Consumption Survey from 1996 to 2011 to assess changes in the financial burden incurred by the households in the Gaza Strip when they seek healthcare in the Gaza Strip. I also reviewed the relevant publications to understand the factors that contributed to these changes. Realizing that my review of publications needs to be enriched by interviewing knowledgeable and experienced health officials and practitioners, I would like to ask you to share with me your knowledge, opinions, and experiences by allowing me to interview you.

I highly appreciate your decision, whether it is allowing or not allowing me to interview you. If you agree on being interviewed, this interview will be audio recorded and the content of the interview will be transcribed, the content will be analysed for use in my doctoral thesis, and the results of this analysis may be used in published works, such as academic articles, and therefore I may make reference to your interview with, and use excerpts from them for making quotations. If you agree on being interviewed, you have the option not to answer specific questions, and you have the full right to withdraw from participating in the interview at any stage of it or even after its completion. I would also like to emphasize that, unless you do not mind using your name and function, the recordings and transcripts of these interviews will be kept in a safe place and your name and any details will be anonymised.

If you are willing to participate in my research by allowing me to interview you, audio record the interview, and use its content as mentioned above, please document this consent by signing the consent form below.

Respectfully,

Majdi Ashour

S1532529@ed.ac.uk

0599636273

I confirm that I have agreed to be interviewed for this research project and that the recorded interview, or excerpt from it, may be used as described above.

Name: -----

Signature: -----

Date: -----

Agreement of using my name: Yes No

Agreement of indicating my function: Yes No

Annex III-IV Data management plan for the Life-history Interviews

Title: Interviews with householders in the Gaza Strip on their experience 30 years before the

Majdi Ashour, who bears all responsibilities for this project and who was the main contributor to it, has been affiliated with the University of Edinburgh School of Social and Political Sciences as a PhD student. He was supervised by Dr Mark Hellowell. This project started from June 2016 to the end of September 2022.

Project abstract: This project explored the health-seeking behaviours of interviewees and the member of their household over a period from 1987 to 2016-2017; the effects of their financial conditions on the provider choice and the effects of using healthcare on their financial conditions.

Data Collection: Interviews with 33 householders over 32 interview sessions in 29 households in the Gaza Strip. All interviews were audiotaped. Audiotaped interviews were transcribed and translated into English.

Ethics & Legal Compliance: Informed consents were obtained from all interviewees and were recorded. Names of interviewees and all names mentioned by them were anonymized when interviews were transcribed and translated.

Storage and Back-Up:

Audiotape recordings of the interviews and their transcripts were stored in one drive and in a Google space, and they will be saved for the long term in Google space.

Audiotaped interviews and transcripts will be accessible only to me, but excerpts from interviews may be used in the PhD thesis or in subsequent publications. I did not get permission from the interviewees for sharing these data with other people.

Annex III-V Data management plan for the Key Informant Interviews

Title: Interviews with Key Informants in the Gaza Strip

Majdi Ashour, who bears all responsibilities for this project and who was the main contributor to it, has been affiliated with the University of Edinburgh School of Social and Political Sciences as a PhD student. He was supervised by Dr Mark Hellowell. This project started from August 2017 to the end of September 2022.

Project abstract: This project explored issues related to the development of private and public healthcare in the mixed health system in the Gaza Strip to complement review of published materials.

Data Collection: Interviews with 17 key informants in the Gaza Strip. All interviews were audiotaped.

Ethics & Legal Compliance: Informed consents were obtained from all interviewees and were recorded. Since this research addresses a public policy issue, interviewees were provided with the opportunity to either disclose or keep their names confidential in the presentation of this research. All, except one, agreed to disclose their names.

Storage and Back-Up:

Audiotape recordings of the interviews were saved in one drive and in a Google space, and they will be saved for the long term in Google space.

Audiotaped interviews will be accessible only to me, but excerpts from interviews may be used in the PhD thesis or in subsequent publications. I did not get permission from the interviewees for sharing these data with other people.

Annex III-IV: An email informing about ethical approval from the University of Edinburgh School of Social and Political Sciences.

Majdi Ashour

From: HUNTER Lindsay <L.Hunter@ed.ac.uk>
Sent: 15 July 2016 10:58
To: Majdi Ashour
Cc: KAPILASHRAMI Anuj
Subject: Your Research Ethics form submission has been reviewed

Dear Majdi,

Your Research Ethics form submission ("Beyond Resilience in the Times of Despair: Changes in Out Of Pocket Payments in the Gaza Strip." [ID: 205199]) has been reviewed.

Category: Approved

Level: 2

Additional comments:

None

Annex IV-I: Calculation of the International Poverty Line (IPL) of 1.9 \$ in the Gaza Strip during the period from 1996 to 2018 based on the change in Consumer Price Index (CPI) and the Purchasing Power Parities (PPP) of the International Dollar.

Year	CPI	Exchange rate 2011	PPP of 1 \$		IPL (1.9 \$) in NIS
			adjusted to CPI	PPP of 1 \$ in NIS	
1996	57.96	3.59	1.182	4.247	8.069
1997	62.65	3.59	1.278	4.590	8.722
1998	66.34	3.59	1.353	4.860	9.235
2004	75.88	3.59	1.548	5.559	10.562
2005	77.73	3.59	1.586	5.695	10.821
2006	81.34	3.59	1.659	5.959	11.323
2007	82.60	3.59	1.685	6.052	11.499
2009	98.31	3.59	2.005	7.203	13.686
2010	100.00	3.59	2.040	7.327	13.921
2011	100.57	3.59	2.052	7.369	14.001
2017	104.20	3.59	2.126	7.635	14.506

Annex IV-II: Multiple comparison using Bonferroni correction of the per capita total consumption expenditure (adjusted to inflation) in New Israeli Shekels (NIS).

	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)
1996		9.96 (23.17)	7.78 (23.95)	116.86**** (22.88)	59.43 (25.47)	45.14 (30.47)	-73.83 (30.86)	87.08** (21.52)	76.42* (21.63)	76.40* (20.89)	-49.87 (21.45)
1997	-9.96 (23.17)		-2.18 (25.39)	106.90** (24.38)	49.48 (26.84)	35.19 (31.61)	-83.79 (31.99)	77.12* (23.11)	66.46 (23.22)	66.44 (22.53)	-59.83 (23.05)
1998	-7.78 (23.95)	2.18 (25.39)		109.08** (25.13)	51.66 (27.52)	37.37 (32.19)	-81.61 (32.56)	79.30* (23.90)	68.64 (24.00)	68.62 (23.33)	-57.65 (23.83)
2004	-116.86**** (22.88)	-106.90** (24.38)	-109.08 ** (25.130)		-57.43 (26.59)	-71.71 (31.40)	-190.69**** (31.78)	-29.78 (22.83)	-40.44 (22.93)	-40.46 (22.23)	-166.73*** (22.76)
2005	-59.43 (25.47)	-49.48 (26.84)	-51.66 (27.52)	57.42 (26.59)		-14.29 (33.34)	-133.27* (33.70)	27.65 (25.43)	16.98 (25.52)	16.96 (24.89)	-109.30** (25.37)
2006	-45.142 (30.47)	-35.19 (31.61)	-37.37 (32.19)	71.71 (31.40)	14.29 (33.34)		-118.97 (37.62)	41.94 (30.42)	31.27 (30.51)	31.25 (29.98)	-95.01+ (30.37)
2007	73.83 (30.86)	83.79 (31.99)	81.61 (32.56)	190.69**** (31.78)	133.27* (33.70)	118.97 (37.62)		160.91**** (30.82)	150.25**** (30.90)	150.23**** (30.38)	23.96 (30.38)
2009	-87.08 ** (21.52)	-77.12* (23.11)	-79.30* (23.90)	29.78 (22.83)	-27.65 (25.43)	-41.94 (30.43)	-160.91* (30.82)		-10.66 (21.57)	-10.68 (20.83)	-136.95**** (21.39)
2010	-76.42* (21.63)	-66.46 (23.21)	-68.64 (24.00)	40.44 (22.93)	-16.98 (25.52)	-31.27 (30.50)	(30.90)	10.66 (21.57)		-0.02 (20.94)	-126.2**** (21.50)
2011	-76.40* (20.89)	-66.44 (22.53)	-8.62 (23.33)	40.46 (22.23)	-16.96 (24.89)	-31.25 (29.98)	-150.23* (30.38)	10.68 (20.83)	0.02 (20.94)		-126.27**** (20.75)
2017	49.87	59.83	57.65	166.73****	109.30*	95.01	-23.96	136.95****	126.29****	126.27****	

Annex IV-III: Multiple comparison of per capita OOPP (adjusted to inflation) in New Israeli Shekels (NIS) from 1996 to 2017 using Bonferroni test.

	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (S)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)
1996		2.0 (4.54)	4.60 (4.70)	1.40 (4.49)	0.37 (4.49)	-3.74 (5.98)	0.11 (6.05)	15.30* (4.22)	9.80 (4.24)	7.49 (4.10)	5.43 (4.21)
1997	-2.01 (4.54)		2.58 (4.98)	-0.61 (4.78)	-1.65 (4.78)	-5.76 (6.20)	-1.90 (6.28)	133 (4.53)	7.78 (4.55)	5.47 (4.42)	3.41 (4.52)
1998	-4.60 (4.70)	-2.58 (4.98)		-3.20 (4.93)	-4.23 (4.93)	-8.34 (6.31)	-4.48 (6.39)	10.69 (4.69)	5.20 (4.71)	2.89 (4.58)	0.83 (4.67)
2004	-1.40 (4.49)	0.61 (4.78)	3.20 (4.93)		-1.03 (5.22)	-5.14 (6.16)	-1.29 (6.23)	13.89 (4.48)	8.39 (4.50)	6.09 (4.36)	4.03 (4.46)
2005	-0.37 (5.00)	1.65 (5.26)	4.23 (5.40)	1.03 (5.22)		-4.11 (6.54)	-0.25 (6.61)	14.93 (4.99)	9.43 (5.01)	7.12 (4.88)	5.06 (4.98)
2006	3.734 (5.98)	5.76 (6.20)	8.34 (6.31)	5.14 (6.16)	4.11 (6.16)		3.85 (7.38)	19.03 (5.97)	13.54 (5.98)	11.23 (5.88)	9.17 (5.96)
2007	-0.12 (6.05)	1.90 (6.28)	4.48 (6.39)	1.29 (6.23)	0.25 (6.23)	-3.85 (7.38)		15.18 (6.05)	9.68 (6.06)	7.38 (5.96)	5.32 (6.04)
2009	-15.29 (4.22)*	-13.28 (4.53)	-10.69 (4.69)	-13.89 (4.48)	-14.92 (4.48)	-19.03+ (5.97)	-15.18 (6.05)		-5.50 (4.23)	-7.80 (4.09)	-9.86 (4.20)
2010	-9.80 (4.24)	-7.78 (4.55)	-5.20 (4.71)	-8.39 (4.50)	-9.43 (4.50)	-13.54 (5.98)	-9.68 (6.06)	5.50 (4.23)		-2.31 (4.11)	-4.37 (4.22)
2011	-7.49 (4.10)	-5.47 (4.42)	-2.89 (4.58)	-6.09 (4.36)	-7.12 (4.36)	-11.23 (5.88)	-7.38 (5.96)	7.80 (4.09)	2.31 (4.11)		-2.06 (4.07)
2017	-5.43 (4.21)	-3.41 (4.52)	-0.83 (4.67)	-4.03 (4.46)	-5.06 (4.46)	-9.17 (5.96)	-5.32 (6.04)	9.86 (4.20)	4.37 (4.22)	2.06 (4.07)	

Annex IV-IV: Multiple comparison of the percentages of OOPP as a share of consumption expenditure between the 11 rounds of PECS from 1996 to 2017 using Bonferroni test.

Year	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)	Difference (SE)
1996		-0.14 (0.22)	-0.16 (0.23)	-0.18 (0.22)	-0.39 (0.24)	-0.68 (0.29)	-0.10 (0.30)	0.19 (0.21)	-0.06 (0.21)	0.05 (0.20)	0.71* (0.21)
1997	0.14 (0.22)		-0.02 (0.24)	-0.04 (0.23)	-0.25 (0.26)	-0.54 (0.30)	0.04 (0.31)	0.33 (0.22)	0.08 (0.22)	0.19 (0.22)	0.85** (0.22)
1998	0.16 (0.23)	0.02 (0.24)		-0.01 (0.24)	-0.23 (0.26)	-0.52 (0.31)	0.06 (0.31)	0.36 (0.23)	0.11 (0.23)	0.21 (0.22)	0.87** (0.23)
2004	0.18 (0.22)	0.04 (0.23)	0.01 (0.24)		-0.21 (0.26)	-0.51 (0.30)	0.08 (0.31)	0.37 (0.22)	0.12 (0.22)	0.23 (0.21)	0.88** (0.22)
2005	0.39 (0.24)	0.25 (0.26)	0.23 (0.26)	0.21 (0.26)		-0.30 (0.320)	0.29 (0.32)	0.58 (0.24)	0.33 (0.25)	0.44 (0.24)	1.09*** (0.24)
2006	0.68 (0.29)	0.54 (0.30)	0.52 (0.31)	0.51 (0.30)	0.30 (0.32)		0.58 (0.36)	0.88 (0.29)	0.63 (0.29)	0.73 (0.29)	1.39*** (0.29)
2007	0.10 (0.30)	-0.04 (0.31)	-0.06 (0.31)	-0.08 (0.00)	-0.29 (0.32)	-0.58 (0.36)		0.29 (0.30)	0.04 (0.30)	0.15 (0.29)	0.80 (0.30)
2009	-0.19 (0.21)	-0.33 (0.22)	-0.36 (0.23)	-0.37 (0.22)	-0.58 (0.24)	-0.88 (0.29)	-0.29+ (0.30)		-0.25 (0.21)	-0.14 (0.20)	0.51 (0.21)
2010	0.06 (0.21)	-0.08 (0.22)	-0.11 (0.23)	-0.12 (0.22)	-0.33 (0.25)	-0.63 (0.04)	-0.04 (0.30)	0.25 (0.21)		0.11 (0.20)	0.76* (0.21)
2011	-0.05 (0.20)	-0.19 (0.22)	-0.21 (0.22)	-0.23 (0.21)	-0.44 (0.24)	-0.73 (0.29)	-0.15 (0.29)	0.14 (0.20)	-0.11 (0.20)		0.66+ (0.20)
2017	-0.71* (0.21)	-0.85** (0.22)	-0.87** (0.23)	-0.88** (0.22)	-1.09*** (0.24)	-1.39*** (0.29)	-0.80 (0.30)	-0.51 (0.21)	-0.76* (0.21)	-0.66+ (0.20)	

Levels of Statistical Significance: 0.05<+ <0.1, 0.01>*>0.05, 0.001>**>0.01, 0.0001>***>0.001 , 0.0001>****>0.001

Annex IV- V: The quintiles' specific Means and Standard Errors (SE) of the Mean of per capita OOPP in New Israeli Shekels (NIS) in the Gaza Strip during the period from 1996 to 2017.

quintile	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
1st	3.19	2.38	3.38	3.70	3.14	3.05	3.36	5.62	5.50	4.78	5.65
SE	0.36	0.30	0.51	0.45	0.52	0.69	0.68	0.63	0.77	0.46	0.58
2nd	5.19	5.09	5.26	8.15	6.75	8.89	6.51	8.37	7.25	8.64	8.24
SE	0.52	0.62	0.80	1.00	0.88	1.44	1.36	0.85	0.64	1.02	0.81
3rd	7.24	7.53	8.46	12.49	10.60	6.72	8.10	11.91	14.17	13.48	15.68
SE	0.71	0.83	1.11	1.16	1.21	1.13	1.44	1.09	1.47	1.42	1.74
4th	10.38	13.82	13.57	12.92	16.96	13.54	13.98	21.08	20.46	22.05	26.72
SE	0.97	1.91	1.82	1.50	2.34	1.89	2.34	1.91	2.33	1.72	2.25
5th	25.98	33.31	44.26	34.21	32.84	24.10	42.41	118.29	87.28	74.96	64.22
SE	3.27	6.56	18.43	3.94	8.80	5.18	8.16	23.85	20.02	10.34	9.01

Annexe IV-VI : The quintiles' specific Means and Standard Errors (SE) of the Mean of per capita consumption in New Israeli Shekels (NIS) in the Gaza Strip during the period from 1996 to 2017.

quintile	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
1st	126.98	142.74	152.14	188.35	199.22	208.02	166.61	257.56	266.67	270.33	225.49
SE	1.80	2.26	2.52	3.16	4.02	4.42	5.37	3.44	3.38	2.99	3.25
2nd	198.55	220.98	241.46	297.73	311.27	310.29	261.62	389.85	406.33	401.50	345.76
SE	1.15	1.50	1.63	2.06	2.32	3.37	2.40	2.10	2.22	1.91	1.71
3rd	265.56	300.94	326.69	412.57	419.91	411.89	358.99	528.37	539.69	529.11	456.49
SE	1.30	1.72	2.05	2.43	3.20	3.21	3.68	3.03	2.72	2.49	2.14
4th	373.14	405.56	441.29	571.39	579.52	554.71	489.37	748.27	731.78	716.67	634.95
SE	2.84	2.87	3.42	4.20	5.22	5.90	5.25	4.83	4.67	4.52	4.05
5th	799.04	859.01	885.99	1222.13	1061.87	1115.88	922.60	1502.89	1432.09	1455.33	1224.59
SE	30.41	38.02	40.64	54.52	36.14	62.38	44.73	59.82	45.76	45.66	33.65

Annexe IV-VII: The quintiles' specific Means and Standard Errors (SE) of the percentages of OOPP as a share of per capita consumption.

quintile	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
1st	2.44	1.60	2.15	1.88	1.50	1.38	1.82	2.11	1.98	1.79	2.47
SE	0.27	0.19	0.32	0.22	0.23	0.31	0.35	0.23	0.26	0.17	0.26
2nd	2.61	2.31	2.16	2.69	2.16	2.88	2.39	2.13	1.77	2.14	2.38
SE	0.26	0.28	0.32	0.32	0.28	0.48	0.47	0.21	0.16	0.25	0.23
3rd	2.68	2.49	2.58	3.02	2.55	1.65	2.26	2.25	2.62	2.58	3.45
SE	0.26	0.27	0.33	0.28	0.29	0.28	0.41	0.21	0.27	0.28	0.37
4th	2.78	3.33	3.09	2.23	2.87	2.45	2.83	2.80	2.78	3.02	4.19
SE	0.26	0.43	0.44	0.26	0.39	0.35	0.46	0.25	0.32	0.23	0.34
5th	3.45	3.49	3.17	3.13	2.87	2.09	4.12	5.69	4.40	4.50	4.91
SE	0.38	0.56	0.58	0.36	0.50	0.42	0.64	0.73	0.55	0.48	0.56

Annex IV-VIII: The total and the quintile specific incidence of Catastrophic Health Expenditure at threshold of 10% of household consumption.

Quintile	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
Lowest	7.79	3.02	5.88	1.39	1.46	4.19	3.80	2.04	3.53	2.33	7.20
SE	2.07	1.58	2.17	0.80	1.06	2.42	2.19	0.90	1.38	1.08	3.12
Second	4.41	5.35	2.09	3.28	4.74	6.25	4.18	2.33	2.39	2.06	5.69
SE	1.66	1.80	1.22	1.38	2.19	3.16	2.71	1.14	1.15	0.98	2.54
Third	4.21	2.02	4.75	7.64	3.49	5.21	9.20	6.96	1.93	5.67	7.87
SE	1.34	0.99	1.55	2.04	1.43	2.58	3.96	1.98	0.83	1.86	2.64
Fourth	4.54	5.49	5.58	5.21	2.80	3.92	5.43	6.05	3.99	3.03	12.27
SE	1.21	1.64	1.65	1.86	1.38	2.45	2.86	1.79	1.27	1.34	3.09
Highest	4.44	8.57	3.32	3.72	4.58	5.59	5.14	10.23	6.03	9.40	11.78
SE	1.17	1.87	1.07	1.13	1.70	3.09	2.14	2.03	1.34	1.82	2.77
Total	5.08	4.89	4.32	4.25	3.42	5.04	5.55	5.54	3.57	4.51	8.96
SE	0.69	0.72	0.71	0.68	0.72	1.24	1.28	0.74	0.54	0.66	1.27

Annex IV-IX: The total and the quintile specific intensity of Catastrophic Health Expenditure at threshold of 10% of household consumption.

Quintile	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
Lowest	0.44	0.15	0.52	0.05	0.04	0.11	0.09	0.19	0.26	0.09	0.30
SE	0.15	0.12	0.28	0.04	0.03	0.08	0.08	0.09	0.14	0.05	0.14
Second	0.16	0.29	0.04	0.21	0.29	0.46	0.06	0.11	0.12	0.23	0.43
SE	0.06	0.19	0.04	0.11	0.15	0.31	0.04	0.06	0.06	0.17	0.22
Third	0.26	0.10	0.40	0.45	0.13	0.16	0.58	0.33	0.07	0.55	0.51
SE	0.13	0.05	0.18	0.17	0.06	0.11	0.36	0.12	0.03	0.31	0.25
Fourth	0.33	0.26	0.66	0.22	0.33	0.10	0.21	0.25	0.22	0.17	0.77
SE	0.11	0.09	0.33	0.09	0.18	0.06	0.12	0.09	0.09	0.08	0.30
Highest	0.32	0.91	0.27	0.33	0.54	0.25	0.53	2.40	0.81	1.01	1.44
SE	0.10	0.43	0.12	0.13	0.31	0.13	0.22	1.03	0.31	0.29	0.44
Total	0.30	0.34	0.38	0.25	0.26	0.22	0.29	0.66	0.30	0.41	0.69
SE	0.05	0.10	0.10	0.05	0.08	0.07	0.09	0.22	0.07	0.09	0.13

Annex IV-X: The total and the quintile specific incidence of Catastrophic Health Expenditure at threshold of 25% of household consumption.

Quintile	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
Lowest	0.50	0.00	2.16	0.00	0.00	0.00	0.00	0.00	0.58	0.00	0.35
SE	0.50	0.00	1.58	0.00	0.00	0.00	0.00	0.00	0.58	0.00	0.35
2nd	0.09	0.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.91	0.00
SE	0.09	0.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.66	0.00
Third	0.86	0.00	0.94	0.74	0.00	0.00	1.65	0.00	0.00	1.32	0.00
SE	0.70	0.00	0.69	0.57	0.00	0.00	1.64	0.00	0.00	0.98	0.00
Fourth	0.82	0.15	1.41	0.35	0.90	0.00	0.00	0.00	0.63	0.10	1.14
SE	0.49	0.15	1.04	0.30	0.90	0.00	0.00	0.00	0.37	0.10	0.81
Highest	0.54	1.90	0.40	1.01	0.77	0.00	0.67	3.73	1.85	2.18	3.02
SE	0.34	1.04	0.23	0.57	0.69	0.00	0.55	1.58	0.70	0.86	1.15
Total	0.56	0.57	0.98	0.42	0.33	0.00	0.46	0.76	0.61	0.90	0.90
SE	0.21	0.27	0.41	0.17	0.23	0.00	0.35	0.33	0.20	0.29	0.29

Annex IV-XI: The total and the quintile specific intensity of Catastrophic Health Expenditure at threshold of 25% of households' consumption.

Quintile	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
Lowest	0.005	0.00	0.04	0.00	0.00	0.00	0.00	0.00	0.04	0.00	0.01
SE	0.005	0.00	0.03	0.00	0.00	0.00	0.00	0.00	0.04	0.00	0.01
Second	0.000	0.07	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.09	0.00
SE	0.000	0.07	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.08	0.00
Third	0.016	0.00	0.06	0.05	0.00	0.00	0.04	0.00	0.00	0.18	0.00
SE	0.016	0.00	0.05	0.05	0.00	0.00	0.04	0.00	0.00	0.15	0.00
Fourth	0.012	0.01	0.24	0.01	0.02	0.00	0.00	0.00	0.06	0.00	0.14
SE	0.012	0.01	0.18	0.01	0.02	0.00	0.00	0.00	0.04	0.00	0.12
Highest	0.113	0.44	0.13	0.07	0.19	0.00	0.02	1.51	0.39	0.31	0.60
SE	0.050	0.28	0.08	0.05	0.18	0.00	0.01	0.80	0.21	0.15	0.26
Total	0.029	0.10	0.09	0.03	0.04	0.00	0.01	0.31	0.10	0.12	0.15
SE	0.011	0.06	0.04	0.01	0.04	0.00	0.01	0.17	0.04	0.05	0.06

Annex IV-XII: Distribution Sensitive Measures for the incidence and the Intensity of CHE from 1996 to 2017 for the thresholds of 10 % and 25% of total household consumption.

Threshold	Indicator	1996	1997	1998	2004	2005	2006	2007	2009	2010	2011	2017
10%	Concentration index of Incidence (SE)	-0.107 (0.079)	0.189 (0.086)	-0.041 (0.093)	0.097 (0.071)	0.142 (0.121)	0.019 (0.141)	0.010 (0.105)	0.324 (0.070)	0.138 (0.098)	0.262 (0.081)	0.149 (0.091)
	Rank-weighted Incidence (SE)	5.623 (0.942)	3.968 (0.793)	4.499 (0.993)	3.8401 (0.716)	2.933 (0.787)	4.944 (1.387)	5.494 (1.477)	3.742 (0.659)	3.082 (0.653)	3.325 (0.654)	7.625 (1.503)
	Concentration index of Intensity (SE)	0.001 (0.105)	0.343 (0.141)	0.0368 (0.144)	0.159 (0.104)	0.399 (0.167)	- 0.015 (0.162)	0.260 (0.129)	0.682 (0.110)	0.382 (0.160)	0.395 (0.116)	0.313 (0.102)
	Rank-weighted Intensity (SE)	0.301 (0.064)	0.225 (0.072)	0.364 (0.114)	0.212 (0.053)	0.158 (0.048)	0.219 (0.095)	0.217 (0.084)	0.211 (0.047)	0.184 (0.053)	0.248 (0.080)	0.473 (0.103)
	Concentration index of Incidence (SE)	0.112 (0.202)	0.451 (0.240)	- 0.152 (0.224)	0.424 (0.190)	0.758 (0.139)	0.000	0.240 (0.280)	0.976 (0.021)	0.494 (0.234)	0.399 (0.167)	0.561 (0.146)
	Rank-weighted Incidence (SE)	0.501 (0.247)	0.313 (0.220)	1.132 (0.594)	0.242 (0.138)	0.081 (0.077)	0.000	0.352 (0.350)	0.018 (0.018)	0.310 (0.196)	0.543 (0.259)	0.396 (0.182)
25%	Concentration index of intensity (SE)	0.554 (0.147)	0.611 (0.140)	0.399 (0.139)	0.427 (0.244)	0.947 (0.055)	0.000	0.253 (0.273)	0.982 (0.20)	0.73 (0.161)	0.468 (0.200)	0.762 (0.093)
	Rank-weighted Intensity (SE)	0.013 (0.005)	0.040 (0.30)	0.057 (0.026)	0.016 (0.011)	0.002 (0.022)	0.000	0.008 (0.008)	0.006 (0.007)	0.026 (0.015)	0.061 (0.036)	0.036 (0.018)

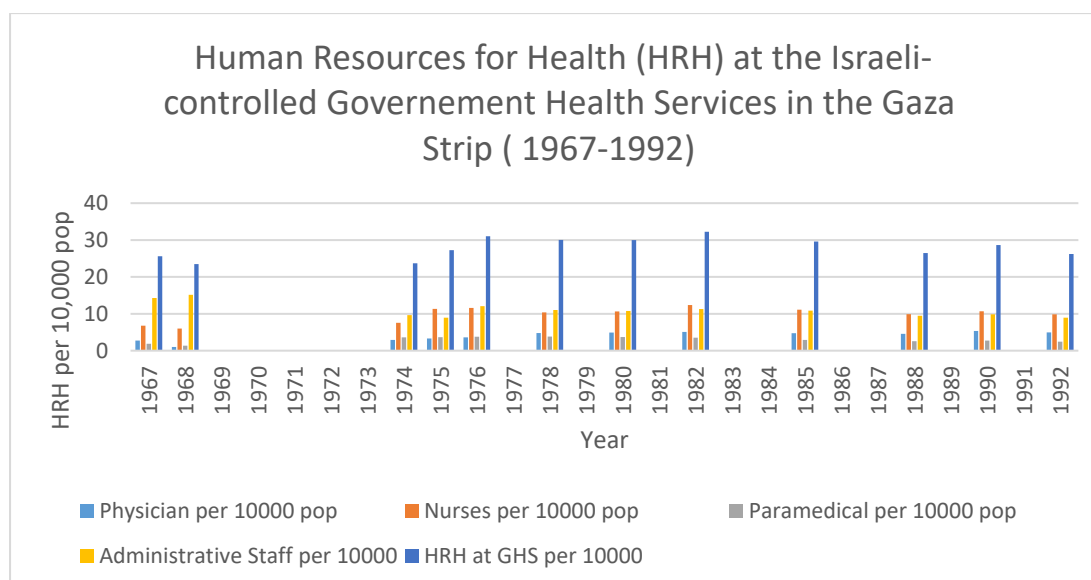
Annex IV-XIII: Multivariate odds ratios of incurring Catastrophic Health Expenditure at the threshold of 10% of household consumption different correlates, including refugee status and place of residence, during the period from 2004 to 2017.

Number of Cases	7365
Missing cases	0%
-2 logit Likelihood	3530%
Nigel	630%
Cox	0.023
Hosmer	0.005
% correct	93.80%
Variable	Odds Ratios (95% CI)
PECS rounds year (2017- reference)	***
2004	0.385 (0.241-0.615) ***
2005	0.311 (0.182-0.532) ***
2006	0.337 (0.187-0.608) ***
2007	0.448 (0.257-0.782)**
2009	0.675 (0.503-0.906)**
2010	0.460 (0.332-0.637)***
2011	0.538 (0.397-0.728)***
Payment for Health Insurance (Did not pay - reference)	
Paid premiums for Health Insurance	0.997 (0.799-1.244)
Refugee Status (not refugees – reference)	
Refugees	0.860 (0.701-1.055)
Place of residence (outside the refugee camps-reference)	
Refugee Camps	1.000 (0.776-1.287)
Size of households (10 or more - reference)	+
1-4 members	1.811 (1.130-2.903) *
5-7 members	1.475 (1.009-2.156)*
8-9 members	1.247 (0.850-1.827)
Presence of 65 years old or older households members (Yes- reference)	
No	0.710 (0.477-1.056) +
Number of children (5 or more - reference)	***
No children	0.863 (0.596-1.250)
1-2 children	0.538 (0.366-0.792) **
3-4 children	0.618 (0.453-0.843) **
Sex of the head of the households (Female -reference)	
Male	1.323 (0.927-1.889)
Literacy status of the head of the households (Literate - reference)	
Illiterate	1.518 (1.032-2.232)*
Age of the head of the households (65 years and above – reference)	
15-34 years	1.039 (0.629-1.717)
35-54 years	0.943 (0.573-1.551)
55-64 years	0.718(0.419-1.230)
PER CAPITA CONSUMPTION QUINTILE	***
The 1st lowest	0.462 (0.308-0.693)***
The 2nd	0.320 (0.210-0.488) ***
The 3rd	0.624 (0.445-0.883)**
The 4th	0.827 (0.616-1.110)
Interaction between the quintiles and the two periods **	
The 1st lowest	1.435 (0.721-2.853)
The 2nd	3.135 (1.642-5.986)**
The 3rd	1.728 (0.958-3.116) +
The 4th	0.876 (0.473-1.625)
Constant	0.175 ***

Annex IV-XIV: Multivariate odds ratios of incurring healthcare impoverishment at the IPL 1.9 International Dollars by different correlates, including refugee status and place of residence, during the period from 2004 to 2017.

Number of Cases	7365
2 logit Likelihood	1988.052
Nigel	0.028
Cox	0.06
Hosmer	0.123
% correct	97.20%
Variable	Odds Ratios (95% CI)
PECS rounds year (2017- reference)	
2004	0.799 (0.483-1.322)
2005	0.694 (0.393-1.227)
2006	0.900 (0.468-1.732)
2007	0.937 (0.463-1.897)
2009	0.765 (0.472-1.239)
2010	0.743 (0.458-1.206)
2011	0.838 (0.533-1.317)
Payment for Health Insurance (Did not pay premiums for Health Insurance - reference)	
Paid premiums for Health Insurance	2.159 (1.432-3.275)***
REFUGEE STATUS (not refugees - reference)	
Refugees	0.908 (0.672-1.226)
Place of residence (outside the refugee camps- Refugee Camps	1.106 (0.777-1.574)
Size of households (10 or more - reference)	*
1-4 members	0.834 (0.436-1.596)
5-7 members	0.904 (0.582-1.403)
8-9 members	1.425 (0.950-2.138)+
Availability of 65 years old or older households members (Yes- reference)	
No 65 years old or older households members	1.089 (0.607-1.954)
Number of children (5 or more - reference)	+
No children	0.575 (0.334-0.990) *
1-2 children	0.833 (0.516-1.345)
3-4 children	1.077 (0.752-1.542)
Sex of the head of the households (Female -reference)	
Male	1.325 (0.660-2.660)
Literacy status of the head of the households (Literate - reference)	
Illiterate	1.381 (0.717-2.661)
Age of the head of the households (65 years and above - reference)	
15-34 years	1.003 (0.419-2.405)
35-54 years	0.905 (0.386-2.121)
55-64 years	1.234 (0.505-3.018)
Constant	0.016 ***

Annex VI. I: Human Resources at the Government Health Services during the Israeli Military Occupation.

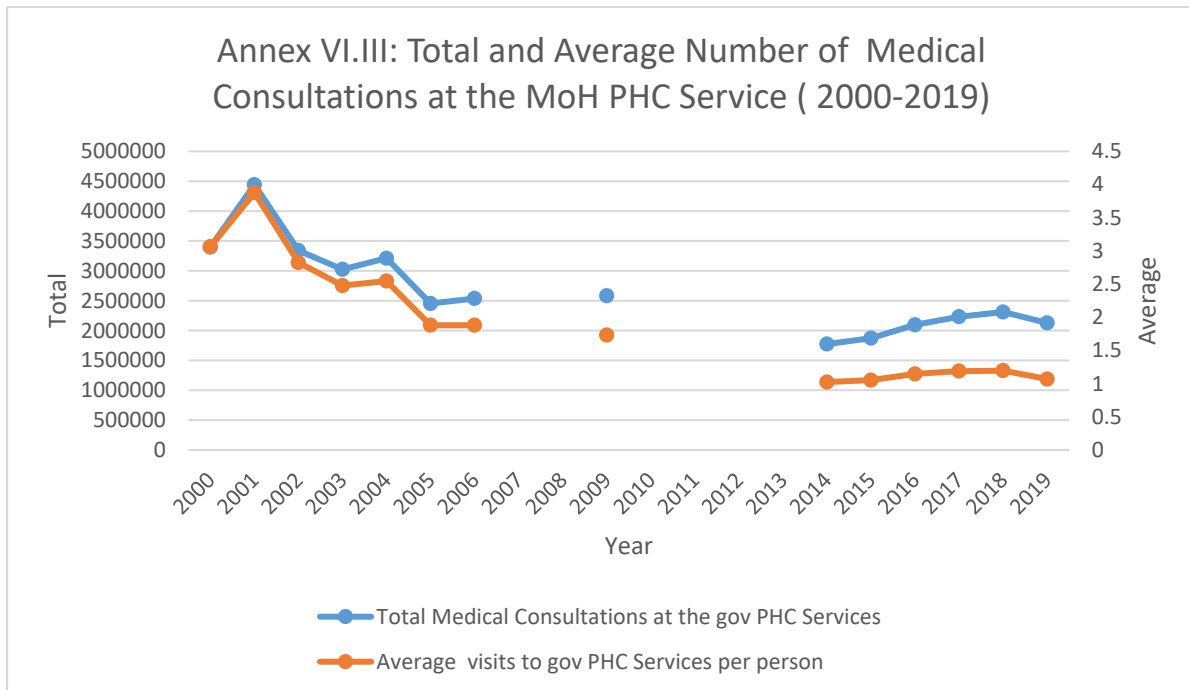


Annex VI.II: UNRWA resources before and after Intifada

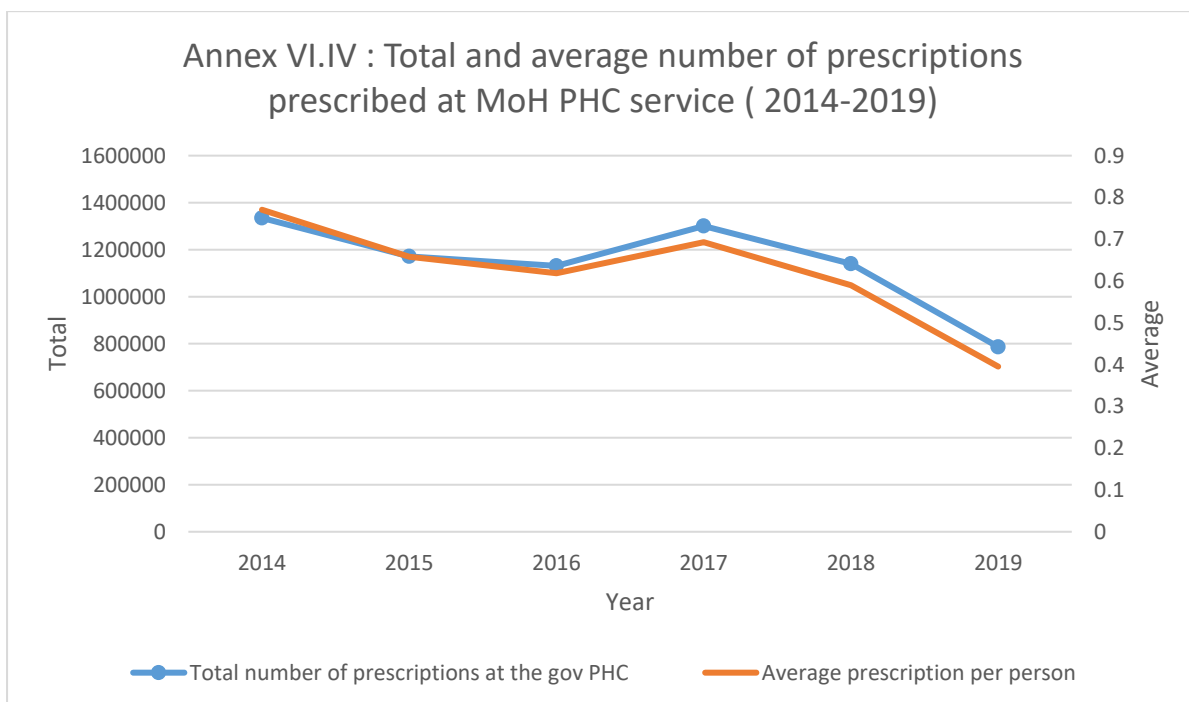
Number/ year	1987	1988	1989	1990	1991	1992	1993
Registered refugees (thousands)	450	460	470	496	529	560	625
PHC centres	9	9	9	9	9	9	10
Maternal and Child health clinics	16	16	16	16	16	16	17
Dental Units	6	6	7	7	8	8	10
Medical Laboratories	6	6	7	7	7	8	8
Number of Regular HRH							
Doctors	28	34	33	37	ND	44	47
Dentists	5	7	7	7	ND	8	10
Pharmacists	1	2	2	2	ND	2	2
Paramedical Staff	26	29	30	32	ND	32	52
Nursing Staff	123	139	132	133	ND	149	152
Health Educators	5	5	5	5	ND	7	5
Number of Administrative Staff							
Administrative Staff	30	29	31	32	ND	33	33
Total HRH	218	245	240	248	ND	275	301
Number of Posts under extraordinary measures in the oPt							
Doctors			16	18	ND	20	17
Nurses			34	47	ND	50	53
Paramedical			4	4	ND	27	16
Administrative			1	1	ND	7	8
Other / Labourers			9	9	ND	19	19
Total posts			64	79	ND	123	113

ND : No Data

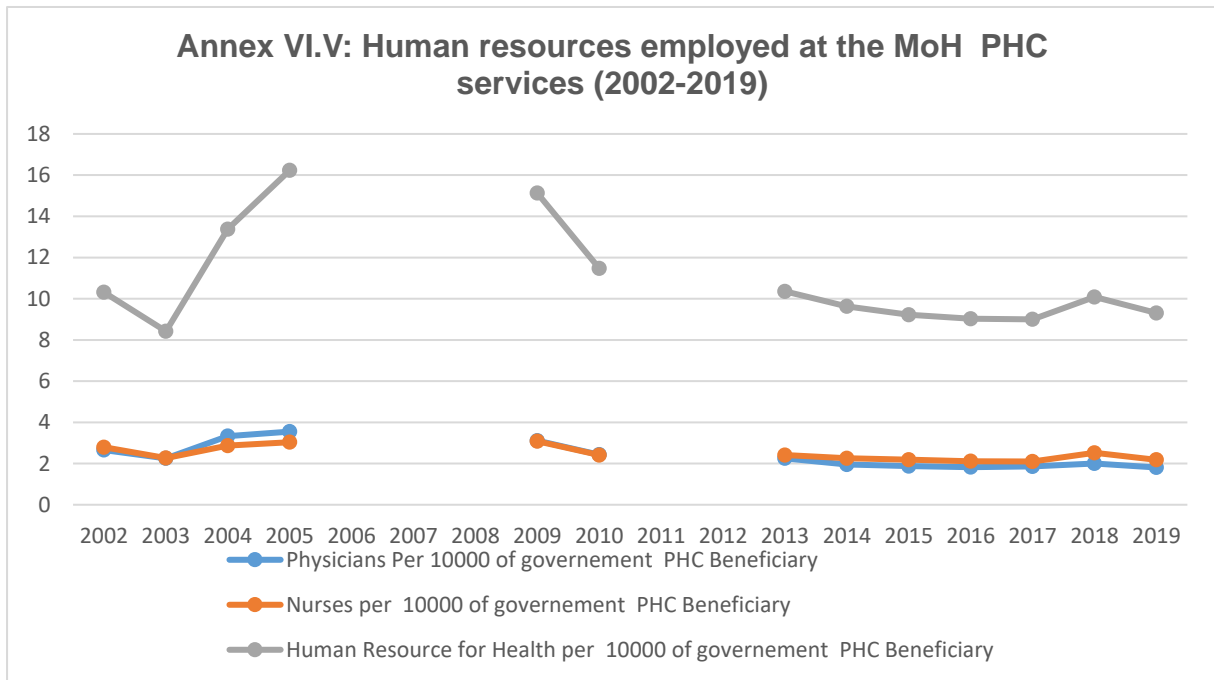
Annex VI.III: Total and average medical consultations at the MoH PHC services (2000-2019).



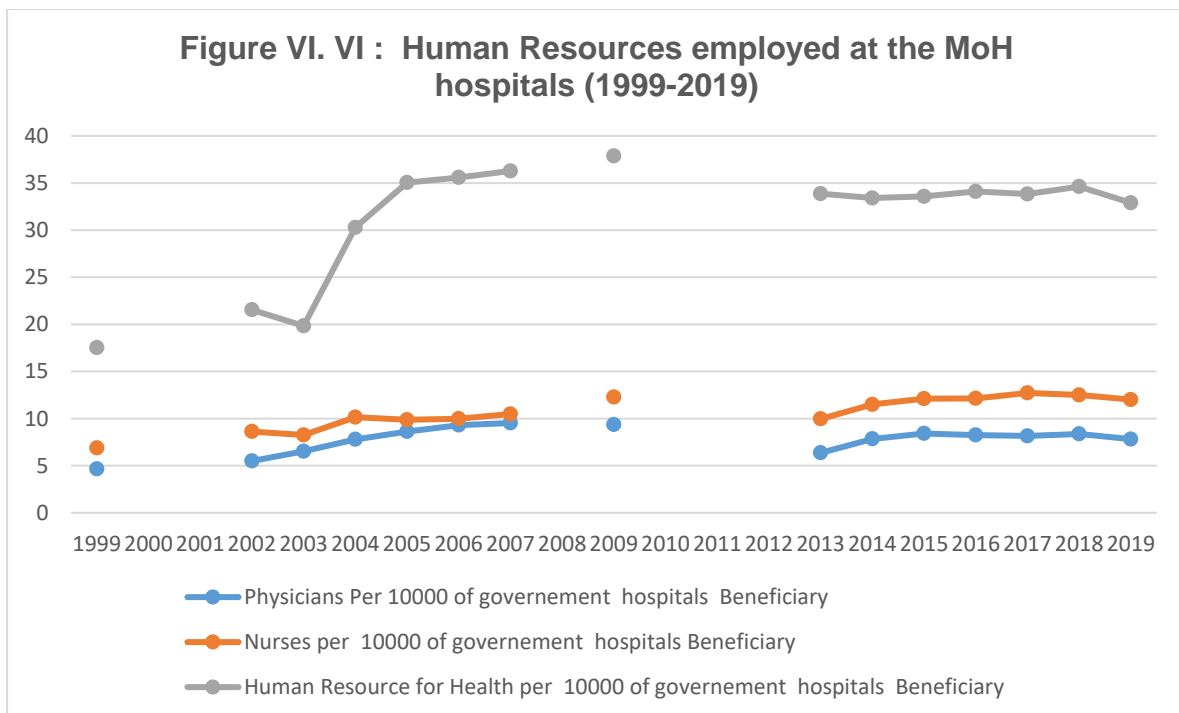
Annex VII.IV: Total and average number of prescriptions prescribed at MoH PHC service (2014-2019)



Annex VI.V: Human resources employed at the MoH PHC services (2002-2019)



Annex VI.VI: Human Resources employed at the MoH hospitals (1999-2019)



Annex VI.VII: Ratios of UNRWA Health Program workforce to 10000 of registered Palestinian Refugees in Gaza Strip during the period from 2006 to 2019

