



Received: 14/01/2025

Peer-reviewed: 06/05/2025

Accepted: 30/06/2025

Budgeting and Spending in Palestine's Health Care System: Addressing Gaps and Opportunities (2000-2024)

Bilal Abed AL-Rhman Nemr Jawabreh



PhD in Public Health, Faculty of Public Health, Al-Quds University, Jerusalem–Palestine

bilaljawabreh@gmail.com

Motasem Hamdan



Professor of Health Policy and Management, Faculty of Public Health, Al-Quds University, Jerusalem–Palestine

mhamdan@staff.alquds.edu

Abstract

Objectives: This study analyzes health financing patterns in Palestine from 2000 to 2023, with a focus on the 2023 expenditure indicators. It explores the growing burden of household out-of-pocket (OOP) payments, the allocation imbalance between curative and preventive care, and the need for increased government investment in health.

Methodology: A systematic literature review, secondary data analysis, and expert interviews were conducted using data from the Palestinian Ministry of Health (MoH), Ministry of Finance, and the Palestinian Central Bureau of Statistics (PCBS). The latest indicators from 2023 were integrated to update policy insights.

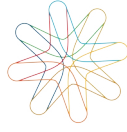
Results: In 2023, total current health expenditure (CHE) reached \$1.87 billion, or 10.4% of GDP. Government contributions accounted for 46.4% of this spending, while households financed 42.1% through OOP payments, which accounts for more than double the WHO's recommended ceiling. Per capita health expenditure stood at \$363. Despite health expenditure reaching 10.4% of GDP in 2023, significant imbalances persist, with approximately 71–75% of spending directed toward curative care compared to only 1.5–4.8% allocated to preventive services. Combined with low government health expenditure (4.9% of GDP), this raises concerns about efficiency, equity, and long-term fiscal sustainability.

Originality: This policy brief provides a context-specific analysis using the latest national data. It highlights financial vulnerabilities in the Palestinian health system and offers evidence-based recommendations to improve equity and efficiency under conditions of political and economic constraints.

Keywords: Health expenditure; Out-of-pocket payments; Primary healthcare; Budget allocation; Financial sustainability; Palestine

Cite as: Jawabreh, B. A. N. & Hamdan, M. (2025). "Budgeting and Spending in Palestine's Health Care System: Addressing Gaps and Opportunities (2000-2024)". *The Academic Network for Development Dialogue (ANDD) Paper Series, Third Edition*, 2025. <https://doi.org/10.29117/andd.2025.011>

© 2025, Jawabreh, B. A. N. & Hamdan, M., Published in *The Academic Network for Development Dialogue (ANDD) Paper Series*, by QU Press. This article is published under the terms of the Creative Commons Attribution-NonCommercial 4.0 International (CC BY-NC 4.0), which permits non-commercial use of the material, appropriate credit, and indication if changes in the material were made. You can copy and redistribute the material in any medium or format as well as remix, transform, and build upon the material, provided the original work is properly cited. The full terms of this license may be seen at: <https://creativecommons.org/licenses/by-nc/4.0>



تاريخ القبول: 2025/06/30

تاريخ التحكيم: 2025/05/06

تاريخ الاستلام: 2025/01/14

الموازنة والإنفاق في نظام الرعاية الصحية الفلسطيني: معالجة الفجوات واستثمار الإمكانات 2000-2024

بلال عبد الرحمن نمر جوابرة 

دكتورة في الصحة العامة، كلية الصحة العامة، جامعة القدس، القدس-فلسطين

bilaljawabreh@gmail.com

معتصم حمدان 

أستاذ في السياسات والإدارة الصحية، كلية الصحة العامة، جامعة القدس-القدس

mhamdan@staff.alquds.edu

ملخص

أهداف الدراسة: تحلل هذه الدراسة أنماط تمويل الرعاية الصحية في فلسطين خلال الفترة 2000-2024، مع تركيز خاص على مؤشرات الإنفاق الصحي لعام 2024. وتسلط الضوء على عبء المدفوعات المباشرة من الأسر، واختلال التوازن بين الرعاية العلاجية والوقائية، والحاجة إلى زيادة الاستثمار الحكومي في القطاع الصحي.

منهج البحث: تم إجراء مراجعة منهجية للأدبيات، وتحليل ثانوي للبيانات، ومقابلات مع خبراء باستخدام بيانات وزارة الصحة الفلسطينية، ووزارة المالية، والجهاز المركزي للإحصاء الفلسطيني. وتم إدماج مؤشرات عام 2023 الأحدث لتحديث النتائج والسياسات. **النتائج:** بلغ إجمالي الإنفاق الصحي الحالي في عام 2023 نحو 1.87 مليار دولار، أي ما يعادل 10.4% من الناتج المحلي الإجمالي. ساهمت الحكومة بنسبة 46.4% من هذا الإنفاق، بينما جاءت 42.1% من الأسر من خلال مدفوعات مباشرة تفوق بكثير الحد الموصى به من قبل منظمة الصحة العالمية. وبلغ الإنفاق الصحي للفرد 363 دولارًا. رغم أن الإنفاق الصحي بلغ 10.4% من الناتج المحلي الإجمالي في عام 2023، إلا أن اختلالات كبيرة لا تزال قائمة، حيث يُوجَّه نحو 71-75% من الإنفاق إلى الرعاية العلاجية مقارنةً بـ 1.5-4.8% فقط للخدمات الوقائية. وبالاقتران مع انخفاض الإنفاق الحكومي على الصحة (4.9% من الناتج المحلي)، فإن ذلك يثير مخاوف جدية تتعلق بالكفاءة، والعدالة، والاستدامة المالية على المدى الطويل.

أصالة البحث: توفر هذه الورقة التحليلية فهمًا معمقًا ومحدثًا للنظام الصحي الفلسطيني باستخدام بيانات وطنية حديثة، وتقدم توصيات قائمة على الأدلة لتعزيز العدالة والكفاءة في ظل التحديات السياسية والاقتصادية.

الكلمات المفتاحية: الإنفاق الصحي، المدفوعات المباشرة، الرعاية الصحية الأولية، تخصيص الميزانية، الاستدامة المالية، فلسطين

للاقتباس: جوابرة، بلال عبد الرحمن وحمدان، معتصم. (2025). "الموازنة والإنفاق في نظام الرعاية الصحية الفلسطيني: معالجة الفجوات واستثمار الإمكانات 2000-2024". سلسلة الأوراق البحثية للشبكة الأكاديمية للحوار التنموي - النسخة الثالثة، 2025. <https://doi.org/10.29117/andd.2025.011>

© 2025، جوابرة وحمدان. سلسلة الأوراق البحثية للشبكة الأكاديمية للحوار التنموي، دار نشر جامعة قطر. نُشرت هذه المقالة وفقًا لشروط العمل إلى صاحبه، مع بيان أي تعديلات عليه. كما تتيح حرية نسخ، وتوزيع، ونقل العمل بأي شكل من الأشكال، أو بأية وسيلة، ومزجه وتحويله والبناء عليه، طالما يُنسب العمل الأصلي إلى المؤلف. <https://creativecommons.org/licenses/by-nc/4.0>

Abbreviations

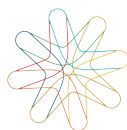
PA		Palestinian Authority
MoH	Ministry of Health	
GG		General Government
GDP		Gross Domestic Product
UNRWA	United Nations Relief and Works Agency	
PCBS		Palestinian Central Bureau of Statistics
NPISH		Non-Profit Institutions Serving Households
THE		Total Health Expenditure
TCHE		Total Current Expenditure on Health
CHE		Current Expenditure on Health
OOP	Out of Pocket	
UHC	Universal Health Coverage	

Key Terms and Classifications

The following definitions are grounded in the System of Health Accounts (SHA, 2011), Ministry of Health classifications, and economic terminology relevant to health financing.

Term	Definition
Budgeting	The process of planning and allocating available financial resources to different sectors or services, such as health, based on priorities and needs.
Spending	The actual use of allocated financial resources, often measured in monetary terms, is used to assess how funds are distributed and utilized across programs.
GDP (Gross Domestic Product)	The total monetary value of all goods and services produced within a country over a specific period. It is used as an indicator of a country's economic performance.
GG Budget (General Government Budget)	Refers to the total budget managed by all levels of government, including central, local, and municipal. It funds key public services like health, education, and infrastructure.
Per Capita	A Latin term meaning “per person.” In financial terms, it often refers to expenditure or income divided by the total population. For example, “health expenditure per capita” measures the average health spending for each citizen.
Program Budgeting	A budgeting approach that allocates funds based on specific health programs or services, rather than by administrative units. It helps link spending to health sector goals and priorities.
Functional Classification	Categorizing expenditures by the purpose they serve (e.g., inpatient care, outpatient care, administration), often used to assess how resources align with health service delivery needs.
Economic Classification	Groups spending based on the nature of the goods or services procured (e.g., wages, equipment, supplies), helping track input costs and resource efficiency.
Input vs. Output-based Budgeting	Input-based budgeting focuses on funding resources (e.g., staff, buildings), while output-based budgeting links funds to measurable results (e.g., vaccinations delivered).
Health Accounts	Systematic tracking of health expenditure flows to analyze trends and identify gaps.
Current Expenditure	Spending on health services for residents, regardless of where the services are received.
Capital Formation for Health Care Providers	Investment in long-term assets like hospitals and equipment used in health care provision.
Accrual Basis	Accounting method that records financial flows when economic value is created or transferred.
Health Care	All professional services and goods are aimed at health improvement and treatment.

Term	Definition
Government Sector	Includes central and local governments, plus social security units funding health services.
Non-profit Institution Serving Households (NPISH)	Non-governmental, non-market entities supporting households, often funded by donations.
Household	Individuals or groups sharing a dwelling and living expenses, a source of private spending.
Primary Health Care	Initial, accessible, and ongoing care, like diagnosis, chronic disease management, and prevention.
Secondary and Tertiary Care	More specialized or advanced diagnostic and treatment services, often hospital-based.
Health Insurance	A contract where the insurer covers health service costs under specific conditions.
Out-of-Pocket Expenditure	Direct payments by households for health services at the point of use; major burden in Palestine.
Government Financing Schemes	Schemes are funded through taxes or compulsory contributions to ensure health coverage.
Voluntary Health Payment Schemes	Insurance or funding schemes not mandated by the state, based on private initiative.
Rest of the World (Financing)	External funding sources not routed through national systems; includes international aid.
Health Care Functions	Categorization by service purpose, such as curative, preventive, or rehabilitation.
Curative Care	Focuses on treating symptoms, injuries, or diseases, including inpatient and outpatient care.
Preventive Care	Efforts to avoid diseases and promote health include public health campaigns and screenings.
Long-term Care	Care for chronic conditions or disability, combining health and social services.
Governance and Financing Administration	Oversight and coordination of health policy, regulation, resource allocation, and quality assurance.



1. Introduction

Effective budgeting and spending in healthcare are crucial to the success of any healthcare system. It is imperative to comprehend the principles of budgeting to advocate for the importance of health. Unfortunately, in many countries, a lack of understanding regarding budget-related matters leads to disjointed processes. This means that health policymaking, planning, costing, and budgeting occur independently, causing a misalignment between the outlined health sector priorities in strategic plans and policies and the actual allocation of funds through the budgeting process (Rajan et al., 2017).

The Palestinian Ministry of Health (MoH) is the main entity responsible for governing, regulating, and delivering health care services in the West Bank and Gaza Strip. Five major providers share responsibility for health care provision: the MoH, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), various nongovernmental organizations, military medical services, and the private sector. As a developing country, Palestine faces significant challenges in the provision of healthcare services to its Palestinian people due to limited financial resources and political instability.

The healthcare budgeting and spending in Palestine are critical to ensuring the provision of adequate healthcare services to the population. For effective health policy development and planning, it is also critically important to evaluate and examine the current healthcare spending and utilization patterns and the limitations of these patterns. However, the scarcity of published studies on healthcare spending and utilization patterns in Palestine presents challenges to evidence-based planning.

To inform future health policy-making and planning, through a deep-purposeful analyses of health care spending patterns in Palestine over the period 2000–24, this policy brief specifically aimed to study and analyze the following: health expenditure as percentage of GDP%; health expenditure by type of financing schemes; health expenditure by function of health care; health expenditure projections and MoH budget vs GG budget (General Government Budget). The evidence generated allows decision-makers to gain a better understanding of the existing health financing, which is critical for making policy decisions and planning.

2. Background and Context

Palestine seeks to operate under a sophisticated and restrictive geopolitical environment as a result of the ongoing Israeli occupation and wars against the Palestinian people, mainly in the Gaza Strip. The health system, like all sectors of governance, faces chronic instability due to withheld tax revenues legally owed to the Palestinian Authority under peace agreements but routinely delayed or blocked by Israeli authorities. This has led to severe budgetary shortfalls, compounded by the diminished

international donor support. In recent years, the Palestinian Authority has struggled to pay public sector salaries on time, significantly weakening health workforce motivation and performance. These conditions create extraordinary challenges for health care planning, financing, and sustainability, demanding innovative, context-sensitive policy responses. Over the past two decades, a lot of research has explored the structural and financial challenges facing Palestine's health system. Despite considerable increases in total health expenditure, rising by over 360% from 2000 to 2022 (PCBSc & Palestinian MOH, 2023). Studies consistently show persistent inefficiencies, inequitable access, and high out-of-pocket payments. Mataria et al. (2010) revealed that the share of households experiencing catastrophic health payments more than doubled from 1998 to 2007. Similarly, Hamidi et al. (2015) found that public hospitals, while absorbing the majority of MOH funds, underperform compared to their private counterparts in both efficiency and care quality.

In sum, the Palestinian healthcare financing debate remains under-contextualized, often failing to account for the external occupation-related constraints, internal political fragmentation, and unsustainable reliance on household financing. Addressing these realities is vital for creating actionable and equitable reforms.

3. Methodology

To investigate healthcare budgeting and expenditure in Palestine, a structured multi-source approach was employed. While not a full mixed-methods study, it combined a comprehensive literature review, secondary quantitative data analysis, and a single expert consultation to triangulate findings.

3.1 Literature Review

An extensive review of scholarly and institutional literature was conducted to provide evidence-based context for policy questions. Sources included: PubMed, Google Scholar, World Health Organization (WHO), and Global Health Observatory. Search terms used included: "health care budgeting in Palestine," "health care financing in Palestine," and "health expenditure trends." The review identified global best practices, local fiscal challenges, and contextual constraints specific to the Palestinian health care system.

3.2 Data Collection

Secondary data was retrieved from key national and international institutions:

- Palestinian Ministry of Health (MoH): National Health Accounts and annual reports.
- Ministry of Finance (MoF): Citizen Budget Reports and fiscal performance summaries.
- Palestinian Central Bureau of Statistics (PCBS): Health-related socioeconomic indicators.
- World Health Organization (WHO): Global health expenditure databases.

The following datasets were specifically analyzed:

- Health Expenditure by Financing Agents (2000–2023).
- Health Expenditure by Financing Schemes (2000–2023).
- Health Expenditure by Health Care Providers (2000–2023).
- Health Expenditure by Function of Health Care (2000–2023).
- Total Health Expenditure as % of GDP and per capita figures (2000–2023).

These datasets are detailed in the annexes and formatted in Excel.

3.3 Data Analysis

The quantitative data were cleaned, aggregated, and visualized using Microsoft Excel. Time-series analysis was conducted to examine:

- Trends in total health expenditure growth.
- Changes in financing structures and dependency on out-of-pocket payments.
- Budget allocations by health care functions and providers.

Additionally, ARIMA modeling was performed using R software to forecast expenditure patterns up to 2033, supporting strategic planning and fiscal projections.

3.4 Expert Interview

A single semi-structured interview was conducted with the Director of the Health Economics Department / Health Policy Unit at the Palestinian Ministry of Health. The expert was selected based on their pivotal role in national budgeting. The interview offered insight into:

- Budget formulation and resource prioritization.
- Structural inefficiencies in financial flows.
- Perspectives on sustainability and reform opportunities.

3.5 Policy Recommendations

Based on the literature review, data analysis, and expert interviews, policy recommendations were developed for budgeting health care in Palestine. These recommendations were based on the principles of equity, efficiency, and sustainability.

3.6 Significance of the Study

This study is highly significant in the context of Palestine's prolonged fiscal austerity, fragmented governance, and ongoing political instability. It provides timely, data-driven insights into how health care funds are allocated and spent, revealing critical inefficiencies and inequities in the current financing structure. These insights are

especially important given the limited domestic resources and declining donor support.

The findings align directly with the objectives of the Palestinian Ministry of Health's National Health Sector Strategic Plan (2021–2023), which emphasizes the need for financial sustainability, reduced out-of-pocket payments, and equitable access to essential services. By identifying the overdependence on curative services and the marginalization of preventive care, the study highlights areas where resource reallocation could improve system resilience and long-term efficiency.

To reinforce the policy relevance of this research, the study employs trend analysis and forecasting models to project that health expenditures may reach 12–14% of GDP by 2030, should current patterns continue. These projections are critical for informing budget negotiations, engaging international donors, and guiding reforms towards Universal Health Coverage (UHC) and the achievement of Sustainable Development Goal 3 (SDG 3).

Ultimately, this study serves as a foundational resource for policymakers, health economists, and development partners to rethink financing models in fragile settings like Palestine, where strategic use of evidence is essential for maximizing limited public health resources.

4. Findings

This section presents a detailed analysis of health expenditure trends in Palestine, focusing on the period from 2000 to 2024. By examining key indicators such as total health expenditures, financing mechanisms, and spending patterns across different health care functions, the findings highlight critical areas that require attention. The evidence confirms the challenges in achieving financial sustainability, equity, and efficiency within the Palestinian health system while identifying opportunities for strategic improvements.

4.1 Total Health Expenditures

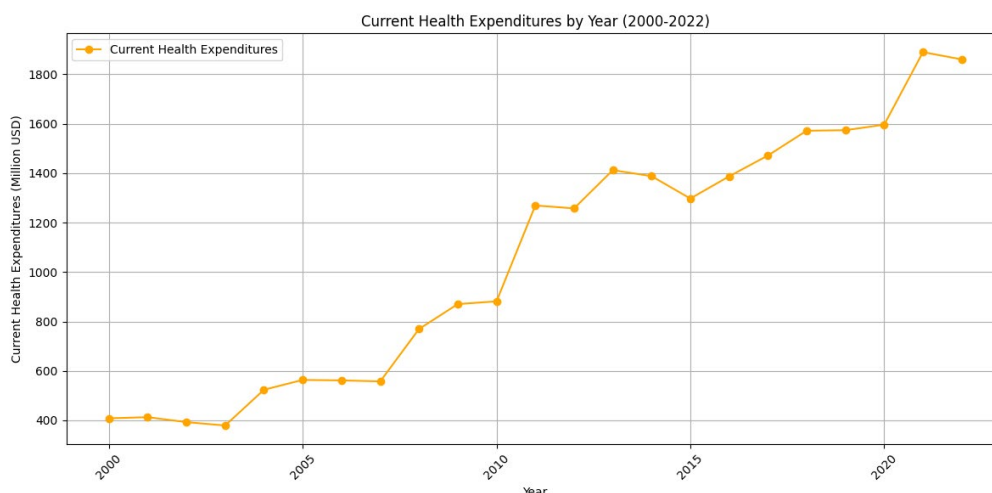


Fig. 1: Total Current Expenditure on Health in Palestine, 2000-2022

Source: (PCBS and Palestinian MOH, 2023)

The trend of total health expenditures in Palestine has been increasing steadily over the past two decades. From the year 2000 to 2022, the total health expenditures increased from 408.3 million USD to 1889.6 million USD, which is an increase of approximately 362.3%.

There have been some fluctuations in the trend, with some years experiencing a slight decrease in expenditures compared to the previous year, such as in 2002 and 2003. However, overall, the trend has been upward, with the highest increase occurring between 2008 and 2009 when there was a 12.4% increase in health expenditures. In recent years, from 2017 to 2021, the total health expenditures in Palestine have been increasing at a slower rate compared to the previous decade.

The overall trend of total health expenditures from 2000 to 2022 reflects a commendable commitment to strengthening the healthcare system in Palestine. It also emphasizes the importance of strategic planning and policy interventions to ensure sustainable and equitable improvements in the Palestinian health care system.

4.2 Health Expenditure as a Percentage of GDP

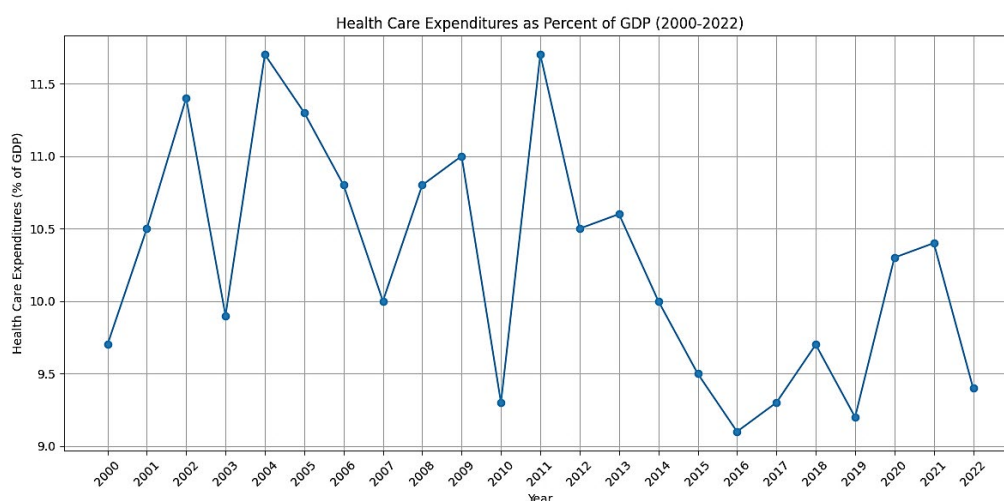


Fig.2: Health Expenditure as a Percentage of GDP

Source:(PCBS and Palestinian MOH, 2023)

The health expenditure as a percentage of GDP is a critical indicator of a country's commitment to health care and its prioritization of health as a key sector. This metric reflects the proportion of a country's economic resources allocated to health care, with higher percentages often correlating with better access to services, improved health outcomes, and stronger health systems.

Figure 2 shows the percentage of GDP spent on health care in Palestine from the year 2000 to 2022. The trend in health expenditure as a percentage of GDP in Palestine has fluctuated over the years, with some years experiencing an increase while others show a decrease. Between 2000 and 2003, the percentage of GDP spent on health care increased, reaching its peak of 11.4% in 2002. However, in the following years, there was a decrease in health expenditure as a percentage of GDP, with the lowest point occurring in 2015 at 9.5%.

From 2016 to 2019, the percentage of GDP spent on health care in Palestine remained relatively stable, ranging from 9.1% to 9.7%. In 2020, there was a significant increase in health expenditure as a percentage of GDP, reaching 10.3%, which is the highest percentage since 2011.

The percentage of current health expenditure to Gross Domestic Product (GDP) in Palestine at current prices was 9.4% in 2022 and 10.4% in 2021. Total health expenditure per capita was USD 368.8 in 2022 and USD 383.9 in 2021.

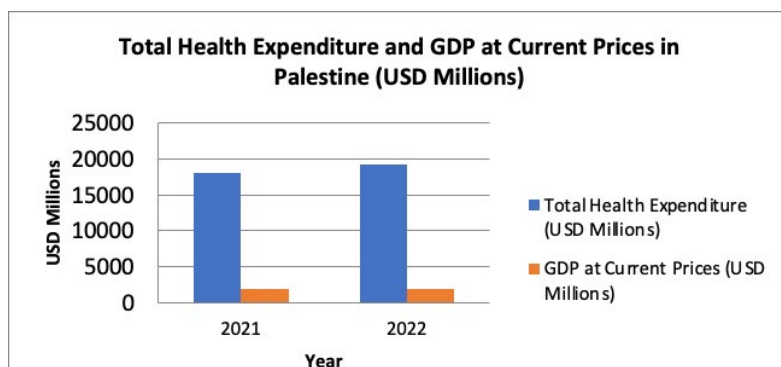


Fig. 3: The latest data for 2022 indicates a marked decline in health expenditure as a percentage of GDP

The latest data for **2022** indicates a marked decline in health expenditure as a percentage of GDP. While exact numbers are not available in the chart, the sharp drop suggests a reduction in pandemic-related spending, coupled with potential fiscal tightening. Policymakers must assess whether this decrease is sustainable or indicative of critical underfunding in essential health services.

Health Expenditure by Type of Financing Schemes

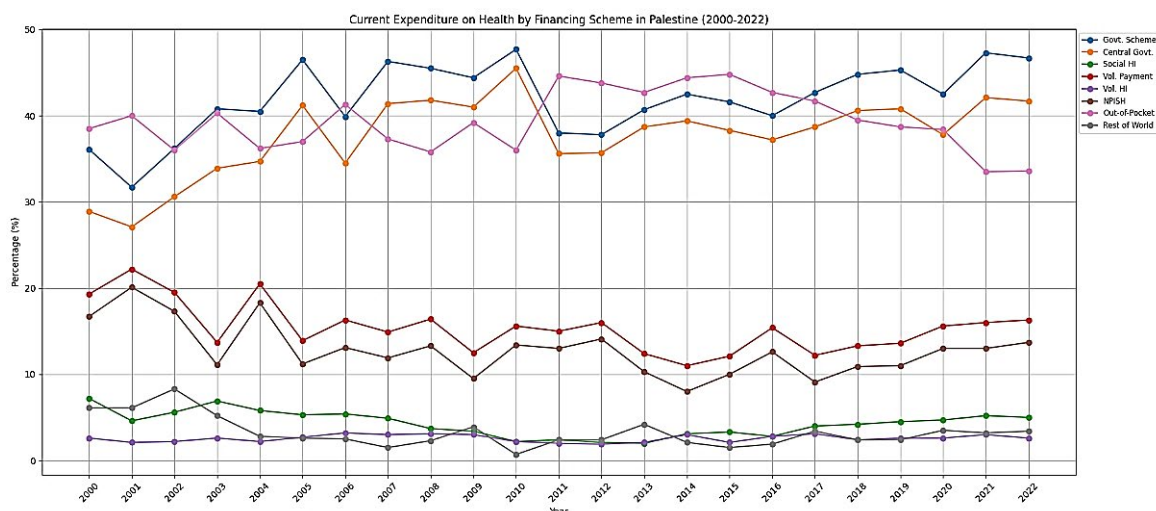


Fig. 4: Health Expenditure by Type of Financing Schemes

Source:(PCBS and Palestinian MOH, 2023)

Figure 4 illustrates that financing schemes, households, and the central government have consistently been the two largest contributors to health expenditure in Palestine. It also shows that the government scheme as a financing agent was considered the highest contribution in 2022, which reached 4 out of the total expenditure, compared to 47.3% in 2021. This is followed by household contributions, at 33.6% of health expenditure in 2022 compared to 33.5% in 2021. In addition, the percentage contribution of non-profit institutions serving households (NPISH) was 17.1% in 2022 compared to 16.2% in 2021. Insurance corporations slightly decreased by 2.6% in 2022 compared to 3% in 2021(See Figure 4).

The data analysis highlights several critical issues in the financing structure. Heavy Reliance on Out-of-Pocket Pay despite a reduction in recent years, households bear a significant financial burden, which can lead to inequities and financial hardship, particularly for low-income families.

The steady rise in government contributions reflects a positive trend towards strengthening public healthcare financing, but there remains a need to reduce reliance on out-of-pocket payments and enhance financial protections for households. NPISH, Non-profit institutions continue to play an essential role, particularly in providing services to vulnerable populations. However, their contributions are subject to fluctuations based on donor priorities and external factors. Underdeveloped Insurance Sector, the limited contributions from insurance corporations highlight the need to expand health insurance coverage to alleviate the financial burden on households.

4.3 Health Expenditure by Function of Health Care

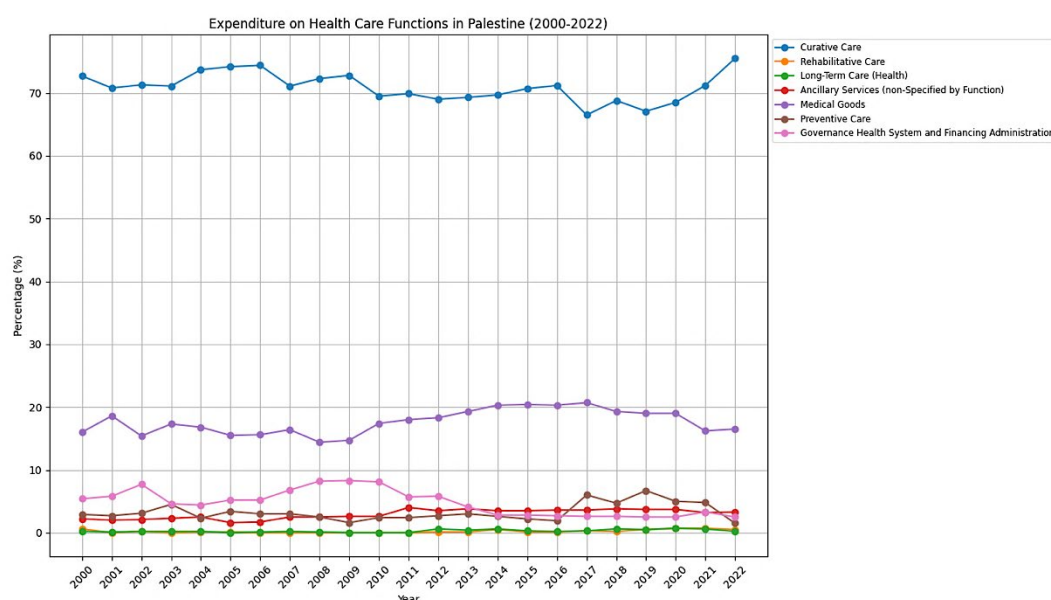


Fig. 5: Health Expenditure by Function of Health Care
Source: (PCBS and Palestinian MOH, 2023)

Figure 5 shows the percentage distribution of current expenditure on health in Palestine by health care functions from 2000 to 2022. Overall, the majority of current expenditure on health in Palestine goes towards curative care (inpatient curative care and outpatient curative care), with a percentage ranging from 66.5% in 2017 to 74.4% in 2006, accounting for 71.3% of the total health expenditures in 2021.

Medical goods, including pharmaceuticals and medical supplies, have consistently accounted for a notable share of health expenditure. Although there have been minor fluctuations—ranging from 14.4% in 2008 to 20.7% in 2017—the share stood at 16.2% in 2021. Expenditure on preventive care has shown variability, ranging from 1.6% in 2005 to 6.7% in 2019. However, a sharp decline to 4.8% in 2021 raises concerns about the long-term sustainability of investments in this critical area.

A critical analysis of resource allocation reveals that the Palestinian health system remains heavily skewed towards curative care, which consumes 75.5% of the total health budget, while preventive services are severely underfunded, receiving only 1.5%.

4.4 Health Expenditure Projections

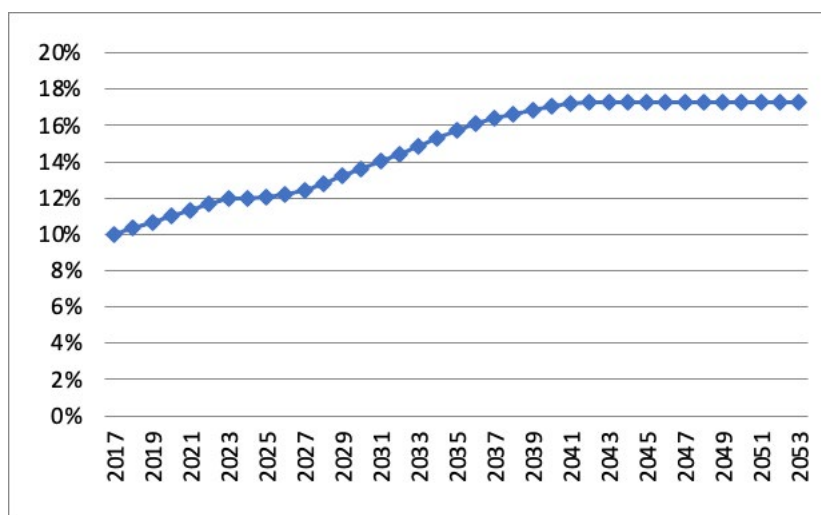


Fig. 6: Health expenditure projections in Palestine
Source: (PCBS and Palestinian MOH, 2023)

The expected rise in health expenditure as a percentage of GDP from 6% to 8% between 2025 and 2030 is also a positive sign, as it suggests that the government is planning to allocate more resources towards healthcare in the future. However, it is important to ensure that these funds are effectively utilized and directed towards priority areas such as improving access to primary care, strengthening health systems, and addressing health inequities.

5.4.1. MoH budget Vs GG budget in Palestine (2015-2024)

Table 1: The Table shows the MoH budget vs the GG budget in Palestine (2015-2024)

Year	MoH Budget \$	GG Budget \$	MoH Share (%)
2015	485 million	4,081 million	12%
2017	480 million	4,654 million	11%
2018	491 million	4,730 million	11%
2021	646 million	5,560 million	13%
2022	596 million	5,885 million	15%
2023	706 million	6,000 million	14%
2024	683 million	5,543 million	14%

Source: (PCBS and Palestinian MOH, 2024; Ministry of Finance, 2024)

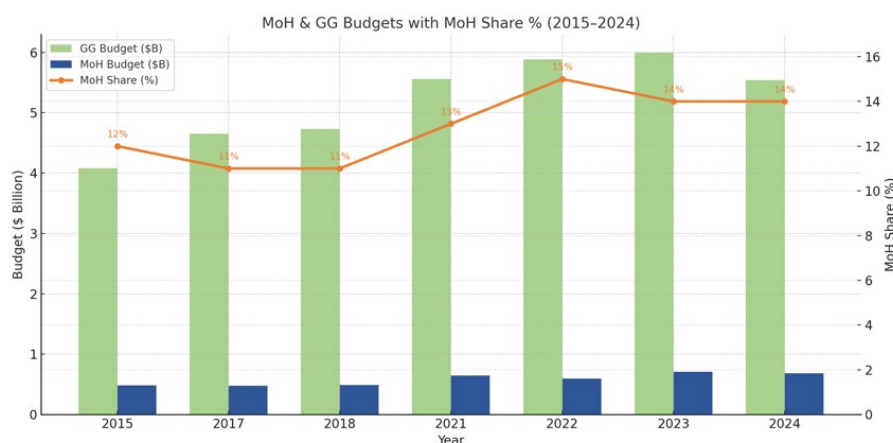


Fig. 7: MoH budget Vs GG budget in Palestine (2015-2024)

Source: (PCBS and Palestinian MOH, 2024; Ministry of Finance, 2024)

From 2015 to 2024, the Ministry of Health (MoH) budget in Palestine has demonstrated a consistent upward trend, reflecting the government's prioritization of the health sector. Starting at 1.74 billion ILS in 2015, the MoH budget steadily grew to an estimated 2.77 billion ILS in 2024, marking significant investment increases over the decade. This growth aligns with rising health care demands and the need to strengthen health care services and infrastructure. The general government budget also expanded significantly, growing from 14.28 billion ILS in 2015 to 21 billion ILS in 2023, before declining slightly to 19.4 billion ILS in 2024. Despite these fluctuations, the MoH's absolute budget continued to increase, highlighting the government's dedication to sustaining and expanding health care services. However, the relative decline in the MoH's share in the last two years indicates potential challenges in maintaining the health sector's prominence amidst competing fiscal demands.

4.5 Palestine's 2023 Health Expenditure Snapshot: Between Investment and Inequity

As indicated in Table 2, the 2023 health expenditure indicators reveal critical dynamics shaping Palestine's health care financing landscape. Total current health expenditure (CHE) reached \$1,869.9 million, accounting for 10.4% of the GDP, which is a relatively high proportion for a middle-income, aid-dependent context. Government health expenditure (GGHE) contributed 46.4% of CHE, reflecting moderate public sector engagement. However, 42.1% of health spending came directly from households via out-of-pocket (OOP) payments, which accounts for more than double the WHO's recommended maximum of 20%, pointing to deep financial vulnerability. Although per capita health spending stood at \$363, this figure remains modest when weighed against the high OOP burden. With GGHE amounting to only 4.9% of GDP, there is a pressing need for expanded public investment to reduce household costs and build a more resilient, equitable health system.

Table 2: Palestinian Health Accounts Indicators (2023)

Indicator	Value
Current Health Expenditure (CHE)	\$1869.9 million
CHE as % of GDP	10.4%
Government Health Expenditure (GGHE) as % of CHE	46.4%
Out-of-Pocket Expenditure (OOP) as % of CHE	42.1%
CHE per capita	\$363
GGHE as % of GDP	4.9%

Source: (PCBS and Palestinian MOH, 2023-24)

4.6 Financial Status of the Ministry of Health, Palestine 2023

4.6.1 Budget of the Palestinian Ministry of Health 2023

Table 3: Ministry of Health Budget in NIS by item, Palestine 2023

Category	Amount (ILS)	Percentage of Total Budget (%)
Salaries	1064872097	41.9
Operational Budget	1213401784	47.7
Capital Budget	29319599	1.2
Developmental Budget	234055339	9.2
Total	2541648819	100

Source: (Palestinian Ministry of Health, 2023)

4.6.2 Actual Expenditures of the Palestinian Ministry of Health

Table 4: Ministry of Health expenditures in NIS by item, Palestine 2023

Category	Amount (NIS)	Percentage of Total Expenditure (%)
Salaries	1,064,872,097	37.8%
Service purchases outside the Ministry of Health	1,130,396,918	40.2%
Medicines, vaccines, and medical supplies	480,555,840	17.1%
Operational, developmental, and other expenses	139,485,323	4.9%

Source: (Palestinian Ministry of Health)

Tables 3 and 4 illustrate the allocation of the Palestinian Ministry of Health's budget and actual expenditures for 2023. The planned budget shows that 41.9% was allocated for salaries, 47.7% for operational expenses, 1.2% for capital investments, and 9.2% for development. In terms of actual expenditures, 37.8% was spent on salaries, 40.2% on purchasing services from outside the Ministry of Health, 17.1% on pharmaceuticals and medical supplies, and 4.9% on various operational, developmental, and capital expenses.

4.7 BMinistry of Health Budget: Required vs. Allocated Funds (2017–2022)”

Table 5: Budget Allocations vs. Actual Needs of the MOH (2017–2022)

Year	Actual Need (NIS)	Allocated Budget (NIS)	Financing Gap (NIS)
2017	2,187,056	1,839,753	347,312
2018	2,289,696	1,892,601	388,095
2019	2,391,693	1,977,559	414,134
2020	2,652,421	2,175,336	477,106
2021	2,746,762	2,256,549	490,213
2022	2,823,780	2,331,233	492,547
Total	15,091,407	12,473,031	2,609,407

Source: (Ministry of Health, 2022)

According to the Palestinian National Health Strategy (2017-2022): “The Budgetary ceilings allocated to the MOH are in fact below the actual needs, with a funding gap in the operational and capital expenses starting from NIS 347 million in 2017 and reaching NIS 492 million in 2022 if the Ministry of Finance does not adopt financial policies to close the gap in operational and capital expenses” (Ministry of Health, 2022).

4.8 Global and Neighboring Countries' Spending on Health

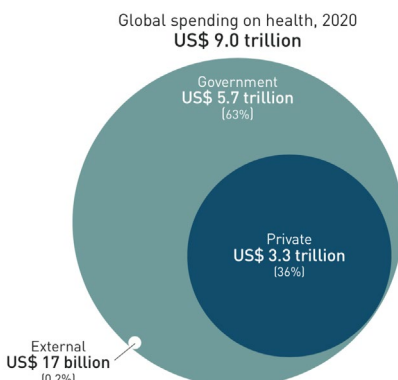


Fig. 8: Global spending on health

Source: (WHO Global Health Expenditure Database, 2022)

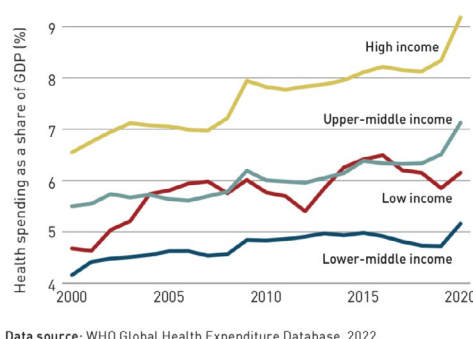


Fig. 9: Health spending as a share of gross domestic product (GDP)2000-2020

Source: (WHO Global Health Expenditure Database, 2022)

In 2020, global health spending amounted to US\$9 trillion, equivalent to 10.8% of global GDP, and exhibited significant disparities across income groups, with rising per capita and GDP shares of health spending across countries. Government spending played a vital role in driving the overall increase in health spending from 2019 to 2020, as per capita government expenditure on health rose in all income groups at a faster pace compared to previous years. Except for high-income countries, health spending as a proportion of total government expenditure, which reflects the prioritization of health, increased in all income groups from 2019 to 2020 (World Health Organization, 2022).

4.9 A Comparative Regional Analysis Grounded in Palestine's Structural Constraints

Palestine's health system presents a unique case in global health financing due to its constrained fiscal autonomy under prolonged military occupation. Despite comparable or even higher per capita health spending than neighboring countries like Jordan and Lebanon, Palestine's reliance on out-of-pocket

spending and external aid reflects a fragile and donor-dependent system. This study offers novel insights by grounding analysis in empirical data from 2000 to 2024 and contextualizing it within Palestine’s geopolitical restrictions, unlike most health financing studies, which assume sovereign control. It contributes new evidence by applying forecasting methods to a non-sovereign, conflict-affected context—addressing an underexplored area in health economics.

Table 6: Comparative Health Spending Indicators in Palestine and Selected Regional Countries (2022)

Country	Gov. Health Spending (% of CHE, 2022)	Out-of-Pocket Spending (% of CHE, 2022)	Health Spending Per Capita (US\$, 2022)	Priority to Health (% of Gov. Expenditure, 2022)	GDP Per Capita (US\$, 2022)	Key Notes
Palestine	40.3	53.8	351	13.5	3602	High OOP burden, low fiscal control under occupation
Jordan	36.5	40.2	295	7.6	4322	Strong past gov. role, declining trend
Lebanon	34.3	33.4	392	15.5	6842	Pre-crisis gov. strength, post-2019 instability
Egypt	37.9	53.8	171	7.2	3634	Very high OOP, modest gov. commitment

Source: World Health Organization (WHO) Global Health Expenditure Database, 2022. Available at: <https://apps.who.int/nha/database>

Across the region, Jordan once demonstrated strong public sector engagement in health financing, with government spending reaching 66.7% of total health expenditure in 2010 and a notably low out-of-pocket (OOP) burden of 21.9%. However, by 2022, Jordan’s profile had shifted closer to Palestine’s, reflecting reduced public commitment and increased household financial strain, though Jordan still benefits from more robust insurance systems and diversified funding mechanisms. Lebanon, before its financial crisis, exhibited stronger government engagement in health, but has since experienced significant volatility. While both Lebanon and Palestine face political instability, Palestine’s challenges are uniquely intensified by prolonged Israeli occupation, severely limiting fiscal sovereignty and budgetary flexibility. Egypt, on the other hand, consistently reports very high OOP spending (over 60%), with modest government contributions and low per capita health expenditure (\$171 in 2022). Despite some gains in budget prioritization (up to 7.2% in 2022), Egypt’s geopolitical and fiscal autonomy differs markedly from Palestine’s constrained environment. This regional data highlights Palestine’s distinct structural limitations and underscores the need for context-specific budgeting and health financing strategies.

Table 7: Per Capita CHE in Selected Middle Eastern Countries

Year	Country	CHE Per Capita
2020	Tunisia TN	US\$222
2020	Egypt 	US\$151
2020	Jordan JO	US\$299
2020	Iraq IQ	US\$202
2020	Iran IR	US\$573
2021	Palestine PS	US\$384

Source: (WHO, Global Health Expenditure Database 2022)

Table 7 presents the per capita current health expenditure (CHE) in selected Middle Eastern countries based on data from the World Health Organization's Global Health Expenditure Database 2022. The findings reveal that Palestine has a comparatively higher health expenditure per capita in comparison to the other countries mentioned, indicating the significance of studying and analyzing this indicator. In 2020, Palestine's per capita CHE stood at US \$384, positioning it above countries such as Tunisia, Egypt, Jordan, and Iraq. Notably, Palestine's healthcare spending surpassed Egypt's US \$151, Iraq's US \$202, and Tunisia's US \$222.

5. Discussion

This policy paper provides a rare and context-specific contribution by examining health financing under the compounded pressures of fiscal scarcity, geopolitical fragmentation, and prolonged Israeli occupation now in its 77th year. Unlike generalized discussions of budgeting in low- and middle-income countries, Palestine's health system operates under conditions of non-sovereignty, restricted fiscal mobility, and volatile donor dependence, which make its situation fundamentally non-comparable to others.

Internal government data reveal that the Ministry of Health's total outstanding debt more than doubled from \$339 million in 2020 to \$775 million in 2024, a 128.74% increase, highlighting a systemic inability to maintain procurement flows for essential medicines, transfers, and service contracts. Medical referrals alone account for over \$503 million in liabilities by 2024, compared to \$199 million in 2020. Pharmaceutical and consumables debt also surged from \$121 million to \$243 million, and operational debt from \$18.7 million to \$29.2 million. Unlike countries such as Jordan or Lebanon, which benefit from pooled risk mechanisms and relative state stability.

Palestinian context is defined by fragmented governance, limited fiscal sovereignty, and the structural constraints of military occupation. These realities make health budgeting in Palestine not only more precarious but strategically distinct, offering a deeply original empirical lens on how health systems can or cannot function under protracted occupation and siege.

Unlike generalized discussions of health budgeting in low and middle-income countries, this analysis integrates Palestine-specific trends derived from national longitudinal data, including 2000–2023 expenditure reports from the Ministry of Health (MOH) and the Palestinian Central Bureau of Statistics (PCBS). Notably, household out-of-pocket payments have remained the dominant financing source over the past two decades—demonstrating sustained financial pressure on Palestinian families. Central government schemes have seen only modest growth and continue to fall short in reducing this burden. Meanwhile, voluntary health payments and external aid from international actors remain volatile and insufficient, revealing the unpredictability of donor reliance.

Delays in budget disbursement from the Ministry of Finance, especially during fiscal shocks such as in 2021, led to severe medical stock-outs and delays in essential services across West Bank hospitals. This contrasts sharply with neighboring countries such as Jordan and Lebanon, where more stable financing mechanisms (e.g., pooled donor funds or insurance-based systems) have been deployed to mitigate volatility. In Palestine, however, a bifurcated governance structure, coupled with geopolitical constraints, limits such integration. The MOH's growing dependency on private and NGO-based outsourcing further reflects this structural fragmentation, yet also signals adaptive financial strategies tailored to a uniquely unstable environment.

The following sections explore key findings and their implications, focusing on the burden of out-of-pocket payments, inefficiencies in government spending, the imbalance in resource allocation, and the fragmentation of services.

5.1 The Burden of Out-of-Pocket Expenditures

Household out-of-pocket (OOP) expenditures dominate health care financing in Palestine, ranging from 33.6% in 2022 to 44.6% in 2011. This dependence places an unsustainable financial burden on families, particularly the most vulnerable populations. According to the World Bank, the least wealthy 20% of the population in the Occupied Palestinian Territories allocated 40% of their income towards paying for medical expenses, leaving them financially strained and unable to meet other essential needs (Hamidi et al., 2015). This financial strain has worsened over time. In 1998, only around 1% of surveyed households spent 40% or more of their non-food expenditures on health care, but by 2007, this figure had more than doubled, a clear indication of the growing inability of families to absorb rising health care costs amid persistent political and economic instability (Mataria et al., 2010).

Upon these findings, achieving universal coverage and protecting citizens against financial hardship are challenging issues, particularly when out-of-pocket payments exceed 30% of total health expenditures. Universal Health Coverage (UHC), which aims to provide everyone with necessary and high-quality health services without causing financial hardship, is a key principle emphasized by the World Health Report 2010. The Palestinian national health strategy aligns with this objective by

prioritizing the enhancement of the health financing system and ensuring citizens are protected from incurring excessive healthcare costs (NHS, 2017-2022). The importance of UHC is also underscored by its integration into various sustainable development goals, including poverty eradication, hunger reduction, access to quality education, gender equality, and partnership for achieving the goals (The 2030 Agenda and the Sustainable Development Goals, 2018).

High levels of out-of-pocket expenditure by households in healthcare can have several negative impacts on the health system and the population. Some of these negative impacts include:

1. **Financial burden on households:** When households have to bear a significant portion of health care costs out of their own pockets, it can lead to financial strain and hardship. This can cause families to cut back on other essential expenses or go into debt, which can have long-term implications on their financial stability and well-being.
2. **Inequitable access to health care:** High out-of-pocket costs can also create barriers to accessing health care services, particularly for low-income households. This can lead to inequities in health care access and outcomes, as those who cannot afford to pay may not receive the care they need.
3. **Delayed or foregone healthcare:** When households cannot afford healthcare services, they may delay or forego necessary medical care. This can result in health problems becoming more severe and requiring more expensive treatments in the long run.
4. **Overuse of emergency care:** In some cases, households may forgo primary or preventative care and only seek medical attention when an emergency arises. This can lead to an overuse of emergency services, which are typically more expensive and less efficient than primary care.
5. **Strained health care system:** High out-of-pocket costs can also place a burden on the health care system, as it may lead to increased demand for emergency care or other services. This can strain health care resources and impact the quality of care that is provided.

Overall, high levels of out-of-pocket expenditure by households in health care can have serious negative impacts on both the health system and the population. It is important to find ways to reduce these costs, improve access to affordable health care services for all, and build a new financial mechanism to lessen the financial load on households.

5.2 High Level of Government Spending on Health Services

Government health spending accounts for 46.7% of total health expenditure in 2022, a marked increase from previous years. However, “inefficiencies” persist in resource utilization, undermining the impact of this spending. Significant portions of the Ministry of Health’s budget are allocated to

salaries (37.8%) and outsourced services (40.2%), leaving limited resources for critical operational needs and long-term investments.

Despite receiving for approximately 59% of the Ministry of Health's budget, government hospitals in Palestine seem to lag behind private hospitals in terms of efficiency and quality. This raises concerns about the financial sustainability of these hospitals (Hamidi et al., 2015). To address this issue and empower hospitals to tackle financial challenges more effectively, it is crucial to introduce a clear division between finance and service provision. One potential approach involves transforming the existing government health insurance scheme into a separate agency with its own dedicated financial resources. This would create an environment that encourages competition among government and private health care providers while simultaneously promoting improvements in quality and efficiency.

By establishing an independent agency responsible for health insurance, the MOH can foster a more dynamic and competitive health care landscape. This would not only enhance the overall quality of health care services but also drive hospitals to become more efficient in their operations. Such a significant approach has the potential to reshape the health care system, ensuring better financial sustainability and delivering higher value to patients.

Challenges in government spending include:

- Increased debt and financial instability: If the government spends more money than it can afford, it could lead to increased debt and financial instability. This could have negative consequences on the overall economy of the country.
- Inefficient use of funds: If the government spends money on health care services that are not efficient or effective, it could lead to a waste of resources and funds.
- Inequitable distribution of resources: If the government does not ensure that health care resources are distributed equitably across the population, it could lead to disparities in access to health care services and health outcomes.
- Overreliance on Outsourcing: External providers account for a substantial share of the budget, raising concerns about cost control and quality assurance.

To improve financial sustainability and system efficiency, separating financing from service provision is crucial. Creating an independent health insurance agency could stimulate competition and quality improvement across public and private sector providers, a solution also aligned with the WHO's recommendation for strategic purchasing reforms in the Eastern Mediterranean region Health Financing (World Health Organization, Regional Office for the Eastern Mediterranean, 2019).

5.3 Imbalance in Resource Allocation: High Level of Spending on Curative and Low Spending on Preventive Care

The disproportionate focus on curative care over preventive services highlights a critical misalignment in resource allocation. Curative care accounted for 75.5% of total health expenditure in 2022, while preventive services received only 1.5%. This imbalance not only inflates health care costs but also limits the potential for long-term health improvements.

It is widely acknowledged that curative care is not as cost-effective as preventive services, which are relatively less expensive. Studies have demonstrated that investing in evidence-based clinical preventive services can effectively prevent disease and provide excellent economic value (Luce et al., 2006). As a result, it is recommended that the Palestinian MOH should make a deliberate effort to redirect resources from curative care towards preventive services.

This misalignment limits the impact of health care investments, especially considering that preventive care offers higher cost-effectiveness and long-term health returns. According to the Eastern Mediterranean Region *Health Financing Atlas*, low investment in preventive care is a regional trend that impedes the achievement of Universal Health Coverage (UHC) (World Health Organization, Regional Office for the Eastern Mediterranean, 2019).

Investing in preventive measures for a young population has the added benefit of reducing the future burden of non-communicable diseases (NCDs). The under-30 demographic (70% of the population) in Palestine presents a significant opportunity for preventive investment. By focusing on health promotion, the Palestine MOH can mitigate the morbidity associated with NCDs, resulting in a healthier population. Furthermore, health promotion interventions offer a cost-effective approach that rivals or even surpasses the effectiveness of many conventional health care methods. To make a meaningful impact, it is essential to address key issues such as tobacco use, drug abuse, alcohol consumption, unhealthy diet, physical inactivity, obesity, and stress. By targeting these factors, health promotion can enhance overall health and well-being in the OPT, offering an attractive and cost-effective solution to improve population health outcomes (State of Palestine & UNFPA, 2017).

5.4 Fragmentation of Health Care Services

The Palestinian health care system suffers from fragmentation among the MOH, NGOs, private providers, and UNRWA. This results in duplication, inefficiencies, and gaps in care continuity—problems also emphasized by Abu-Zaineh et al. (2008), who found that unequal access and disjointed financial arrangements undermine equity and responsiveness in service delivery (Abu-Zaineh et al., 2008). Key issues include:

- **Duplication of Services:** Overlapping responsibilities among providers lead to inefficient use of resources.

- **Gaps in Continuity of Care:** Patients often face difficulties navigating the fragmented system, resulting in delayed or inadequate care.
- **Coordination Challenges:** Efforts to integrate services and streamline care pathways remain limited, exacerbating disparities in access and outcomes.

5.5 Insufficient Prioritization of Health in National Budgets

Despite its critical importance, health remains a relatively low priority in national budget allocations. Between 2018 and 2024, the Ministry of Health received only 11-14% of the General Government budget, compared to 20.1% for security and 19.5% for education. This underfunding limits the health system's ability to invest in reforms, expand coverage, or improve primary care, an issue also acknowledged in regional policy frameworks urging increased fiscal prioritization for health (Mataria et al., 2021).

Without a shift in resource prioritization, the MOH may struggle to meet rising health demands, particularly in a context of socioeconomic vulnerability and demographic pressure.

The limited prioritization of health funding also hinders the implementation of key initiatives, such as improving primary care services, expanding health insurance coverage, and addressing the rising burden of NCDs. Without increased investment, the health care system risks becoming further strained and unable to meet the demands of a growing population.

5.6 Discussion Summary

The discussion highlights the critical challenges facing the Palestinian healthcare system, including financial inequities, inefficiencies in government spending, and imbalances in resource allocation. Addressing these issues requires systemic reforms, enhanced coordination among stakeholders, and a renewed focus on preventive care. These insights will inform the subsequent section, which presents actionable policy recommendations to strengthen the health care system and achieve equitable health outcomes. The following factors represent the primary obstacles that need to be addressed:

Challenge	Burden on Health System and Society
Burden of Out-of-Pocket Expenditures	Financial strain on households, reduced access to health care, and increased inequities in health outcomes
High Level of Government Spending on Health	Limited funds for operational costs, inefficiencies, and unsustainable financing for essential services
Imbalance in Resource Allocation	Overreliance on curative care; inadequate funding for preventive services, leading to higher long-term costs
Fragmentation of Health Care Services	Duplication of efforts, inefficiencies, and inequitable access to care across providers and regions

Challenge	Burden on Health System and Society
Insufficient Prioritization of Health in the Budget	Undermines health care improvements, hampers progress towards universal health coverage (UHC)
High Burden of Non-Communicable Diseases (NCDs)	Increased morbidity and mortality; strain on health care resources due to costly treatment requirements
Underfunded Primary Care	Overcrowding in secondary care facilities, increased costs, and inefficiencies in service delivery

6. Policy Implications and Programming Recommendations

The findings and challenges explored in this policy paper need to be addressed urgently for a strategic shift in Palestine's health financing and resource allocation strategies. To enhance the efficiency, equity, and sustainability of health care services, the following actionable recommendations are proposed:

- Introducing the Adaptive Resilience Budgeting for Occupied Territories (ARB-OT Model)- This study proposes a new, context-specific innovation—the Adaptive Resilience Budgeting for Occupied Territories (ARB-OT) Model—to enhance the financial sustainability and efficiency of the Palestinian health care system. Grounded in local data, international benchmarks, and projected expenditure trends, the Autoregressive Integrated Moving Average (ARIMA) model addresses the unique challenges Palestine faces due to ongoing occupation, political instability, and economic fragmentation.

Palestine is not just a low-resource setting; it is a territory under prolonged occupation, facing chronic fiscal restrictions, dependency on donors, and limited control over borders and trade. Traditional budgeting models are not designed for such environments. ARB-OT is therefore proposed as a resilience-based model that accounts for:

1. Interrupted funding flows.
2. Sudden humanitarian shocks.
3. Structural political and fiscal constraints.
4. High out-of-pocket spending burdens.

This model adapts international best practices (from countries like Cuba and the USA) but tailors them to the realities of health system fragility under occupation.

7.1. Core Pillars of the ARB-OT Model and Recommendations:

1. Increase Government Health Financing

- The Ministry of Finance should raise health allocations in the general budget.
- Domestic resources can be improved through better tax collection and reducing waste.

2. Improve Cost-Efficiency

- Evaluate when to outsource vs. strengthen internal service delivery.
- Invest in skilled health workers to reduce costly external contracts.
- Use cost-effectiveness analysis tools from ARB-OT to guide spending decisions.

3. Restructure Health Insurance

- Establish a semi-independent national health insurance fund.
- Separate financial management from service delivery for greater transparency.
- This supports national reforms aiming to rationalize expenditures.

4. Shift to Preventive Health

- Reallocate part of the budget from hospitals to primary care and prevention.
- Learn from Cuba's success in community-based prevention with limited resources.
- Focus on non-communicable disease prevention through health education.

5. Reduce Hospital Cost Burdens

- Transition from global budgets to more efficient models (e.g., DRG or capitation).
- Promote outpatient and home-based care over expensive inpatient stays.

6. Cut Out-of-Pocket (OOP) Payments

- OOP should be reduced below 20% to reach Universal Health Coverage (UHC).
- Measures include:
 - More public health funding through fair taxation.
 - Subsidized insurance for vulnerable groups.
 - Negotiating lower drug prices.
 - Reducing waste through digital health systems.

7. Fix Drug Supply and Pricing

- Strengthen local pharmaceutical production.
- Implement pooled procurement with neighboring countries.
- Improve storage, distribution, and cost-monitoring systems.

8. Learning from Global Best Practices

Drawing insights from countries like Cuba, a deep analysis reveals significant findings regarding the total health expenditure. There is a remarkable difference between the two states; at the same time, the

total health indicators show us that high budgeting is not the main determinant. Cuba and the United States have different healthcare systems, and their approaches to health promotion and curative care reflect these differences

8.1. Cuba and the United States' health care systems' approaches, lessons could be learned

Statistics	Details/Units	United States	Cuba
Population	(000s)	314,659	11,204
Total expenditure on Health	(per capita) ⁽¹⁾	\$7,410.00	\$503.00
Life Expectancy at Birth (yrs)	Male/Female/Both	76/81/79	76/80/78
Neonatal Mortality Rate	(per 1000 live births)	4	3
Under-Five Mortality Rate	(Probability of dying by age 5 per 1000 live births)	8	9
Measles immunization coverage among 1-year-olds	(%)	92	96
Maternal Mortality Rate	(per 100,000 live births)	24	53
Births attended by skilled personnel	(%)	>99	>99
Prevalence of HIV	(%)among adults aged 15-49 years	0.6	0.1
Antiretroviral Therapy coverage among people with advanced HIV infection	(%)	—	>95

*Statistical information provided by the World Health Statistics 2011 Report by the World Health Organization.

Table 8: CUBA versus the United States of America health care indicators

Palestinian Ministry of Health in Palestine can take learning lessons from both the U.S. and Cuban health care systems, despite their different controversial approaches and different socio-political, economic, and cultural aspects. The Ministry of Health in Palestine can learn from Cuba's strong emphasis on preventive care and community-based health promotion. Implementing community outreach programs, health education initiatives, and proactive preventive measures can help address health issues at an early stage and reduce the burden of curative care. The Ministry of Health in Palestine can rely on innovations, research, and cost-effective practices.

9. Increasing the Efficiency and Effectiveness of Financial Resources Management

To operationalize these recommendations, the Ministry of Health, in collaboration with key stakeholders, can adopt the following programmatic measures. These recommendations are outlined in the health sector strategic plan for the southern Palestinian governorates (2021-2025).

Table 9: The Increasing Efficiency and Effectiveness of Financial Resources Management

Objective	Programs
Objective 1: Strengthening the sources of health financing	1. Increasing the contribution of the Ministry of Finance for health expenditures 2. Controlling and developing health revenue systems 3. Strengthening and developing mechanisms for communication with donors and project marketing (fundraising) 4. Restructuring the health insurance system, aiming at the rationalization of expenditures on health services 5. Enhancing the skills of the personnel working in the field of health financing

Objective	Programs
Objective 2: Rationalization of expenditures on health	1. Updating the lists of the Ministry of Health essential needs (drugs, medical consumables, laboratory materials, medical equipment, etc.) 2. Setting up standard costs for health services 3. Controlling and rationalizing operational expenses
Objective 3: Developing financial control systems	1. Developing and strengthening financial control systems in the health sector 2. Developing procedures manuals for the financial control systems 3. Institutionalizing the system of financial control workflow in the health sector 4. Activating the role of control over expenditures
Objective 4: Ensuring provision of drugs and medical disposables	1. Increasing the proportion of financial resources allocated for the provision of drugs and medical disposables 2. Enhancing coordination between health service providers 3. Improving administrative procedures and storage conditions for drugs and medical disposables 4. Promoting the pharmaceutical industries for drug supply
Objective 5: Enhancing the performance of health economy indicators	1. Building national health economy indicators 2. Developing standard criteria for the MOH facilities' estimated budget 3. Building national standards for economic efficiency based on equitable distribution of health services

References

- Abu-Zaineh, M., Mataria, A., Luchini, S., & Moatti, J. P. (2008). Equity in health care financing in Palestine: The value-added of the disaggregate approach. *Social Science & Medicine*, 66(11), 2308–2320. <https://doi.org/10.1016/J.SOCSCIMED.2008.01.028>
- Dheepa Rajan, Helene Barroy, & Karin Stenberg. (2017). *Chapter 8: Budgeting for health Modelling pathways and estimating resource needs for countries to make progress towards the Sustainable Development Goals View Project Strategizing national health in the 21st century: A handbook View project Dheepa Rajan World Health Organization WHO*. <https://www.researchgate.net/publication/318961618>
- Hamidi, S., Naci, H. Ö., Akinci, F., & Nacakgedigi, O. (2015). Examining health care spending trends over a decade: The Palestinian Case. *Eastern Mediterranean Health Journal*, 21(12). <https://www.emro.who.int/emhj-volume-21-2015/volume-21-issue-12/examining-health-care-spending-trends-over-a-decade-the-palestinian-case.html>
- Luce, B. R., Mauskopf, J., Sloan, F. A., Ostermann, J., & Paramore, L. C. (2006). The return on investment in health care: From 1980 to 2000. *Value in Health*, 9(3), 146–156. <https://doi.org/10.1111/j.1524-4733.2006.00095.x>
- Mataria, A., El-Saharty, S., Hamza, M. M., & Hassan, H. K. (2021). Transforming Health Financing Systems in the Arab World Toward Universal Health Coverage. In *Handbook of Healthcare in the Arab World* (pp. 1–50). Springer International Publishing. https://doi.org/10.1007/978-3-319-74365-3_155-1
- Mataria, A., Raad, F., Abu-Zaineh, M., & Donaldson, C. (2010). *Catastrophic Healthcare Payments and Impoverishment in the Occupied Palestinian Territory*. <https://doi.org/10.2165/11318200-000000000-00000>. PMID:21043541.
- Ministry of Finance. (n.d.). *Citizens budget in Palestine*. Retrieved in 2024 from <https://citizenbudget.ps/ar>
- Ministry of Health. (2017). *National health strategy 2017–2022*. State of Palestine. Retrieved from: https://site.moh.ps/Content/Books/OhV2yDbK3NBuMaBgZxRM13Tgf5Ek46VMsINeNQ9CvdRJ68xSIueheN_CUmin4TqPtVNgd7v3aBpOzbD57AZWl5OPlGu6RsGzmnu3mNE745Rr5.pdf
- Palestinian Central Bureau of Statistics (PCBS). (2024). *Palestinian Health Accounts, 2024*. <http://www.pcbs.gov.ps>
- Palestinian Ministry of Health. (2024, June). *Health Annual Report, Palestine 2023*. Palestinian Health Information Center. Retrieved from <https://www.moh.ps>
- Saksena, P., Hsu, J., & Evans, D. B. (2014). Financial Risk Protection and Universal Health Coverage: Evidence and Measurement Challenges. *PLoS Medicine*, 11(9). <https://doi.org/10.1371/journal.pmed.1001701>
- State of Palestine, & United Nations Population Fund (UNFPA). (2017). *Palestine 2030: Demographic change – Opportunities for development*. <https://palestine.unfpa.org/sites/default/files/pub-pdf/Palestine%202030%20Full%20Report%20English.pdf>
- World Health Organization. (2022). *Global spending on health: Rising to the pandemic's challenges*. World Health Organization. <https://apps.who.int/iris/handle/10665/365582>
- World Health Organization. Regional Office for the Eastern Mediterranean. (2019). *Strengthening health financing systems in the Eastern Mediterranean Region towards universal health coverage* (R. O. for the E. M. World Health Organization, Ed.). World Health Organization, Regional Office for the Eastern Mediterranean. <https://iris.who.int/handle/10665/311328>