Inequitable delivery of Health Care in Palestine

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Presentation at ISEqH, Adelaide, September 2006

Evidence Based Planning

- Substantial reports produced each year
- Little evidence that the information is taken into account in planning, EXAMPLES:
  - Appropriate allocation of budgets to areas
  - Extent of private health care expenditure
  - Use of government health care facilities for especially chronic conditions
  - Costs of treatment abroad
  - Variations in costs between hospitals for same condition
  - Extent of treatment abroad for routine conditions and implications for bed

Evidence and Resource Allocation

- There is potentially unlimited demand, the issue is how to distribute resources appropriately according to need
- Currently, resources are distributed to hospitals according to historical and often hysterical expenditures patterns
- To respond to need, we have to know the pattern of need to which the health service can respond
- Often very difficult to know patterns of need, so we have to rely on whatever data is available.

Allocation of Budgets

- Distribution of human and physical inputs in Annual Reports; although only beds are broken down to governorate level
- Varies from 0.54 per 1000 in Jenin to 3.71 per 1000 in Bethlehem (see column 'm' in Table); similarly for MoH beds.
- Ratio of all beds to population has increased in Jenin by 34.5% since 1998, by 108.9% in Bethlehem; if restricted to government beds, excluding psychiatric beds, increases have been 31.4% and 32.9% respectively.
- So inequities not being redressed

Possible Equitable Allocation

- Assuming that distribution of beds should be inversely related to per capita total cash income, possible more equitable distribution given in column 'n' of Table
- Large discrepancies between actual and estimated no. of beds; correlation 0.102
- Correlation between percent increase in bed ratio and income is -0.323; in right direction but small

Evidence on Level of Private Health Care Expenditure

- Estimate of mean household monthly expenditure in 2004 HHES was US$453 millions (11.3% GDP)
- Estimate from 2004 PCES was:
  - US$265millions (6.6% GDP) direct estimate;
  - US$216millions (5.4% GDP) indirect estimate consistent with national accounts
- Both nearly double MH expenditure

Distribution of Private Health Care Expenditure Relative to Income

- From HHES
  - Use of each service increases with income
  - Use of acute and is more or less flat
  - Use of chronic higher among poorer
  - Use of injury increases
  - Use of dental services increases sharply
- Dividing expenditure distribution into quintiles (see Table), estimate that about one eighth of household income spent on health care and highly regressive

Evidence on How Services are Used

Of the 2719 health problems reported in the Access Survey (PCBS December 2003),

- 1617 (or nearly 60%) were physical health problems,
- 517 (or 19%) were chronic diseases,
- around 5% each report
  - routine check up
  - emergency or
  - more than one problem.

Which Conditions to Which Health Services

- Of those reporting a chronic health condition 31% went to a government facility, 27% went to a physician, and 21% to a private facility (see Table).
- Of those reporting a physical health problem 33% went to a Government Facility, 31% went to a physician and 16% to a private facility.
- Of the 142 urgent cases, 42% went to a government facility, 34% to a physician and 17% to a private facility.

Satisfaction with Service

- Overall 63% are totally satisfied, 31% partially satisfied and 5% dissatisfied.
- Lower levels of satisfaction with the government facilities lower (46% with hospitals and 40% with health centres)
- Higher levels with the overall service provided by physicians (78%) or by private facilities (85%). Rationalisation with expenditure?
- Findings repeated for each dimension: 'treatment by staff', 'cleanliness', 'order in the service facility', 'availability of equipment', 'availability of medicines', 'experience and skills of staff'

Needing and Receiving a Consultation and its Quality

1355 who reported a Medical Consultation; less than one fifth use government facilities, (see Table):

62% thought overall that they had a good consultation, but assessment varied by provider.

from below 50% in government for UNRWA facilities to 84% with private facilities and 79% of those by phone.

Implications

- Population have recourse to the private sector for all kinds of services and specifically for chronic conditions
- *Any patient index has to be developed collaboratively with the other service providers; and*
- *lack of coverage of chronic conditions by the public sector is especially worrying.*
- Wide differences in reported quality between government and non-government services.
- *Proposed training in quality improvement could benefit from working with the other providers to see what it is that they do that is more appreciated by the public.*

Evidence on Treatment Abroad

- In 2004, 31,744 patients involved (23,581 inpatients and 8,163 outpatients).
- Total cost was NIS 261 million, i.e. nearly USD60 million, about 50% MoH budget
- Assuming average LOS 5 days for in patients and 1 day for out-patients, equivalent to c. 125,000 bed days
- With 85% occupancy rate, equivalent o 400 beds

Who Gets Referred

- Large amounts spent on 'treatment abroad' varies widely by governorate
- Correlations between numbers and cost of being treated abroad per 1000 population and the per capita total cash expenditure are -0.013 and +0.066 respectively.
- If treatment abroad were reserved for needy cases, the correlations would have been strongly negative.
- Issue raised in 2003 Annual Report but apparently no action taken

An Odd Age-Sex Cost Curve

- Breakdown by age and sex could be basis of an age cost curve;
- Doesn't behave like typical age-se cost curve which has a blip at birth then stays pretty low until mid-late fifties when it rises at an increasing rate until death.
- Suggests that older people are being discriminated against for treatment abroad

Where are people Referred

- Nearly 30% referred to private hospitals within Northern Governorates (=WB)
- About 20% each to Egypt and Jerusalem and 13% to Jordan
- Around 8% each to Israel and Southern Governorates (=Gaza)
- Clear discrimination in which type of cases go where

Conclusions

Recognising overall concrete constraints

- Geographical variation in provision
- High levels of private expenditure
- Publicly provided services are seen as of relatively poor quality
- No continuity in treatment of chronic health problems
- 'Treatment abroad' not for most needy
- Doing themselves no favours …